Official Language Minority Communities in Ontario: Understanding the Lived Experiences of Francophone Patients and their Nursing Care Providers

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Thesis submitted to the University of Ottawa

in partial fulfillment of the requirements for the

Doctorate in Philosophy degree in Nursing

School of Nursing

Faculty of Health Sciences

University of Ottawa

DEDICATION

To M6:

Je vous aime. Je vous adore.

I lacked nothing. I was always pushed to strive for the best.

I was comforted with warm hugs and encouragement.

Thank you for your love.

ABSTRACT

Although Canada is a bilingual country, official language minority community patients struggle to access quality care in their language. This reality has been of concern for Francophone minority communities in Ontario, but has seldom been examined in a nursing context. This research sought to examine the lived experiences of registered nurses and nursing students providing care to French-speaking patients in Ontario, as well as the realities of Francophone patients seeking French language health care services in Ontario.

The conceptual frameworks guiding the study were the "Four Levels of Change for Improving Quality" model and the "Four-Level Model of the Health Care System." Using qualitative phenomenological inquiry, as influenced by Martin Heidegger and Max van Manen, 31 semi-structured interviews were conducted with three subsets (n=10 Francophone patients; n=10 nursing students; n=11 registered nurses) throughout Ontario who had experience with the phenomenon being investigated. Data collection took place over a year (2018-2019) and was analysed thematically.

Significant findings were identified across the three groups. Participants revealed the patchwork of individual actions taking place to remedy the existing gaps regarding care for Francophone minority populations. This included navigating a health care system where good enough care was the unfortunate standard for Francophone patients, and discussing how Francophone patients and nursing care providers implement strategies individually to manage the lack of resources for Francophone patient populations in Ontario.

This thesis asserts that official language minority communities and their nursing care providers remain faced with difficulties providing and receiving care in Ontario. While numerous structures and resources exist to remediate the problems, these interventions and resources are not always implemented systemically, leading to a disproportionate burden on individuals, significant risks for safety for patient populations, and ethical dilemmas for nursing care providers. Recommendations are provided to bridge the gaps and ensure considerations of the needs of linguistic minorities throughout the health care system.

Keywords: Francophonie, Linguistic Minorities, Nursing, Phenomenology, Qualitative Research

ACKNOWLEDGEMENTS

I would like to acknowledge everyone who played a role in my academic accomplishments. I am grateful to God for the privilege, pleasure, and honour of experiencing this enriching journey. It takes a village to complete a PhD, and thus, this is not an exhaustive list of individuals who deserve recognition. Please accept this page as a special thank you for those who have provided me with advice, guidance, energy, motivation, and unwavering support.

- **To my thesis supervisors**, Julie Chartrand and Amélie Perron: Instead of doctoral supervisors, I was provided with fairy godmothers, big sisters, incredible examples, and inspiring role models. I am in awe of how you have stretched my thinking, my understanding, and my ways of knowing, as a nurse, researcher, professor, professional, and human. You provided me with wisdom and guidance even and especially when I felt like I was in over my head. I learned so much from you both. Thank you for everything.
- **To my thesis committee members**, Dave Holmes, Bernard Pinet, and Chantal Backman: Thank you for your time and dedication. Thank you for sharing your insights and advice. Thank you for contributing to making this thesis the work that it is. I am grateful for your guidance throughout this endeavour.
- **To my family, friends, and writing groups**: I appreciate you carrying me in, carrying me through, and most thankfully, carrying me out of this doctoral journey. I could not have survived this without you and am indebted to you all. Words cannot describe how dearly I cherish you.
- **To my participants**: Sharing oneself so deeply and vulnerably, you provided me with the most wonderful gift. Thank you for letting me learn from your experiences and allowing me to share your stories. I hope that this work will honour each and every one of you.

ACKNOWLEDGEMENT OF FUNDING SOURCES

My doctoral research was made possible through the financial support of the following funding sources. Thank you for your generosity.

- Laura J. (Elliott) Wiley Nursing Scholarship
- Teena Hendelman Graduate Scholarship in Nursing
- University of Ottawa Excellence Scholarship

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BScN: Bachelor of Science in Nursing

CNO: College of Nurses of Ontario

FLSA: French Language Services Act

GReFoPS: Groupe de recherche sur la formation et les pratiques en santé et service social en contexte Francophone minoritaire

HCP: Health Care Providers

NCLEX-RN: National Council Licensure Examination for Registered Nurses

NS: Nursing Student

OLMCs: Official language minority communities

PT: Patient

RN: Registered Nurse

RNAO: Registered Nurses' Association of Ontario

Chapter 1: Introduction

Canada is a bilingual nation, with its official languages being English and French, as established by the Official Languages Act of 1985 (Government of Canada, 1985b). French is identified as the mother tongue for 7,914,498 (22.8%) Canadians, with 550,595 (4.1%) individuals listing French as their first official language spoken in Ontario (Government of Canada, 2019a). Official language minority communities (OLMCs) include French-speaking minorities outside of Quebec and Quebec's Anglophone communities.

Outside of Quebec, French-speaking individuals are the largest official language minority group in Canada (Statistics Canada, 2011, 2017b). Such groups are frequently referred to as Francophone minority communities. According to the Office of the Commissioner of Official Languages of Canada (2020b), the largest French-speaking minority community in Canada is located in Ontario. Currently, 42.7% of Francophones in Ontario live in the Ottawa region, followed by 20.7% residing in Northeastern Ontario, and 19% in the Toronto area. Furthermore, 58% of Francophones in Ontario are born in Ontario, with 25% born elsewhere in Canada, and 17% born outside of Canada.

Francophone minority communities are part of Canadian heritage, and much effort by the federal government has been invested to see these communities thrive. National lobbying has been done to promote the advancement of both official languages and to support the development and vitality of official language minority communities (Government of Canada, 2020a). Canadian federal services must be provided in both English and French to ensure that individuals can interact in the official language of their choice. The Official Languages Act also led to the implementation of a number of features such as encouraging community consultations with the Canadian Francophonie and supporting access to schools in the French language for families within

Francophone minority communities, reinforcing Canada's bilingual character (Government of Canada, 2019b).

However, French-speaking minority groups have experienced numerous challenges and disadvantages with receiving comprehensive, accessible, and timely access to quality health care (L. Bouchard, 2013; P. Bouchard et al., 2009; Bowen, 2001; de Moissac & Bowen, 2017; Drolet et al., 2014; Forgues et al., 2011; A. P. Gauthier et al., 2015; H. Gauthier & Reid Triantafyllos, 2012; Hien & Lafontant, 2013; Lortie & Lalonde, 2012). According to the World Health Organization, quality of care can be defined as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes" (World Health Organization, n.d.). Social and cultural determinants of health consider an individual's language, noting that the inability to access health care in one's own language is a major health concern (P. Bouchard et al., 2010; Bowen, 2001, 2015). When patients are not receiving the health care services that they ultimately need, the entire health care system should be concerned.

As the life expectancy of Canadians continues to rise, the population is living longer but may have more complex health care needs (Canadian Institute for Health Information, 2011, 2017; Canadian Medical Association, 2016; Canadian Nurses Association, 2007; Cline, 2015). With the advent of technology, change is ongoing, and health care providers must keep up with greater complexities system wide, as well as heightened care provision responsibilities (Cline, 2015). However, with the demographics of nursing as an aging workforce itself, nursing shortages remain a concern; the necessity for nurses in all capacities continues to climb as do the needs of the aging Canadian population (Canadian Institute for Health Information, 2020; Chartrand et al., 2019; Kwok et al., 2016).

With these forces at play, targeted efforts in health care planning are required to avoid

causing harm to patients at a time where they may need nursing care the most. It is important to understand the lived experience of patients and their health care providers given the evolving health care system. With the dynamic changes in the aging nursing workforce, it is also important to understand the perspective of nursing students providing clinical services, as they are the future of the nursing profession (Institute of Medicine, 2011; Saber et al., 2016). Furthermore, the patient remains the focus of the care experience. Thus, it is important to understand the perspective of the patient when considering the experiences of actors in the health care system.

Significance of the Study

The problems affecting the ability of French-speaking linguistic minorities to access linguistically congruent health care in Ontario are significant and relevant to nursing practice because nurses must advocate for the health of all patient populations. Currently, 490,715 Ontarians claim French as their mother tongue, with 277,045 identifying French as the language most often spoken at home (Statistics Canada, 2017b). With 40,040 Ontarians stating that French is the only official language they know (Statistics Canada, 2017b), nurses must be prepared to care for and communicate with these populations safely.

Canada continues to increase its population by receiving immigrants and refugees, some belonging to OLMCs (Canada Immigration News, 2016; Government of Canada, 2016). To that effect, Immigration, Refugees and Citizenship Canada has planned “to have Francophone newcomers make up at least 4% of all economic immigrants settling outside Quebec by 2018, with an additional target of 4.4% by 2023” (Canada Immigration News, 2016). Outside of Quebec, 61% of French-speaking individuals who immigrated to Canada settled in Ontario, thus contributing to an increase in the provincial Francophone minority communities (Government of Canada, 2017b). With such a demographic landscape, equity of accessible health care services remains essential for

all patient populations, and the barriers challenging the provision of health care services need to be examined and understood. Comprehension of the impact of communication and linguistic barriers is important in consideration of the potential impact on quality of care, ethical care provision, health care outcomes, informed decision-making, and patient satisfaction (Bowen, 2001, 2015).

Regardless of patients' linguistic or cultural background, nurses must be prepared and supported to provide the quality care that these patients require (Canadian Nurses Association, 2017). There is a need for linguistically congruent health care to be made available in both official Canadian languages. With the diversity of health care providers available to meet patient needs, multiple nursing perspectives may exist to depict the state of health care provision to official language minority communities. Nursing care providers can be Anglophone, Francophone, or bilingual, living in urban, rural, or remote regions of the province (College of Nurses of Ontario, 2017b). Some live in French designated regions, while others may be more isolated. These providers may have had a wealth of positive or negative experiences informing the way they provide care to patients.

Understanding the perspectives of these providers is necessary to best equip them to care for Francophone patients, regardless of if they are novices or proficient in the French language. In 2020, 117,053 registered nurses (including nurse practitioners) were entitled to practise in Ontario (College of Nurses of Ontario, 2021c). In Ontario post-secondary institutions, 5,674 students were enrolled in a Bachelor of Science in Nursing (BScN) program during the 2017-2018 school year, with 4,676 students successfully graduating in 2018 (Canadian Association of Schools of Nursing, 2019). In 2020, 5,963 applicants (including those from Ontario, other Canadian provinces, and international candidates) wrote the National Council Licensure Examination for Registered Nurses

(NCLEX-RN) at least once to gain permission to practise nursing in Ontario (College of Nurses of Ontario, 2021a). In 2015, 4,785 (4.8%) of the 99,275 nurses in Ontario claimed French as their first official language, 6.9% of nurses used French at work on a regular basis, and nearly 12% of nurses declared that they could converse in French (Statistics Canada, 2015b, 2015a). Unfortunately, language-based data reflecting the language capacity for nurses is not released with every census, so the full capacity for nursing care provision in Ontario in recent years remains unclear.

When considering the vast sociodemographic differences of the population throughout Ontario (e.g., urban or rural, etc.), the lived experience of Francophone patients cannot be assumed to be homogenous (Government of Ontario, 2016). Despite these differences, across official language minority communities, speaking the minority language can be an influential factor in a person's health and wellness. In the words of Clark (1983), "without language, the work of a physician and veterinarian would be nearly identical" (p. 807). The same can be said about the role of most health care professionals. Language is so significant with regard to health care that it has been coined as a social determinant of health by Bouchard and Desmeules (2013) and echoed in other publications, both in Canada (Drolet, Bouchard, & Savard, 2017) and internationally (Showstack et al., 2019; U.S. Department of Health and Human Services, n.d.). Bouchard and Desmeules (2013) attest that individuals who belong to the official language minority community may also be faced with numerous disadvantages and inequities when considering social determinants of health (L. Bouchard & Desmeules, 2013). These further take place with unfair distributions of resources such as education, money, and power, which can bolster inequities in health (L. Bouchard & Desmeules, 2013). A better understanding of the needs of official language minority community groups such as French-speaking patients in Ontario is required to ensure that

language discordance does not compromise their access to quality health care services.

Research Purpose

The aim of the study was to examine the lived experiences of registered nurses and nursing students providing care to French-speaking patient populations in Ontario, and to understand the perspectives and lived experiences of Francophone linguistic minority patients who have received health care in Ontario.

Research Questions

The phenomenological research questions asked were "What are the lived experiences of registered nurses and nursing students providing care to French-speaking patients in Ontario?" and "What are the lived experiences of French-speaking patients seeking French language health care in Ontario?" The underlying research questions were the following:

1) What challenges or barriers do nursing students and registered nurses encounter in the provision of high quality and safe care to French-speaking patients in Ontario?
2) What supports, strategies, or opportunities exist for providing high quality and safe nursing care to French-speaking patients in Ontario?
3) What are some concerns for quality of care and patient safety with regard to the provision and reception of care for French-speaking minority communities in Ontario?

Over the course of this research, the plan was to acquire an in-depth understanding of the realities of caring for linguistic minorities from the perspective of both patients and nursing care providers, by means of identifying the emerging themes and allowing for interpretation of the insights shared by participants. This research sought to provide a holistic representation of realities of care to official language minority communities in Ontario by examining the lived

experiences of nursing providers and Francophone patients within the health care system. This research will be of great interest to the nursing profession, from clinical practice to nursing management, and nursing education to nursing research, as it addresses the existing reality of access to quality nursing care, and informs which practices are helping and hindering nursing professionals and the Francophone populations within their care.

Philosophical Stance

A particular interest for researching this problem arose with the researcher's own lived experiences, both as a Francophone registered nurse practising in Ontario, as well as a clinical education leader, supporting the training of nursing students, while building capacity for clinical educators and BScN program faculty. Being bilingual, she saw what challenges could exist for French-speaking nurses in the workplace, especially within a linguistic minority context. She saw both the distress of Francophone patients, as well as their relief when they realized that they could express themselves in their language with a provider who could understand their ailments. She also saw the challenges with training nursing students to thrive in Anglophone environments, realizing that unique considerations would be required to see them succeed within clinical settings as Francophone learners.

As such, the researcher's beliefs about nature come from a subscription to relativist ontology (Guba, 1990; Guba & Lincoln, 1994). This is grounded in the researcher's belief that the way one sees the world is informed by one's unique worldview and lived experiences, and that context defines one's understanding of nature. Reality must be context bound. The same experience may be perceived differently in the eye of another beholder. Without an understanding of what is affected by our lived experiences and our privilege, it is difficult to comprehend and address the questions of the world. Individuals come with their perspectives and biases. Although

these are important to reflect upon, these biases may not be completely eliminated. Rather, they are components that inform one's reality and shape an individual's humanity.

Relativism allows for greater representation of differing realities, whereby there is tolerance, understanding, and space for accepting and respecting diverse truths. Thus, a subjectivist epistemology informed the relationship between this researcher and the participants of this study. With a subjectivist epistemology, this researcher's values shaped not only the questions for inquiry, but they also informed her perspective on the results obtained (Guba, 1990; Guba & Lincoln, 1994). In acknowledging that her values and beliefs inform what she desires to research, her understanding of research, and how she analyzes information, the researcher positions herself as an instrument for the research, capable of valuing the unique insights provided by subjects throughout the inquiry. She can appreciate the transactional nature of her interactions with the participants, and thus, further appreciate their role in the creation of the study findings. The participant is not the only source that informs the study results; the researcher is also deeply immersed in the iterative process of interpreting and creating the findings (Guba & Lincoln, 1994). Such an approach, using qualitative research methods, supports the transactional exchange of knowledge (Denzin & Lincoln, 2005), wherein the voice of the participant is brought forward through the research process. In upcoming chapters, hermeneutics and interpretive phenomenology as a methodology is discussed.

Outline

This qualitative research study sought to focus on the perspectives and lived experiences of participants, gaining greater understanding of the phenomenon of health care for Francophone minority communities in Ontario. By researching the lived experiences of registered nurses and nursing students providing care to Francophone patients in Ontario, the context and realities of

practice of these care providers can be better understood, and an evidence base can be created to address the inequities challenging the service provision to French-speaking patient populations. Simultaneously examining the realities of Francophone patients in the same study allowed for the voice of patients to be heard on the issues that affect their health, wellness, and vitality as Ontario's official language minority community members. The data provided by nursing and patient participants fostered a greater understanding of the realities of care for these populations, reflecting on the state of health care administration and identifying opportunities for improving health care for linguistic minority communities systemically across Ontario.

This dissertation follows a traditional format. Chapter 1 describes the research problem and its background and the worldview within which the researcher is situated. Chapter 2 provides a literature review regarding official language minority communities and the state of health care for Francophone patients and their health care providers. Chapter 3 presents the conceptual framework guiding the study. Chapter 4 describes the research design and methodology used in this study. Chapters 5 and 6 provide the findings of this study, including verbatim quotations from the patients, registered nurses, and nursing students who took part in the study. Chapter 7 offers a discussion of the study findings, including further analysis and interpretation of the data. The limitations of the dissertation are also discussed, along with recommendations for future practice. Chapter 8 concludes the dissertation, offering an overview of the work done thus far and setting the stage for subsequent advances required to see official language minority communities continue to thrive.

Chapter 2: Literature Review

The literature addressing minority populations is vast. However, more research from a nursing perspective is needed to further understand care for linguistic minority patients in Canada. A review of the literature was performed to determine the state of the evidence on health care for linguistic minorities, as well as to determine the future directions needed for this research. The search process reviewed articles published up to April 2018 in either English or French. These articles were retrieved from various databases, notably the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Web of Science, Scopus, Érudit, Embase, and Medline. These database searches were repeated in 2021 to retrieve newly published articles. Keywords searched included variations and combinations of health, language, linguistic, minority, and nurse (nurs* or infirmi*). Search results included publications from numerous disciplines, such as education, medicine, midwifery, occupational therapy, physiotherapy, psychology, public health, social work, sociology, linguistics, and nursing.

Governmental Policies

Perusal of the existing literature and reports regarding linguistic minorities demonstrated that the subject was of international concern. The following references demonstrate that maintaining and reinforcing a country's linguistic vitality is a preoccupation for patients, communities, researchers, and governance structures both nationally and internationally. Literature reviewed presents the challenges of supporting the vitality of linguistic minority populations in numerous countries and regions, such as Finland, Wales, Ireland, Spain, and Canada (Ballester Cardell & Marí Mayans, 2021; Ibáñez Ferreté & Mestres i Farré, 2021; Johnson & Doucet, 2006; Montes Lasarte et al., 2021; Nyqvist et al., 2021; Pere Mas, 2021; Prys et al., 2021; Williams, 2016; Williams & Walsh, 2019).

Mindful of the needs of minority European communities, as well as the requests from individuals to use their language in public spheres, the "European Charter for Regional or Minority Languages of the Council of Europe" was created (Council of Europe, 1998; Roberts et al., 2007). This treaty is designed to maintain, protect, and promote European heritage and traditions, both in the private and public sectors (Council of Europe, 1998). In the United States, "National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care" have been developed to support health care delivery while reducing health disparities for minority populations, overseen by the Office of Minority Health at the U.S. Department of Health and Human Services (Estrada & Messias, 2015; Goeman et al., 2016; Gómez et al., 2016; Office of Minority Health, 2000). Excerpts of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (Office of Minority Health, 2000, p. 1) include the following:

> Principal Standard:
> 1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
>
> Communication and Language Assistance:
> 5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
> 6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
> 7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
> 8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

The significance of such national standards (and the lack thereof) has been discussed with regard to nursing researchers and providers (Benavente, 2004; Estrada & Messias, 2015; Logan, 2007; Registered Nurses' Association of Ontario, 2007; Roberts et al., 2010), as well as with regard

to Francophone minority communities (Drolet et al., 2014; Drolet, Bouchard, & Savard, 2017; Farmanova, Bonneville, et al., 2018; H. Gauthier & Reid Triantafyllos, 2012; Réseau santé en français Î.-P.-É., 2013; S. Tremblay & Prata, 2011), though an equivalent standard does not exist in Canada.

Understanding the role and status of official languages in Canada warrants a review of both the federal and provincial government structures. The Official Languages Act, decreed in 1969, is the federal legislation stipulating that Canada's official languages are English and French (Government of Canada, 1985b; Office of the Commissioner of Official Languages of Canada, 2018). This act supports the provision of federal services in both English and French, with the expectation that the services are accessible "in the official language of your choice without delay, and the services must be of equal quality, regardless of the language you choose" (Office of the Commissioner of Official Languages of Canada, 2018).

In tandem with the official languages act was the creation of the role of the Commissioner of Official Languages of Canada, a position created in 1970 to promote and oversee the implementation of the act. The Government of Canada instituted the Canada Health Act of 1984, legislating that all Canadian citizens are entitled to receive publicly funded health care services (Government of Canada, 1985a). This act was established to ensure that Canadians could receive reasonable access to publicly funded health care services across the country. The "Roadmap for Canada's Official Languages 2013-2018: Education, Immigration, Communities" was established (Government of Canada, 2017a), backed with a budget of $1,124.04 million. This Health Canada initiative allowed for the support of organizations such as the Société santé en français and the Consortium national de formation en santé, building capacity for patients to access bilingual health care providers in official language minority communities by creating opportunities for training,

education, and community networking (Government of Canada, 2017a; Société santé en français, 2019).

Such initiatives have remained federal priorities, as evidenced by the sequel of official language planning with the release of the "Action Plan for Official Languages – 2018-2023: Investing in Our Future" (Government of Canada, 2018). This plan reveals pillars of joint importance, notably priorities for focusing on strengthening communities, supporting access to health care services, as well as promoting bilingualism throughout Canada. The action plan's measures continue to point to the health needs of the community, of education in minority languages, as well as to meeting the regional access to health services which vary across provinces and territories (Government of Canada, 2018). The plan further asserts the supports, including financial resources, which are to be invested in educational and governmental services, as to promote vitality of official language minority communities. This is also evidenced in bursaries for individual students to access minority language post-secondary education (Government of Canada, 2018). This investment is also beneficial to groups such as the Société Santé en français (SSF) and the national French Language Health (FLH) networks as they continue working towards the wellbeing of Francophone linguistic minority communities and their access to health services to this day (M. Tremblay & Leis, 2021).

Though Canada shares two official languages, the various provinces and territories have addressed linguistic policies surrounding French differently. For example, New Brunswick is the only officially bilingual province in Canada (Province of New Brunswick, 2021). The right for citizens to receive government services in their language is supported by the Official Languages Act (1969) of New Brunswick. Another Canadian example of French language support is in Manitoba. Manitoba supports the Francophone minority language using the Francophone

Community Enhancement and Support Act of 2016 (Manitoba, 2016; 2021a). This act contributes to enhancing the linguistic vitality of the French minority, with one tool being supporting French-language service planning for government agencies and departments to meet the needs of the public (Manitoba, 2016; 2021a). Both Manitoba and New Brunswick have the support of Regional Health Authorities Act that addresses the French language, which reinforces the health authority's engagement to continue to provide improved delivery of French language services in their jurisdiction (Province of New Brunswick, 2021b). Ontario also has legislation in place to support the official minority language. The French Language Services Act (FLSA) of 1990 (Government of Ontario, 1990a), which was passed in Ontario, affirms Canada as a bilingual nation and supports the need for equally accessible government services in both English and French across Ontario, even in areas where the resident may be in a linguistic minority. The FLSA was most recently updated in 2021, to strengthen support for beneficiaries of the law (Government of Ontario, 2021c). Amendments to the law include a mandatory review of the law every 10 years, as the law had not been updated in nearly 30 years. The law also incorporates the active offer of services as a right for French-speaking individuals in areas designated under the Act. Additional changes were implemented to increase accountability measures, which would help enhance the delivery of French language services (Government of Ontario, 2021c).

By means of the French Language Services Act, individuals must be able to obtain provincial government services throughout the province if they live in a French designated region (Foucher, 2017; Government of Ontario, 1990a). Although Ontario is largely English-speaking, the province recognizes that there are 26 designated areas in Ontario whereby over 5000 individuals, or at least 10% of the population, is Francophone (Government of Ontario, 2016; Appendix A). As 80% of Franco-Ontarians reside in these designated regions, government

services are expected to be provided at the same level, availability, and quality, in both French and English (Government of Ontario, 2021a).

While the majority of Francophones live in the French designated areas of Ontario, significant gaps in equity of access exist for the 20% of Francophones who do not live in French designated areas, and who may experience further challenges in accessing the linguistically congruent services that they need (Office of the French Language Services Commissioner of Ontario, 2016a). Although several agencies are designated and listed as capable of meeting the health needs of the Ontario public in both official languages (Government of Ontario, 2021b), those that are not provincially funded are not under legal obligation to provide French language services (Government of Ontario, 2016). As such, though there is oversight for offering French language services to designated institutions, there are no sanctions or fines imposed upon organizations that are not fully bilingual if they operate without such government funding (Office of the French Language Services Commissioner of Ontario, 2018). While a number of nursing homes and facilities which provide nursing services are designated agencies (Government of Ontario, 2021b), in institutions that are not designated, official obligations for nurses to offer French language services in Ontario are limited.

Responsibility for overseeing the mandate of the French Language Services Act (FLSA) in Ontario has been transferred to several parties over the years. The Office of Francophone Affairs, also referred to as the Ministry of Francophone Affairs (depending on the political office in power), was responsible for receiving complaints regarding violations of this law until 2007 (Office of the French Language Services Commissioner of Ontario, n.d.). Thereafter, the Office of the French Language Services Commissioner was conceived, led by the independent French Language Services Commissioner of Ontario, to represent the needs of citizens requiring French language

public services throughout Ontario (Office of the French Language Services Commissioner of Ontario, 2019). The Office of the French Language Services Commissioner of Ontario would evaluate an agency's ability to meet the needs of Francophone communities every three years, providing agencies with recommendations on how they could continue to enhance their support of Francophone patient populations (Office of the French Language Services Commissioner of Ontario, 2018).

The French Language Services Commissioner of Ontario hoped to see further support offered to organizations that sought designated agencies with the Office of Francophone Affairs, in anticipation that more consistent French language public services would be provided to Francophone linguistic minority groups (Commissariat aux services en français de l'Ontario, 2018). To further enhance French language services, in 2016 the Office of the French Language Services Commissioner recommended that "the Minister Responsible for Francophone Affairs propose the designation of the entire province of Ontario under the amended French Language Services Act" (Office of the French Language Services Commissioner of Ontario, 2016, p. 38). However, the Office of the French Language Services Commissioner has since been abolished, and as of May 2019, the Office of the Ontario Ombudsman is responsible for managing and addressing complaints and concerns regarding French language services and violations of the FLSA (Office of the French Language Services Commissioner of Ontario, 2019).

Access to services for French language minorities throughout Ontario presents numerous tensions and considerations in the face of a changing provincial landscape. For example, in April 2021, Ontario transitioned from Local Health Integration Networks to Ontario Health teams (Ministry of Health and Long-Term Care, 2021b). This new structure is mandated to oversee

funding and health system planning provincially, which includes the integration of French language services in communities (Ministry of Health and Long-Term Care, 2021a, 2021b).

Despite the change in names, this novel structure continues to integrate French language services in its planning, frequently referring to The People's Health Care Act of 2019 (Government of Ontario, 2019b), which includes the Connecting Care Act, 2019 (Government of Ontario, 2019a). These acts stipulate the requirement for the publicly funded health care system to "recognize the diversity within all of Ontario's communities and respect the requirements of the French Language Services Act in the planning, design, delivery and evaluation of health care services for Ontario's French-speaking communities," with expectations to address the "accessibility of health services in French" (Government of Ontario, 2019b). The six French Language Health Planning Entities further help advise the government and advocate for French-language services, while engaging in collaboration and partnership with their respective communities (Groupe de travail sur les services de santé en français, 2005; Ministry of Health and Long-Term Care, 2021a). Government advisers have argued that greater involvement and authority for French Language Health Planning Entities would yield better protection of the health interests of Francophone minority communities in Ontario (Groupe de travail sur les services de santé en français, 2005).

Active Offer

The active offer has frequently been referred to as a means of ensuring the right to accessible services in both official Canadian languages (Drolet, Bouchard, & Savard, 2017; Office of the Commissioner of Official Languages of Canada, 2020a; J. Savard & Casimiro, 2017). The active offer is a proactive invitation for members of the public to express themselves in their official language (French Language Health Planning Entities & French Language Health Networks

of Ontario, 2015). It is extended by the service provider intentionally greeting an individual in both official languages. This allows the individual to choose the language in which they desire the interaction to take place. The active offer is a service standard for those working for the federal government (Office of the Commissioner of Official Languages of Canada, 2020a). An active offer can start with a verbal cue, such as a bilingual "Hello! Bonjour!" greeting over the telephone or in person (Government of Canada, 2012; Office of the Commissioner of Official Languages of Canada, 2020a). The active offer is also supported by visible cues, including posters, labels, and signs within the workplace, substantiating the invitation.

While the active offer is an expectation for employees of government funded, designated institutions (Government of Ontario, 2016, 2021a, 2021b), many groups support the necessity for integrating the active offer in the provision of health care services for health institutions across Ontario (Commissariat aux services en français de l'Ontario, n.d.; Doucet et al., 2019; Farmanova, Bonneville, et al., 2018; Office of the French Language Services Commissioner of Ontario, 2016b). Numerous training opportunities and resources exist to increase the active offer and improve the quality and safety of services throughout the health care system (Casimiro et al., 2018; Consortium national de formation en santé, 2013; GReFoPS, n.d.-d; Lortie & Lalonde, 2012; Réseau du mieux-être Francophone du Nord de l'Ontario, n.d.-a, n.d.-b; J. Savard et al., 2015) at the systemic, organizational, professional, and individual patient levels (French Language Health Planning Entities & French Language Health Networks of Ontario, 2015).

Patient Access to Minority-Language Health Services

Researchers are cognizant that language and culture go hand in hand with health literacy and overall health education (Kaszap & Zanchetta, 2010; Merlino et al., 2020; Nierengarten, 2018; Sauvé-Schenk et al., 2020; Singleton & Krause, 2009; Zanchetta et al., 2012, 2014, 2018;

Zanchetta & Poureslami, 2006). Yet, linguistic minority populations across the globe have historically struggled to access quality health care in their language (Jacobs & Diamond, 2017). Several countries acknowledge the significance of minority languages and their role in preserving a country's heritage, cultural identity, and linguistic vitality (Council of Europe, 1998; Johnson & Doucet, 2006; Tranter et al., 2011). In Wales, in the United Kingdom, Welsh is the minority language, spoken by 500,000 residents or 21% of the population (Tranter et al., 2011). Strategic language planning was required and initiated to promote and maintain the vitality of the official minority indigenous language (Darmody & Daly, 2015; Irvine et al., 2006; Roberts et al., 2010; Tranter et al., 2011). However, the minority language continues to hold a precarious position (Darmody & Daly, 2015), and several years later, great efforts remain necessary to ensure that legislative changes and policies in support of minority language are respected (Prys et al., 2021).

In the United States, many Hispanic patients who believe that they are proficient in English demonstrate health literacy levels that are inadequate, and thus have a lower English language proficiency than they believe (Zun et al., 2006). Even though they have limited English proficiency, patients may persist through a health encounter though they are not fluent in the language (Cox & Humblé, 2017; Moreno et al., 2016; Zun et al., 2006). Furthermore, health care providers tend to overestimate the English language proficiency of their Hispanic patients (Cox & Humblé, 2017; Zun et al., 2006). Interestingly, the Zun et al. (2006) study only included participants based on whether their last name sounded Hispanic. However, research has shown that one's name may not be indicative of one's preferred language. Such can be the case in Canada, especially in exogamous marriages whereby an individual's last name may be that of their spouse, or in situations where an individual's name can be pronounced easily in both English or French (de Moissac et al., 2011; de Moissac, de Rocquigny, et al., 2012).

In the United States, Logan (2007) supports that linguistically and culturally appropriate health care services are required for patient safety, given that one in five Spanish-speaking Americans do not access health care services due to language barriers. Furthermore, Logan (2007) also iterates that patients with low English proficiency may not even know where and how to access health care services, nor what programs are available to them (Logan, 2007). Such linguistic discordance can yield dangerous outcomes, as evidenced in reports documenting patient intubations in Hispanic populations that could have been prevented if the language barrier had been overcome during their emergency department visits (Bard et al., 2004). Similar difficulties were discovered for Francophone women in Ontario who struggled to find and access linguistically congruent care for themselves and their children in the face of domestic violence (Lapierre et al., 2014).

Members of minority groups may also not readily access social services such as psychological therapy (Kapasi & Melluish, 2015; Sanou et al., 2020), or they may present with unique particularities and the need for additional considerations (Côté et al., 2015; Lapierre et al., 2014). Moreover, challenges in attending certain health services and preventative care may be further exacerbated for immigrant populations identifying as official language minority populations, especially when considering the potential existence of several linguistic and cultural variations (Sanou et al., 2020; van Allen et al., 2021). Difficulty accessing minority language health care is heightened for patients living in rural and remote communities, where access to linguistically congruent services may be further limited (de Moissac, 2016a; de Moissac et al., 2011; de Moissac, Savard, et al., 2020; de Moissac & Bowen, 2017; Dubé et al., 2019; Hien & Lafontant, 2013; Meuter et al., 2015; Tsai et al., 2018). Consequently, certain groups, such as geriatric linguistic and cultural minorities, especially those living with dementia, were found to

have numerous challenges with their health care experience (Cooper et al., 2018; Czapka & Sagbakken, 2020; Sagbakken et al., 2020), including increased agitation when residing in English language care homes (Cooper et al., 2018; Sagbakken et al., 2020). Overall, linguistic minority patients and families face increased anxiety when forced to communicate health information in the majority language (Drolet et al., 2014; Jutras et al., 2020; Zhao et al., 2019).

While Canada hosts numerous minority communities, official language minority communities in Canada includes only individuals whose official language (French or English) is different than the official language of the province or territory where they reside (Office of the Commissioner of Official Languages of Canada, 2018, 2020b). The Office of the Commissioner of Official Languages of Canada has proclaimed that "the defence of the rights of Francophones outside Quebec, and the defence of the rights of the Anglophone minority within Quebec, is a priority for the Government" (Office of the Commissioner of Official Languages of Canada, 2021, p. 17). Studies have found that Canadian linguistic minority populations may also refrain from seeking services in their language to not cause trouble to the health care personnel if they believe that services are limited or will be delayed, or that requesting services is perceived as a burden (Bourhis, 2018; Bourhis & Montreuil, 2016; Cardinal et al., 2017; Commissariat aux services en français, 2016; de Moissac, Ba, et al., 2012; Drolet, Bouchard, & Savard, 2017; Hubert, 2019; Jreige, 2018; Kubina et al., 2018; Le clé, 2015; Santé en français, 2016).

The experiences of Francophone minority patients outside of Quebec, both native Canadian and immigrant populations, have been examined in the literature. Patients and families seeking French language services may struggle to access comprehensive and timely health care offered in their language of choice (L. Bouchard, 2013; P. Bouchard et al., 2009; Bowen, 2001; Drolet et al., 2014, 2015; Forgues et al., 2011; A. P. Gauthier et al., 2015; H. Gauthier & Reid Triantafyllos,

2012; Hien & Lafontant, 2013). Furthermore, Francophone patients may hesitate to request French language services for several reasons (de Moissac, de Rocquigny, et al., 2012; Hien & Lafontant, 2013). For example, some patients perceive that French language services are not available in their communities to the extent and ease that they are available in English (L. Bouchard, Beaulieu, et al., 2012; de Moissac, de Rocquigny, et al., 2012; Mercure et al., 2018). Often patients assume that their health care provider does not understand French, and as they do not want to risk being misunderstood, they comply with the language of the English-speaking provider, further enhancing the risk of being misunderstood (P. Bouchard et al., 2009; Hien & Lafontant, 2013; Meuter et al., 2015).

Francophone minorities may also hesitate or delay seeking linguistically appropriate health services when they presume a lack of French-speaking staff because of longer wait times for French interpretation (P. Bouchard et al., 2009; Casimiro et al., 2018; Drolet et al., 2014). It is frequently suggested that interpreters can remediate language barriers between health care providers and patients (Blay et al., 2018; Gerrish et al., 2004; Kalich et al., 2016; Schouten et al., 2020; van Eechoud et al., 2016; Zun et al., 2006). However, all too often, patients do not know about the availability of certain French language services, when they are available at all; patients share that French language options are not explained to them (de Moissac, 2016b). Further concerns regarding authority, respect, and power dynamics between patients and health care providers must be considered with regard to a patient's ability and inclination to request care in French (P. Bouchard et al., 2009).

It must be noted that receiving health services in a language that is not fully understood may be detrimental to the patient. If a patient does not understand their health care provider, they are unable to fully comprehend their health situation and to give informed consent, despite their

necessity for optimal health outcomes (P. Bouchard et al., 2009; Bowen, 2001; de Moissac & Bowen, 2019; Hien & Lafontant, 2013; Meuter et al., 2015; Patel et al., 2016). Linguistic minority patients may be less detailed in their communication of symptoms with their providers when the health interactions are conducted in the provider's language (Garcia et al., 2014; Jutras et al., 2020). Moreover, certain terms and nuances can be missed when a patient is less proficient in the provider's language (Garcia et al., 2014). When patients have difficulties understanding their health care professional, detrimental outcomes may ensue; they may not fully follow prescribed treatment plans or access follow-up in a timely manner (Drolet et al., 2014; Langille et al., 2012; Meuter et al., 2015). In light of these experiences and challenges, French-speaking patients with non-French-speaking health care providers may be hesitant to request health services in French if they doubt the possibility of receiving quality health care in their official language (Bowen, 2001).

Access to linguistically congruent health care services has proven to be significant to many linguistic minority groups, and this need is amplified with vulnerable populations in these groups such as young children or individuals with mental health conditions (Beaton et al., 2018; Benoît et al., 2015; L. Bouchard, Batista, et al., 2018; Canadian Nurses Association, 2007; Cardinal et al., 2018; de Moissac, Graham, et al., 2020; Drolet et al., 2014, 2015; Kalay et al., 2013; Roberts & Burton, 2013). Challenges accessing specialized care in French can be further heightened for individuals with multiple health concerns (for example, living with both mental health issues and HIV/AIDS), especially when identifying as both Francophone and racialized minorities (Buissé, 2006; Djiadeu et al., 2020; Samson & Spector, 2012). While certain Francophone immigrants may arrive to Canada in good health, their actual and perceived health can decline over time; thus, the needs of these populations must be culturally and linguistically congruent, even in the minority context (Bowen, 2001; Sanou et al., 2020).

Furthermore, health care centres such as psychiatric institutions may not be responsive to the needs of official language minority communities, or realize the importance of French language services (LeBel, 2016). For example, not finding suitable resources in Ontario, some Francophone families have sought services in Quebec, such as Tel-Jeunes, for crisis support (Drolet et al., 2015). Similarly, Francophone and Acadian minority youth requiring mental health services, especially at the onset of the illness, require culturally and linguistically tailored services, but may find a paucity of safe, accessible resources in their region (Dubé et al., 2019; Tranchant et al., 2019). Such linguistically and culturally adapted supports are also essential for international students, as they may be less inclined to share about mental health than their Canadian peers (de Moissac, Graham, et al., 2020).

Challenges obtaining quality French language care have been voiced regarding elderly populations as well (L. Bouchard, Chomienne, et al., 2012; Cooper et al., 2018; de Moissac, Savard, et al., 2020; Drolet et al., 2014, 2015; Dupuis-Blanchard et al., 2013; Kubina et al., 2018; Roberts & Burton, 2013; J. Savard, Bigney, et al., 2020; Majella Simard, 2019). Although elderly Francophone patients perceive that access to health services in their language contributes to their health and well-being (L. Bouchard, Chomienne, et al., 2012; Dupuis-Blanchard et al., 2014), linguistic minority patients and their families may struggle to access public health information in French as easily as the Anglophone majority population, causing additional delays in recognizing illnesses such as dementia (Garcia et al., 2014). These difficulties are especially evidenced in diagnosing health concerns that rely heavily on communication (Garcia et al., 2014), as in the case of dementia, where a bilingual patient may revert to speaking his or her primary language (Garcia et al., 2014; Sagbakken et al., 2020). Issues of language discordance may also present when

bilingual Francophone patients experience strokes, as miscommunications may take place when aphasic patients receive care from unilingual health care providers (Sauvé-Schenk et al., 2020).

Other cases of language reversion may present when individuals are stressed, ill, or fatigued (Roberts et al., 2007). While an individual may be fluently bilingual, in times of crisis or precarious health, a patient may be more at ease in one language than another (Boudreau & Dubois, 2008; Drolet et al., 2014; Lapierre et al., 2014). Furthermore, case reports continue to reveal that one's grasp of a secondary language may decrease in times of health crises, making one's ability to communicate in English if they are Francophone difficult to impossible (Office of the French Language Services Commissioner of Ontario, 2015). Thus, an individual who is usually bilingual may struggle to comprehend the health care received and express themselves accordingly, a situation that compromises their safety. Such examples include the case of a Francophone patient whose stroke-like symptoms were mistaken for psychiatric symptoms, as she was unable to express herself in English, though she was usually bilingual (Office of the French Language Services Commissioner of Ontario, 2015). Without improvements in their health care services, linguistic minority patients are thus a vulnerable group: disadvantaged, disempowered, and not fully able to participate in their health care (Drolet et al., 2014).

Health Care Providers and French-Language Health Services

Health care professionals globally are faced with numerous situations where linguistic and cultural competence affects their health care interactions. To provide quality care to linguistic minority populations, health care providers need to be well supported. Some health care providers voiced concerns regarding the lack of organizational support in the provision of linguistically congruent health care to minority populations, as manifested notably in unilingual English

communications and the under- (or inappropriate) utilization of Francophone and bilingually designated positions (P. Bouchard et al., 2009; J. Savard et al., 2014).

Researchers found that communication with linguistic minorities is improved when health care professionals display positive attitudes towards the minority language (Noels, 2017; Roberts et al., 2007), and further enhance their proficiency in that language (Roberts et al., 2007). This includes competence and sensitivity with regard to situations concerning informed consent (Isaacs et al., 2011; Schenker et al., 2007), during the provision of critical information or bad news (Isaacs et al., 2011), or when discussing challenging topics such as suicide, palliation, or death and dying (Isaacs et al., 2011), situations that can already be daunting without linguistic and cultural barriers.

Even when French language clinical tools and documents are available, some Anglophone providers default to providing documents and explanations in English, because they do not understand the written information in French (Timony et al., 2016). Researchers discuss the problem whereby health care providers are inclined to assume that services are understood by patients in the majority language, simply because a demand for French-language services did not take place (Zanchetta et al., 2014). Some providers are not well abreast of issues facing linguistic minorities, stating that language was not a problem with regard to their patient population because everyone was so bilingual (Timony et al., 2016). However, not all Francophone individuals are bilingual (Cardinal et al., 2018; Commissariat aux services en français, 2014). This presumption, more frequently held by Anglophone providers, in turn decreased the inclination to make active offers for patients in their midst (Timony et al., 2016).

Numerous researchers and community groups stress the importance of initiating an active offer for health care services in the patient's language, supporting their right to safe health care services (L. Bouchard, Beaulieu, et al., 2012; Cardinal et al., 2018; de Moissac et al., 2015; Drolet,

Bouchard, & Savard, 2017; Dubouloz et al., 2014; Lortie & Lalonde, 2012; J. Savard et al., 2014). The inability to understand a French-speaking patient may result in the conception of inappropriate treatment plans, which is a grave concern regarding patient safety (P. Bouchard et al., 2009; Bowen, 2001). For example, health care professionals' assessments of considerations such as nutritional screenings can be incomplete with Francophone patients, leading to underreporting of conditions such as malnutrition (Villalon et al., 2013).

Though an increasing array of educational material exists to support Anglophone and Francophone providers with French language services (Consortium national de formation en santé, n.d.-b, n.d.-a; Dubouloz et al., 2014), frequently expressed in the literature were the limited opportunities (or knowledge about the opportunities) for the training and professional development of health care providers seeking to serve minority language communities in Canada (Benoît et al., 2015; P. Bouchard et al., 2009; de Moissac, de Rocquigny, et al., 2012; A. P. Gauthier et al., 2015; Lortie & Lalonde, 2012). Without proficiency in the language of the linguistic minority, health care providers may experience difficulty performing comprehensive assessments and taking health histories. According to several scholars, a language barrier requires longer assessment and consultation times and more tests and invasive investigations are ordered in order not to miss concerns; however, there are more errors due to miscommunication (Benavente, 2004; Bowen, 2001; Doucet et al., 2019; H. Gauthier & Reid Triantafyllos, 2012).

Although some health care providers are bilingual, they do not always have the same aptitude in both languages, and could benefit in receiving additional support to care for linguistic minority patient populations (Drolet et al., 2014; A. P. Gauthier et al., 2015). Other providers who turn to interpreters for support with patients have found numerous problems and inconsistencies in communication of sensitive information, especially with untrained individuals such as family

members (Blay et al., 2018; de Moissac, 2016a; Flores et al., 2003; Timony et al., 2016). As it stands, the offer and use of interpreters, both formal and informal, presents with inconsistencies and challenges for minority language patients (de Moissac, 2016b; Gerrish et al., 2004; Schouten et al., 2020; Zun et al., 2006). The cost of interpretation services are frequently referred to as a deterrent to their use, if used at all (Cooper et al., 2018; Flores et al., 2003; Gerrish et al., 2004; Zun et al., 2006), despite cost-benefit analyses in favour of such expenses (Flores, 2006). Moreover, several researchers raise issues regarding the lack of health care professional training for best practices when collaborating with these interpreters (Brisset et al., 2014; Gerrish et al., 2004; Hsieh, 2010), including misunderstanding the role and expectations for the provider and for the interpreter during the interaction (Estrada & Messias, 2015; Hsieh, 2010).

The literature has also explored the distribution of French-speaking health care providers. Certain researchers suggest that while the numbers of health care professionals who are capable of speaking in French may be reasonable, the distribution may be problematic, especially when comparing the ratio of French-speaking physicians for southern Ontario to that in rural northern Ontario (A. P. Gauthier et al., 2012; Timony et al., 2013). Warnke and Bouchard (2013) found that the geographic location of providers capable of providing care in the minority language is not well distributed across Canada. Consequences of the shortage of bilingual staff was evident throughout the literature, and themes of increasing pressure and expectations on bilingual employees were noted, with augmentations in their workload that were frequently unrecognized and uncompensated (P. Bouchard et al., 2009; Canadian Nurses Association, 2007; A. P. Gauthier et al., 2015; Lortie & Lalonde, 2012; J. Savard et al., 2014; Timony et al., 2018).

As such, French-speaking health care providers may find themselves more frequently interpreting and translating information to their patients from other non-French speaking providers

and specialists (Drolet et al., 2014; Garcia et al., 2014; Timony et al., 2016). These additional steps and processes require more time for the providers to best serve their patient population (Drolet et al., 2014; Garcia et al., 2014). The additional work required and ensuing stress brought on by the need to compensate for colleagues' linguistic barriers, by adapting/translating documents, supporting patients and families who are not in their care, and informally interpreting and translating without appropriate training, leads to lower job satisfaction and challenges with recruiting and retaining qualified bilingual health care professionals (P. Bouchard & Vézina, 2015; Canadian Nurses Association, 2007; Drolet et al., 2014; J. Savard et al., 2014; S. Savard et al., 2013, 2017; Timony et al., 2016; S. Tremblay, 2015). Such situations reveal heightened isolation for the Francophone or bilingual providers as well (Canadian Nurses Association, 2007; S. Savard et al., 2013). Many do the additional work in hopes of yielding better outcomes for French-speaking patients and families in their midst (Drolet et al., 2014). Others attest to glaring concerns regarding patient safety for Francophone patients, an additional stressor to add to their work day (Canadian Nurses Association, 2007).

Few scholars focus on the particularities for nursing work with linguistic minorities in Ontario. However, what was found was that French language nursing manuals may suggest language that is inconsistent with current linguistic practices in Francophone Canada (Beaulieu, 2011). While native French speakers may be able to navigate these nuances, these can add a layer of difficulty for nurses or students who are not Francophone (Beaulieu, 2011). A report from the Canadian Nurses Association (2007) revealed numerous challenges with regard to the experiences of Francophone nurses providing care in Canada. The report echoed concerns for patient safety, the complexity of translating information for the patient and the health care team, as well as the difficulty obtaining time off if they were the only French-speaking staff nurse, indicating that

overall, support for providing French language services is scarce (Canadian Nurses Association, 2007). However, 14 years after the Canadian Nurses Association (2007) report, there still remains a paucity of recent data regarding the state of quality nursing care for Francophone minority populations, a pressing issue in light of the aging population and persistent nursing shortages (Canadian Institute for Health Information, 2020; World Health Organization, 2016). Given that the largest French language minority population resides in Ontario, an examination of the experiences of registered nurses, nursing students, and Francophone patients seeking and providing care within this province is due.

Student Preparation for Minority Language Care

Few scholars examine the experiences of nursing students with regard to official language minority communities in Canada, Francophone or Anglophone alike; however, with numerous countries having linguistic minority communities in their region, linguistic minority student groups may face their own unique challenges in pursuing their health education (Beaulieu, 2011; N. James, 2018; King et al., 2017; Koch et al., 2015; Skisland et al., 2018). In some cases, nursing students identifying with the minority language face concerns over lower academic performance, which is often related to higher attrition rates (King et al., 2017; Koch et al., 2015). Moreover, reviews of students for whom the English language was a second or additional language, and who were placed in English language clinical placements, were "associated with a less positive clinical experience" (Koch et al., 2015, p. 308). It is not uncommon for students to be enrolled in a minority language program (and taught in the minority language), to find that their clinical placement is in the majority language clinical setting, which can cause additional challenges and difficulties (de Moissac et al., 2017; GReFoPS, n.d.-c; Mattila et al., 2010). However, bilingual students had positive experiences and an improved capacity to meet the needs of Francophone minority

communities when placed in French language placements, and supported accordingly (J. Savard et al., 2018).

Students value culturally, ethnically, and linguistically congruent academic experiences, especially ones that reflects the diversity of the Canadian population (Donnelly et al., 2009). To better support Francophone minorities in Canada, Health Canada funds and supports the Consortium national de formation en santé (CNFS), an organization with the mandate to support the education of students and health care professionals in French (Lortie & Lalonde, 2012). The program supports the active offer of French language services and builds capacity for students in health education programs as well as health care professionals to care for Francophone populations in minority language community settings (Lortie & Lalonde, 2012). However, while students may be enrolled in a French-language program, studies reveal that this may not guarantee their ability or confidence to integrate this active offer into their clinical practice in Francophone minority communities, and potentially once they begin their practice as health care professionals (Benoît et al., 2015; P. Bouchard et al., 2010; Dubouloz et al., 2014; J. Savard et al., 2014).

Despite receiving education and training to serve linguistic minority communities, the literature indicates that French-speaking students and novice health-care providers may still require more support to provide the active offer of French-language health care services to Francophone minorities across the country (Benoît et al., 2015; P. Bouchard et al., 2010; Casimiro et al., 2018; de Moissac et al., 2015; Dubouloz et al., 2014). While studies have examined the ability of Francophone students to implement and provide French-speaking language services to Francophone patient populations (Benoît et al., 2015; P. Bouchard et al., 2009, 2010), few have examined the perspectives and experiences of nursing students and fewer still have explored the perspective of Anglophone nursing students caring for patients of OLMCs. Beaulieu (2011) speaks

to the difficulties students and nurses may face learning to provide nursing care in French in Western Canada, from navigating various French accents to deciphering the different expressions used in French textbooks. More work needs to be done to delve into the realities of nurses and nursing students in Canada's linguistic minority communities, including those in Ontario. Moreover, while scholars discuss the Canadian realities of integrating bilingualism into schools in Francophone minority regions (Landry et al., 2007), studies integrating a cultural autonomy model in the Canadian Francophone minority for the post-secondary level, including for nursing education, were not found.

The challenges faced by the nursing profession in providing care to Francophone patients may be noted from the moment students seek enrolment into a nursing school. Despite Canada having 136 Schools of Nursing offering the RN designation, only 14 of the schools offer entry-to-practice registered nursing programs in French, or in both English and French (Canadian Association of Schools of Nursing, 2016). Obtaining a French nursing education can be difficult in Ontario, as there are limited options for French baccalaureate nursing education. Laurentian University and the University of Ottawa are the only universities to offer the French language Bachelor of Sciences in Nursing (BScN) program in the province. The situation of nursing education in French gained national attention, discussed in the House of Commons, when the transition of the nursing licensure exam to the National Council Licensure Examination (NCLEX-RN) caused concern regarding French translation, Francophone student success rates, and eventual issues of capacity for providing care to official language minority communities (Paradis, 2018).

While securing a nursing education in French in Ontario can present with challenges, some students may struggle more than others (Laperrière, 2010, 2012). Calgary sociologist Madibbo (2006) coined the concept of the "minority within a minority," noting that individuals identifying

with more than one minority group experienced heightened barriers for success (p. 8). The intersectionality of these concepts is evidenced in considering the challenges that being a part of a language minority as well as a visible minority may entail (Crenshaw, 1989). The challenge of minorities within a minority was confirmed among nursing students by Laperrière (2010, 2012), who found that nursing students identifying with multiple minority groups, notably linguistic minorities, visible minorities, and recent immigrants, experienced more stressors, which compromised their ability to succeed in their academic and clinical programs. As it stands, a greater understanding of the experiences of both French and English-speaking nursing students is essential given that they are the future of the nursing profession.

Organizational Practices

Since the Government of Ontario recognizes that some Francophone linguistic minority populations are substantial enough to become designated regions in the province, it is important for health organizations in these regions to understand how this reality applies to their institutions and their health-care providers (J. Savard et al., 2015). While some organizations such as government-funded hospitals and community agencies are mandated to be bilingual health institutions in Ontario, other organizations may seek voluntary bilingual designation from the government (Commissariat aux services en français de l'Ontario, 2018; Government of Ontario, 2021b). In all these institutions, the provision of French-language health-care services should be adequately supported and implemented throughout all levels of the organization (Dumont & Doucet-Simard, 2013). When addressing linguistic minorities in the literature, researchers across the globe stress that organizations must recognize the link between language and culture of its health care providers and patient populations, and the implications that these can have on safety (Divi et al., 2007; Drolet, Bouchard, & Savard, 2017; Johnstone & Kanitsaki, 2006, 2009;

Williamson & Harrison, 2010). For example, in light of the aging population and demographics of Francophone linguistic minority communities, researchers assert that there is a need to establish more Francophone senior care services and institutions to meet the needs of linguistic minority clients (de Moissac, 2013; Forgues et al., 2011).

Overall, human resources emerge in the literature as a theme that must be addressed to meet the needs of Francophone minority communities. For example, greater representation of linguistic minorities and cultural group employees throughout the organizational structure is called for, to reflect that the organization values diversity and linguistic competence (Bowen, 2001; Cooper et al., 2018; H. Gauthier & Reid Triantafyllos, 2012; Luna, 2002; Williamson & Harrison, 2010). Several authors speak to the importance of hiring bilingual staff to build organizational capacity to serve Francophone minority communities (de Moissac, 2016a; de Moissac et al., 2011; de Moissac, de Rocquigny, et al., 2012; S. Savard et al., 2017), with an emphasis on retaining these staff members within the organization (P. Bouchard & Vézina, 2015; S. Savard et al., 2017). The literature supports having designated bilingual positions for care sectors that encounter official language minorities (H. Gauthier & Reid Triantafyllos, 2012), with respect and support for those positions by the organization and management (P. Bouchard et al., 2009; J. Savard et al., 2014).

According to the Ministry of Health and Long-Term Care (Government of Ontario, 2017), in keeping with the FLSA, organizations must equip employees to support the administration of quality health care in both official languages (J. Savard et al., 2015). Bilingual documents and resources that are accessible and consistently available for the French-speaking, English-speaking, or bilingual health care providers are essential (Drolet et al., 2014; J. Savard et al., 2015). These providers would also benefit from having lists of Francophone/bilingual providers in their midst

and French educational resources, as much for patients as for themselves (de Moissac et al., 2011; de Moissac, de Rocquigny, et al., 2012; J. Savard et al., 2015).

English-speaking health care providers shared that health materials, documents, and tools within their organization could support their provision of services to linguistic minorities (Drolet et al., 2014). Also important are initiatives such as providing French language training or educational opportunities, as well as offering resources such as readily accessible interpretation services (de Moissac et al., 2011; de Moissac, Savard, et al., 2020; J. Savard et al., 2015). Moreover, the implementation of interpreter-companion services could better accompany French-speaking patients in health organizations, while supporting the care offered by providers (de Moissac, 2016b). Furthermore, the addition of resources such as bilingual terminology banks to help support English-speaking health care providers can build capacity for the health care team within the organization. This strategy also addresses the repercussions and overwork for French-speaking/bilingual staff members, who tend to carry a significant burden when French-language resources or services are unavailable or underutilized (Betancourt et al., 2003; Bowen, 2001; Drolet et al., 2014; A. P. Gauthier et al., 2015; H. Gauthier & Reid Triantafyllos, 2012; J. Savard et al., 2015). Importantly, the Canadian Nurses Association (2007) report highlights that the additional work of bilingual and French-speaking staff must be recognized by employers and compensated accordingly.

J. Savard et al. (2015) share extensive resources for health organizations with regard to implementing the active offer to Francophone communities in their midst, including the means of improving patient-facing amenities, resources and training for front line health care providers, and tools for management seeking to support their staff (J. Savard et al., 2015). For example, the Canadian research group entitled Groupe de recherche sur la formation et les pratiques en santé et

service social en contexte Francophone minoritaire (GReFoPS) provides best practices, suggestions for organizations, and detailed checklists to help institutions working with Francophone communities improve the quality of their French- language services (GReFoPS, n.d.-b, n.d.-d). The integration of such practices, if adequately supported by health organizations, could significantly improve the quality of care for patients while enhancing the quality of the work environment of the health care providers in their midst (J. Savard et al., 2015).

Société Santé en français and the French-Language Health Networks of Canada continue to assert that organizations and health administrators must remain accountable for supporting French-language services (Société Santé en français & the French-Language Health Networks of Canada, 2017; M. Tremblay & Leis, 2021). This devotion must be evident throughout the organization, including in institutional documents such as policies and procedures, as to fully build an organizational culture and capacity for the active offer of French language services (de Moissac, de Rocquigny, et al., 2012; Société Santé en français & the French-Language Health Networks of Canada, 2017; Vézina, 2017). Société Santé en français (2019; n.d.) further suggests that organizations diligently collect the language-based data for patients that frequent health organizations, as to better know how to serve these communities. This is one of the objectives of the Réseau des services de santé en français de l'Est de l'Ontario, which continually asserts the importance of accessing quality data on Ontario's Francophone population, as there remains a dearth of data regarding both health services and the health status of Francophones in Ontario that needs to be resolved (Réseau des services de santé en français de l'Est de l'Ontario, 2021). Researchers invite organizations to work in collaboration with the government to best implement practices that benefit providers in supporting the active offer to Francophone minorities within

their sector (Farmanova, Bonneville, et al., 2018; Société Santé en français & the French-Language Health Networks of Canada, 2017; M. Tremblay & Leis, 2021).

Framework for the Analysis of Health and Social Services Access and Integration for Official Language Minority Communities

Released during this doctoral program period, the Framework for the Analysis of Health and Social Services Access and Integration for Official Language Minority Communities (see appendix D) has proven to be an appropriate lens through which to address issues of access to health care for Francophone minority communities in Canada (J. Savard, Savard, et al., 2020). The framework was initially published in French in 2017, with an English translation available in 2018, and a revision of the framework published in 2020 (J. Savard, Savard, et al., 2020). While it was not used as a conceptual framework for the design of this study (which started in 2016), its significance is further emphasized in the discussion chapter.

Developed by the Groupe de recherche sur la formation et les pratiques en santé et service social en contexte Francophone minoritaire (GReFoPS), this Canadian framework addresses the system-wide trajectory for Francophone patients and their social and health care providers, and as well offers pillars to address the improvement of the active offer for official language minority communities throughout the health care system (J. Savard, Savard, et al., 2020). This framework depicts the health-service trajectories and influencing structures through the lens of the health-service providers (Anglophone, Francophone and Francophile, having an affinity or interest in the French language) and the service user/community structures, while touching on particularities for consideration with regard to organizational structure, political and regulatory structures, and symbolic structures, described below (J. Savard et al., 2021; J. Savard, Savard, et al., 2020). All these structures are interdependent and affect one another. They also influence care along the

continuum of preventative, curative, and supportive health services, in aims of improving the health and well-being of official language minority communities (J. Savard, Savard, et al., 2020).

Symbolic Structures

The symbolic structures touch on the values, beliefs, and social structures of the health care system in a given society (J. Savard et al., 2021; J. Savard, Savard, et al., 2020). This includes the society's social conceptions of health and understanding of determinants of health. This structure also encompasses the social culture, values, and linguistic identity (J. Savard et al., 2021; J. Savard, Savard, et al., 2020). The GReFoPS states that the Canadian government has pronounced its valuing of linguistic duality, supported by the *Roadmap for Canada's Official Languages*, which guides and affirms policies and actions for linguistic revitalization (Government of Canada, 2017a; J. Savard, Savard, et al., 2020). These symbolic structures and understandings influence health policies, as well as the values, beliefs, and priorities of all actors within them, including patients and providers. These structures can also affect an individual's inclination to seek or to offer culturally adapted health care services (J. Savard, Savard, et al., 2020).

Community Structures

The community structure level addresses concerns of improving population health and wellbeing (J. Savard, Savard, et al., 2020). The framework demonstrates that community members share the community's values and resources, which thus impacts their perspectives on health (J. Savard, Savard, et al., 2020). Moreover, there are several components that contribute to healthy communities and positive living environments, stronger community action and involvement, as well as public policies, all of which are multisectoral, but in unison, can improve the community's wellbeing (J. Savard, Savard, et al., 2020). The community can have an active role in identifying, declaring, and advocating for their needs (J. Savard, Savard, et al., 2020). Community members

can also join in collaboration to meet the needs of the community from within as peer support entities, for example, which engage groups of like-minded individuals seeking to advocate for OLMCs. Official language service users need to be abreast of the community and health services available in their language, thus emphasis is needed on increasing the promotion, visibility, and accessibility of existing services to encourage their use (J. Savard & Paquette, 2018). From health facilities to neighbourhood groups, several actors can contribute to positively impacting the health of community members, all while improving a community's linguistic vitality as well as continuity of access to linguistically congruent health services (J. Savard, Savard, et al., 2020).

Political and Regulatory Structures

Encompassed in the political and regulatory structures are the provincial and federal laws and regulations that affect the offer of health and social services, such as the Canada Health Act, the Official Languages Act, and others based on each region and jurisdiction (J. Savard, Savard, et al., 2020). The state of such political and regulatory structures can impact modifications and amendments to health or language laws, or to policies and regulations, affecting communities and organizations under such directives and incentives (J. Savard, Savard, et al., 2020). Changes to the existing laws, policies, or even political parties in power can either facilitate or hinder access to linguistically congruent health and social services.

Organizational Structures

The next level points to the organizational structure, which includes the various health and social services, as well as the distribution and organization of resources for each entity (J. Savard, Savard, et al., 2020). The use and distribution of allocated resources may vary geographically, as well as according to the organizational culture, the existing leadership, and the different managers (J. Savard, Savard, et al., 2020). Moreover, organizational resources may be allocated and used

differently according to the type of care (primary, secondary, or tertiary), the type of services (public or privatized health care), and even the clientele being served or accessing services, and the language accessible for patients seeking care (J. Savard, Savard, et al., 2020). Support for linguistically congruent care and an effective active offer requires an organizational culture and management that subscribes to such values and that strives for equity for all its clients (J. Savard, Savard, et al., 2020). Moreover, it requires appropriate resource planning, and accordingly, efficient deployment of staff to maintain the required service level. This also requires the receiving of organizational feedback regarding linguistic and cultural competence, and integrating such feedback when improving services (Kubina et al., 2018; J. Savard, Savard, et al., 2020).

Health Care Providers

The framework hones on health care providers and patient participants in the health care and social services system, reflecting the trajectory of integrated services. To best serve official language minority communities, health care providers must be "prepared, proactive, trained in the active offer of services" (J. Savard, Savard, et al., 2020, p. 6). Ideally, these providers would be capable of offering services in both official languages, and capable of making their clientele comfortable to receive services in the official language of their choice (J. Savard, Savard, et al., 2020; J. Savard & Paquette, 2018).

Moreover, providers need to be equipped with appropriate resources, both human and material, to provide linguistically congruent services. Such an arrangement supports the provider in the offer of safe quality care. This requires skills and proactivity from health and service-care providers to successfully coordinate such encounters (J. Savard, Savard, et al., 2020). This also requires appropriate equipping of health care professionals with system-wide resources, clinical tools, and infrastructures that support care processes beneficial for official language minority

communities (J. Savard, Savard, et al., 2020). Such systems must also support the integration of such services, enabling them to occur seamlessly intra- and inter-facility, minimizing disruptions for patients and providers (J. Savard, Savard, et al., 2020). Beneficial tools may include promoting the active offer with signs within the institution, identifying the provider's language, as well as identifying the patient's preferred language (the "linguistic variable") (J. Savard, Savard, et al., 2020). As appropriate, health care providers can facilitate the networking of patients to other health care providers capable of offering services in the patient's official language of choice, contributing to the improved access to services and increased community and linguistic vitality (J. Savard, Savard, et al., 2020; J. Savard & Paquette, 2018).

Francophone Service Users

The Francophone service user level includes the individuals receiving services, as well as their caregivers (J. Savard, Savard, et al., 2020). To have a successful care interaction, all participants, patients, and caregivers included must be sufficiently informed to collaborate and to have as much of an active role as desired. Moreover, the patient and family need to be capable of expressing their needs and concerns freely, while being fully informed, engaged, and involved in the care services received, to the desired extent (J. Savard, Savard, et al., 2020). This also enables them to better manage their health condition and integrate health care provider recommendations, thus improving their living conditions, their health, and their overall outcomes (J. Savard, Savard, et al., 2020). Access to care in one's official language affects one's experience along the care continuum, an issue for consideration for participants and for health care providers, especially as they consider health outcomes (J. Savard, Savard, et al., 2020).

Minding the Gap

The challenges experienced by linguistic minorities are not unique to Ontario, Canada, or North America. Moving forward, academic and organizational research must consider the distinctiveness of linguistic minorities by actively seeking for them to participate in research and allowing them to identify themselves as a linguistic minority (Bowen, 2001; H. Gauthier & Reid Triantafyllos, 2012). Numerous researchers acknowledge the significance of providing linguistically and culturally congruent health care, including several scholars dedicated to examining the progression of official language minority communities in Canada (Bowen, 2001, 2015; de Moissac, 2016b; Drolet, Bouchard, & Savard, 2017; Farmanova, Bonneville, et al., 2018; Jutras et al., 2020; Kubina et al., 2018; J. Savard, Savard, et al., 2020; J. Savard & Paquette, 2018; Société Santé en français & the French-Language Health Networks of Canada, 2017). However, providers continue to face numerous challenges with adequately servicing Francophone minority communities, while patients struggle with consistently receiving linguistically congruent care (Office of the French Language Services Commissioner of Ontario, 2017). Work is still needed to increase the health access of French-speaking patients in minority communities, and to see how to improve their health care experiences, with several priorities identified by Kalay et al. (2013) that include education, health planning, mental health, and senior health.

Along with influences of globalization, the landscape of the Francophone population across Ontario and Canada continues to diversify. For several years, the majority of French-speaking immigrants outside of Quebec have resided in Ontario (Government of Canada, 2020c; Houle et al., 2014). As such, official supports such as the Government of Canada's Action Plan for Official Languages – 2018-2023: Investing in Our Future, and updates to the French Language Services Act (Government of Canada, 2018) will need to consider the different needs of the Canadian

Francophonie, and the supports needed for it to thrive. This involves considering the current trends with regards to migration and immigration of Francophones outside of Quebec (Government of Canada, 2017b; 2021). For example, across Canada, certain communities have been identified as being Francophone communities whereby newcomers are encouraged to settle outside of Quebec. As such, these communities, which include cities in Ontario, will need to pay particular attention to the unique needs, including health requirements, of these new Francophone settlers (Immigration Francophone, 2022).

Thorough understanding of these realities in research will be even more important, given that many Francophone immigrants settle in Canada being healthier than their counterparts, and yet this health can decline as these individuals spend more time in Canada (RésoSanté Colombie-Britannique, 2019), a phenomenon so rampant that it has been coined the "healthy immigrant effect" (Statistics Canada, 2019; Vang et al., 2015). As such, simultaneously examining health care and language will be important, along with understanding the various other social determinants of health which can affect the health care experience of Francophones in Canada.

The Comité consultatif des communautés Francophones en situation minoritaire (2007) also supports further examining the experience of nurses and other health care providers serving French-speaking patient populations as a means of improving patient care and increasing representation of their care experiences in the literature. Despite the wealth of literature available regarding linguistic minorities, the Canadian nursing perspective remains limited on the issues of linguistic minorities and their nursing care providers (Canadian Nurses Association, 2007). Moreover, it is important for future research to examine how to translate best practices into clinical practice for health care professionals, including registered nurses. Furthermore, given the aging population and the aging nursing workforce, nursing students are the future of the profession and

must have the opportunity to share their experiences providing care to French-speaking patients in Ontario.

Beaulieu (2011) suggests the need to examine the experience of non-Francophone students and nurses, as it may inform researchers about their unique challenges and help create strategies to bridge the linguistic barriers. Such consideration of all health care providers, regardless of their French language proficiency, is essential to portray the realities of Ontario's health care landscape and to effectively address the realities of care. Moreover, examination of wider geographical and regional strategies could benefit in further understanding the challenges of health care providers and patients, not excluding the populations in rural and remote communities (Eckhardt et al., 2005; A. P. Gauthier et al., 2015; Nailon, 2006; Roberts et al., 2010). Thus, it is valuable to examine the state of health care for linguistic minorities throughout the province. Understanding the experiences of both patients and providers is essential, as they give significant insights as to the state of health care and the state of nursing education, and yield insights to the realities of clinical learning and practice environments. Such an approach also helps understand the impacts to health care for Francophone minority communities across Ontario.

Chapter 3: Conceptual Framework

Seeing as this study seeks to explore the experiences of registered nurses, nursing students, and Francophone patients with regard to nursing care for official language minority communities in Ontario, it is important to guide the work with a conceptual understanding of the various components of the health care system. Two conceptual frameworks informed the structure of the study with regard to the experience of accessing and providing care for minority francophone communities in Ontario. Although the health care system historically leaned towards prioritizing cost-effective services, more health systems are seeing the significance of evaluating the administration of quality health care with organizational performance (Ferlie & Shortell, 2001). While a systematic review by Hussey et al. (2013) found the relationship between health care costs and quality of care to be unclear, Reid et al. (2005) stress that "poor quality of care has enormous costs" (p. 12). Thus, though the work of Ferlie and Shortell (2001) was based on the state of the health care system in the United Kingdom and the United States, the importance of assessing quality of care is now being demonstrated in other developed countries such as Canada (Brazil et al., 2006; Laberge, 2015).

Scholars such as Gauthier and Reid Triantafyllos (2012) support that there is a business case to be made for language-congruent care in the Canadian health care system, indicating that quality and linguistic congruence can be mutually beneficial priorities for health-care recipients and health-care providers alike, across the various components/level of the health care system. As such, this chapter discusses the "Four Levels of Change for Improving Quality" model (Ferlie & Shortell, 2001) and the "Four-Level Model of the Health Care System" (Reid et al., 2005), as a means to conceptualize the multidimensional position and context of official language minority communities and their care providers within the health care system.

Four Levels of Change for Improving Quality

Ferlie and Shortell (2001) proposed the Four Levels of Change for Improving Quality model (see appendix B). This continuous quality improvement model is rooted in examining medical services in the United States and the United Kingdom. The model is based on the possibility of multiple actors having a significant impact on the health care system and in improving quality of care. Ferlie and Shortell (2001) also assert that efforts for change would be unsuccessful in the long term without the adoption of a comprehensive approach to change, which includes the multiple levels of the health care system. The first level is the individual/the patient, followed by the group or the team, next by an organization, and lastly, by the encompassing system or environment (Ferlie & Shortell, 2001). Ferlie and Shortell (2001) suggest that multiple levels have a role in improving the quality of care, and thus, practitioners and policy-makers must consider the role of each level for creating sustainable change and improvements in the quality of care. This model can support the improvement of quality health care services to linguistic minority populations. The authors assert that such an approach can be a valuable consideration whether or not the change happens with a top-down hierarchal structure, or inversely, from the individual level upwards (Ferlie & Shortell, 2001).

Four-Level Model of the Health Care System

Ferlie and Shortell's (2001) Four Levels of Change for Improving Quality model has been widely used and reproduced. Reid, Compton, Grossman and Fanjiang (2005) adapted the model into a figure entitled "Four-Level Model of the Health Care System" (see appendix B) in response to the health care system delivery in the United States. This framework suggested the role that improved information technology throughout the health care system could have with regard to improving the care infrastructure. The conceptual drawing produced by these researchers is centred

on the individual patient, followed by rings of the care team of frontline care providers, of the organization, and of the environment, speaking to divisions of labour and levers for change system wide. This visual depiction demonstrates that the different levels affecting change in health care should not be viewed as silos, but rather as interdependent levels. Echoing Ferlie and Shortell (2001), many efforts have been focused on single levels, thus contributing to change failure (Reid et al., 2005). However, the different levels are interrelated and must work together to rectify challenges within the system (Ferlie & Shortell, 2001; Reid et al., 2005).

Adaptations of such a model have proved to be effective with regard to analyzing and discussing the impact of the health care system within linguistic minority communities (Prata & Tremblay, 2015; S. Tremblay & Prata, 2011). They display a focus on the patient, as well as a regard to health access and determinants of health (Solar & Irwin, 2010), and thus are applicable to the topic at hand. For this study, the individual level represented Francophone patients, and the health care team level consisted of registered nurses and nursing students. These participants spoke to the four levels of the health care system based on their experiences as care providers and care recipients. The participants also shared overlapping perspectives with regard to the experiences of patients and nursing care providers. As such, the results of this thesis will also include a section discussing shared perspectives (see figure 1 below). While remaining patient centred, the four-level health care system model is relevant for speaking to the issues affecting French-speaking official language minority communities in Ontario, reminding us of the complex systematic environment that shapes and affects health care services in the province.

Figure 1: Four Level Representation of Participant Perspectives for the Conceptual Model

Individual Level

The individual level revealed experiences pertaining to individual patients interviewed in this study. Though changes can take place at the individual level, the four-level health care system stresses that changes made solely at the individual level are rarely effective on their own. As such, Ferlie and Shortell (2001) recommend that changes should be implemented throughout the multiple levels of the organization to be sustainable. Such individual level efforts can include education, or individual adoption and implementation of guidelines and protocols (Ferlie & Shortell, 2001).

Reid et al. (2005) centre the individual level on care recipients, acknowledging that the preferences and needs of patients must be considered in the health care system infrastructure. Developments in the way the health care system is administered have increased expectations and pressures on patients for being actively involved in their care experience. Patients are increasingly expected to be vectors for change in improving care quality. This responsibility is even more challenging, as patients frequently have less access to critical resources such as quality health care information and tools. Framework authors Reid et al. (2005) suggest that given their role in the

health care system, providers need to include patients and their families as health system actors. Patients are free to be as little or as deeply involved in their care; however, they require sufficient information to make informed choices, and their wishes and values must be taken into consideration, such that care can truly be patient centred. Depending on the desired involvement in care, patients need sufficient information to be informed decision makers. Such information must be evidence-based, but also accessible such that it can be understood by patients or their network. Reid et al. (2005) asserts that "improving the timeliness, convenience, effectiveness, and efficiency of care will require that the patient be interconnected to the health care system" (p. 20). Thus, improving communication and health care, both synchronous and asynchronous, is a factor that can enhance care quality. Throughout this study, the challenges that can present with regard to the care experience of Francophone patients are discussed considering the levels-based health care system frameworks at hand.

Health Care Team Level

The health care team level revealed experiences pertaining to individual health care practitioners (BScN nursing students and registered nurses) interviewed in this study. Ferlie and Shortell (2001) assert that teams, such as teams of health care professionals, can be powerful drivers for health care change. They describe high-functioning teams as actors that can create meaningful quality improvement and support the provision of high-quality care. They also acknowledge that not all teams are effective, therefore overreliance on solely the group level is an ineffective strategy for sustainable change (Ferlie & Shortell, 2001). Often, teams are interdependent with other teams, thus, coordination with other groups is required to achieve and to sustain the desired or required change. Ferlie and Shortell (2001) have also found that, at times,

organizational and environmental factors are detrimental to the formation and support of effective teams, an issue that must be addressed systemically.

Reid et al. (2005) describe the care team as those individuals surrounding the patient, including family members, caregivers, and health care providers. Like Ferlie and Shortell (2001), they also point out the realities of medical professionals, who are not always accustomed to working as part of health care teams but rather in a more independent contractor role (Reid et al., 2005). They also suggest the comparison of effective groups to microsystems, which can act as small functional units representing the greater organization (Ferlie & Shortell, 2001; Reid et al., 2005). While certain teams can thrive as microsystems, this involves the standardization of health care services, which is not adaptable to all teams. Furthermore, some changes take time to implement and adopt, such as the integration of evidence-based/best practice protocols. For teams to function efficiently, health care providers need to be equipped with teamwork techniques, tools, and appropriate infrastructure, such that different groups can work effectively together (Reid et al., 2005). Moreover, patient-centred care involving individual patients and patient populations in the decision-making process requires more responsiveness on the behalf of providers to the preferences and needs of their patient populations, as well as consideration and inclusion of families, according to the desired involvement level of patients and families.

Organizational Level

Many health care organizations saw a movement towards the improvement of care quality that aligned with integration of continuous quality improvement (CQI) models, or total quality management (TQM) based models (Ferlie & Shortell, 2001). These models were originally designed for industry but adopted by the health care sector. However, the transition of these models for the health care system has not always been successful, sometimes failing to yield the desired

results or targeted benchmarks (Ferlie & Shortell, 2001). Many organizations saw such an approach become an organizational expectation to meet accreditation standards (Ferlie & Shortell, 2001). As such, the mixed success rates varied based on the organizational culture (both clinical culture and managerial culture), organizational leadership, and on several other factors, such as whether the organization is an early adopter or reluctantly espousing the model by obligation (Ferlie & Shortell, 2001; Westphal et al., 1997).

For organizational change to be implemented effectively, careful consideration of the context is key. Thus, the organizational culture and climate, including the "decision-making systems, operating systems, and human resource practices" needed to be considered and receptive to supporting such transitions (Ferlie & Shortell, 2001, p. 287). Ferlie and Shortell (2001) suggest that change strategies need to be less prescriptive and more adaptive to the needs of health organizations, such that change can be more successfully integrated using a multilevel approach (Ferlie & Shortell, 2001). Moreover, notions of learning, a focus on teamwork, and an emphasis on the needs of care recipients (often defined as care "customers" or "consumers") are fundamental to the cultures of organizations seeking to make progress in their quality improvement objectives (Ferlie & Shortell, 2001).

The organization provides the infrastructure and resources required for health care providers and care recipients. Such resources include everything from financial, material, and human resources to information management and processing systems, all of which are coordinated to meet the needs of several units or microsystems. However, organizations rely on the political and economic environment, which increasingly puts pressures and expectations on organizations and providers to "accomplish more work with fewer people to keep revenues ahead of rising costs" (Reid et al., 2005, p. 21). Once again, financial incentives take precedence within health care

organizations, one of many challenges faced by health care management, as discussed by Ferlie and Shortell (2001). Reid et al. (2005) also add that the hierarchal structures between health care professionals are a supplemental challenge for team management, and the sustaining of effective teams. Thus, bridging these differences may also be required when trying to orchestrate the effective delivery of patient care, given the fragmented nature of the health care system, health care organizations, and even health care teams (Reid et al., 2005). As stated by Ferlie and Shortell (2001), Reid et al. (2005) also assert that organizational culture change is required to enhance or develop a patient-centred care approach that meets the needs of all levels within the systems.

Environmental Level

Ferlie and Shortell (2001) assert that for changes to occur at the individual, team, and organizational levels, macro level changes in the larger system environment are required. This includes considerations such as the political climate or the economic market, which affect the health care system (Ferlie & Shortell, 2001). For example, the authors assert that while some organizations may have a desire to implement quality improvement in their sectors, the health care system and larger environment have lagged in providing incentive for such changes, as the priorities remained on achieving financial objectives (Ferlie & Shortell, 2001). Moreover, for proposed changes to be effective, accountability would also be required (Ferlie & Shortell, 2001).

In discussing environmental considerations, Reid et al. (2005) speak to the political and economic/market environment. Such considerations include the factors influencing the health care system, including regulations and financing/payment regimens, and even touches on government structures, both federally and at the state level (Reid et al., 2005). The federal government has a "responsibility to monitor, protect, and improve public health, [thus shaping] the market environment for health care" (Reid et al., 2005, p. 22). Such notions are significant to understand,

as they influence the incentives of organizations and health care providers, and thus, influence how care may be received by patients. Reid et al. (2005) suggest that environmental policies conflict with patient-centred care approaches. As such, changes in regulatory practices at the governmental level, both federal and state, may be required to drive much needed health care change to improve care quality.

Multilevel Change

As mentioned above, the numerous levels of the health care system often operate as independent entities (Ferlie & Shortell, 2001; Reid et al., 2005). Though there is habitual reference to the health care system, such a system does not act or perform as a system, but rather as independent silos (Ferlie & Shortell, 2001; Reid et al., 2005). However, these entities are interdependent, and rely on the buy-in from other levels to succeed and operate effectively (Ferlie & Shortell, 2001; Reid et al., 2005). While each level can create small changes, to advance required system wide changes, each of the levels needs to be considered (Ferlie & Shortell, 2001).

Ferlie and Shortell (2001) assert that sustainable change can only be achieved if the multiple levels are simultaneously concerted in creating the long-term change and yielding the greatest impact. Thus, the larger environment, including the financial, regulatory, and political climate, needs to be attuned and respond to the needs of health care organizations, such that they can provide better health care (Ferlie & Shortell, 2001). Moreover, organizations must consider the needs of the various groups and teams within their sector, including patients and the direct health care providers (Ferlie & Shortell, 2001). In turn, the health care teams must consider the needs of the individuals such that change can be effective.

This thesis contends that there is a need for considering the requirements of the individual health care providers as well as the patients within the health care system to create sustainable

change, both upstream and from the top-down (Ferlie & Shortell, 2001). As such, if change is to occur at the environmental level, decision makers must consider the impact this has on the three other levels and support them accordingly with regulatory and financial changes or incentives (Ferlie & Shortell, 2001). Similarly, if the organization desires to create a change, it must consider the impact to the individuals and teams, and equip them accordingly, while being abreast of the larger health care environment climate and potential limitations that may affect plans (Ferlie & Shortell, 2001). This is because changes to one level often cause or require changes to the various levels. At times of crisis (e.g., pandemics), simultaneous change may be required at all levels concurrently, which requires more coordination and navigation such that every sector can still benefit in receiving, providing, supporting, and equipping the various levels of the health care system. This model informed the semi-structured interview guides with participants to start discussions with regard to challenges in the health care experience of Francophone minority community patients and their nursing health care providers, aiming to direct a discussion over the barriers and strategies to improve care throughout the various levels of the health care system (see appendix I).

Changes in approaches and attitudes to the health care system are required to bridge gaps and inefficiencies in quality of care (Reid et al., 2005). These models may help understand the health care system beyond its existing silos, and to look at it instead as an integrated structure that can facilitate the experience of patients and care providers along a care trajectory. In congruence with the results emerging from this study, the discussion chapter will reflect on the applicability and lessons learned from these models, as well as address relevant considerations given the experiences of Francophone minority communities and their nursing care providers in Ontario.

Chapter 4: Research Design and Methodology

To understand the lived experiences of official language minority communities and their nursing care providers in Ontario, a qualitative interpretive phenomenological study was conducted. This chapter outlines the methodology and research designs undertaken to execute this work. The choice of qualitative research is reviewed, followed by the underpinnings of the phenomenological research tradition, as well as the pertinence of interpretive phenomenological research for this work. Research methods are also discussed, as well as considerations of rigour and ethics for qualitative research with human subjects.

Qualitative Research Approach

A qualitative interpretive phenomenological study was conducted. The qualitative research approach was recognized for its ability to explore the complexity of human realities, permitting an in-depth understanding of the lived experiences of participants involved in this study (Duffy, 2005; Pickler, 2007). There is also an understanding that reality is context laden, thus allowing for multiple subjective realities to exist concurrently (Bailey & Tilley, 2002). Qualitative research is well-positioned to explore the relativity and multiple realities of research participants, while allowing the involvement of the researcher as an instrument (Bogdan & Biklen, 1997; Duffy, 2005; Teherani et al., 2015). It allows for the co-construction of knowledge with the researcher and participant. As such, both the researcher and the participants are actively involved in meaning making (Bailey & Tilley, 2002), wherein their various experiences, thoughts, perspectives, social contexts, and reasoning contribute to solving the research question. In qualitative research, the process can be inductive (Braun & Clarke, 2013), such that there may be uncertainty in the outcome of the research. The participants' voice and knowledge are a valuable source of data and expertise (Bailey & Tilley, 2002), permitting the identification of themes, patterns, and new

knowledge. Given that this study aims for a deep understanding of the lived experiences of Francophone patients and their nursing care providers in Ontario, a qualitative approach using interpretive phenomenology was an appropriate means to answer the research questions, while remaining aligned with the researcher's philosophical stance.

Phenomenology

Phenomenology is a qualitative research methodology with aims of understanding the essence and conveying the lived experience of a phenomenon (Connelly, 2010; Dowling, 2007; Matua & Van Der Wal, 2015; van Manen, 2014). Stemming from post-positivist paradigms, phenomenology was originally coined by Edmund Husserl, a mathematician and philosopher who used the methodology as a means of understanding lived experience and consciousness (Husserl, 1970). Experience was understood as a source of knowing, and thus, it was deemed that the essences of experiences could be used to create knowledge valuable to qualitative research (Husserl, 1970). Phenomenological research lends itself well to the examination of lived experiences using data collection methods such as interviews, discussions, observations, and stories (Connelly, 2010; Lester, 1999). Moreover, phenomenological approaches yield rich, detailed data with a few purposefully selected participants (Mackey, 2005). Small sample sizes are usually sufficient for data collection (Connelly, 2010). Thereafter, data analysis for phenomenological studies takes place with the researcher spending much time with the collected data, reviewing and rereading the transcripts, and embedding themselves with the data (Connelly, 2010; van Manen, 1990). This approach is consistent with the design of this study.

Husserl emphasized the importance of going "back to the things themselves" (Husserl, 1970a, p. xxiii), and supported the descriptive aspect of phenomenology, in that "epoché," also referred to as bracketing, was used to prevent the researchers' convictions and philosophies from

interfering with the data and its analysis (Husserl, 1970b, 1970a). Such bracketing in descriptive phenomenology called for researchers to take note of their biases and presuppositions and put them aside (Connelly, 2010; Eberle, 2014). This approach, however, is not relevant for all phenomenological traditions. Husserl trained numerous philosophers, including Martin Heidegger, who saw the potential for phenomenology to not only be descriptive, but even interpretive or hermeneutic (Connelly, 2010; Laverty, 2003), with the researchers' interpretations shaping the meaning-making process. A hermeneutic phenomenological approach was used for this study, as conceptualized by Heidegger (1962) and van Manen (1990).

Hermeneutic Phenomenology

Interested in theology and philosophy, Martin Heidegger was a student of Husserl's who opened opportunities for variances in phenomenological work (Heidegger, 1962). Identifying with what came to be known as interpretive phenomenology, Heidegger also valued phenomenology as a methodology that could permit the understanding of moments, anecdotes, and experiences shared by participants' qualitative narratives (Heidegger, 1962). Rather than seeking only a description of the data, Heidegger subscribed to the notion that "every description is an interpretation" (Heidegger, 1988). Therefore, Heidegger's position was that phenomenology could grant opportunities for interpretation of the human experience and its meaning (Heidegger, 1962; Laverty, 2003). Removing of the self was not emphasized; rather, being in the world and acknowledging one's "dasein" (existence) and contributions was valued (Heidegger, 1962). Thus, there was appreciation for interpretations that varied from one person to the next. As such, the values of the researcher are included and necessary for the research process.

Max van Manen is a Canadian philosopher and pedagogy educator, interested in phenomenology of practice (van Manen, n.d., 2014; van Manen et al., 2016). His work supports

the reflection *on* and *in* professional practice using phenomenological research as a qualitative methodology (van Manen et al., 2016). Focusing on educational research, his work allows for developments in the field of pedagogy, which has been traditionally viewed in an "objective lens," integrating understanding of human experiences and perspectives (van Manen, n.d.). Through phenomenological inquiry, van Manen's work seeks to understand, to probe, and to reflect on the meaning of human experiences and phenomena in clinical practice fields (van Manen, n.d.). However, van Manen acknowledges that "no explication of meaning is ever final, no insight is beyond challenge" (van Manen, 2011). This philosophical approach is especially pertinent to this doctoral work, as different humans have different experiences, and may acknowledge, interpret, and explain them relative to their own understanding. As such, phenomenological inquiry is an appropriate theoretical approach to examine the lived experiences of Francophone patients and their nursing care providers in Ontario.

The use of interpretive phenomenology allows for the examination of participants' lived experiences, with consideration of how such experiences influence their perceived realities (Matua & Van Der Wal, 2015). Consideration of "influences such as culture, gender, or employment" is welcomed in interpretive phenomenology, allowing for further understanding and interpretation of the phenomenon being observed, as understood by the participants sharing their narrative (Matua & Van Der Wal, 2015, p. 22). In this study, the use of interpretive phenomenology allowed for a deeper understanding of the lived experiences of Francophone patients in Ontario, as well as those of registered nurses and nursing students providing care to French-speaking minority communities in the province. This research methodology supports further examination of the events and the meaning of these events and experiences in the lives of the participants (van Manen, 2014). The lived experiences of Francophone patients form the basis for understanding and

interpreting the realities of those seeking health care while living as linguistic minorities in Ontario, as does gleaning an understanding and interpreting the realities of the nursing care providers.

In keeping with hermeneutic interpretive phenomenology, bracketing is not required or even desirable (Connelly, 2010); rather, there is an acknowledgment that pre-understanding exists and informs the research (Laverty, 2003). As the phenomenological tradition evolved, researchers proposed that one's presuppositions and biases can never be fully recognized or eliminated (Connelly, 2010; Lester, 1999). Thus, bracketing is rejected by certain hermeneutic phenomenologists, as researchers' preconceptions are deemed valuable and integral for the research and interpretive process (Eberle, 2014; Lester, 1999). Reinharz (1983) supports phenomenology as a dynamic process, describing five transformations of the data with the involvement of the participant, the researcher, and the eventual audience: a) as the participant articulates their lived experience; b) as the researcher hears and understands the experience; c) as the researcher conceptualizes and categorizes the story; d) as the researcher writes and disseminates the data; and e) as the audience reads and understands the experience for themselves. van Manen (2002) suggests that as the audience reads the phenomenological text, they also become a writer, "rewriting the text again at every reading" (p. 238). Thus, interpretation of the text takes place at multiple levels of transmission, appraisal, and interpretation of participants' narratives.

As such, I acknowledge that this phenomenological research process is informed by my own experiences. Memories of accompanying and supporting Francophone family members through challenging health encounters with Anglophone health care systems fueled my work. Furthermore, my pre-existing knowledge and perspectives as a Francophone registered nurse are embedded in the processing and interpreting of the data, while I sought to obtain a deeper

understanding of the participants' own lived experiences. Moreover, throughout the research process, there is the potential of uncovering hidden or underlying phenomena associated with the topic of interest (Flood, 2010; Humble & Cross, 2010; Matua & Van Der Wal, 2015; Willig, 2014), which is interpreted based on the researcher's worldview. This work can also help expose "taken-for-granted assumptions or" challenge "a comfortable status quo" (Lester, 1999, p. 4), which I contend is necessary given the sensitivity of research examining access to and provision of health care. Having worked in Ontario as a registered nurse, in acute care and in academia, seeking to meet the health care needs of Francophone linguistic minority communities, my experiences affect my inquiry and understanding of the phenomenon. Similarly, a primary investigator with a different experience or in a different context may view the same research question in a different lens due to the relative nature of the phenomena.

Study Setting

This study was set in Ontario, which is both the second largest Canadian province and the most populous (Statistics Canada, 2017a, 2017b; Statistics Canada, 2012). The east border of the province neighbours Quebec, a majority Francophone and French-speaking province. The province of Ontario includes 26 French designated areas, which are home to over 5,000 Francophones, or where Francophones consist of 10% or more of the population (Government of Ontario, 2016). Ontario has the largest French-speaking population (550,595, 4.1%) in Canada after Quebec (Government of Canada, 2019a, 2019c). For the scope of this research, it was important to set the study across the province, to collect accounts from participants from a variety of backgrounds, especially those who may be underrepresented in research due to location. Moreover, rural/remote communities are often regions with more challenging access to French-

language services and resources, therefore, understanding Francophones' health care realities in those areas was important to build a more accurate portrayal of the research problem.

Participant Recruitment

Patients, nursing students, and registered nurses were recruited by means of invitations sent through community organizations. Nursing professionals were also recruited through professional and student associations. Prospective participants were free to contact the researcher by telephone or by email, at their will, to set up an interview. Prior to the interview, phone and email exchanges with the participants took place to ensure that the individuals met the eligibility criteria, and had thorough opportunities to ask questions, receive answers, and provide informed consent.

Francophone patients were recruited by means of community organizations such as l'Assemblée de la Francophonie de l'Ontario (www.monassemblee.ca), la Fédération des aînés et des retraités Francophones de l'Ontario (www.farfo.ca), and le Réseau des services de santé en français de l'Est de l'Ontario (www.rssfe.on.ca). These organizations sent out an invitation for Francophone participants by means of their mailing lists and posted invitations to participate in the study on their websites. The Mouvement d'implication Francophone d'Orléans also allowed for printed posters to be displayed within their building.

Nursing students invited to participate in the study were Bachelor of Science in Nursing (BScN) students. Students from all years were welcomed, allowing for individuals to share experiences that they deemed significant. Anecdotes sought were those acquired during nursing clinical interactions with official language minority communities. The Canadian Nursing Students' Association sent out emails to all BScN nursing students in Ontario, and also shared the recruitment poster on their Facebook platform. Targeted recruitment was done for nursing students at Laurentian University and the University of Ottawa, as both universities are established in areas

that are densely populated by Francophone citizens and they both offer a French BScN program. The Laurentian University nursing secretariat displayed the recruitment email so that it was visible to their student body. The University of Ottawa nursing secretariat emailed the poster to professors, lecturers, and clinical instructors, who could choose to share the poster in their online classroom management platforms. The nursing simulation centre displayed the recruitment poster to students in hallways outside of the laboratory classrooms. Registered nurses in the general and extended class (nurse practitioners) were solicited via the Nurse Practitioners' Association of Ontario email list (with one reminder email sent), and thereafter snowball sampling was used.

Individuals who were interested in taking part in this study contacted the researcher by telephone or by email. Upon assessment of eligibility and review of the informed consent procedures, an interview date and time were scheduled. Once initial data collection was initiated, snowballing for key informants was supplemented through participating registered nurses, nursing students, or patients' knowledge of information-rich individuals who could provide additional significant narratives. The snowballing method also assisted in the acquisition of a negative case example, yielding greater depth to the rich data collected (Lincoln & Guba, 1985).

Sample

For this phenomenological study, three sample populations were examined as separate subsets. Purposive sampling is frequently used in qualitative research (Barbour, 2001; Coyne, 1997; Schreier, 2018), and is an appropriate means to answer the research questions of this doctoral study. Criterion sampling, a subset of purposive sampling, was used to ensure that the phenomenon could be explored in depth with the selected participants (Teddlie & Yu, 2007). For example, using the criterion sampling technique, all Francophone patients desiring to receive health care services in French met the criterion of interest, along with being minority language residents of Ontario.

This was followed by snowball sampling to allow for interviews to take place with key informants. Such a process was repeated for registered nurses and nursing students. Given the sample set, it was expected that the sample would have a certain amount of heterogeneity, but would also be "homogeneous with respect to the selected criteria" (Schreier, 2018, p. 8). Such a sample set was important to respect the goals of the research project (Onwuegbuzie & Leech, 2007).

Registered nurses invited to participate in the study were working in Ontario at the time of the study. They were purposefully selected for their clinical experience in providing care to Francophone linguistic minorities within their region. Nursing students invited to participate in the study were those with clinical placement experiences in a BScN nursing program. It was required that they had experiences providing care to linguistic minorities, such that they could discuss the academic and clinical preparation experienced by the nursing care providers of tomorrow. Participants of interest were those who had provided care to Francophone linguistic minorities in their nursing placements, especially those positioned to provide salient information as to how they found opportunities to create meaningful interactions with linguistic minority patients or if they provided the active offer to the patients in their care.

Patient participants were those who had sought health care in Ontario and could speak to the realities of accessing and receiving health care as an official language minority community member in Ontario. As patients in Ontario are a diverse group, this qualitative study permitted informants, who had unique perspectives of accessing French-language health care across the province, to share their experiences.

For inclusion criteria for study participation, based on whether the individual was a registered nurse, a nursing student, or a patient, see Table 1.

Table 1: Inclusion Criteria for Study Participants

Registered Nurses	Nursing Students	Francophone Patients
Registered Nurse in Ontario	BScN student in Ontario	Francophone or bilingual resident of Ontario
Anglophone, Francophone, and/or bilingual	Anglophone, Francophone and/or bilingual	Has received health care in Ontario at least once
Has provided care or been involved with the care of Francophone patients	Has provided care or been involved with the care of Francophone patients during their nursing clinical placements	Prefers receiving health care services in French
Willing to do an interview in English or French	Willing to do an interview in English or French	Willing to do an interview in English or French

These criteria allowed for a comprehensive group, having relevant experience with the phenomenon of interest, to share their lived experience. While sample sizes for qualitative research have been a subject for debate (Baker & Edwards, 2012), such preoccupations are not always commensurable with phenomenology (van Manen, 2014). As per the qualitative research tradition, small sample sizes remain indicated (Baker & Edwards, 2012). Scholars have found valuable data from sample sizes ranging between 3 and 30 participants (A. James et al., 2014), usually with 30 participants or less when using purposive sampling (Teddlie & Yu, 2007). As such, I recruited a sample of 10 Francophone patients, 11 registered nurses and another 10 nursing students, for a total of 31 participants, which was ample for the collection of rich narrative data. Participants were interviewed on a first come, first-served basis in the official language of their choice.

Data Collection

In-depth semi-structured individual interviews were conducted. This was an opportunity to gather detailed data from the participants about their understanding and perspectives pertaining to the phenomenon in question. This format made it possible for each participant and the researcher to engage reflexively in a dialogue about a complex, multi-layered issue; it also set the groundwork

for the interpretive process. The opportunity to probe for rich, thick descriptions was a valuable strength of this phenomenological research. As indicated earlier, high quality data can be obtained without requiring large sample sizes. Given the diversity of the sample sets and the larger sample size, there was a possibility that saturation would not be attained, but the narratives, underlying findings, and phenomena remain important to explore (Morse, 1989; Saunders et al., 2018; van Manen et al., 2016). Moreover, some authors question saturation as a standard (Baker & Edwards, 2012; O'Reilly & Parker, 2012), while others suggest rejecting saturation as a data collection objective altogether, as it tends to be a reflection of "researcher-centric decision making rather than being reflective of the experiences, intentions and preferences of study participants themselves" (Garcia et al., 2014, p. 974). This is echoed by van Manen et al. (2016, p. 5), who asserts that:

> The idea that you keep looking until you have saturated your material, until your data are saturated, does not make sense because there is no saturation point with respect to phenomenological meaning. In phenomenological inquiry, you open up a question, which becomes bottomless –so it does not make sense to say that you caught all the meaning or meaningfulness of a human phenomenon.

Congruent with the above-mentioned notion, this research was conducted with the assumption that saturation was not an appropriate or realistic goal, especially given that sampling would include participants with experiences spanning the entire province.

In order to develop the interview guide, the research questions and the conceptual models were carefully considered. Reflection on what topics and conversations were required to answer the research questions ensued, and interview questions were crafted accordingly. Probes and prompts were also prepared to guide the conversation. This was an important consideration, as quality qualitative interviews depend on the preparation of the interviewer and the thoughtful navigation and management of participants' responses (e.g., participants providing minimal

responses, as well as verbose participants who may require skillful redirection from an experienced interviewer). The interview questions and potential issues were discussed with the thesis supervisors, who are experienced researchers; troubleshooting techniques were also prepared (Roulston & Choi, 2018). A preliminary interview guide was piloted with a bilingual graduate student nurse participant familiar with the topic. A mock interview took place, testing the demographic questionnaire and the interview guide. Feedback was provided following the interview and minor changes were made accordingly. The final socio-demographic questionnaires and interview guides are included in appendices 9 and 10.

With the participants spanning an entire province, multiple interview formats were used. Participants in the Ottawa area were met in person, at a location that was convenient for both the participant and the researcher and that allowed for good quality audio-recordings. However, all participants were given the option of conducting the interview by telephone, enhancing accessibility for participants across Ontario.

Interviews took place between September 2018 and June 2019. Interviews were audio recorded with participants' permission, followed by verbatim transcription. One participant chose not to be recorded. However, this individual accepted that detailed note taking could be taken throughout the interview. As such, these notes were considered with the other participant transcripts for data analysis.

Throughout the interview process, field notes were taken before, during, and after the interviews, allowing me to reflect on and describe my stance, thoughts, and ideas about the data or the broader phenomenon of interest, thereby enhancing the data analysis process. Written informed consent was obtained prior to conducting the interviews, with a promise to respect participants' anonymity and confidentiality.

Data Analysis

Data collection and data analysis were done concurrently. Data analysis included reviewing recordings of transcripts, identifying emerging themes, quotes, and perspectives. Thematic analysis was performed, guided by the work of Braun and Clarke (2006), as appropriate for qualitative research as well as interpretive research traditions (Berry, 2018; Christie et al., 2021; Peterson, 2017)

Data analysis occurred during data collection, the writing of field notes, transcription of the interviews, and thereafter. Each interview was listened to and read repeatedly for accuracy and to ensure immersion in the participants' narratives. Thereafter, repeated reading of the interviews continued, along with further analysis of each transcript. This process allowed for building an understanding of the dataset early on in the research process (Kowal & O'Connell, 2014). The researcher highlighted and took preliminary notes of the data set, reviewed field notes that were taken during the interview, as well as journaled reflections that developed throughout the data analysis process. The analysis was conducted by the primary researcher, with regular discussions of findings with the doctoral supervisors.

Consistent with the approach of Braun and Clarke (2006), thematic analysis started with coding of the data. As influenced by van Manen (1990), coding was done using a detailed line-by-line analysis of each interview transcript. This allowed for the creation of initial codes that were close to the data. This process was meticulous and lengthy, ensuring that sufficient time and attention were given to each piece of data (Braun & Clarke, 2006).

Line by line analysis was followed by the coding and analysis of key phrases, sentences, and paragraphs. Thereafter, analysis of each interview text in its entirety took place to garner and make sense of the overall meaning of the dataset (van Manen, 1990). Such an approach also

allowed for the maintenance of contextual richness throughout the coding process (Ayres et al., 2003; Dierckx de Casterlé et al., 2012). This process was repeated for each interview, allowing for the generation of codes, identification of patterns, and analysis of frequently recurring themes. Thereafter, interviews were compared to one another, identifying patterns in data codes, until all codes were reflected in the resulting themes (van Manen, 1990). This ensured that the codes found in individual interviews were consistent and coherent in relation to the comprehensive interview data set (Braun & Clarke, 2006).

Meetings with supervisors, both experienced researchers, took place for each participant group (first nurse interview, first patient interview, and first nursing student interview), to ensure a quality coding structure (Barbour, 2001). Thereafter, meetings took place intermittently, in order to make sure that codes aligned, consensus could be found, and that the code structure was true to the data. The set of codes and themes were shared with the thesis committee, ensuring that they were distinctive and comprehensive.

Rigour and Trustworthiness of Data

As coined by Lincoln and Guba (1985), trustworthiness of qualitative work can be verified by considering the credibility, dependability, transferability, confirmability (Guba, 1981; Lincoln & Guba, 1985) and authenticity (Guba & Lincoln, 1994) of the data throughout the study. Reliability and validity metrics for qualitative research have long been questioned and debated (Morse et al., 2002; Rolfe, 2006). Thus, ultimately, the rigour and trustworthiness of this study is determined in large part by the reader's trust in the data as presented and explained (Rolfe, 2006). Therefore, as a researcher and writer, my role is to demonstrate the efforts that were made to design and conduct a rigorous study, to be reflexive throughout the process, and to stay true to the data collected from the participants (Shenton, 2004).

When demonstrating credibility, the emphasis was on providing the reader with confidence that the participants' lived experiences were conveyed and interpreted in a truthful manner (Cope, 2014; Lincoln & Guba, 1985; Tobin & Begley, 2004). This was demonstrated by building a comfortable rapport of trust with the participants, allowing for detailed sharing and responsiveness to my probes when seeking additional information and depth. Significant participant quotes are shared verbatim in the results section, permitting the reader to understand and to relate to the experience as shared vividly by Francophone patients, nurses and nursing students. To further strengthen credibility of the findings, the research process included maintaining an audit trail (Cope, 2014; Long & Johnson, 2000; Sandelowski, 1986; Tobin & Begley, 2004). Furthermore, researcher credibility was enhanced by the involvement of my doctoral supervisors and of the thesis committee members in the peer review of themes. Prolonged and meaningful engagement with the data throughout the analysis process took place to remain true to the data, a practice maintained up until the completion of the writing of the thesis. Triangulation for completeness was enabled through the use of field notes, which provided to be a valuable source of supplemental data, especially for one participant who chose not to be recorded (Jones & Bugge, 2006).

The study also evidenced dependability by maintaining an audit trail and allowing for scrutiny of the research process, should a reproduction be attempted (Lincoln & Guba, 1985). Tracking descriptions of decisions affecting the study also helped establish trustworthiness of data and transparency regarding participant attrition, difficulties in recruiting, methodological changes, or other decisions relevant to the research process (Cope, 2014; Tobin & Begley, 2004). During this study, recruitment by purposive sampling went smoothly, and participants were eager and forthcoming to share their stories. Thereafter, snowballing was adopted to recruit several more Francophone patient participants. Numerous patient participants revealed that they were rarely

solicited for such studies, and eagerly spoke of other potential informants with significant lived experiences as Francophone minority patients in Ontario. All the individuals who were made aware of the study by means of the snowballing method accepted to take part in the study, and indeed proved to be rich informants who provided generous narratives with thick descriptions. Digital recording of the interviews followed by verbatim transcription allowed for enhanced dependability and access to the original raw data that was consulted as required. As interviews, transcription, and analysis were conducted concurrently, reflective journaling proved to be a valuable means of recording thoughts that emerged during these processes (Long & Johnson, 2000; Tobin & Begley, 2004).

Transferability involves the potential for applying the findings to other settings (Lincoln & Guba, 1985). Although the findings of this phenomenological study are not intended to be generalizable, they may be relevant to other linguistic minority contexts. As such, rigorously providing a rich, thick description of the research design, sampling, setting, and overall process may further support transferability, permitting readers to determine the relevance of the findings to their own minority language contexts that impact the health care experiences of individuals (Cope, 2014).

Confirmability of the data involves neutrality from researcher bias (Lincoln & Guba, 1985). In an interpretive phenomenological research study, this is not a worthwhile objective. However, the results obtained remain mainly derived from the participants' data (Tobin & Begley, 2004). With the numerous other means in place to conduct a rigorous study, confirmability was consequently enhanced by representing participants' voice in the findings, using raw data with numerous deep quotes (Cope, 2014). The involvement of other researchers in confirming for accuracy of the data analysis and interpretation also took place to enhance the rigour of this work

at several steps during the research process, from the development of research questions to the data collection and analysis process. Consulting my doctoral supervisors, thesis committee, as well as doctoral peers enhanced the validity of this work (Long & Johnson, 2000). As mentioned before, codes were reviewed with supervisors; themes and their organization were reviewed extensively with supervisors and the thesis committee. Confirmability was also enhanced by the use of an audit trail and reflexive journaling (Houghton et al., 2013; Long & Johnson, 2000; Sandelowski, 1986). Journal notes were kept following discussions with supervisors and the thesis committee. Reflective journaling also permitted me to record my evolving understanding of the findings and of the research process as a whole while reconciling those with participants' lived experiences (Long & Johnson, 2000; Schwandt, 2014; Tobin & Begley, 2004).

Authenticity refers to the researcher's ability to faithfully represent the participants' true emotions and feelings (Cope, 2014) and a fair representation of their realities. This was another process that drew on reflexivity, allowing participants to share significant anecdotes and lived experiences, even though it may cause a detour in the researcher's plans as a novice researcher and interviewer (Davies & Dodd, 2002). This process allowed for several rich, in-depth quotes, where participants could share significant experiences regarding care for Francophone minorities in Ontario. The numerous quotes that confirm similar experiences from one participant to the next evidence how participants could be active in co-creating the data in the study, sharing the narratives most important to them. Moreover, using purposive sampling, the researcher sought the representation of unique realities of nurses, nursing students, and patients across the province as a means to add richness to the study, while providing data on a significant research question and societal query.

Ethical Considerations

The duty to conduct ethical research, with attention to participants' needs, was considered throughout the research process. Principles of minimizing research harm and burden for participants was a subject for frequent reflection. In accordance with the Tri-Council Policy Statement for conducting ethical research with human participants, I considered the importance of justice, respect for participants, and the maintenance of concern for their welfare (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council, 2018). Before proceeding with the study, Research Ethics Board (REB) approval was obtained from the University of Ottawa (see appendix E). Study processes strictly adhered to the ethics protocol approved by the University. The study anticipated minimal risks for participants involved in the project. Numerous psychological supports, located in multiple locations across the province, were available to the participants (Dickson-Swift et al., 2008) in both official languages, as individuals process lived experiences and their recounting differently.

Participation in the study was strictly voluntary, with the right to withdraw from the study at any time. The study was explained to all participants before data collection to allow for questions and concerns to be expressed, and to ensure that informed consent was obtained prior to the study, thus safeguarding participants' autonomy. Participants were assured they could revoke their consent at any time during or after the interview, though none chose to. Participants could also choose not to answer certain questions, or for their responses not to be recorded. After the interviews, participants could also declare that they were no longer interested in having their interview data be part of the study. One participant chose not to be recorded, and no participants chose to withdraw their consent or data throughout or after this study. There was no coercion or

financial incentive for participants to engage in this research. Francophone patient participants were specifically included in this study for their language-based experience, which they were free to share in their preferred official language. Otherwise, given the scope of the research, there was no requirement to discriminate or exclude participants on the basis of "religion, race, disability, sexual orientation, ethnicity, linguistic proficiency, gender or age" (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council, 2018, p. 49).

Privacy and confidentiality were key considerations throughout the entire research process. All personal information entrusted was received and treated in a confidential manner, only accessible to the researcher and her thesis supervisors. All digital interview data was safely stowed on an encrypted, password-protected laptop computer, with the possibility of remote deletion of the hard drive should the need arise. According to participant consent, interviews were collected using a digital recording device, secured in an encrypted file. Once the interview recordings were transferred to my secure laptop, they were deleted from the recording device. All written data was de-identified and coded such that names, data, and any other personal information could not be traced back to an individual participant. Paper documentation was shredded once digitalized. Similarly, the interview that was manually recorded, and not audio-recorded, was also handled in such a manner. The paper record of the interview notes was scanned then shredded, and the digital notes are locked with encryption and secured on the same laptop. There are no conflicts of interest to disclose for this research process.

Chapter 5: Results — Good Enough Care: The Lived Experience of Study Participants

Patients, nursing students, and registered nurses alike shared numerous accounts. Their experiences were sorted into individual level (patient) and health care team level (registered nurses and nursing students). In this chapter, I will also discuss the overlapping data shared by all participants regarding the individual and health care team levels and I will provide their experiences pertaining to the various institutions at the organizational level. Following, participants address the research questions from a societal perspective with regard to the environmental level. Such an approach to the data reflects the vast impact of the participants' experiences as care recipients and care providers and the implications these have for the health care system. To be true to the data provided, I have used anecdotes of patients, registered nurses, and nursing students, including verbatim quotes. This process walks us through the four levels of the health care system model, as coined by Reid et al. (2005) and adapted from Ferlie and Shortell (2001), as to frame the experience of individual patients, nursing providers, organizations, and the larger environment. Strategies which participants discussed throughout the interviews are shared in the subsequent results chapter.

Sociodemographic Characteristics of Interview Participants

Participants were recruited throughout Ontario, solicited for their experiences, either as a Francophone patient having accessed health care in Ontario, or as a nursing provider having cared for patients in Ontario. Participants were interviewed across the province, both in person and over the telephone, with the average interview lasting approximately one hour. Respondents reflect experiences of individuals living in the cities of Hamilton, Hornepayne, Ottawa, Sudbury, and Toronto. The age of the participants ranged from as young as 19 years old up to 82 years old, and they had various educational backgrounds and experience with the health care system. Of the 31

interviews, 30 interviews were audio-recorded and transcribed. For the one interview that was not audio-recorded, detailed handwritten notes were taken for the data collection process. A portrait of the participants, including patients, registered nurses, and nursing students, is provided in the following tables (table 2, table 3 and table 3).

Table 2: Patients' Sociodemographic Characteristics

Francophone Patient Participants (PT) n = 10	n (%)
Gender Identity	
Female	8 (80%)
Male	2 (20%)
Age	Average: 55 years old Range: 26-82 years old
Ethnicity	
White	3 (30%)
Black	7 (70%)
Highest Level of Education	
High school	2 (20%)
College/diploma	3 (30%)
Bachelors	3 (30%)
Masters	1 (10%)
PhD	1 (10%)
Language of Schooling	
French	7 (70%)
French & English	2 (20%)
Other	1 (10%)
Language of Work	
French	6 (60%)
French & English	4 (40%)
Mother Tongue	
French	6 (60%)
Other	4 (40%)
Preferred Official Language	
French & English	1 (10%)
French	9 (90%)

Table 3: Registered Nurses' Sociodemographic Characteristics

Registered Nurse Participants (RN) n = 11	n (%)
Gender Identity	
Female	11 (100%)
Age	Average: 31.7 years old Range: 24-42 years old
Ethnicity	
White	9 (82%)
Black	2 (18%)
Employment	
Casual	3 (27%)
Part Time	4 (36%)
Full Time	4 (36%)
Nursing Membership: Registered Nurse, General Class	
RN	8 (73%) Average: 6.2 years of practice
Nursing Membership: Nurse Practitioner, Extended Class	
NP	3 (27%) Average: 10.7 years of practice
Highest Level of Education	
BScN	3 (27%)
MScN	8 (73%)
Language of Nursing School Program	
French	4 (36%)
English	6 (55%)
French & English	1 (9%)
Language of Work	
French	1 (9%)
English	1 (9%)
French & English	9 (82%)
Mother Tongue	
French	5 (45%)
English	4 (36%)
Other	2 (18%)
Preferred Official Language	
French	3 (27%)
English	7 (64%)
French & English	1 (9%)

Table 4: BScN Students' Sociodemographic Characteristics

Nursing Student Participants (NS) n = 10	n (%)
Gender Identity	
Female	10 (100%)
Age	Average: 22.5 years old Range: 19-30 years old
Ethnicity	
White	7 (70%)
Black	2 (20%)
Asian	1 (10%)
Status	
2nd year	3 (30%)
3rd year	5 (50%)
4th year	2 (20%)
Highest Level of Education	
Undergraduate student	7 (70%)
College	1 (10%)
University	1 (10%)
University + College RPN	1 (10%)
Language of Nursing School Program	
French	6 (60%)
English	3 (30%)
French & English	1 (10%)
Mother Tongue	
French	3 (30%)
English	3 (30%)
French & English	1 (10%)
Other	3 (30%)
Preferred Official Language	
French	5 (50%)
English	4 (40%)
Other	1 (10%)

Findings

Patients, registered nurses, and nursing students shared many concerns regarding care provision for Francophone patients, highlighted at the individual, organizational, and environmental level. Participants acknowledged that the current situation regarding health services for Francophone patients yields decreased quality of care. Patients spoke to the cognitive and emotional labour of poor access to French-language health services. Nursing students and

registered nurses acknowledged the visible and invisible workloads that accompanied servicing Francophone patients in a health care system ill-equipped to do so. Together, patients, registered nurses, and nursing students discussed the disruptions in the flow of care, revealing how fragmentation in individual interactions rippled throughout the entire health care system. Participants further revealed the lack of resources at the organizational level, which causes health policy impacts on Francophone patients' human rights. Throughout the interviews, participants shared a number of strategies, both formal and informal, that they or care partners adopted to bridge existing gaps. They also provided numerous recommendations and strategies to palliate existing inequities. In the verbatim quotes, patients are referred to as PT, registered nurses referred to as RN, and nursing students referred to as NS. Verbatim quotes are shared in the language of the interview. However, geographic location, age, and sex are not attributed to the quotes to respect privacy, anonymity, and confidentiality of participants.

Individual Level: Patients — Poor Access to French-Language Health Services

Personal experience compelled patients to share their realities and challenges regarding access to French language health services in Ontario. Throughout the individual interviews, a number of participants revealed their own experiences, yet shared their stories in reference to the French-speaking community group. This choice of voice revealed that there was solidarity among the minority Francophone and immigrant populations that spoke to the shared struggles of individuals who frequently felt marginalized and powerless during their health care interactions. Their echo of individual issues pointed to a systemic problem, revealed in delays in care, heavy burdens for individual patients and their families, and socio-professional costs, as well as barriers that were present for the most vulnerable Francophone minorities. These challenges resulted in

numerous emotional impacts, from distress, despair, and feelings of discrimination to a disproportionate sense of relief if ever they had access to French-speaking staff.

Delays in Care.

Increased delays in care were a major concern voiced by nearly all patient participants. In a health care system that is already bogged down with lengthy wait times to access health care providers, French-speaking patients noticed that they were further disadvantaged. Not only did they face the existing lags which all patients face accessing health care in Ontario, their wait times were further enhanced when it came time to finding someone who could serve them in their language. PT07 states:

> Parfois, je fais les demandes, mais c'est difficile. Si tu demandes quelqu'un qui parle français, ça va prendre longtemps… donc ça va prendre le temps pour avoir quelqu'un qui parle le français… ça va durer.

Although the patient states that she occasionally requests care in French, this is not done consistently. This patient demonstrates the conflict that presents with requesting care in their language of choice, weighed against the possibility of further lengthening an already extensive waiting time. While she considers the language in which she needs to receive care, she is also cognizant of the limitations of the health care system. As such, to mitigate difficulties related to increasing wait times, avoiding the request at times seems more efficient. PT08 describes this difficulty:

> Je ne connaissais pas l'anglais . . . quand j'allais à l'hôpital, des fois je trouvais des professionnels médicaux qui n'étaient pas bilingues. Alors pour expliquer les problèmes de santé que j'avais, ce n'était pas facile. Des fois il fallait que j'attende qu'on aille chercher un professionnel médical qui parle français, mais des fois ça prenait du temps.

This concern was repeatedly voiced, and the problem was even more challenging when the language need was not assessed upon the patient's arrival, which further delayed access to health

care for all parties involved, from the individual patient and health care providers to the other patients and families waiting for care. RN04 voices the difficulties faced by patients in the emergency department:

> Disons qu'on a un médecin qui ne parle pas en français qui rentre avec une famille Francophone… donc on a déjà perdu du temps parce qu'on vient de réaliser que le médecin ne peut pas vraiment communiquer avec la famille. Donc il sort et là c'est à trouver une infirmière qui parle bien en français… on perd encore plus de temps. Là c'est que l'infirmière doit arrêter tout ce qu'elle fait ou il fait pour aller rentrer avec ce médecin-là. Mais là disons que c'est moi et que j'étais dans le milieu de faire quelque chose de très important, le patient qui est Francophone avec un médecin qui ne parle pas en français, il continue d'attendre et d'attendre et d'attendre jusqu'à temps que par exemple moi je sois prête pour rentrer. C'est vrai que ça retarde vraiment les soins à ce patient-là, mais à cause que c'est un département d'urgence, ça veut dire que ça retarde les soins à tout le monde d'autre que ce médecin s'est assigné à aller voir.

In the above statement, a nurse speaks to her experience in seeing how wait times can be prolonged for patients in the emergency department, despite the hospital being a French-speaking health care provider. Patients already see prolonged wait times, and this reality is even more challenging for patients of a linguistic minority. The increase in wait times not only affects the patient and their family, but also the workflow of health care providers, in this case, the physicians and nurses. Physicians find themselves waiting on available translation, while bilingual nurses, whether assigned to that patient or not, need to accommodate everyone involved. This may involve leaving their own patients and workload to intervene in such situations. Meanwhile, the wait time for all the others in the emergency department is extended. Delays in care are experienced for the many patients waiting to see any available emergency physician. Delays are also extended for patients already assigned to the specific physician working with the Francophone family. Furthermore, care is also delayed for the other patients under the care of the nurse pulled to translate, since her other clinical responsibilities must be put on hold.

Burden.

These situations provide a significant burden on all those involved in such care situations. Patients attest to feeling the pressures of being a Francophone linguistic minority in an Anglophone health care system. Acknowledging the time it can take to receive care in French, some patients have taken on additional responsibilities of complying with the health care system, and accommodating to the needs of their health care providers rather than their own individual necessities and priorities. For example, PT03 states:

> [Le patient] va sauter les détails importants. . . parce qu'il se sent fatigué… tu [cherches des] services de santé, tu vas te faire soigner, tu es malade, et on te demande de fournir encore des efforts… Ça c'est embêtant un peu surtout si c'est une grosse maladie, tu vois, une maladie qui t'ennuie terriblement. Tu vas juste pour trouver une réponse à ça puis il faut que tu te mettes à réfléchir en anglais. C'est fatigant dans la tête.

This patient speaks to their experiences as a Francophone patient accessing health care services in English. The patient speaks both in generalities and in the first person, referring to individual experiences, yet acknowledging that this is a struggle shared by many members of the Francophone minority group. In this quote, the participant depicts how they go above and beyond to reflect and express themselves in English, indicating how taxing this is when they are already ill, preoccupied, and seeking health care. This is done to accommodate health care providers when they are unable to obtain services in their language of choice. As such, they are not providing the full extent of the details pertaining to their health condition, and the health care provider receives a truncated health history, which is not always enough to address the wealth of potential health ailments. The patient participant acknowledges what a burden this can be, especially for those requiring repeated access to the health care system, as is the case with patients living with chronic health issues. This is due to such patients having more frequent interactions with the health care

system and with their health care providers, although the interactions could be incomplete due to the linguistic discordance.

PT03 speaks to the exhaustion that can happen for patients in such cumbersome encounters, indicating that an already stressful meeting becomes more so burdensome when they must process their health care in English. They are seeking health and speaking in English solely to accommodate the perceived needs of the health care providers, rather than putting their needs first as a patient. In these cases, the responsibility for successful patient-provider interactions is shifted away from health care providers and the health care system, and weighs heavily on patients, as indicated in the quote from PT03.

Numerous participants voiced similar challenges, from burdens of feeling the need to censor themselves during health care interaction to deciding to avoid seeking health care services altogether. This has been observed by NS06, who noticed the burden of self-censoring amongst several patients:

> [En tant que patient,] si on a une question on va vraiment essayer de bien la formuler, que ça soit pertinent, que [le professionnel de la santé] comprenne vraiment ce qu'on essaye de dire. Puis là, si jamais tu as de la misère à formuler ce que tu veux dire, ça se peut que tu vas éviter de poser une question parce que tu as l'impression de perdre [le] temps [des professionnels de la santé].

Curating content to provide the necessary information to assist the health care provider is a recurrent theme in this study. This nursing student supports the perspective of patients regarding challenges accessing care as a Francophone linguistic minority. While some patients may be fluent in both official languages, for those who are more comfortable in French, the process of rehearsing and translating questions and statements for the health care team can be quite cumbersome, to the point that it may silence the patients who are struggling the most in English. In such situations, if a patient is not confident that they have phrased questions or statements appropriately, they may

choose to omit them. The attempt to make the health care interaction smoother leads to the provision of less health care information. As such, the dynamic continues, whereby patients do not fully manage to express themselves, and health care providers receive an incomplete health history.

As stated earlier, while some patients may avoid recounting some aspects of their health histories, others might avoid seeking health care altogether. This sentiment is echoed by PT03, further indicating how significant the notion of language and care avoidance proves to be for linguistic minorities in Ontario. PT03 states:

> Des fois, ils ne vont pas se faire soigner parce qu'ils disent « Ils vont me parler en anglais, moi je ne comprends pas ce qu'il va me dire. Je vais m'acheter juste un petit Tylenol ou quelque chose comme ça. »

PT03 rationalizes how the linguistic barrier can lead to health care avoidance for French-speaking patients. Though they desire health care services, a patient may conclude that a visit with health care providers may not be worth the hassle, and instead decide to self-medicate and to self-manage their health ailments. In some cases, knowing that they will be unable to understand and communicate with a health care provider, avoiding the health care interaction altogether can be the outcome.

The disproportional burden that is experienced by patients is further demonstrated by a young family that struggled to understand the full extent of their baby's emergency medical situation. PT06 states:

> Avec le médecin, il n'y avait personne [qui parlait français] donc là on devait faire de notre mieux pour comprendre et pour lui expliquer aussi ce qu'il demandait. Il n'y avait personne pour nous traduire. . . Quand le médecin est arrivé, lui non plus ne parlait pas français et là il n'avait personne, alors là on était obligé de se forcer à comprendre avec détail. Entre-temps mon mari a dit, pour être sûr qu'on a tout compris, je vais enregistrer. . . au cas où on arrive à la maison parce qu'il nous avait donné des consignes à suivre pour surveiller le bébé… il nous avait donné même des formulaires. Ils étaient en anglais. Il a dit ce qu'on pouvait lire, voir s'il y a quelques symptômes que on pourrait remarquer que le bébé a,

> qu'on le ramène à l'hôpital, mais tout était en anglais. On était arrivé ici c'était comme si tu avais des notes à étudier. On a fait ça, on a commencé à lire…

Participants shared numerous difficult situations, further complicated by language. This couple exemplifies the distress of trying to accommodate their child's physician during their family's crisis. Though their baby was ill, they struggled to fully understand the health information that they were receiving. Despite neither of them understanding the care received, they were not offered French language services or translation services. Left to themselves, there were no resources provided to them in a language that they could fluently understand. As such, they were left to study the documentation provided, as they would study for an exam. Their stress continued at home, as they tried to make sense of health care information in English while taking care of an ill child. Rather than leaving the hospital in full confidence, reassured and comforted, this couple depicts the burden that is disproportionately carried by linguistic minorities.

Socio-Professional Cost of Barriers.

The challenges faced by Francophone minority patients in Ontario extend beyond the individual and pose difficulties for their network, notably friends and family. Some participants raised the socio-professional costs of language barriers that could be incurred, notably those that arise when patients must overcome these barriers. For example, many patients seek to find their own informal translators, which entails asking bilingual individuals in their network if they can forsake their own obligations to attend medical appointments with them. For example, PT10 states that « [Mon mari] apprenait l'anglais alors les jours de mon rendez-vous il ne pouvait pas aller à l'école. Il devait m'accompagner. » This patient reports several medical appointments, revealing that she frequently had encounters with the health care system. However, she was French-speaking, and required assistance to understand her health care services provided in the majority

language. To support the patient, her husband was unable to go to school, so that he could attend the medical appointments and interpret for her. Yet, attending school was essential for their family (as much for employment as for cultural integration), as he was trying to learn to speak English. Furthermore, as the patient was not bilingual, and the spouse was a novice English speaker, their difficulties were not fully eliminated once they arrived at the medical appointment.

PT07 echoes this struggle: « Tout le monde est occupé avec le travail, tu ne peux pas laisser tes choses pour aller accompagner quelqu'un [à une consultation médicale]. » This patient shares that with everyone's responsibilities, assisting a Francophone patient at the expense of their own priorities, work or otherwise, is not achievable or sustainable. Unfortunately, Francophone patients and families face this recurrent issue regarding health care in Ontario. PT06 had a similar experience:

> Mon oncle il m'a amené à l'hôpital, mais après il fallait qu'il parte au travail. C'était un centre de santé Anglophone. . . au début il était là pour expliquer ce que je ressentais puis après il m'a laissé pour que j'attende les résultats et tout. Mais le problème que j'avais eu vraiment c'est parce que juste après il fallait qu'on me dise ce qu'ils ont diagnostiqué et qu'on me suggère, qu'on me donne les médicaments, qu'on me dise comment les prendre et tout. Mais là j'avais deux mois [depuis mon arrivé au Canada], si tu comprends. J'avais d'abord du mal à comprendre et le peu d'anglais que je connaissais au pays et l'accent d'ici… n'était pas le même alors je n'étais pas en mesure d'écouter quoi que ce soit.

This participant was fortunate enough to have her uncle support her while she accessed health care, but he was not able to stay for the duration of the visit as he had to return to work. This left the patient in a situation where she was unable to understand the health care received, from diagnosis to discharge instructions. In this situation, as with many others, there was no assistance from French-speaking staff, and professional translation was not offered. The responsibility remains on the patient to make sure that they are equipped to understand their health care, including bringing their own families, friends, or other means to understand the care received.

In such cases, this creates an undue responsibility for both the patients and families. The socio-professional costs of such barriers are heightened for patients with frequent interactions with the health care system, as the linguistic accommodations that must be provided are taxing to both the patient and their network.

Emotional Impacts.

Francophone patients are faced with many challenges, burdens, and barriers, which ultimately yield emotional impacts. Patients spoke of distress, despair, and feelings of discrimination due to the violation of their language rights. All patients voiced an immense relief when able to receive care from French-speaking staff. The distress lived by patient participants was frequently recounted. Patients shared openly and candidly about their experiences, with hopes for better outcomes for the future, all while acknowledging the difficulty of the reality against which they were faced. PT06 states:

> [Notre bébé] avait quatre mois, quand il a eu des malaises. C'est ça qui était le plus grand challenge parce que je devais l'amener à l'hôpital [pédiatrique] et là vraiment la plupart des gens parlent anglais. Quand on est arrivé, je me rappelle la réceptionniste, elle ne comprenait même pas le français et c'était notre première expérience comme cela avec notre bébé. Donc moi et mon mari on paniquait, mais quand on est arrivé, on voulait vraiment expliquer avec tous les détails. On voulait que la personne à qui on parle… comprenne vraiment ce qu'on dit parce qu'on voulait que [notre bébé] ait des soins qu'il lui faut. Mais la personne elle ne comprenait pas.

The patient shares her stress as a new parent accessing the emergency department services for the first time, only to notice that she and her husband would not be able to receive services in French. From the start of their appointment, the medical team was unable to speak French, and to serve them in their official language. This stress added to the distress already brought on by not knowing what was happening to their baby. Though they sought care with the intent to explain their care needs, the existing care structures were unable to provide for that need. As such, it was

difficult for the couple to convey their baby's symptoms, understand the care received, and ascertain that their needs and concerns were understood effectively and properly addressed.

As a result of numerous experiences such as the one described above, many patients spoke of the emotional impacts that took a toll on them. The difficulty and distress caused to patients varied from one individual to the next, with potent consequences to their health care and outcomes. This impact is noticeable in the way certain patients access health care services. In some cases, patients are so desperate to access care in French that obtaining translation services from anyone that will help is work that they necessarily do beforehand. For example, PT07 states:

> J'avais une amie qui. . . avait eu des difficultés pour aller à l'hôpital. Elle était malade, mais vu que son médecin ne parle pas le français… elle m'avait demandé « Est-ce que tu pourrais venir pour m'aider pour faire la traduction? », j'ai dit « Moi aussi, en anglais je suis vraiment terrible, zéro ». Elle a été obligée de chercher quelqu'un qui parle anglais pour aller avec elle à l'hôpital.

It is unreasonable to require that individuals find their own translator before accessing health care, be it a routine assessment or an emergency visit. PT07's statement echoes the difficulties of other participants, knowing that health care services do not always offer care in French. This quote exemplifies the despair that can be experienced by participants who do not have a bilingual network. In this situation, the patient is left asking friends and acquaintances in her network if they speak English as well as French, so that they can accompany her to the hospital. The search for an appropriate person to assist with interpretation is further complicated by the fact that this person hears very confidential information, which they would not have been privy to in other circumstances. Indeed, for these patients, letting other individuals into their medical appointments means divulging very personal details, which may put them in an even more difficult position. Therefore, patients' decisions not only pertain to whether they should seek medical attention or skip health care appointments, but also to the extent to which they are willing to

compromise or forego their right to privacy and confidentiality. As such, participants provide insight into a reality that creates hardships for many linguistic minority patients, in the form of having to accommodate and prepare to safely access care with the result of allowing others into a very personal space. Furthermore, this highlights the dependence that some must have on their Anglophone or bilingual community, to ensure that they understand the health care services that they are to receive.

Such maneuvers have become standard practice for many patients, as the presence of official translators, or even bilingual staff, is limited and most often unreliable based on this participants' lived experience. The above experience emerged more than once throughout the interviews. The importance of linguistic congruence is further demonstrated by PT06. "Il n'y avait personne, vraiment personne. Même tous les patients parlent anglais. Donc tu ne pouvais pas trouver quelqu'un d'autre qui pouvait te dire « Ok, moi je parle français, je parle anglais, je peux traduire pour toi »." This patient experience depicts the difficulty lived by Francophone patients seeking health care services, and the solutions they are willing to consider when faced with language barriers. While some patients may have someone bilingual in their networks to help them access care, others may not be able to mobilize such help, as in the situation above. In this case, the patient needed to understand their English-language health care providers, but in the absence of Francophone providers or translation, they were left with few options. As such, they were desperate enough to ask anybody, including other patients, for help, as indicated in the quote above. PT06 illustrates the heavy distress that French-speaking patients experience when they feel that the care they seek is jeopardized, to the point that they would welcome help from complete strangers in the waiting room. But as shown by PT06, even such a drastic solution can be

unavailable to Francophone patients, as they may not always find bilingual individuals available to help.

In certain cases, patients recounted their experiences and realized that they felt discriminated against. PT04 states:

> Je suis allé à la clinique la plus proche, le docteur avait un nom Francophone et je lui ai parlé en français. Manifestement, il ne comprenait pas le français ou ce sont des gens qui se sont anglicisés complètement… Il m'a fait attendre. Je crois que, je ne sais pas ce qu'il venait faire, j'avais enlevé la chemise, il est parti, il n'est pas revenu. J'ai l'impression qu'il était vexé que je lui aie demandé si je peux parler en français.

This patient recounts a delicate situation of seeking health care services in French, one that left him wondering if he should have done things differently to receive better care, namely by not addressing the physician, whose name sounded Francophone, in French. The patient perceived a possible connection between this and the fact that the physician left him, alone, topless in the exam room, and never returned. The patient speaks to the dilemma of desiring care in his official language, all the while questioning if his linguistic preference led to avoidance, especially since the physician did not return to him after starting the consultation. PT04 later elaborates that receiving French language care is also important to him as a visible minority:

> La sympathie s'établit plus facilement parce qu'entre Francophones immédiatement on se sent entre minoritaires dans la même condition. Donc ça, ça peut aider. . . Ça peut aider parce qu'il peut y avoir d'autres choses qui n'aident pas. Je suis Noir, je l'ai déjà dit, ça, ça peut-être un handicap.

This participant acknowledged that certain patients who were Francophone and belonged to visible minorities may face greater challenges during their interactions with the health care system. While receiving care in French is important, he acknowledges that there can be difficulties for racialized individuals in certain cases. As such, being able to bond over language makes him more comfortable when seeking care.

Among the many difficult experiences shared by patient participants, a positive emotion frequently voiced by participants was the relief related to engaging with French-speaking staff. Some patients had more access to French-speaking health care professionals, while others would rarely find them. In both cases, patients described of their experiences speaking to Francophone health care providers as a moment that both startled them and provided them with significant solace. PT03 states:

> Très souvent, je tombe sur des médecins Francophones, comme par enchantement j'arrive et je me mets à baragouiner mon anglais puis ils me regardent et disent « Tu parles français? », je dis « Oui » et il m'explique les choses en français et ça, ça fait plaisir. . . Tu te sens bien là déjà, tu dis wow là on va bien me prendre en charge parce que tu peux t'exprimer et puis il va comprendre ce que tu dis, il va saisir ton problème.

The patient speaks to the joy of obtaining care in French. Patients often start by speaking the primary language of the health care facility, regardless of the language proficiency of the patient or the health care provider. Noticing PT03's broken English, some physicians engage with her in French, much to her relief. PT03 indicates that once there is a linguistic concordance, the healing is already well underway. She becomes more confident that her health care interaction, and at very least, communication, will take place effectively, as she will be understood.

The relief experienced by French-speaking patients when they can speak with a Francophone provider was also noticed by health care providers in the community and acute care settings. For instance, this reality was witnessed several times by NS02 who states:

> En tant qu'étudiante qui parle français, j'ai eu beaucoup d'occasions de faire du bien aux patients en leur. . . donnant des soins dans leur langue qu'ils préféraient, comme ce n'était pas possible pour l'équipe soignante des fois. J'ai vu des patients vraiment soulagés quand ils ont vu que j'étais étudiante, mais que je parlais français, je parlais leur langue. « Là tu vas pouvoir m'expliquer, ça va être une belle journée », donc c'est vraiment comme, ça a été très positif pour moi parce que je maîtrise bien les deux langues officielles. Je trouve que c'est un grand atout pour moi auprès des patients.

Many providers, nursing students and nurses alike, attested to positive experiences and interactions with their French-speaking patients. For example, NS05 notes:

> I felt very grateful to be able to give their care in a language that they understood. For me that is something that, in working in the places that I've worked, it is something that I have seen is very, « les patients Francophones le tiennent vraiment fort au cœur », to have care in French. So to be able to give that to those people, I felt very grateful to be able to do that for them.

In this quote, the nursing student speaks to a mutual gratitude that emerged from these experiences as a bilingual health care provider, capable of providing quality care to Francophone patients. This emotion was shared by numerous nurses and nursing students throughout the study, resonating with the experiences of patients.

As much as the privilege of delivering services to the minority population who needed health care in French provided satisfaction to them, some participants found the experience to be bittersweet. NS07 states:

> Quand ils voient que je suis Francophone puis que je peux parler avec eux en français, ils sont tellement contents puis ça me fait un peu triste. Je comprends qu'ils sont contents, mais ils ne devraient pas être contents comme ça. [Avoir des services de santé en français] devrait être la norme.

Echoing the thoughts of the previous participant, RN07 also notes:

> I've had like catheters in my hands ready to go do that and then someone will grab them out of my hand say, "Nope, they need you to speak French in room 8."… I remember this one shift where it was a 12-hour shift and I honest to God did three hours of translation, and I was like this is unacceptable, absolutely not… I am happy to do it and I like those interactions and I like making sure that they're able to understand, but I also, like, I'm don't really know how that should work. I also feel like the more I am a Band-Aid, the more it won't get changed. If I stop saying yes, will they actually do something to change it systemically?"

This reality shared by these study participants reveals disappointment with the status quo. The NS07 admits that receiving care in one's official language of choice can bring joy to many

patients but remains saddened by the overjoyed response of her patients. She believes that receiving and accessing care in one's official language should be the norm, and not the exception. The RN07 describes numerous hours of translation and assisting Francophone families, acknowledging that she is one of the few in her sector that can contribute in such a manner. While it is a pleasure to support these families, she reflects on feeling like a Band-Aid solution to her institution and to the health care system, questioning how change can happen if she keeps intervening in such a capacity. As such, there is a gamut of emotional impacts tied to the reception and offer of care to Francophone patients in Ontario.

To summarize, patients shared poignant lived experiences regarding their realities as Francophone minority patients seeking health care in Ontario. From an individual perspective, they described the challenges that presented with regard to securing care in their language, sometimes to no avail. These lived experiences included delays in care, the additional burdens that they carried, the socio-professional cost that they and their families, caregivers, and communities bore to secure health care services, as well as the emotional impacts which resulted from challenges experiencing poor access to health care.

Health Care Team Level: Nursing Care Providers — (In)visible Workloads

Nursing students and registered nurses interviewed discussed the complicated experience of caring for official language linguistic minorities. They revealed the tension that arises from the need to ensure that French-speaking patients receive quality French-language health care services. However, the gaps in the system made this a very difficult task, which led to significant workload increases, whether it was acknowledged by their health care institution or not. Many spoke about nursing school as the beginning of these challenges due to lack of preparedness to care for Francophone patients. The difficulties included increased expectations for upholding care, and

delved into the unique experience of French students' workloads with regard to linguistic minority care provision. Francophone nursing students and nurses also spoke to the challenges in transitioning from being a Francophone nursing student to entering the workplace as a French-speaking registered nurse. They considered the differences that language proficiency can have on their nursing practice, and their experiences trying to sustain a therapeutic relationship despite and considering the linguistic component. Numerous emotions came to light, notably frustration, avoidance, and gratitude.

Student Experiences.

Throughout the interviews, nurses and nursing students recalled their educational experiences. An overarching theme was the lack of linguistic and cultural competence preparation in the nursing curriculums, both in English and French nursing programs. With time, nursing students and nurses learned to be independent in seeking the resources that they needed for their own practice but acknowledged that academic preparation could have an influence on their clinical practice.

Nursing students and nurses who had studied in French explained that their courses prepared them to practise nursing with both Francophone and Anglophone patients in Ontario. For example, NS03 states:

> J'ai beaucoup apprécié avoir fait mes études en français pour pouvoir offrir les services en français. C'est sûr que même si j'avais fait mon bac en anglais, je pourrais parler en français avec des patients. Mais je ne connaîtrais pas autant les termes techniques. Alors du côté linguistique, oui, je me sens adéquatement prête à parler aux patients en français ou en anglais.

Several bilingual health care providers in the study explained that being bilingual could be an asset in their practice, especially when speaking to the technical terms that were particularly important to understanding and explaining concepts to Francophone patients. Many participants

also spoke to the pride that comes with being able to provide care in whichever official language was needed by patients. RN04 echoes this sentiment:

> Absolument, je pense que mon éducation au niveau du bac et même à la maîtrise ça m'a très bien préparée à prodiguer des soins en français. C'était mon choix personnel de faire le programme en français parce que j'ai toujours fait mes études en français et je trouve que c'est très important de continuer.

In the quote above, the nurse indicates that her education in French has been valuable to her. She also appreciates the preparation that it offered her, allowing her to provide quality care in French. Several nurses and nursing students also repeated this.

Nursing care providers recalled experiences upholding care to Francophone patients during their clinical placements. The experiences of French-speaking providers and English-speaking providers were insightful. For example, NS05 shared the following experience:

> The patient spoke no English and luckily, I was on shift to take them because there was no other person in the department, in the hospital building that spoke French. So, I had to sit in on the surgery consults, the teaching and do all those things for the patient to be able to understand because the patient had consented to the surgery without having it explained to him in French and [the patient was] very clear on the fact that [he wasn't] really sure [about information provided regarding the surgery].

Similarly to French-speaking registered nurses, French-speaking students saw their workloads and responsibilities significantly increased once their bilingualism and French language skills were seen as an asset for the clinical setting. In the situation above, the bilingual nursing student contributed heavily to the care provision for this patient. The care was extensive, including not only nursing responsibilities, but also interpretation and translation services. These services were not provided in an official capacity, but to fill a need that the hospital had not provided for. This was immediately helpful for the patient, as he was unable to safely consent for surgical care without the nursing student's intervention. Such experiences were regular occurrences for

numerous French-speaking nurses and nursing students in the study. Furthermore, many health care institutions are in such situations, where individual health care providers take on additional responsibility to ensure that patients' needs are met. This leaves the health care system with a gap that administrators do not perceive, as it has been bridged by the intervention of individual nurses and nursing students. To further elaborate on this, NS05 continues:

> [The patient] didn't know really what was going on, we spoke to them and they signed the consent, and I was like "Wow, okay," so then I brought the patient in and I spoke to them and was like "Hey, you know, do you know what you've signed here? Do you know what's happening? Do you know...?" and they were like "No, thank you so much for explaining this to me" and so then I grabbed the surgeon back in and we had the conversation again together so that they could ask any of the questions again and go through all the teaching that they had kind of gone through preoperatively and then I made sure, I stayed after my shift so that when they were in recovery I could at least give some main teaching tips when they first woke up and provide resources to the nurses that would be caring for him to be able to communicate with him in French. So, I told him to write out everything that they wanted [to know], and [the patient and health care team] were able to Google Translate to get a gist of things.

NS05 implemented extensive measures to ensure that the patient received the information and care they needed. This included numerous patient assessments, reaching out to the surgeon, as well as staying beyond her assigned shift for follow-up care. This was done to ensure that the patient would receive comprehensive preoperative and postoperative care. The patient indicated gratitude for this care. The nursing student did this to make up for care that she deemed to be essential for the patient but that the health care institution was not able to provide at the time.

The experience of nursing students remains complicated through the lens of the health care system since they are present as both learners and health care providers. Nursing students provided a unique perspective, as they gained knowledge of the profession, and were during developing their professional identity and determining what it meant to be a nurse, all while obtaining introductory experiences that would shape their professional practice and worldview. French-

speaking nursing students frequently voiced the feeling they were made responsible, not only as a learner and practitioner, but also as an informal interpreter. Nursing students can often spend more time with individual patients because they have reduced patient loads. As such, they were often present in situations where they noticed the linguistic gap. Francophone students were very often the solution to such gap. For example, NS02 speaks to this dynamic:

> Je faisais un stage à [hôpital pédiatrique] l'année passée. J'étais étudiante justement avec une patiente et sa mère qui était là aussi. Pendant la ronde des médecins. . . ils sont arrivés devant la porte de cette patiente-là et tous les médecins parlaient, parlaient, parlaient. À la fin ils ont demandé à la mère « Avez-vous des questions? » Là, elle m'a regardé comme en paniquant et elle a dit « Je vais la poser en français parce que je ne sais pas, je ne sais pas la dire en anglais. » Je disais « C'est correct, c'est correct. » Alors, elle a posé la question. Tous les médecins se sont regardés, comme, « on ne comprend pas ce qu'elle dit ». Alors, je me suis dit « C'est à moi de traduire. Comment ça fonctionne » . . . elle m'a regardé, la patiente, la maman m'a regardé. Puis là j'ai juste traduit la question. Les médecins ont répondu en anglais. Il a fallu que je traduise à la maman, dans le fond.

The situation above brings up numerous dynamics. The nursing student was able to support both the patient, the family and the physician group by providing an informal interpretation. This translation was done on an impromptu basis, as she happened to be in the room at the time the physicians were making rounds. The rounds took place in English, although the patient and family were Francophone. The patient, family, and nursing student were left flustered as they struggled to come up with a way to ameliorate the situation and to ensure proper communication and information sharing. Had the nursing student not been there, it is unclear as to the options that would have been deployed. The presence of the nursing student allowed the mother and pediatric patient to have a voice, encouraging the mother to express herself in her official language of choice, French, despite the linguistic discordance that existed between her and the care providers. This was an unplanned responsibility for the nursing student, who was uncertain how to proceed, but was able to intervene. Moreover, since there seemed to be no other options presented to the nursing

student and family, the improvised strategies were the default position in this situation. The student had to improvise to break the impasse. This situation depicts one clinical encounter but does not broach what happens after this undergraduate nursing student leaves at the end of her shift. For Francophone nursing students, the workload can easily increase due to such unforeseen circumstances in which they must manage time-sensitive situations in ways that fall outside of their normal responsibilities as students.

Ethical dilemmas and morally distressing situations emerged as nursing students shared their stories. To illustrate, participants described situations in which care providers demonstrated discriminatory behaviours towards Francophone patients, such as reducing their interactions with them. For example, NS02 states:

> Je ne dirais pas qu'ils me l'ont dit, mais je dirais que je l'ai senti. Tu sais, j'ai senti qu'une infirmière était moins portée à aller voir un certain patient parce que justement moi j'étais avec ce patient-là puis moi j'étais Francophone. Elle disait comme « Tu t'en occupes, tu vas me dire s'il y a quelque chose. » J'ai dit « Oui, oui, mais tu sais c'est quand même ton patient… comme… tu ne veux pas aller le voir, il aimerait ça te voir toi. »

We can see a parallel between the experience of NS02 and that of PT04, who spoke about being abandoned topless on an examination table, wondering if the linguistic component was a factor as to why his health care provider would not return to see him. In the quote above, the nursing student describes noticing that the primary nurse was avoiding interacting with their Francophone patient, leaving the care in the hands of a student who was still learning. While NS02 was willing to provide the required care, the most responsible provider in this situation did not readily reach out or engage with this patient, relying instead on the student to do assessments and collect the patient's concerns on her behalf. With linguistic discordance exists, the reasons underlying decreased patient interaction are questioned not only by patients, but also by nursing students who witness these encounters.

Studies and Work in French.

English-speaking participants also shared their struggles and disappointments while reflecting on their student experiences and their clinical practice. While French-speaking nurses and nursing students saw their clinical workload significantly heightened, English-speaking participants were disappointed that there were few opportunities to learn to provide care to patients who spoke different languages, notably the official minority language. For example, RN07 states:

> The approach to people kind of speaking different languages was just "Oh, well we won't assign you that patient." Versus like, how do we problem solve that… Which is, not great. I don't know if they were just trying to simplify it because we were learners … and they thought it would just be an extra hurdle that we couldn't manage … but actually a lot of the nursing students today who I went to school with, English was their second language. They were already working in their second language. So, might as well thrill us who were working in our first language, give us a little obstacle to work with. But I also hate the idea of people's languages being an obstacle.

In this quote, the registered nurse speaks to the frustration of receiving few of these clinical opportunities, as a student, to engage with linguistic minority patients during her academic training. They did not develop the learning and the skills to engage with clinical resources, tools, and aids that could help them be proficient in adapting their nursing care to linguistically diverse needs (both during and after their clinical placements). Moreover, RN07 conveys her disappointment that these opportunities were presented as hurdles, thrills, and obstacles. While she sees these learning challenges as beneficial to students, these kinds of situations also frame French-speaking patients as "difficult" or "challenging" patients to work with. Many participants reflected on their own clinical practice throughout the interviews, as did this registered nurse, who acknowledged that a patient's language could be seen as an obstacle.

Indeed, many Anglophone nurses and nursing students questioned the existing system that did not lead students to learn to manage and appropriately care for linguistic minority patients,

relying instead on escapist and avoidance strategies. Many participants expressed a desire for more problem-solving skills and strategies to care for linguistic minority patients, and yet noticed that few opportunities to excel in that domain existed during their formative years. These dynamics were present in both English and French language nursing programs. For example, NS07 explains:

> Notre prof de stage il disait. . . « Ben je ne vais pas t'assigner un patient Francophone à chaque semaine. Je ne vais pas m'assurer que ton patient il est Francophone ». . . notre prof de stage il refusait de donner des patients Francophones aux Francophones. Essentiellement ce qu'il disait. . . c'est que les soins ici à [ville/city] sont français et en anglais… il faut être capable de parler en anglais aussi. Donc ça, c'était un peu, c'était vraiment difficile pour certains étudiants. . . pour certains c'était vraiment une grosse barrière. »

The quote above further reveals how varied students' clinical experiences could be, from having significant control over how one desires to provide care, to having little agency in the clinical opportunities received. In the quotes above, patients indicated how much they would like to receive care in their official language of choice. In the quote from NS07, it is suggested that even attending a Francophone institution does not guarantee that students will be able to provide care to Francophone patients. Though nursing students were willing to give services in French, they did not have the agency to do so if their clinical instructor did not support it. The earlier quote from RN07 speaks to her wish to care for patients who did not speak the same language as a means for professional and personal growth, although she suggests this situation was typically discouraged by clinical educators. All the while, French-language programs strive to prepare nursing students to provide care, which can result in less linguistic discordance during patient care interaction yet fulfill the requirement of providing students opportunities to competently care for patients in both official languages.

To add further stress and challenges to nursing education, Francophone nursing students also voiced concerns with regard to continuity of care for French-speaking patient populations, especially when clinical placements were cancelled. NS07 reveals that:

> Ça frustre un peu particulièrement dans le cas de l'étage de schizophrénie. Ils n'ont juste pas pu trouver un prof Francophone. Donc c'est, c'était malheureux comme situation. . . c'est certain qu'il y a des [patients] Francophones là . . . s'ils ne peuvent pas trouver quelqu'un à enseigner sur cet étage-là, est-ce qu'il y a des professionnels de santé sur cet étage-là qui peuvent prodiguer des soins en français pour ces patients Francophones-là? Je ne sais pas. J'espère que oui, mais je ne le sais pas.

This quote is telling of the experience of several Francophone students in French language nursing programs. Curious and interested in exploring a potential mental health career, these nursing students elected to be placed in a specialty schizophrenia unit. The clinical placement was cancelled as there were no available registered nurses to mentor a group of French-speaking students. She was so concerned by this situation and so eager to explore this field that she contacted the clinical manager and was told that this clinical placement would be available only in English due to the shortage of French-speaking clinical educators. As much as this student was disappointed in not having the clinical opportunity that she desired, she also saw that this situation could have concerning repercussions beyond herself. She related this situation to the fate of Francophone patient populations. With the placement being cancelled, she had her doubts as to the availability of French-language services in this clinical sector. She voiced concerns with regard to the number of French-speaking registered nurses who are present on the specialty unit on a regular basis to provide care to patients living with schizophrenia. Cancelling of such clinical opportunities for Francophone nursing students also raises questions regarding the future of French-speaking nursing care providers on these clinical units, as students are not having exposure to the unique unit and its particularities. This quote points to challenges facing nursing students, the nursing profession, as well as French-speaking communities.

Anglophone Nursing Experiences.

After graduation, nurses continued to have opportunities to reflect on their clinical practice and the care that had been provided to Francophone patients over their careers. Many of the experiences they recounted reflected subpar environments with regard to the provision of quality care to official language minority communities. These clinical environments were also taxing on the nursing staff. For example, RN03 states:

> We maybe have one nurse a shift that could speak French. So, if we did have French-speaking patients, we usually tried to assign them to that nurse. Sometimes they were patients that were one-day patients where you'd only want the nurse to really be with the patient one day in a row … she didn't want them the next day. So, someone like me, who speaks a little bit of French, would end up working with the patients. So, I mean for the most part, it's okay, because I know how to ask, "Are you in pain?" I know how to ask things like that, but sometimes they'd be talking, and I'd just be like, "Mm hm," I don't really know what story you're telling me, so there was kind of a bit of distress for me because I'm like I can't converse with my patient. I can't hear their life story. Things like that… I know the basics … it was still better than having someone that didn't speak French at all, because I was still able to be like "This is your medication." "Are you in pain?" I think the hardest part I ever … did was have to do catheter care teaching in French. So, I mainly read through the book, just verbally reading it with them and did a lot of just like sign language and miming and being like "attachez ici," and "mettre ici." Because there are some "body" [anatomy] words I don't know.

The account of this nurse indicates how challenging it can be for an Anglophone health care provider to try to bridge the gap and provide basic care for Francophone patients. This nurse speaks to the challenges that come with being able to speak only a little French, just enough to articulate a few short sentences. She struggles to converse with her patients beyond the basics and to understand their responses, a critical component of the patient care interaction. Usually, the care of Francophone patients is assigned to the most fluent nurse but sometimes the most fluent nurse is barely bilingual, as RN03 describes. Despite the best efforts, care provision can be difficult in the presence of language discordance, and the quality of care needs to be ensured beyond the basics. Although RN03 was comfortable with basic care, such as assessing for pain, she was unable

to converse with the patient regarding more complex evaluations and procedures. In such a dynamic, the patient would also struggle to engage and respond appropriately. In her account, RN03 acknowledged that this circumstance caused her distress.

As the quote shared by RN03 suggests, nurses desired to meet their patients' needs and to be a team player on a clinical unit that needs more support caring for Francophone patients. However, distress may arise when a nurse realizes that her linguistic skills and resources are not good enough. Although having access to booklets (if available) and having the confidence to mime and "signal" her way through a clinical interaction may be a start, the quote above clearly shows that this is not the best for either patients or staff.

The difficult efforts required to navigate an English health care system for Francophone patients were shared by several nursing care providers. Many nurses go to great lengths to make sure that their patients are receiving proper care. For example, RN09, an intensive care unit nurse, states:

> That questionnaire that I was talking about earlier, I had a nurse sit with me while I read it and they helped me pronounce all the words correctly and things like that. Just so that once I'm going through that with the patients, they're able to understand what I'm saying.

In this example, the nurse is diligently seeking help to best navigate her patients through assessments in French, although she does not identify as a French-speaking nurse. This effort is valuable to the nurse and to the patient but is also a timely investment of human resources. For example, these two intensive care nurses may have numerous priorities and responsibilities. As such, it is difficult to make time for such a linguistic investment and on-the-spot training, even though it can be helpful to the immediate care providers and patients involved. Though the quote received is from RN09, her Francophone colleague's workload is heightened with unexpected responsibilities, to support proper patient care while educating her Anglophone colleagues. This is

an example in which invisible work takes place throughout the health care system, benefiting patients and the organization, but often unnoticed by the institution.

French-Speaking Nursing Experiences.

While many Anglophone nurses and nursing students struggled with the feeling that they could not provide enough care to French-speaking patients on their own, Francophone nurses and students experienced the opposite, and were frequently placed in situations that led to overwork with no clear end in sight. Speaking to this very issue, RN04 states:

> Ben on s'entend que j'ai quand même une charge de patient moi-même . . . Et donc quand c'est mon propre patient pour qui il faut que je fasse de la traduction, par exemple, pour le médecin, ça me dérange moins parce que je travaille déjà avec ce patient et cette famille. Donc je connais déjà quel est l'historique médical. Et oui, j'aimerais quand même entendre ce que le médecin a à dire. Cependant quand c'est un autre patient et une autre famille, je ne trouve pas que j'ai vraiment le temps à donner pour aller faire la traduction là, alors que j'ai neuf patients, dix patients à moi-même qui ont des besoins médicaux et qui ont des ordonnances, etc. Et ce, encore moins quand je travaille dans le département qui est moins aigu, parce qu'on a un volume de patients encore plus élevé…

This nurse speaks to the challenges of managing her own workload, while accommodating the needs of her department, and more specifically, the needs of physicians who are unable to speak French to Francophone patients. When many Francophone nurses and nursing students described additions to their workload, much of it starts with interpretation, as described by RN04. While the desire to help is there, there is an underlying burden that comes with the increase in workload, especially when assisting patients that are not already under one's care. The increased workloads on nursing staff, in combination with varying patient acuity and heightened responsibility, leads to a situation where nurses are left balancing what can do to help the team, and what is safe for them and their patients. As such, the invisible workload and burden increases, and this is disproportionally heightened for Francophone staff.

Other nurses voice similar concerns. The stress related to care provision to Francophone patients is not only present when patients are actively receiving care on their unit, but also extends after discharge when a patient is transferred outside of the institution. For example, RN01 states:

> Si quelqu'un veut vraiment que ça soit en français, j'appelle souvent la place pour dire « Est-ce que le client va avoir des soins en français? » Si c'est non, ben là, « Est-ce que vous offrez des services de traducteur? » Si c'est non, ben là… c'est de voir avec les clients. . . « c'est vraiment important que tu ailles là, mais on peut peut-être voir si y'a une autre option » …des fois, j'essaye de trouver d'autres options pour le client, si c'est vraiment un problème… Si ce n'est pas disponible, je fais juste faire du coaching au client comme… « ce n'est pas disponible, mais je pense c'est super important, tu comprends un peu l'anglais. Moi, je peux t'aider à comprendre s'ils te donnent une formation », des choses comme ça… Donc, j'offre le support, si tu veux… le client peut revenir me voir s'il a une question ou parce qu'il a vu quelqu'un qui n'était pas Francophone.

In this quote, RN01 reveals that not only is she responsible for patients under her care, but her oversight extends to other institutions and other service providers. The nurse comes up with numerous solutions and strategies to assist and accommodate the patient, such that other health care professionals and facilities may not even notice the extent of the burden that is placed on the patient, let alone other health care providers beyond their institution. The relationship negotiated in this quote exemplifies how the nurse seeks to support the patient in navigating a situation where they will likely receive care in English. Yet health care providers realize that this is unlikely to be sufficient, and they expect the patient to return with questions that remain unanswered by the other team. Again, this testimonial exemplifies the invisible workload of the nurse. While it may be witnessed by the patient and by some other health care professionals, organizations rarely acknowledge or realize the work and effort that has been invested on the sidelines to keep their business activities and organizational performance afloat.

RN02 identifies other challenges French-language health care providers may face, which are not limited to direct interactions with patients:

> De plus en plus [la documentation] est en anglais. Il y a beaucoup de personnes qui n'ont pas de problème pour lire cette documentation-là. Mais par exemple, le patient que tu reçois à l'admission, puis que tu as besoin de ses antécédents, tu as besoin de vérifier combien de fois ce patient-là a été admis, a été à l'hôpital, a été hospitalisé, des fois dans les autres hôpitaux, et puis quand tu regardes toute la documentation est en anglais… est-ce que c'est tout le personnel qui est capable de saisir que la dernière fois il a eu une réaction à ce médicament-là? Il faudrait qu'on fasse attention. Je veux dire, quelquefois c'est banal, mais des fois ça peut prêter à beaucoup de choses qui peuvent être en rapport avec la sécurité, entre autres. Fais que, ce n'est pas juste la langue, mais je trouve que la langue, ça, c'est un élément vraiment important dans la prestation des soins.

In this quote, the nurse indicates the compounded challenge that some Francophone nurses may face when nursing in Ontario, especially if their English comprehension or proficiency is limited. The Ontario health care system, being rooted in a predominantly Anglophone environment, has resulted in English documentation being the norm in all sectors, including in many French-speaking facilities. Documentation and health interactions are expected to be conducted in English. However, nurses trained and more comfortable in French acknowledge a heightened safety risk in the face of such a potential language barrier, like that which would be present when Anglophone nurses are charged with caring for Francophone patients. This risk is important because it relates to the safety of patient care. The language of documentation can pose a challenge for the person documenting and for the readers of documentation, such as fellow health care workers and patients themselves. For Francophone patients specifically, even the language of documentation that pertains to their own file is likely to be unavailable in the official language of choice, which is increasingly the case, even when they access care in a French-language facility.

Preserving the Therapeutic Relationship.

During such challenges, some nurses and nursing students did speak well of the encounters that emerged. NS08 states

> Je trouve pour la relation thérapeutique, il y a certaines techniques de communication qu'il faut faire. Mais je trouve que si tu es capable de parler avec les patients selon leur langue

> qu'eux autres sont le plus confortables, quant à moi ils vont probablement partager plus avec vous. Ils vont peut-être faire parvenir plus d'inquiétudes qu'ils ont. Ils vont se sentir peut-être plus confortables. C'est ça que moi j'ai trouvé dans mes stages quand j'ai des patients qui sont Francophones. L'équipe de soins. . . ne communique pas bien en français, alors ils vont partager beaucoup plus de choses avec moi qu'avec l'équipe de soins. Donc ça se peut que ça soit que je parle le français puis qu'on est capables de bien communiquer. Ça se peut, qu'il y a d'autres raisons. Peut-être à cause que je suis étudiante puis je suis plus souvent dans leur salle que l'infirmière. Il y a ça aussi… Mais le fait que. . . on est capable de bien communiquer entre nous, je pense que ça aide un peu.

This nursing student speaks to the fact that language congruence with her patient bolstered the therapeutic relationship. The student saw an opportunity to assist the patient when few resources and personnel were available. She also speaks to the importance of accommodating the patient in their language of choice. As such, she was comfortable engaging with the patient and was able to gain more health information. The patient benefited from increased trust beyond what was offered by the team, which can in turn lead to the identification of additional care concerns and needs.

Emotional Impacts.

Numerous emotional impacts coloured the clinical experiences of registered nurses and nursing students. For example, RN08 states:

> I had a patient who was primarily Francophone, he did speak a little bit of English and he did understand a bit of English, but in terms of the medical questioning and what we were trying to understand about his medical history … it was not clear for him… And he said, he made a valid point, but he was also agitated, upset, frustrated and then he took one nurse's input who is solely Anglophone offensively. So, he was nice, kind with me… I don't think he meant to be offensive in any way, but I think in the end it wasn't a great experience for him because, rightfully he said to us, "You know this is a bilingual hospital I should be able to get services in French and in English.

This registered nurse was bilingual, and yet was caught in the dissatisfaction of the patient, who was rightfully expressing his dismay of being cared for in English. While this patient voiced frustration over inconsistent French services, this situation caused frustration for RN08 as well,

who tried to provide quality services in French in a bilingual hospital. RN08 speaks to the valid frustrations of this patient, highlighting the fact that a patient can be bilingual, but nonetheless more comfortable addressing health and medical concerns in their official language of choice. As such, despite being a bilingual registered nurse, this participant is left with the memory of a dissatisfied patient due to the lack of linguistic competence in a bilingual facility.

Nurses were aware that linguistic discordance can cause numerous issues other than frustration for both the patient and the health care provider. For example, RN10 states:

> I'd also imagine some patients would almost see that as a reason not to come to an appointment. Like if they're—either they're afraid that they're not going to understand everything that is said and so I can see that as a big barrier. They might just avoid coming to appointments in general. So yeah, I think that's important to consider.

RN01 echoes this sentiment:

> C'est sûr que c'est une barrière… Ça devrait être un déterminant de la santé si ça ne l'est pas. Avoir accès à des soins dans ta langue, comme tu le sais, ça peut déterminer si tu vas bien… prendre ton traitement. Si tu vas bien… te sentir confortable d'aller voir ton médecin… Je travaille avec des gens sans-abri, à revenu très, très, très faible… ils ne viennent pas me voir, je vais dans leurs maisons… J'entre dans leur building… Si je ne parlais pas leur langue, c'est sûr qu'ils ne viendraient pas me voir. Pourquoi tu irais voir un médecin qui ne parle pas français, si c'est la seule chose que tu parles? C'est un peu ça. Si tu n'as pas d'argent pour te rendre… au médecin, tu n'y vas pas.… Même si tu es le plus riche au monde, si tu parles juste le français, [et ton professionnel de la santé] ne te comprend pas, tu ne vas plus les voir.

These registered nurses provide important insight into the problem of care avoidance. RN01 and RN10 discuss the numerous deterrents that can exist to patients' access to care. The fear of being misunderstood is onerous, and language congruence is a facilitator for care for many patients and families. The respective accounts RN10 and RN01 lend support to PT03's reflection, quoted earlier, relating how the use of over-the-counter medication may seem like a suitable substitute for health care interactions when they are not offered in their language of choice. RN01's

testimonial is particularly pertinent and in line with PT03's perspective. As she described her experience doing home visits for patients, she identified that language affects not only access to treatment, but also its adherence, the ability to follow directions appropriately, and more. As such, RN01 considered that language should be a determinant of health, as linguistic congruence can be a factor as to whether or not a patient will access care.

In summary, nursing students and registered nurses in this study have had several experiences with regard to caring for patients from official language minority communities. These lived experiences pointed to the (in)visible workloads for providers trying to navigate a health care system with various levels of preparation to address the needs of its clientele and its providers. Moreover, nursing participants talked about the difficulties of navigating the therapeutic relationship, as well as the emotional impacts that these care experiences had on them as professionals and as individuals. These experiences varied between students and registered nurses and differed with English and French-speaking providers. However, these participants spoke to challenges that started as early as during their clinical experiences as students, and which continued into their various places of employment.

Patients and Nursing Care Providers: Disruptions in the Flow of Care

Patients, nursing students, and registered nurses alike spoke of challenges associated with the provision of care to members of the official language minority community by those providers incapable of offering services in French. These included barriers to speaking with linguistic minority patients and to seeking and obtaining services. These barriers also had an impact on care services brought about primarily by a lack of comprehension between the patient and the providers that led to difficulties with clinical assessments, language access in emergency/urgent care situations, and the continuity of care. Multiple issues were raised with regard to interpretation and

translation. The quotes also highlighted challenges from Francophone patients being regarded as "difficult" patients.

Barriers Speaking with/Seeking Health Care Providers.

Nurses, nursing students, and patients alike realize that being part of the official language minority can create barriers in terms of speaking with health care providers, as well as seeking out the required health care. PT08 speaks to this saying:

> J'ai de la difficulté à m'exprimer. Des fois de lui-même [le professionnel de la santé] me dit « Vous parlez français? », « Oui », là on continue en français. Mais des fois il est bilingue, mais le français qu'il parle… il n'arrive pas à expliquer aussi ce qu'il voulait te dire. Il se sent mieux de te l'expliquer en anglais. En français, il y a des mots qui lui échappent aussi… pourtant il parle français, un peu français. Alors là, il est obligé d'aller chercher un collègue qui parle français et là ça peut prendre un peu de temps.

This patient speaks to the perplexing situations that can surround access (and lack thereof) to French-language services in Ontario. Like many patients, this individual's health care interaction starts with muddled English and difficulty in fully expressing her needs. The health care professional realizes the challenge and is able to switch to French. However, the health care provider's proficiency in French is limited, leading to a language discordance, since the Francophone patient still cannot effectively express her needs. This strains the health care interaction and adds a barrier to the care. The health care provider must seek a colleague, who can speak more proficiently in French than they can, which adds to the Francophone patient's wait time to obtain care. Sometimes there are no other health care providers who are more fluent in the minority language, further heightening existing barriers.

Challenges with Interpretation and Translation.

While easy access to translation and interpretation services may be constructed as an ideal solution, participants' accounts demonstrated concerns and challenges that were raised by health care providers and patients alike. For example, PT10 states:

> La première fois quand j'avais l'interprète, comme je comprenais au moins un peu d'anglais, à un moment donné l'interprète… voulait interpréter ce que je n'ai pas dit. Alors je l'arrêtais puis je disais « Non, ce n'est pas ça ce que j'ai dit ». Alors avec ça, ça me met en tête que « Non, est-ce que réellement l'interprète va faire comprendre le médecin ce qui est mon problème? » Alors j'avais des doutes…

This quote raises concerns with regard to professional interpretation services. The Francophone patient spoke minimal English but enough to grasp whether what was being relayed to the physician by the interpreter was accurate. The patient was concerned to hear such misinterpretation of her statements, which led her to seriously doubt the process and the care team's ability to understand her health issue if the interpreter himself had limitations in terms of comprehension and interpretation. In PT10's case, interpretation, which was meant to be a solution to linguistic barriers, proved to be an additional barrier and stressor for the patient, who began doubting her care. PT10 continues along this vein, stating:

> Quand je suis arrivée au Canada, on disait que surtout ici en Ontario, on me disait que c'était bilingue. Mais c'était très difficile, car je me rendais à des hôpitaux, c'était par exemple comme [hôpital Francophone]… On a toujours dit que c'était un hôpital qui est Francophone, mais quand vous arrivez, vraiment c'est différent. Ce n'est pas ce qu'on dit. Alors quand vous essayez de demander les services, il est vrai que vous pouvez trouver les Francophones et les Anglophones. Mais des fois quand vous êtes transférés à un spécialiste, plus de fois ce sont des Anglophones. C'est toujours difficile avec un Anglophone, leur expliquer ce qui ne va pas. Même si on te donne un interprète, des fois tu ne te trouves pas quelques fois à l'aise et tu n'es pas sûr de ce que vraiment il va dire au médecin.

PT10 reflects on her experiences living in a province where services in French remain spotty, despite discourses suggesting otherwise. While patients may be able to receive care in

French in certain centres, especially Francophone institutions, there is no guarantee of continuing services in French if a patient is referred to a specialist. To further add challenges to the situation, the difficulties with interpretation and translation also contribute to the difficulty faced by Francophone patients. As such, continuity of care is limited and difficult for Francophone patients and health care providers alike.

Many patients echoed such concerns with translation and interpretation and were especially concerned with the doubts that these problems engendered. NS02 shared her insecurities about her own interpreting experiences:

> J'avais plutôt peur de donner. . . les mauvaises informations. Parce que tu sais, quand tu traduis, tu n'as pas toujours les mots exacts. C'était vraiment un contexte important… On parlait du pronostic, on parlait de ce qui allait se passer… La mère a dit « Est-ce que mon enfant va marcher? » puis là, tu sais, les médecins, je voyais qu'ils pesaient leurs mots en anglais donc je voulais m'assurer de peser mes mots en français aussi . . . J'étais comme l'interprète. Tu sais, il y avait plusieurs infirmières sur le plancher et tout, mais c'est moi, l'étudiante qui a fait la traduction. Donc ça, ça serait un des exemples les plus frappants. Je trouvais ça un petit peu triste que si je n'avais pas été là, je ne sais pas ce qui se serait passé.

NS02 stated that interpretation was a significant responsibility and that she was nervous about the possibility of misinterpretation and sharing the wrong information, especially when the conversation was emotionally laden for the patient, family, and health care team. Being the one responsible for sharing a poor prognosis and other challenging information was arduous for a student, especially without appropriate training in fulfilling this critical function. This sentiment was compounded by the awareness that she was one of the only bilingual individuals on the unit, leading her to worry about what would have happened in her absence.

Nurses further elaborated on the challenges of having so little regular standardized access to interpretation and translation. As RN03 explains,

> For French it's usually just find another nurse, find someone and have them pop in and help you, but then like they don't stay the whole shift with you, right? So, it doesn't seem

> to be as formal of a process with getting a French translator. And I find that we rely a lot more on family members to translate, not just with French, than we should … because they could misconstrue the information, right. I mean I speak French… I understand French well enough that I usually would understand if they weren't translating it right, but … because I can understand more than I can speak and I can read more than I can listen, but, yeah, it's still hard. Yeah, there's not any formal… I sometimes use Google Translate … most of our rooms are shared, so there's one patient and their family and another patient and their family and this patient's family was translating for me. Because the first patient's family spoke no English and the other patient's family was bilingual. So, they were translating for me. I didn't ask them to, but they were just behind the curtain being like la la la la… She said this."

This excerpt reveals how patients and nurses are left to improvise when it comes to interpretation and translation. There is a high dependence on Francophone colleagues, or at the very least, on nurses with any ability to speak French. Moreover, French-speaking families, as well as anyone who can lend a hand, are used as a resource for translation. This informal translation and interpretation strategy is used as opposed to formally accessing a French translator. RN03 acknowledges the challenges with informal translation and the possibility of misinformation. Technology such as Google Translate is used extensively to compensate for the language gaps between health care providers, patients, and families. Not only is there a challenge accessing appropriate translation and interpretation, but also from including the right individuals in the circle of care. Not only do other nurses, families, or neighbours across the curtain end up contributing, but this dynamic emerges with very little or no appropriate alternatives provided. As such, this issue is significant in considering once more the problems surrounding privacy and confidentiality with a patient's health care services. Hence, appropriate translation and interpretation services remain challenging for patients and health care providers alike.

For example, RN05 is a nurse who is often pulled to aid her colleagues with interpretation in the workplace.

> I also work pretty closely with the [nursing team] that is in the community and right now they don't have any nurses who speak French. I have gone with them to see their patients in [ville/city] to act as like an interpreter when it is something that is like the same day thing. . . parents have a big question, nurse is going anyways, I'm in the office… "would you come?" "Sure," and we'll have this discussion.

This registered nurse shares how she can be pulled to assist with interpretation outside of her role, and even outside of her workplace, as she has been requested to be present and translate in clients' homes. Other nursing participants who were bilingual also talked about being pulled to interpret French in numerous areas, and many felt that it was their responsibility as they had been hired as a French-speaking staff member for their clinical unit. There is no reference in this quote of seeking professional interpretation or translation services, nor of their availability. However, RN05 is called upon when she happens to be in the office to assist throughout the community. Even when professional interpretation services were available and called upon, confidentiality remained a cause for concern. NS09 states:

> In the acute care setting… Having an interpreter on the phone … beds are divided by curtains … also that confidentiality … you know the phone is on speaker most of the time, teleconference, right? … Before getting an interpreter on board … you almost have to overcome this not visible barrier of letting them know that bringing in an additional person that they can't see or they don't know, it's okay into their care and it's safe, it's confidential that this person … is also part of the health care team.

While this nurse was fortunate enough to have access to translation and interpretation services, she noticed that it was not without pitfalls. Although in-person translation was not always available, telephone interpreters were a service provided by NS09s' facility. With the nature of hospital beds being separated by curtains, confidentiality was an issue for the patients and providers alike when interpretation was offered through a teleconferencing service. Navigating the speaker mode meant that the confidential health care interaction was projected for the entire room to hear. Furthermore, trusting the teleconferencing service was an issue for certain patients, who

had not yet come to trust the individual on the telephone. As such, while the interpretation services were meant to help, this mode added an extra barrier to the health care interaction.

Francophones as "Difficult" Patients.

Another concern emerged from participants' accounts related to the nature of blame that could come with seeking care in French, as such that Francophone patients can sometimes feel like and be labelled as difficult patients. For example, PT04 speaks to this saying:

> Comment ça va d'habitude? Je pense qu'automatiquement les services qui sont offerts sont en anglais. C'est automatique. Maintenant, pour obtenir des services en français je crois qu'il faut le demander explicitement. C'était compliqué, la première fois, parce que tu vois parfois des dames deviennent rouges parce qu'elles ne parlent pas français. Tu dis « Est-ce que tu parles le français? » et puis tu as l'impression que tu les as agressées en posant la question. Des dames ou des hommes… si la personne ne parle pas français, ils se sentent intimidés quand tu poses directement la question. Il y en a qu'il faut être délicat pour ce genre de chose.

This patient speaks to the need for extra caution when seeking out services in French and suggests that this is not without consequence. Because the services are always offered in English first, he must explicitly request services in French. Thereafter, he must anticipate that the request may not be well received, as reactions range from discomfort and intimidation to resentment in the person being asked, especially if they are not able to provide services in French. As such, PT04 highlights the need to walk on eggshells, feeling like he should proceed with vigilance so as not to jeopardize the relationship with the health care provider. However, in light of several negative experiences, PT04 reports that the interaction may still turn out poorly, and he may leave feeling like he was judged to be a difficult patient. Several care provider participants were well aware of this labelling process. For example, RN07 observed the following:

> I imagine it's frustrating for the [care provider] who doesn't speak the language as well, but I think that's when the complicated families I was telling you about… I think that's when people get labelled as difficult. I think that's probably what causes that.

Having witnessed interactions between Francophone patients and their health care providers, RN07 acknowledges the impact that language can have on a quality health care interaction, for both patients and health care providers. This participant noted how the latter's frustration could result in an unfair judgment towards patients seeking to be served in their minority language.

Impact on Care Activities.

Participants in the study stressed that not having language fluency and linguistic congruence can have an impact on clinical assessments. For example, RN03 shares:

> You don't want to miss anything. Like you have to rely a lot more on your assessment skills and … rather than their subjective but around like pain and stuff, sometimes people don't want to tell you about their pain right away. There are some cultural things in there and in English I can kind of just… I can talk them through it. Be like "it's okay. Do you have any aches? Do you have any discomfort?" Whereas in French I don't know those words, so I just ask, "as-tu mal?" "No? Okay." I don't go as in-depth because I don't have the vocabulary to do it.

RN03 discusses the difficulty of assessing patients in the presence of a linguistic barrier. She speaks to the challenges for both patients and providers, which arise sometimes because of cultural factors. Some patients may not be forthcoming with their health challenges and ailments. When the health care provider and patient share the same official language, questions can be rephrased to allow for the patient to share comfortably. RN03 suggests there are cultural differences between Francophone and Anglophone individuals, which engender nuances and can make health care interactions more complex to navigate. This challenge is further heightened with linguistic incongruence, as the vocabulary to probe and to obtain a more detailed clinical assessment is limited. As such, the health care provider cannot ask questions in the way that they usually would, and the patient's opportunity to provide important information is restricted. As a result, the clinical assessment is incomplete, which may compromise clinical care activities.

Lack of comprehension during the care interactions was a significant challenge faced by both patients and providers. For example, PT08 states:

> Il arrive des fois que je n'arrive pas à trouver un Francophone quand je demande qu'un Francophone m'explique (surtout dans les cliniques là où il n'y a pas de Francophones). Le médecin se sent obligé de m'expliquer [en anglais] dans des termes plus simples… À l'époque quand je venais d'arriver [au Canada], même des fois dans des termes plus simples je ne comprenais toujours pas, alors je suis rentré [à la maison] sans avoir eu ce que je voulais.

In this quote, PT08 recalls her experiences seeking care in Ontario as a recently arrived Francophone patient, noting she rarely had access to services in French. She also had very limited proficiency in English. Health care providers present did not provide her services or interpretation in French. As such, the health care team, including the physicians, would simplify their English vocabulary to increase the possibility of her understanding the terminology. And even this was not enough. Thus, the patient was incapable of expressing herself to the health care team. She was also unable to understand the care received. Simultaneously, the physicians speaking to her lacked the means to obtain the full extent of her health concerns, and consequently, clinical assessments and care failed to be offered in a comprehensive manner. The patient speaks to leaving disappointed following this health care interaction, as her health care needs were not met.

The challenges with comprehension and health assessments can be significant, as expressed by RN09.

> Another barrier is understanding. So, comprehension of what they're saying. I mean it's great if I can ask, "are you having any pain?" But if I don't understand what they're saying when they say something back, that's a whole additional barrier. An example that I had once, I had a patient that I was asking them are you having any pain, and it took them a few minutes … they were trying to explain to me, and I said, you know, just simply, are you having pain, and they said yes. They were talking about their headache and this and that and they kind of went on and on, then the patient said, heart pain, like "mal au cœur." And I was like oh you're having chest pain? The patient kept talking and I just remember that patient speaking very fast, and I found it very difficult to understand. So here I am with a little red flag being like, this patient has chest pain, I need to act, I need to react to this.

> So, I went and I got an ECG, as per our directives that we have at the hospital and here I am all flustered. I don't know what else to ask this patient, I don't know how to form other questions, I need to get help, I need to get another nurse. This other nurse comes in and he explained to me that what the patient said means nausea, but I just misunderstood. So here I am doing a half-cardiac workup, while this patient has a headache and some nausea. Not a headache and chest pain. So that's another whole barrier there, just being able to give them the right treatment sometimes with miscommunication.

Numerous challenges are raised by RN09 in this interaction, both of concern for the patient and for the health care provider. During her care interactions, it can be difficult to accurately assess her Francophone patients due to the language barrier. Even though she has learned a few key assessment questions, her comprehension of the patient's responses is limited. As such, she ends up misunderstanding her patient's primary complaint, and mistakes nausea for chest pain. In executing the standing orders for the chest pain protocol, she implements interventions and testing that was not required. RN09 is flustered and anxious in her care provision until receiving assistance from a bilingual colleague. The patient's main concerns, which included a headache and nausea, were belatedly addressed. RN09's account lends further support to the negative impact of language barriers on patient care.

One patient voiced the challenges of seeking out health care providers when there were little choices available within his community. PT04 states:

> Oui c'est-à-dire il y a un médecin à qui je peux parler en français, mais le médecin n'est pas accessible tout le temps. Quand j'ai un problème, quand j'ai une crise je ne veux pas aller à l'urgence parce qu'il ne faut pas toujours aller à l'urgence tu vois.

In this quote, the patient acknowledges that there are some physicians in his area who speak French, some of whom are emergency physicians. The patient states he cannot go to the emergency department every time he has a health concern only because services may be available in his official language of choice. PT04's testimonial illustrates the options that Francophone patients

may be left with accessing French services and weighing options that may not be ideal (e.g., being forced to use the emergency department for non-urgent ailments).

Continuity of care was another challenge that emerged frequently in interviews. For example, RN01 states:

> Je parle français, mais est-ce que le service que je les réfère va être Francophone? Comme ça, c'est un autre obstacle, si tu veux… les services Francophones, il n'y en a pas tant que ça . . . J'ai souvent transféré des clients à des centres… différents centres, qui n'étaient pas Francophones. Une fois rendus à l'autre institution, les clients avaient plus de misère à s'exprimer. Pis aussi, même, puisque des fois notre documentation à [hôpital Francophone] c'est en français. S'ils vont à l'autre hôpital, ils sont comme « Ah, qui peut lire ça »? Pas tout le monde pouvait lire. C'était difficile dans ce sens-là de communiquer entre les hôpitaux parce que le français c'est… ce n'est pas tout le monde qui le connaît. Donc, c'est sûr qu'à ce moment-là, il y a probablement un manque de… manque d'information, manque de communication.

This nurse speaks to the challenge of being a French-speaking health care provider, but always wondering about what the next steps or hindrances will be for her patients once they leave her facility. She describes her experiences referring patients to other health care professionals and health care institutions. She recalls her patients' difficulty in communicating and expressing themselves with the next provider who is unilingual Anglophone. She also speaks to the challenges of documenting her care in French, since the next providers may be unable to understand French language reports. As such, she reveals numerous tensions that arise from the care referral process. RN06 echoes this concern, emphasizing that in the context of specialized care, these issues are even worse: « Quand on est spécialisés, il y a souvent juste une ou deux personnes qui peuvent parler français pour une certaine population. » This nurse, who works in a specialized setting, observes that the more specialized a setting, the more difficult it is to access care in French, pointing to the dearth of resources available to patients and providers with regard to care provision

in minority languages. All these challenges add difficulty for ensuring the continuity of care for patients and providers alike.

In summary, while Francophone patients and nursing care providers had different realities, they shared a number of similar lived experiences with regard to accessing and providing care within the linguistic minority context. They all had strong perspectives on barriers within the health care interaction, challenges with interpretation and translation service experiences, as well as impacts on care activities. They also shared important experiences regarding the portrayal of Francophone patients and families as being "difficult."

Organizational Level: Lack of Resources

Participants revealed numerous experiences that they had as individuals within the health care system, both as care recipients and care providers. These participants also reflected on the organizations where they access and provide care. Patients, nurses, and nursing students brought up numerous points of consideration with regard to the lack of resources within the health organizations designated to supporting French-language services. They also spoke of the state of bilingualism within these organizations. Individuals also brought up the state of the French language itself, frequently seen as a luxury rather than a necessity. Lastly, the lack of organizational support for fostering the improvement of French language services emerged as a theme as well.

Institutional Designation.

Delays in care were a major concern expressed by nearly all patient participants. In a health care system that is already bogged down with lengthy wait times to access health care providers, French-speaking patients noticed that they were further disadvantaged. Not only did they face the existing lag time which all patients face accessing health care in Ontario, their wait times were

further enhanced when it came time to finding someone who could serve them in French. In Ontario, several health care institutions are designated to consistently provide French-language services to those who require them throughout the province. However, study participants revealed that the offer often fell short, despite these organizational designations. For example, RN07 reflects on the situation saying:

> It is tough when people act like there is not time in the emergency department to make that effort or that it is somehow [the patient's] problem that they do not speak English, when really, we are funded to provide bilingual services.

In this situation, the participant speaks to how her workplace and its employees do not always make the time to accommodate linguistic minority patients. Time is referred to as a barrier for providing the care needed by patients. As such, the burden for accessing linguistically congruent care returns to the patient and their family. This is even though this nurse works in a designated institution that should be able to consistently provide care to official language minority communities in French, since it is funded by the government of Ontario to do so.

Patients are also concerned about the way Francophone patients are treated when they access health care in French designated health centres. PT05 states:

> Bien, d'abord, ça me frustre parce que c'est un hôpital bilingue. Donc ça ne me rend pas satisfaite ni contente et ça m'humilie qu'on doit aller chercher un membre de personnel de soutien pour venir faire la traduction. Je plains cette pauvre personne… Ce n'est pas son travail et on la dérange dans ce qu'elle fait. Ce n'est pas normal.

PT05 expressed numerous frustrations that came with not being able to receive health care as expected. This challenge is further perplexing when patients go out of their way to seek health services in facilities that are supposed to be bilingual. Despite doing their part as a patient to go to a facility that should be able to provide services in their official language, this is not always the case. As such, improvised solutions are created to remedy the situation, but the patient may feel

flustered, frustrated, and humiliated in such a situation. This is challenging in a health care context, where a patient may already have numerous health care concerns to discuss and are now faced with an additional stressor. Moreover, the solutions proposed are not always appropriate, for example, when support staff are called away from their role to assist the Francophone individual. The patient acknowledged that this is not part of their role, and that the individual intervened to help patients in need. However, this is not the standard of care expected by patients accessing bilingual institutions, especially French-designated facilities. Issues of interpretation and translation remain problematic in several health care institutions in Ontario.

Bilingualism in the Organization.

Another challenge revealed by study participants was the varied, if not to say incomplete bilingualism. Whether or not the facility is designated Francophone, many health care facilities claim to offer bilingual services. As study participants could attest, the extent to which the facilities' services were bilingual differed from one institution to another. For example, RN06 speaks to the state of bilingualism within her community centre, stating:

> En tout cas, ça, c'est un des problèmes où est-ce qu'on dit qu'on offre des services en français, mais on manque la marque à l'occasion. . . Il y a une minorité de gens qui parlent… d'infirmières qui parlent le français. Et puis par contre l'institution [centre communautaire] cherche beaucoup à pouvoir donner des services bilingues, mais à l'occasion il manque de quoi soit, en particulier je parle du site web qui décrit nos services. Il y a moyen de peser sur un bouton qui dit français et puis au moment, à ce moment-là on va au site et puis c'est le formulaire Anglophone. Alors on n'arrive pas à combler les besoins à 100 %. »

Although the nurse states that health care services could be provided in French to a certain extent, the services received by patients may not always be consistent, despite the centre being advertised as bilingual. For example, if a Francophone patient were to access the health centre's website, the links may not all be functional in French. This can cause challenges to patients and

families seeking to receive health care information or to complete intake forms, as the extent of services are not displayed in their official language. This may also make the full inventory of community services inaccessible for Francophone patients due to the linguistic barrier. RN07 also discussed challenges regarding French language services within her bilingual institution, noting

> We do have quite a lot of nurses who speak French so usually the family is able to be triaged in French but not always because a lot of our more senior staff isn't French-speaking but most of the junior staff is. And those who are technically bilingual often are not functionally bilingual. So, the level of French that they get is a little bit varied.

In this quote, RN07 attests to the inconsistent experience that Francophone patients may face when seeking care in a bilingual hospital. The ability of a patient to receive services in French depends on the availability of French-speaking staff. When it comes to triaging, more frequently senior staff is assigned to the position than junior staff. However, at this facility, many senior staff members are not French speaking. Many junior nurses are bilingual, and thus, the quotas for bilingualism are met. However, this does not necessarily help the patient at the point of entry, where they need to describe their medical emergency and where their medical priority is determined. Furthermore, the notion of technical bilingualism also complicates the quality of care received by French-speaking patients. To the facility, the level of French bilingualism may be sufficient to meet the organizational needs for hiring. However, the fluency of "technically bilingual" nurses may vary significantly, both with French expression and French comprehension, which may also compromise their ability to understand and to be understood by their patients. Even for the health care providers, the technical bilingualism may cause difficulty in the workplace, especially regarding quality of care. For example, RN04 shares a related experience, stating:

> J'ai déjà eu l'expérience où est-ce qu'un médecin parlait assez bien en français, mais on s'entend qu'elle n'était pas Francophone, elle était francophile. Donc elle était allée

> chercher l'histoire médicale de ce patient et de leur famille et elle avait compris une chose alors que quand moi je suis rentrée et que moi j'ai fait ma propre anamnèse, j'ai compris quelque chose très différent. Donc là je suis allée voir le médecin… « Écoute nos notes médicales ne s'alignent pas très bien. J'aimerais juste savoir un peu plus à propos de ta conversation avec la famille. » C'est à ce moment-là où est-ce qu'on s'est entendu que non, enfin, je ne me rappelle pas c'était exactement quoi, mais c'était vraiment différent, comme un mal de ventre versus une oreille qui fait mal. Donc je trouve que ça peut avoir un enjeu dans tout ça.

While technical bilingualism may meet the organizational needs, it may also put a patient's health in jeopardy. In this example, the physician's medical evaluation was compromised because of language, as the health assessment and physical examination were headed in a different direction than the patient's chief complaint, even though the physician was "bilingual." In this situation, the patient was assigned to a bilingual nurse, who was able to identify the inconsistencies in the medical interaction. However, such linguistic congruence does not always happen. Hence, this situation was rather more a good catch, rather than something that can be taken for granted. As such, bilingualism, and linguistic competence can have true consequences within a health care organization.

Not only is incomplete bilingualism a challenge in numerous health care facilities, but the prevalence of bilingualism related to categories of workers remains an issue of contention. For example, RN08 explains that "other than clerks and administration, it's not a requirement … it's sort of a bonus if you have a candidate who in any position is bilingual." Whether or not the French language is valued in the workplace tends to be reflected in the hiring strategy, and multiple participants spoke to the challenges of encountering any bilingual staff along the hierarchy. This finding is consistent with the quote from RN08, who noticed that administrative staff must be bilingual, but beyond many entry-level positions, being bilingual is more so a bonus than a necessity. As such, for bilingual patients entering a health care facility, though the institution may

be bilingual, the odds of them having a bilingual health care provider are at best inconsistent. NS05 describes how this reality is depicted in her sector:

> RPN jobs at [hospital] are all posted as bilingual but if you look for RN positions it just says preferred, it's not a requirement … Any management position is not required to be bilingual. So, our patient service clerks are all bilingual but managerial positions no… It's just really like the clinical nurses that are required, and the patient service clerks. But it's interesting, yeah, no, none of my managers… I see all of them and none of them speak French.

NS05 also observed the reality of the double standard around expectations for bilingualism within an organization. This very difference can be observed in the hiring process, where French can be listed as preferred or as required. Moreover, as an employee secured higher-ranking positions, French may be preferred but eventually may not be required at all, as evidenced by many managerial roles. The clerk may be bilingual, and the RPN may be bilingual. However, the odds of encountering a bilingual RN, charge nurse or manager steadily decrease or are unpredictable.

RN06 questions the process of seeking language competency versus specialized experience.

> C'est un des facteurs ou une des caractéristiques qu'on cherche dans un employé, qu'il ou elle puisse parler français. Mais souvent il y a des, de l'expérience dans un soin spécialisé avec une population spécialisée. À l'occasion ça c'est plus important que la personne qui parle français. Ça semble plus important, mais je ne suis pas certaine… je pense que c'est probablement plus facile d'enseigner le nursing à une personne que d'enseigner une langue.

Working in a specialized field, RN06 recognized that experience in the specialty is an asset. However, she also realized that there are various characteristics that may be an asset in an ideal employee, which extends beyond experience. In her specialized field, the French language is an asset, but often, specialized experience itself is the primary criterion that leads to a hiring decision. However, RN06 suggests that in patient care, sometimes the language can be an important, but more difficult skill, to acquire. She mentions that it might be easier to teach specialty nursing skills

and techniques to a nurse than to teach skills and proficiency at a whole new language, such as French.

French Language Necessity.

Patients, nursing students, and nurses discussed the importance attributed to language. They realized that it could affect the patient experience, patient care, and workflows within the institution. They also spoke to the difficulties that arose when French-language services could not be offered. NS03 asserts,

> C'est juste important d'avoir du personnel Francophone ou au moins des personnes qui ont un minimum de compétence linguistique en français. Comme ça quand on a des patients qui préfèrent avoir des services en français, on pourra les servir. Alors même comme dans un endroit comme [hôpital] ou [hôpital pédiatrique] qui ne sont pas des milieux de soins Francophones, au moins d'avoir quelques personnes qui parlent français permets d'assigner les patients Francophones aux infirmières ou infirmiers qui parlent français.

NS03 realized the importance of having French-speaking staff, and even more so the importance of linguistic competence as it pertains to patient care. Such consideration in organizational planning is important to serve the needs of patients who prefer and who need services in French. This is important as much in general hospitals as specialized centres, including pediatrics. Language planning is important for patient assignments. It is necessary for health care institutions to consider having a certain number of health care providers, especially nurses, capable of speaking in French. Such planning allows for French-speaking patients to be paired with French-speaking staff, and to ensure linguistic congruence as much as possible. When linguistic competence is not accounted for, the health care team can be left to deal with the consequences of the challenges.

On the importance of providing and offering care to patients in their official language of choice, PT04 notes that « une première chose c'est avoir des personnes, des spécialistes, des

préposés aux soins, même à l'accueil qui sont capables de parler en français à tout le monde. » This patient speaks to his experience with regard to the necessity of having multiple French-speaking individuals throughout the health care organization. This is just as important for health care providers as it is for administrative and support staff who support patient care. NS08 declares that « c'est important d'être capable d'avoir les soins dans la langue que tu es la plus confortable. » This nursing student speaks to the recurrent notion among the participants of the importance of patients receiving care in their own official language, in the language that they are the most comfortable in. As such, Francophone patients should be able to access care freely in Ontario, just as Anglophone patients should be able to do the same in Quebec. This sentiment was echoed unanimously by the study participants, from patients to nurses to nursing students.

Managerial and Organizational Support.

The lack of managerial and organizational support was another recurrent theme discussed by health care providers with respect to their care facilities and to their clinical placemat agencies. Discussed earlier were the challenges with representation of Francophones throughout the organization, due to hiring practices and priorities. RN07 considers this issue, stating:

> I think part of their job (management/managers) would be managing crises or people that are not really thrilled to wait six hours in the emergency department, so, they're managing a lot of distressed and upset families. And I can only imagine that there is a barrier there if you can't speak French. I mean like it's hard enough to provide support to a family who is upset in that busy of an environment, let alone when you don't speak their language. That must be so frustrating for them.

The importance of having health care managers capable of meeting patients' needs in both official languages is paramount, as evidenced by RN07's clinical experiences. Regardless of which language they speak, patients and families may encounter challenges in their care experiences that would best be addressed by clinical managers. In the emergency department, having a bilingual manager helps both Anglophone and Francophone patients manage expectations and understand

their health care experience. When there is no such manager in place, Francophone patients and families encounter an additional barrier in their health care experience over and above the other challenges present during frontline care.

While RN07 spoke to experiences in the emergency department, NS09 also has concerns regarding organizational and managerial support in community services. As she states:

> If [HCP are] not equipped enough or if they're not supported properly, how can they really reach out to these communities and be able to provide the care that is very similar to the care that is provided to English-speaking communities?

NS09 had opportunities to provide care for linguistically and culturally diverse communities, and she saw how challenging assuring adequate care for linguistic minorities could be. She asserts that organizational support from management is important to ensure that communities can obtain equitable care. "On an organizational level, there needs to be more education or there needs to be some sort of way to make these resources available to health care providers or for health care providers to have access to them easily." To equip providers to offer health care services, organizational support is a necessity, as affirmed by NS09. Education on the needs of linguistic minority communities is necessary to be able to appropriately support care. Furthermore, education, knowledge of and access to resources can help health care providers ensure that patients obtain access to services that they need and are entitled to receive. Providers need to know what resources are available to them, and how to access them. This is especially important as the study participants have indicated that care to linguistic minorities can be highly varied depending on the health care provider that is serving them. As such, organizational support and education throughout the institution could help bridge the knowledge gaps and support care provision to linguistic minority patients by their health care providers.

Clinical Tools and Resources.

All in all, the lack of resources was a major complaint for patients and health care providers interviewed for this study. This challenge was a reality that extended beyond health care institutions into the global health care environment, encompassing professional organizations as well. NS07 shares her experience:

> J'étais à la recherche d'un best practice guideline donc je suis allée sur le site web du RNAO et puis mon dieu, je me suis aperçu qu'il n'y avait pas d'onglet français. . . Donc ça m'a vraiment surprise. J'étais extrêmement fâchée à cause que je ne pouvais pas trouver, je ne me souviens plus du sujet que je cherchais, mais je ne pouvais pas trouver mon best practice guideline en français. Donc là ce que j'ai fait, j'étais vraiment fâchée alors peut-être que ce n'était pas la meilleure chose à faire, mais j'ai lu la mission du RNAO puis là j'ai envoyé un message puis j'ai dit « Votre mission est ça, mais votre page n'est pas offerte en français. Donc votre mission est de protéger blah blah les patients de blah blah, est-ce que votre mission est de seulement de faire ça pour les professionnels de la santé Anglophones et pour les patients Anglophones? Parce que votre page n'est pas offerte en français… » et puis je n'ai jamais eu de réponse. . . c'est un peu fâchant que nous les professionnels de la santé on dit toujours « Utilisez des résultats de recherches probantes. Utilise des best practice guidelines. Fais des revues de la littérature ». Ben oui, c'est beau, mais le RNAO eux, ils n'ont pas de ressources bilingues. . . moi si je lis un best practice guideline, je préfère le lire en français. . . Oui, je peux lire en anglais, mais ça va peut-être être un peu, ma terminologie médicale je la connais en français. Je ne la connais pas bien en anglais donc ça, c'était extrêmement frustrant. J'étais très fâchée.

The experience described by NS07 was not an exception, as this can be the case for many organizations in Ontario and in Canada. This spans information provided by professional organizations (i.e., clinical resources), to research and scientific publications (i.e., literature reviews), information which is largely published in English. NS07 described seeking out health care resources to support her clinical practice by reaching out to the Registered Nurses' Association of Ontario (RNAO). To her surprise, there was not an option to navigate the website in French, and none of the best practice guidelines she was seeking were offered in French.

Such a situation is problematic for many reasons, as the organization's mission is to support registered nurses and their care provision to patients in Ontario (Registered Nurses' Association

of Ontario, 2012). Health care professionals, patients, and caregivers may require French-language information and resources from nursing professional organizations. Yet, if they seek resources from the RNAO, they may not be able to access resources in French. This causes a strain on Francophone health care providers trying to provide evidence-based care. Even English-speaking health care providers may be interested in reviewing and comparing French documentation to the English language resources. However, this option is not readily available for those who want consistent access to French clinical tools. Such a reality is also problematic for patients who may be navigating the website for their own personal use and who may find themselves limited or restrained by language barriers. To support patient care, NS07 argues that accessing resources in French is important to her, and to her, a lack of resources from her professional organization is a frustrating roadblock. To add insult to injury, she received no response when she tried to contact the organization.

Ensuring service provision in both official languages should remain a priority for organizations. In some cases, institutions strive to do so, but end up missing the mark. For example, NS05 states:

> They try to have like the resources in English and in French. It's not always the case, but at least they try to. You know like handouts having them be bilingual and making sure that you give the right one to the right person. It is a big deal when you are like "This one is in English but it's fine." It's not fine. They do not understand it…

In this quote, NS05 points to a multifaceted issue. For one, an organization can try to have resources available in both official languages. However, these documents may not always be available, despite organizational values and staff efforts. Moreover, even when the document is available in both official languages, will the patient get the document that they need? In this example, NS05 mentions that there is a need for documentation in the appropriate language. Yet,

the critical importance of having minority language resources is frequently minimized. However, when the documents are available, it is important to make sure that the patient receives documentation in the right language in order to understand their care and instructions on it. PT08 has lived this personally many times, and reflects on such experiences:

> Il arrive des fois que je dois compléter des documents. Chaque fois, on me donne en anglais. Parce que comme j'ai dit la majorité de la communauté est Anglophone. Alors souvent, le premier réflexe est de donner en anglais. Si tu présentes le besoin d'être servie en français, là maintenant on essaye de t'aider. Mais le premier, la première approche c'est de t'aider en anglais. Alors des fois on me donne des documents en anglais et là je regarde, je sais, pour moi l'anglais, c'est le parler qui est difficile, mais écrire, lire, tout ça, c'est vraiment facile pour moi. Alors je sais que je peux lire, pas comme un Anglophone bien sûr, mais je sais lire, je peux comprendre et tout. Mais si ce sont vraiment des documents importants, je préfère qu'ils soient en français pour bien cerner la profondeur… alors là je demande si je peux avoir une copie en français. Des fois on me dit « Attends on va chercher, on va imprimer ». À [hôpital] ils ont des documents dans les deux langues, oui, parce que je me rappelle, il y a des formulaires que j'ai complétés pour mon problème de fibro… il m'avait donné le questionnaire en anglais. Pourtant il savait que j'étais Francophone. Peut-être il a oublié? … Je lui ai demandé « Est-ce que je peux avoir en français? », il a dit « Oui », il est parti, il l'a imprimé en français. C'était vraiment facile. »

In this quote, PT08 discussed her process navigating health care services as a Francophone patient. She acknowledged that she speaks the minority language but is not surprised when care is offered in English. Her health care providers know that she is Francophone, and yet, she is most frequently provided documents in English. Every time she receives a document, she essentially does a risk assessment: she can get by in English, especially reading or writing, but struggles at verbalizing in English. When she is provided with English documentation, she always considers the possibility of accommodating the health care team and completing the documentation in English. Nonetheless, she also realizes that this approach is not always the safest option, especially for "important" documents. And yet, when she raised the issue to the health care team, they are easily able to print or to produce a copy of the document in French. As an organization, the institution can support French-language services. However, those services are not consistently,

systematically, or proactively provided, and seem to be offered more on request, even when the language preference of the patient has been well established.

Environmental Level: Health Policy Impacts on Patient Rights

To provide quality patient care, it is important to realize the role of the greater environment, and the impact that it can have on care delivery, as much for patients as for their nursing care providers. Participants in this study reflected on the role of the environment on health care delivery and the political circumstances that maintained an inadequate status quo throughout organizations and across the province. The interviews revealed that health policy has an impact on linguistic minority patient rights and access to health care. This theme was explored through deliberations on many salient issues, including discussions on lack of respect for French, and on issues of access, consent, safety, and quality of care. Study participants also spoke about the unique considerations around language and special populations, explored language rights, and talked about how language could affect health care advocacy. Several discussions emerged concerning "good enough" French-language accommodations, there were insightful revelations considering the active offer and its scarcity in the current health care environment.

Lack of Respect for French.

Beyond the immediate health care environment, participants were concerned with the diminishing status attributed to the French language throughout Canadian society. Although French and English are both official languages in Canada, participants judged that there was a lack of respect for French as an official language and related this to the impact this had on patient care. PT03 asserts:

> On doit d'abord partir avec le point que le français c'est une langue officielle et ce n'est pas une seconde langue, c'est une langue officielle au Canada. Ça veut dire, il faut que les gens se mettent à accepter le français et l'anglais au même pied d'égalité. Ce n'est pas ça. Je ne parle même pas des Amérindiens. Je parle juste des deux langues-là parce que le

> français a tendance à être minimisé, à être jeté, à ne pas être considéré comme une langue des premiers occupants du Canada. Juste, quand j'ai appris que le commissariat aux langues officielles [de l'Ontario] sera fermé, l'Université Francophone ne naîtrait pas, ça ce sont des signes. Ça veut dire qu'on ne considère pas le français comme une langue que les gens peuvent utiliser. Déjà dès le départ que cette langue soit considérée à sa juste valeur. Ensuite, dans les hôpitaux, dans les centres de santé, je ne sais pas les cliniques privées peut-être ou pas, je ne sais pas, mais si tu vas avoir de la clientèle Francophone je pense qu'il faudrait faire un effort d'engager quelqu'un qui parle français. Dans les hôpitaux, les grands hôpitaux de l'état, je crois qu'il faut sensibiliser, qu'il y ait de la sensibilisation auprès des soignants, que le français c'est une langue qu'il faut utiliser, qu'ils fassent un effort. Je n'ai jamais compris, deux langues, juste deux langues, comment est-ce qu'on ne peut pas apprendre deux langues. Moi, ça m'a toujours étonnée. Ça m'a toujours étonnée qu'on ait deux langues qu'on peut apprendre facilement, ce n'est pas quatre, ce n'est pas cinq, deux langues, juste ça pour servir la population parce que, c'est comme, c'est comme si on ne considérait pas les Francophones à leur juste valeur. C'est comme si c'étaient des sous-hommes. Pourquoi ça? Je ne comprends pas, de sorte que ceux qui étaient, qui sont Francophones, qui étaient Francophones même, il y en a qui le sont, mais qui n'osent pas, n'osent pas le crier haut et fort.

The interview with PT03, recorded in 2018, reveals a tumultuous political environment whereby French as a minority language in Canada was faced with immense pressures, especially for Francophones in Ontario. In November 2018, it was announced that the Office of the French Language Services Commissioner of Ontario would be eliminated (Office of the French Language Services Commissioner, 2019). Indeed, the office was closed, and the role of the commissioner became a subgroup included in the portfolio of the Ontario Ombudsman as of May 2019 (Bleytou, 2019). At the time of this announcement, the Conservative government in office also announced that the plans for the Université de l'Ontario français, a French-language university to be created in Toronto, would be cancelled, a mere four months after its conception had been announced (Mathieu Simard, 2018). In January 2020, the provincial and federal government signed a financing agreement to enable finally the launch of this university (Lévesque, 2020).

It is within this context that PT03 reflected on the lack of equality between English and French in Ontario and Canada, although both are official languages. The lack of regard and the

minimizing of the importance of French are evident to this patient when recalling incidents such as the decision to close the Office of the French Language Services Commissioner of Ontario, known as a watchdog for French-language services, including issues pertaining to access to French- language health services and planning. In addition to this, witnessing the birth of the idea of a French-language university, and then the sudden cancellation of this project despite expert opinion, was understood as undermining the importance of French-language services in the province and across the country. PT03 relates this to what she saw when she accessed health care services, seeking care in French with difficulty, and she associated this finding to the detrimental wider environmental and political context. She stressed the importance of building awareness of this disparity, lest Francophone patients become "subhuman" second-class citizens in the health care system and beyond. PT03 insists that valuing and respecting the French language is important to valuing Francophone patients in the health care context.

On a similar note, PT04 contends:

> Souvent [le manque de service en français] n'est même pas de la mauvaise volonté. C'est simplement parce qu'on est paresseux. Mais parfois c'est aussi parce qu'il y a de la mauvaise volonté… Supprimer [hôpital Francophone] comme hôpital Francophone, ça, ce n'était vraiment pas un hasard. C'était de la mauvaise volonté c'est clair.

In this quote, PT04 provides his perspective on the lack of services in French in Ontario. He indicates that sometimes it is unintentional, but other times it seems to be done with ill will. He relates this to the plans to close the Montfort Hospital, one of the largest fully Francophone, yet bilingual, health centres in Ontario (Hôpital Montfort, n.d.). In February 1997, the Conservative government in Ontario announced the closure of this hospital, along with other budgetary constraints in the health care sector. With an outcry from the Francophone community that resonated throughout Canada, and a legal battle that went to Ontario's Court of Appeal, the

hospital was permitted to stay open to respond to the needs of the Francophone community in Ottawa and beyond (Hôpital Montfort, n.d.).

PT04 relates this struggle to a lack of respect for the French language and for Francophones, in suggesting that the choice to close this hospital may have been more than a coincidence and perhaps undertaken with harmful intentions. While this incident happened decades ago, the concern over this cause remains at the forefront of the Francophone community's mind. However, NS05 suggests that this issue may not be a consideration for everyone. She speaks to her experience seeking employment in a health care setting:

> They didn't even ask if I spoke French… I think they are much more business minded but yeah, no, it wasn't even, I don't even think it was considered an asset in my resume or application that I spoke French in [ville/city].

While some participants discuss the importance of the French language in their daily lives and in their care experience, NS05 has found that it is not valued throughout Ontario. In one of her work settings, she was not even asked if she spoke French prior to her employment. Even though she is bilingual, she realized that in the area where she was applying, her ability to speak French did not appear to be an asset to the workplace. As such, the needs of the French-speaking patients may not have been at the forefront of the employer's mind or of the organization's priorities, even though NS05 states that they appear business minded. Thus, respect for a patient's French language needs is not even acknowledged and is lacking in certain workplaces. RN06 continues, saying:

> Je pense qu'il faut respecter les Francophones… En offrant des services en français on démontre un respect de la population Francophone. Alors c'est nécessaire, c'est vraiment nécessaire de mettre ces stratégies-là en place.

As a Francophone nurse, RN06 declares that it remains important to respect Francophones and their language. She states that this can be done by offering services in French as a means of

respecting French-speaking populations. She builds on the importance of this necessity by referring to the numerous strategies that exist to bridge the needs of Francophone patients, stating that it is important to implement these changes into practice as a means of truly respecting the Francophone community and their linguistic needs.

Access.

Throughout all the interviews, access to health care was a theme that emerged repeatedly. Patients, nursing students, and registered nurses brought issues forward regarding systemwide problems and inadequacies. They all voiced concerns with the ability to access health care for those speaking the minority language. For example, PT05 points out that "J'ai fait affaire avec six médecins dans les derniers mois et puis il y en avait cinq qui étaient unilingues anglais." In PT05's experience, accessing services in French was not a given, as all her specialist providers, save one, were Anglophone and unable to provide care in the minority language. This issue is exacerbated by this patient's health condition, which has her accessing medical services extensively (six different physicians in the few months preceding the interview). This patient cannot fully express herself freely about her complex health care challenges, and this stress is exacerbated due to frequent medical encounters.

As RN02 continued: "Tu te rends compte que c'est vraiment un problème. La personne a besoin de se déplacer soit de grandes distances pour avoir accès à des ressources qui normalement est présente dans son lieu." As a health care provider, RN02 expands on the difficulty of access to care, citing numerous barriers that hinder the health care experience that would not be factors of consideration for those speaking the majority language. RN02 explains the disparity in the experience for a Francophone patient. In this case, a patient would need to travel extensively to obtain resources which would normally be in their community. Unfortunately, these local

resources are not available in French. The distance travelled may vary from one patient to another, also a deterrent to adequate access to health care, especially if health care appointments are frequent, or if accessibility and transport are issues. PT04 states:

> Ici où je suis dans [ville/city] on peut essayer [d'obtenir des soins en français] parce que la majorité de la population est quand même Francophone. Parfois ça fonctionne, parfois ça ne fonctionne pas. En plus à certains moments et à certaines heures de toute façon c'est en ville qu'il faut aller. Il y a des services qui sont beaucoup plus accessibles en ville donc je sors de ma périphérie pour aller chez les Anglophones finalement.

PT04 discusses the challenges surrounding access to health care, especially as a Francophone living in a rural/remote area. This individual lives in a small Francophone town. He was not afraid to ask for health care in French, yet indicates that sometimes the request is successful but at other times it isn't. However, access to care in French becomes further limited at certain times, notably evenings and weekends. At such times, he has no choice but to leave his region to seek health care, and once in the nearby city, it is entirely possible that the provider he encounters is Anglophone and that he would not be able to access health care in French. Thus, access to French-language services for Francophone patients living in Ontario is never guaranteed, regardless of how far individuals are willing and able to travel.

Consent.

Issues surrounding consent were brought up by numerous health care providers, especially in discussions of what constitutes informed consent and whether it could be provided in the presence of linguistic barriers. The concerns related to consent are important to discuss at the environmental level, because they point to systemic issues that are problematic for patients and health care providers across the province and are thus significant beyond individual level interactions. This is a monumental concern for all parties involved in the consent process, in light of the fact that consent is regulated by the Health Care Consent Act of 1996 (Government of

Ontario, 2020). As such, if this procedure is not well executed throughout the health care system with Francophone patients, there are significant legal ramifications for all those involved – patients, providers, institutions, and systems alike. NS07 considered this issue with regard to Francophone patients in her clinical placements.

> Si je pense à un patient Francophone qui ne comprend pas… ou si sa compréhension en anglais est vraiment limitée ou minime ou même inexistante et puis on… doit obtenir le consentement pour une chirurgie en pré op, comment est-ce que ce patient-là va [donner] un consentement éclairé si le consentement n'est pas dans sa langue? Si le patient il ne comprend pas l'anglais, je ne peux pas donner un consentement éclairé à ce patient-là en anglais. Puis si j'obtenais un consentement, ben ce consentement, je m'excuse, il n'est pas éclairé d'après-moi…

NS07 makes the link between the importance of comprehension and consent. In many health care settings, health care discussions, including discussions regarding consent, take place in English. If a patient has a low comprehension of English, consent and the extent to which it is truly "informed" become highly problematic. Earlier in the results, NS07 uses the example of preoperative care to illustrate this issue. For Francophone patients, especially those most comfortable in the minority language, the bulk of their preoperative care and information may have been provided in English. Consequently, although they may need to proceed with suggestions from their health care team to make informed health care decisions, they may be ill-prepared to do so. Furthermore, different providers may respond differently in the face of such consent challenges. NS07 suggests that if consent was obtained from a Francophone patient in English, then she would not consider the consent received to be an informed consent. However, many times this situation is not further considered by the health care team, regardless of a patient's comprehension of the events. NS09 further explores the challenges surrounding consent, especially in settings that provide different modalities for interpretation:

> For example, doing, medication administration, do I get an interpreter on the line with me? Like I personally haven't and with the nod or the response of my patient, I just get the consent that they agree, but how do you really tell if they fully understand what's going on or they're fully okay with what you're saying. There's never that use of those resources on a daily hourly interaction, right?

In this quote, NS09 draws on the 24/7 reality of nursing in acute care sectors. With many nursing tasks, care is offered frequently and rapidly. Thus, interpretation and translation are not part of regular nursing interactions. However, this reality is complex in the face of care to linguistic minority patients. NS09 does not speak French, so describes instances of obtaining consent for medication administration by non-verbal cues, such as patients' nodding when offered medications. However, she recognizes that the patient's understanding could not fully be assessed. She admits that she herself did not fully know what the patient understood, and she was aware that the patient could not understand her either. Yet, despite this significant issue, the fact is that interpretation is "never" used for daily or hourly interactions, even for obtaining informed consent to the care interventions about to take place. This poses challenges for both health care providers, faced with an ethical dilemma, and patients, who are subject to barriers and limitations in the quality and safety of their health care interactions. Different responses exist for facing issues of consent in the health care setting. For example, RN05 states that:

> I have pushed back before … the physician was asking me to interpret the consents for French language patients. I say well you know this requires a medical interpreter. I think I have a good understanding of the procedures that happen in my job and, of course, if it was an emergency, I would never ever, ever push back and would do as hard as I could to make sure that the consent is done and that the patient can understand what is happening, but when it is a routine procedure, I think that when patients have good questions… I did not go to medical school in French; especially not high-level neurological testing or heart testing, genetic testing for children … number one it's not within my scope of practice right now and number two it's just not within my understanding.

The quote shared by RN09 further reveals the ethical dilemmas which health care providers face with regard to providing care for linguistic minority patients. RN09 describes an attempt to control what is within her scope of practice and what is in the best interest of her patients. An English-speaking nurse, RN09 can also speak French, and has been frequently requested to aid with the interpretation for patients in her health care sector. However, such requests have different implications for her. In the event of emergencies, she would not risk the wellbeing and safety of patients and would help translate information to save precious time. However, in the case of routine care, she has had to push back against this role of an informal interpreter for obtaining the patient's consent, reminding the medical team of the importance of seeking out qualified medical interpreters for this process. This is all the more important, as RN09 depicts requests for her to provide translation for highly specialized medical information (e.g., neurological, cardiac, or genetic testing), and acknowledges the further challenges that can ensue with her assisting for the consent process, especially if this information is outside of her scope and understanding.

Safety.

Participants in this study, both patients and health care providers, discussed concerns related to speaking the official minority language and challenges that arise that may be related to health care safety. NS02 affirms that "C'est une composante de sécurité puis une composante aussi de stress supplémentaire." This participant mentioned the safety challenges that patients may face when unable to obtain care services in French. Further compounding concerns regarding access to safe care is the accompanying stress that these patients' experience. For many patients, this stress is increased due to memories of past (negative) experiences and being aware of the disparity in care and safety concerns experienced by fellow members of the Francophone community. Such an experience is described by PT04:

> Je commençais aussi à être fatigué d'être servi en anglais parce qu'il y avait des malentendus dangereux . . . Je veux dire qu'elles m'ont dit de faire ceci ou cela, je ne comprends pas ou bien elle me donne une indication ou un ordre contraire à ce que m'a dit le spécialiste. Et je n'ai pas assez d'arguments pour, en fait je n'ai même pas tendance, pour résister et dire non et après quand je retourne chez le spécialiste il est sérieux parce que « Quoi, tu as arrêté de faire ce que je te dis? », j'ai dit « Non, je n'ai pas arrêté, mon médecin de famille m'a dit d'arrêter. Et il dit « Tu reprends tout de suite ce que je te dis, tout de suite s'il te plaît. » Et donc là à cause, en partie en tout cas à cause de la langue que des choses comme ça peuvent arriver. Et puis, on est quand même mal à l'aise parce que quand on est malade c'est le moment où on est le plus faible. Dans une langue qu'on ne maîtrise pas c'est le moment où, comment dire ça, on est le moins compétent pour fonctionner dans cette langue. Quand je suis chez le médecin et que je dois m'exprimer en anglais, je suis moins compétent que quand je suis en train de diriger une réunion en anglais professionnellement, oui, parce que si je dois dessiner, moi je maîtrise la technique, je peux le faire, mais si je dois discuter de mes bobos, de ces maladies en anglais, parce que je n'ai pas toute ma tête, je n'ai pas tous mes esprits. Ça fonctionne beaucoup moins bien…

PT04 describes his experience with health care conflicts exacerbated by language barriers. Although Francophone, PT04 needs to seek health care services from Anglophone health care providers. PT04 can speak in English and operate in a professional capacity. However, this capacity is decreased in the health care context. When seeking medical care, PT04 is most comfortable and competent discussing his ailments in French. In this language, he was more capable of providing information, asking questions, and understanding the care received. In the quote above, PT04 shares his experience with medication errors caused by inappropriately stopping medications prescribed by his specialist, due to a miscommunication with his family physician. PT04 stated that he felt reluctant to correct or question his family physician because he feels less confident in English. It is already difficult for patients to address their health care providers: as PT04 stated, one feels more powerless and vulnerable when one is ill, and either way, he doesn't have the tendency to resist or to question care. However, this issue is further enhanced in English, as he is not able to phrase arguments to have such important discussions. When patients

are sick and stressed, focusing on language and translation is even more burdensome, and ultimately compromising to the quality and safety of their health care services.

Quality of Care.

Quality of care was a resonating factor throughout all interviews, as it touches on all levels of the health care system, from individual patients to the health care team, the organizations, as well as to the greater health system/environment. Participants spoke of their take on quality of care and health care services in French from numerous facets, pointing to systemic issues that should be considered across Ontario. Patient-centred care is pivotal to ensuring successful health promotion. NS07 touches on the challenges faced by members of official language minority communities in Ontario, and how harmful it is as it hinders the possibility of being fully autonomous in their health care, and thus in the quality of care that they can experience.

> Comment [les patients] vont bien comprendre [les soins] qu'ils obtiennent, comment est-ce qu'ils vont demander des questions par rapport à leurs soins, par rapport à leur médicament? Je pense que pour un patient, être informé et pouvoir participer à ses propres soins aide beaucoup à être capable à se rétablir et puis avoir un sentiment de contrôle dans leurs soins . . . Donc je trouve que si quelqu'un est malade souvent, certaines maladies on ne peut pas contrôler le fait qu'on est malade, mais on peut contrôler ce qu'on fait à propos de la maladie. On peut contrôler les soins qu'on a, les médicaments qu'on prend, la façon qu'on se comporte. Donc si on ne sait pas ce que l'infirmière fait, si on ne comprend pas les médicaments qu'on prend puis si on ne peut pas vraiment poser des questions à l'infirmière, en français, comment est-ce que cette personne-là peut se sentir autonome dans leurs soins, peut bien se rétablir?

NS07 sees the importance of being able to engage with one's health care, ask appropriate questions, and see what kinds of interventions can be done to address and take control over their health. However, she acknowledges that such possibilities are limited for patients across the province who struggle to have meaningful exchanges of this nature with their health care provider. This is too often the case for Francophone patients in Ontario interviewed in this study, so much so that it is a determining factor in their health care. PT03 elaborates on this reality, saying:

> Quand tu sers quelqu'un [à titre de professionnel de la santé] dans sa langue, tu auras l'occasion peut-être de savoir plus de choses qu'il [le patient] ne t'aurait pas dit s'il parlait en anglais parce qu'il aurait l'expression facile dans sa langue que dans l'autre langue. Oui, donc il va te dire des choses auquel il ne pensait pas dire, mais le fait de le dire en français donc il a tout un dossier déjà préparé, il ne va pas sauter des points ou dire ça je ne sais pas comment le dire en anglais donc il va sauter ça.

PT03 discusses the importance of providers providing care to patients in their official language of choice, and of the health care provider taking an active role in making this happen. When they are comfortable in their language, patients are much more engaged in care, capable of providing thorough details, information, and responses, instead of skipping important points of conversation due to the language barrier. PT03e addresses challenges that occur when patients second-guess the importance of verbalizing their issues, as they can doubt their ability to clearly get their point across in the provider's language. At times, they are unsure as to how to express their needs in English, so will instead omit their concerns in the discussion. As mentioned in previous quotes, such a practice can cause harm to the patient but can also disadvantage the health care team who will be lacking important information and nuanced details. As a result, the patient is not receiving optimal quality of care, and providers are not able to provide quality care with an incomplete portrait of the situation. RN07 continues this thought, stating:

> To a certain extent, language doesn't prevent from receiving the minimal standard of care, but I certainly feel it's a barrier to accessing good care. You can go to an emergency department and you're having a heart attack and you don't speak any language and you'll get care … of some kind. But trying to seek appropriate or good or holistic or appropriate care I feel is significantly challenging.

RN07 suggests that attempts to care for a patient will not be halted due to their language. However, RN07 makes it clear that there is an important difference between the minimal standard of care and receiving good care. Efforts to provide care of some kind will take place, regardless of the patient and health care team's linguistic ability or competence. However, RN07 recognizes

that indicators of quality of care such as holistic care tailored to the individual's needs will be compromised, and thus providing appropriate quality of care is more challenging to Francophone patients in Ontario. This is especially the case with clinical conditions whereby language is an essential component of the clinical evaluation. While the example provided suggests that a patient requiring care for a heart attack may receive "care … of some kind," the kind of care that is possible or appropriate will be different depending on the patients' ailment.

Some conditions are manifested with atypical symptoms, or have less obvious clinical presentations, or cannot simply be confirmed without a detailed subjective evaluation. For example, if a patient presents with a mental health emergency or crisis, language and verbal communication is a critical component of the clinical assessment and evaluation. As such, the language barrier acutely "prevent[s] [patients] from receiving the minimal standard of care." Even the minimal care is not possible, and thus cannot by any means be compared to standard care, or even less, any quality of care. It is important for the health care system to recognize the difference between "efforts to provide" quality care, and "providing" appropriate quality care, and to understand the changes required to make this a possibility for all patients who access the health care system, regardless of their official language of choice.

RN08 indicates that patients' care quality can actively be harmed due to incongruencies:

> They can kind of fall to the wayside and … maybe not be followed up with … as adequately as if they had been told in their preferred language and or if… If they don't go to a hospital that or … a medical facility that exclusively speaks their language… I think it's challenging for them to access the care that they need and deserve.

The quote above describes the harms that can happen in the face of linguistic incongruencies between the patient and the health care team. RN08 shares concern for patients "fall[ing] to the wayside" and receiving inadequate or no follow-up. This relates to the

conversation above about patients not accessing health care in a language that they do not understand fluently, as well as care avoidance for patients when the health care team is unable to engage in the minority language. RN08 indicates that patients receive the best care when they go to facilities that offer care in their language, such as French-designated health centres, or areas that can "guarantee" bilingual access to health care. However, these health centres are not available to all Francophones in Ontario, and even when the centres exist, the level of French-language care offered may vary depending on the availability of staff members. As such, Francophone patients are challenged with accessing quality care, and this can be an issue across Ontario.

It is important to note that in several quotes, health care providers share their experiences using a passive voice. In the best interest of quality of care, it is important that health care providers have an active role in the care received by patients. Thus, they need to have an active voice in speaking on the matter to create meaningful and sustainable change. Patients do not simply "fall to the wayside," but knowing that this happens disproportionally with linguistic minority groups, health care providers need to actively speak to this matter. In order to improve quality of care, it is important for all parties in the health care system to remain active and accountable participants in the health care services of all participants, so that existing deficiencies in the health care system do not continue to be perpetuated.

Special Populations.

Unique challenges can present for certain populations trying to access health care. During the interviews, participants brought up numerous situations for consideration with respect to their own experiences. These statements were particularly significant in regard to the patients' ability to convey their health needs for certain specialty practices. For example, NS08 affirms that "En santé mentale il faut vraiment écouter ce que le patient a à dire. Puis il faut être capable, tu sais, de

poser nos questions… Pour ceux qui ne comprennent pas l'anglais, ça va mal." In this quote, NS08 addresses the particularities that she has seen in mental health care. With mental health care interactions, the assessment is undertaken using language and verbalization. NS08 has seen the importance of being able to listen to the patient, and realizes the importance of an exchange in dialogue and for the health care professional to be able to engage as well and to ask questions. As a student, she also relates the challenges of mental health assessments to a lack of access of French language resources. She recognizes that those who do not understand English are faced with more difficulty. RN02 has also realized the challenges of mental health care considering linguistic barriers. As she states:

> Ça ne donne à rien que le patient soit vu par un médecin s'il n'arrive à rien comprendre. C'est vrai que le médecin, cliniquement, il peut écouter, il peut faire son diagnostic, il y a la paraclinique, mais quand ton diagnostic dépend de ton entrevue, par exemple, en santé mentale, avec le patient, je ne pense pas que ce soit un choix. Ce n'est pas une option.

RN02 provides an astute observation on the significance of language with health assessment, most especially in the mental health context. Indeed, health care professionals have access to multiple tools. However, these tools do not offer a complete portrait of a patient's situation, especially when the diagnosis requires a subjective assessment, a conversation, and an interview. Although a health care professional may listen and see and hear from the patient, exchanges and engagement are required to adequately assess a patient's mental health status. As such, in mental health care, linguistic congruence is not a question of choice, it truly becomes a necessity in order to offer quality care.

The importance of language and mental health care is observed by several health care providers. Even so, the clinical settings offer a different reality. For example, RN07 reveals her clinical experience, stating:

> None of our crisis workers speak French, which is challenging . . . That's brutal because when you're in a mental health crisis, that's really challenging. Good communication is such an important part of that. ...I also feel like [mental health patients] often get forgotten, that's a whole other issue. For the most part, if you're a Francophone there with mental health issues, you present your issues in English because you have to. And that's brutal. They're already miserable and scared and stressed. Yet, most of the time you have to speak English.

RN07 is aware of the importance of language and health care and alluded to how much of a challenge this can be in specialized fields such as mental health. With mental health care, the importance of communication and language cannot be contested. In RN07's acute care setting, numerous options exist to support care and services for patients presenting with a mental health complaint. However, these services are predominantly offered in English. Crisis nurses are present to support patients through their challenging circumstances. And yet, at the time of the interview, none of the crisis workers was bilingual. Though communication is a cornerstone of mental health care, this standard is not possible for Francophone patients. At this facility, a Francophone patient who presents with a mental health crisis is unable to receive services in their official language. This is important considering the reality of seeking mental health care in acute care settings.

RN07 reveals that she "feel[s] like [mental health patients] often get forgotten, that's a whole other issue." If this is the case for most mental health patients, the reality is further accentuated for Francophone patients, because as RN07 describes, patients present "issues in English because [they] have to." As such, patients return to accommodating the needs of the health care providers rather than their own, even during crisis states of a mental health illness. Despite the challenges that they may be facing, language becomes another burden. Good communication would be the very minimum requirement for these patients; however, for an individual who speaks little to no English, their mental health care is even further compromised. This is difficult for numerous reasons for a patient who is facing a health crisis, as discussed above, and for the health

team, who is incapable of upholding the standard of care, leading to situations that can be "brutal." RN01 shares the experience that one of her patients faced with the dilemma of requiring mental health care in the official minority language:

> Une cliente… était soignée des années… à [hôpital psychiatrique] . . . avec un psychiatre Anglophone… elle a un service communautaire en santé mentale, donc, ils me l'ont référée à moi… Maintenant, elle ne veut plus voir son médecin Anglophone, parce qu'elle trouve qu'elle n'est pas capable de s'exprimer dans sa langue officielle comme il faut… elle ne peut pas s'exprimer en français, parce que le médecin ne comprend pas. Donc, en parlant en anglais, elle trouve qu'elle ne reçoit pas de bons soins parce qu'elle ne se fait pas comprendre en anglais autant qu'en français. Donc, maintenant, c'est d'essayer de lui trouver un psychiatre en français, ce qui n'est pas facile. Donc, pour les clients qui veulent avoir des soins dans leur langue officielle, ou leur langue maternelle… c'est difficile, parce que… les fournisseurs de soins ne sont pas toujours là.

RN01 shares the difficult reality of her Francophone patient. Though the patient's first language was French, she had been receiving mental health services by a psychiatrist for many years in English. She was finally referred to a community mental health nurse and was able to fluently express herself in her mother tongue, her official language of choice. With this experience, she realized that she needed to receive her mental health care in French. She was able to convey that she was not at ease expressing herself in English. She acknowledged that she struggled to be understood throughout her mental health care encounters if the exchange was in English. She realized that she should obtain mental health services with a psychiatrist in French, but her specialist was English-speaking and did not understand her when she spoke French. As such, the language discordance was an obstacle that she could not overcome.

In connecting with RN01, she was able to confide that language was a reason why she was not receiving quality care and that she did not want to continue mental health services in English. With this challenging situation, RN01 realized that there would be difficulties ahead, as there is not an abundance of psychiatrists, and it is not easy to match patients to French-speaking

psychiatrists. She realizes that there is a dearth of these specialists, and thus access to this care for Francophone patients is compromised. The challenges with continuity of care for Francophone patients faced with mental health complaints were shared by several participants. RN05 supports this reality:

> In the primary care clinic trying to intake patients into their mental health services to refer them to a social worker, to refer them to a psychologist or a counselor and have those types of discussions, I can't imagine. Some of those discussions in a second language can be so hard.

RN05 acknowledges the difficulties for both patients and providers when it comes to supporting mental health services in French. From her experience in a clinic, she mentions the challenges that there can already be with regard to appropriately referring patients to members of the interdisciplinary team. She acknowledges the difficulty that would exist for these health care interactions, as they must take place in the minority language. As such, access to mental health care for Francophone patients is met with significant barriers for patients. This barrier is one that also presents a challenge for the health care professionals who need to have discussions with patients to effectively meet their mental health needs.

RN07 acknowledges the multiple challenges that may co-exist regarding mental health, and this time relates the experience of patients and families within the pediatric context:

> With the mental health patients that we see, I think it's so crucial to be able to speak French to them. You're sharing something that's so vulnerable, especially with the families who are so distracted because [of] their child's distress, and there's a lot of misunderstandings about mental health and so it can be really challenging if you don't speak the language.

Language can have a significant impact on one's overall health care experience. In this quote, RN07 speaks to the importance of being able to address patients and families in French, especially significant in pediatric care. She highlights the importance of all parties being able to

speak in French. She also delves into how vulnerable this experience can be for the patients and families. In the pediatric setting, with a patient presenting with a mental health complaint, it is important to be able to engage appropriately with both the patient and family, even when they are Francophone. RN07 touches on the misunderstandings that there can be with regard to mental health, further stressing the importance of being able to speak to the challenges with patients and their families. All these interactions are further challenged in the presence of a language barrier, and when done poorly, can hinder the pediatric care experience. As such, patients with mental health care issues and and/or are very young are populations with needs which require further attention with regard to linguistically congruent care.

A few other participants also discussed the intricacies of pediatric health care, acknowledging that there were unique particularities patients, families, and health care providers. They noted the challenges for Francophone families with infants because of the difficulties of care providers not being able to speak the minority language. It was also necessary to make children comfortable accessing health care, especially when it was not in their mother tongue, all the way through to the transition from pediatrics to young adults. As NS05 notes:

> That lady we were talking about, she neglected to get her consultation for a really long time with cardiology because of that experience. So, I think that they are intimidated by the lack of bilingualism and … it makes them afraid to seek help and seek medical care… we had to convince her to come. …it's for a baby with congenital health issues, you know what I mean? So, it needs follow up and it needs screening and all that stuff. So, I think it really is definitely a social determinate and it really affects if they are going to seek help or not. I also think that the quality of care that they receive is different if people are, you know, somewhat bilingual or kind of able to translate the information. A lot of things get missed.

NS05 reveals an unfortunate situation regarding a Francophone family's experience with pediatric cardiac care. In this situation, the parent did not receive cardiac follow up as promptly as needed due to a language barrier. While they were called back to the hospital, the parent did not understand the message and the urgent nature of the matter. The lack of bilingualism prevented

timely access to care. In this situation, the family had to be notified several times and ultimately convinced to come to the hospital to address the baby's congenital health issues. NS05 once again affirms that language is "definitely a social determinate and it really affects if they are going to seek help or not." In this case, language affected the speed at which care was accessed.

With congenital health issues, this parent and baby will need numerous appointments. These appointments will likely all take place in the majority language. As such, this barrier may impact subsequent follow-ups, especially if the question of language is not rectified. In this situation, access to care is delayed, and the quality of care is compromised. Equitable care is called into question as well, as NS05 indicates that the care that one receives depends on whether or not they are somewhat bilingual, or whether or not they have some understanding of English. Otherwise, they need a means of translating and understanding the information provided in English to receive their health care, or else care gets missed. This is one example of the language barrier and the challenges that it can present to parents, which will ultimately have consequences for the pediatric patient. These situations do not occur in silos — they are issues throughout Ontario. PT02 also shared her experience with regard to pediatric care, this time recalling her challenges accessing care as a mother of young children:

> J'ai trouvé que c'est très limité, c'est très limité surtout quand j'étais une jeune maman . . . Il n'y avait pas trop de choix pour des médecins de famille. Alors j'ai trouvé ça difficile pour les enfants parce que les enfants ne parlaient pas anglais encore avant d'aller à l'école. . . . j'aimerais ça pour les familles françaises qui ont des enfants surtout parce que je trouve que c'est là qu'est la difficulté avec les enfants ça c'est mon opinion. Alors si moi, j'aimerais ça oui qu'on ait plus de médecins en français.

As a Francophone individual living in a rural/northern setting, PT02 learned to receive health care services in English. Now, as an elderly person, she is bilingual, and states that she is comfortable receiving health care in both official languages. However, she recalls the difficulties

she had seeking medical care as a young Francophone family for her French-speaking children. This was especially challenging when they were pre-school aged, as they had not yet been exposed to English. As a result, these health care interactions were difficult and became a stressor for the family. The interactions were not only challenging for her as a mother, but she revealed that they were also scary for her French-speaking children. She pointed out that there was a lack of French-speaking physicians, which made it difficult to overcome the challenge at the time. RN05 continued this thought regarding care to French-speaking children in Ontario:

> When people have a lot of stress, I think it is really important for them to be able to express themselves however they can. Just to be very welcoming in your expression in French I think helps with the stress levels for those patients and also for children because they maybe haven't had the opportunity to learn English.

In the quote above, RN05 shares her experience providing care to pediatric populations. Care to children is very unique in the way that it is offered, taking special considerations to make young patients and families feel the most at ease since health care interactions can be stressful. In RN05's care setting, it is important for patients to express themselves freely in either English or French. Although working in Ontario, where the majority language is English, she has come to notice that many of her patients are not English-speaking. She is adamant that this is a significant consideration for pediatric patient care and attests to the importance of being able to offer care to patients and families openly in French.

While pediatric patients can be a unique population to navigate, others who are French-speaking newcomers to Canada also require special consideration in health care provision. NS09 reveals:

> If you look at new immigrants coming into a country … there's a lot of things that is already determining how their health outcome will become and its language… That ability for them to know their resources and where to seek out any additional resources they might need is

> already severed because they're not able to know … the official language or the language that services are being provided in. So, I think that's already… that's a big one.

NS09 talks about the heightened challenges surrounding immigration and access to health care, especially for those speaking the minority language. Adapting to a health care system in a new country, learning how and where to find resources, and ensuring that they can understand the services offered are immense challenges. Without being well connected, new immigrants, especially those belonging to the minority official language group, are at a significant disadvantage in health care access and resource utilization. This reality can determine their health care outcomes and highlights the way language acts as a determinant of health. RN05 states that "I have patients who are from Congo, Burundi who you know their first language is Kirundi, Swahili or the reverse and then French and very little English, it's a huge determinant of health of the French language services." RN05 shares her own experiences with patients from Francophone countries immigrating to Canada, who are faced with multiple challenges including speaking little English as their official Canadian language is French. She elaborated as well that language is a determinant of health for these patients. This factor will affect and inform numerous health decisions from seeking out medical care and finding points of access. The inability to access timely care can lead to an inventory of difficulties related to health outcomes, as previously discussed. The situation of these patients also contributes to compromised service quality and patient safety. To further support the challenges that can present for minority language immigrant patients, RN10 discusses one situation that took place in a community care setting:

> They only had one nurse and one dietician. And the nurse was bilingual, could speak French and English, and then the dietician did not speak French. It was… I remember just talking to her and she was saying that it was a huge barrier. Especially often for newcomers to Canada, they didn't have a family physician … they sort of discovered that they were diabetic through a random blood test and they were put into our program. But it was hard for the dietician. She said, you know, some of these patients, you're starting them on Insulin

> and you're trying to do teaching and she was saying she uses a lot of pointing and gesturing. Yeah, so they're not getting the same quality of information. It's also hard as educators too, to really double-check whether they are understanding everything that you're saying.

In this example, RN10 describes a situation where the health care team caring for newcomers who communicated in French included a dietician who did not speak the language. Although she needed to provide diabetes education, she could not do so effectively and reverted to much pointing and gesturing. Such patients do not receive the optimal quality of care, as they are entering a health care interaction with very little information aside from the notification that they have been enrolled in a new program. As such, they are significantly disadvantaged, as they may not be familiar with the health care system. Furthermore, the health care team does not speak their language and thus they are ill-equipped to advocate for their needs in the face of a new chronic health challenge. This problem is relevant to health care settings across the province, hindering the quality of the health care experience for both patients and health care providers alike. PT03 shared her perspective on this issue:

> Déjà dès le départ tu es stressé… j'espère trouver quelqu'un qui va parler en français… Parce que la majorité des services qu'on le veuille ou non c'est en anglais… Quand je suis arrivée ici en fait, dans ma tête je me disais je vais parler en français. C'était ça. C'était ancré dans ma tête, mais quand je suis arrivée à [ville/city] et qu'on m'a dit non tu vas parler en anglais, ici c'est plus anglais que Francophone. J'ai été choquée, j'ai été, c'est comme si j'ai manifesté, j'ai eu un blocage en moi. Au début je me disais non, écoutez-moi je viens je parle d'autres langues, je vais encore rajouter l'anglais. Moi je me disais non, non je ne vais pas aller à l'école pour apprendre l'anglais. Je n'ai pas le temps de rentrer à l'école pour apprendre l'anglais. . . . Je parlais déjà quatre langues.

Several participants in this study were once newcomers to Canada. PT03 shared a concern that was echoed by numerous patients who were faced with the realities of adapting to life in Canada, more particularly to life in Ontario. Prior to coming to Canada, they were advised that they were going to be immigrating to a bilingual country. They were under the impression that

they would be able to speak and live their lives successfully in French. Upon arriving to Ontario, they realized that this was not to be the case, that to thrive in Ontario, they would need to be sufficiently Anglophone to navigate the new environment, including the health care system. For many patients in the study, this came to them as a shock.

As a new immigrant, French is often not their only language. For example, PT03 already spoke four languages and she could not envision enrolling in courses to learn a fifth. This reality can be quite distressing for patients newly arriving in Ontario, as health care needs cannot wait for them to learn a new language. Hence, newcomers to Canada face more burdens in their health care experience, especially considering the numerous adaptations that are already required for their transition into a new country. There are further challenges for Francophone minorities in this current health care environment when language barriers and cultural barriers must be considered.

Language as a Right.

Participants had numerous thoughts regarding the status of the French language and its implications for the health care sector. PT03 noted that:

> C'est quand même un droit de se faire servir dans sa langue, quand on pense que c'est un droit je crois qu'il faut faire un effort. Un du gouvernement, de la part des personnes aussi pour servir les gens en français.

PT03 was aware that in Ontario, individuals have the right to obtain care in their official language of choice. She thus linked this right to the importance of having this need recognized by the individuals who oversee the offer of services, notably federal and provincial government authorities, health organizations, and health care providers. This is an important remark, because the formal designation of health care institutions, previously discussed, was meant to remediate this concern in Ontario, yet patients continue to struggle to obtain health care services in their official language of choice.

Good Enough French and Accommodations.

Participants had numerous thoughts with regard to the French language in this current health care environment, reflecting on "good enough" French and "good enough" care. This refers to a level of French being spoken, or a level of care being provided that clearly does not meet basic standards of care. This was a reality that was revealed to be problematic in several regions and sectors. For example, NS09 states:

> As a nursing student, I do have the help of my preceptors and sometimes they do... or they are proficient in the language . . . sometimes that's helpful, but at the times that I don't have the additional resources, I would say the [patient] interactions are really brief, short and they just result down to what is needed to be done at point of care and move on.

In this quote, NS09 shares the process of care provision to patients when there is a language barrier since she is unable to provide care in French. She describes reliance on preceptors, which is expected to some extent for nursing students. However, she also reveals that at times when additional resources are not available, and there is no one present to support her in French, she keeps patient interactions "really brief, short and they just result down to what is needed to be done at point of care and move on." This approach is problematic, as health care interactions that are brief, short, and to the point do not offer a foundation for quality care. Such interactions do not permit the health care provider to know what the patient needs. These interactions also do not permit the patient to be able to go into depth with their health care ailments and concerns. Furthermore, probing and prompting of patients cannot take place, and the full care that the patient needs is not offered because many elements of the care required can be missed. They do not permit any meaningful therapeutic relationship.

Even more challenging is that educating students to practise in such a manner results in a system whereby Francophone patients will continue to be cared for this way by independently

practising registered nurses. With such an approach, quality of care is not optimized, and basic standards of care cannot be met. Instead, quality care for patients is replaced with good enough care for Francophone patients. A system-wide approach is required to improve the care experience for patients throughout the province.

The challenges regarding "good enough" French language services are extensive and have been lived out differently with each study participant. As PT03 notes :

> La personne qui travaille avec toi doit vraiment maîtriser son français. Parce qu'il y en a qui quand même qui sont des [professionnels de santé] Francophones qui ne veulent pas parler en français… tu sais qu'il est Francophone, tu sais qu'il parle français, tu l'entends dans l'accent… il parle bien anglais, mais tu sens qu'il parle quand même un peu de français. Il va tout simplement de dire « Non, écoute, moi je te sers en anglais parce que je ne parle pas français » ou « mon français, c'est juste des mots par-ci par-là. »

PT03 suggests here that even basic or "good enough" care in French can be difficult to come by, raising the question of quality over quantity of French-speaking health care providers. In the current health care environment, being able to speak both English and French is recognized as an asset in Ontario. However, this asset may not always benefit the patient. Through her interview, PT03 shared numerous experiences as a Francophone patient trying to obtain health care services in French. Although she now speaks English, she remains more comfortable interacting and receiving health care services in French. She discussed the perplexing situation of recognizing that a health care provider may speak some French, but not be sufficiently bilingual to provide care in French or may flat out refuse to speak French. Being Francophone, at times she was able to detect a Francophone accent in an employee, but still unable to obtain health care services in French.

At other times, the health care professional may admit to speaking a little bit of French but chooses to pursue the health care interaction in English. This is challenging for a Francophone patient, because they once again find themselves in a situation where they must accommodate the

health care providers' needs and preferences rather than their own. Accordingly, all the different risks associated with not receiving care in their official language are present. Moreover, if it is the case that the employee is bilingual, there is the question as to whether the individual was hired for their ability to speak French. If this is the case, the institution is misinformed as to their ability to serve official language minority communities, as patients who seek and desire health care in French are not having their health care and linguistic needs met.

Active Offer and Lack Thereof.

The active offer is an opening statement by the service provider inviting clients to request services in their official language of choice (Office of the Commissioner of Official Languages, 2020). In Ontario's health care environment, the active offer is a greeting stated in both official languages (i.e., Bonjour! Hello!) extended by health care professionals, inviting patients to continue the health care interaction in their language of choice. Throughout the interviews, it was clear that the active offer was inconsistently applied, causing significant challenges for everyone involved. For instance, NS07 asks: "Excuse, offre active? … Je ne sais pas ce que ça veut dire." Although NS07 was a Francophone nursing student currently enrolled in university studies in French and having provided care to Francophone patients in Ontario, she was not familiar with the concept and terminology of the active offer.

This poses difficulty for Francophone patients in the health care system, as they are often used to receiving health care in English in Ontario, although they best understand and process their health care in French. PT04 reveals that "Même le Francophone ne va pas te proposer automatiquement, ne va pas tester automatiquement. Non, non, ce qui est automatique c'est de parler en anglais même s'il est Francophone." While every health care provider offers care in their unique manner, PT04 shares an experience that was a common denominator for most patients in

the study. Most Francophone patients interviewed were not provided with an active offer. Many realized that the instinct for all health care providers was to speak in English, regardless of the patient's language of choice. However, if they had provided an active offer, the patient would have immediately been made aware that the provider was bilingual and would have been able to receive health care services in French. When asked if they would directly ask for health care services in French, patient participants provided numerous responses. PT02 and PT01 provide two different perspectives on this issue. PT02 states that "Non, je n'ai pas fait la demande [de recevoir des soins en français], non." Meanwhile, PT01 reveals that:

> La plupart des gens font les demandes en anglais. Si je perçois ou que je vois le nom de la personne sur son habit ou j'aperçois un accent Francophone, moi je m'adresse en français. Je ne fais pas une demande « Je veux être servi en français. » Mais je cherche à converser en français autant que possible sur la place publique.

PT01 and PT02 provide insight into the complexity of the active offer for Francophone patients. Being Francophone, PT01 reveals that she did not ask to receive care in French. Throughout her interview, she spoke of the importance of the French language and her comfort with French. However, she is not one to ask a health care provider to address her in her official language of choice. PT02 is also Francophone but has a different approach on the issue. Having realized that most of the health care system operates in English, he also does not explicitly ask for care in French either. Rather, he seeks out hints and opportunities to speak French, checking whether the provider has a French name or a French accent. He also initiates conversations in French. However, in spite of desire to interact and receive care in French, he also would not ask a health care professional directly to serve him in French. NS04 confirms this observation through her clinical experience, stating that « La majorité des gens même Francophones ne vont pas exiger des services en français. »

NS04 notes that several Francophones who she knows will not demand services in French, which is consistent with what other participants in this study shared. However, it is important for health care providers, both Anglophone and Francophone, to note that lack of official demand is not necessarily correlated to lack of need for French-language services. The lack of an official demand may stem from a plethora of reasons, as discussed in the individual level section, not excluding the power dynamics involved within a patient provider relationship, as well as the fear of being deemed a difficult patient and dealing with the consequences of that status. Unfortunately, far too often there is a covert interpretation that lack of demand for services in French means a lack of need for services in French. However, the participants in this study make clear that this is not the case. PT06 attests to the importance of this, saying that « Pour ce qui est de cas de santé, tout le monde aimerait les avoir dans la langue qu'il comprend le mieux, oui, et moi aussi, c'est ça. »

Based on PT06's quote, there is a desire for Francophone patients to be served in their official language of choice. With the active offer, this invitation is extended at the very beginning of the health care interaction, ensuring that the health care environment meets patients' needs. RN04 provides her take on this complex issue, suggesting it is a health care priority: « Inviter les professionnels de la santé d'utiliser l'offre active, et fournir plus d'éducation aux professionnels de la santé sur comment donner les soins culturellement compétents à la population Francophone, surtout qu'ils vivent en contexte de minorité linguistique. »

Throughout the interviews, participants offered numerous perspectives on how to address official language minority communities. RN04 indicates that inviting health care providers to use the active offer with patients is essential. Furthermore, she underscored the importance of educating health care providers with regard to the needs of Francophone patients, as well as the

challenges associated with culturally competent care for linguistic minorities. Although the active offer is voiced as a simple strategy, it is not systematically implemented. This was revealed through interviews with nursing students, registered nurses, and patients in this study.

Chapter 6: Results — Strategies to Manage the Lack of Resources for French-Speaking Populations

To ameliorate the deficiencies and lack of resources in the health care system with regard to French-language care in Ontario, patients, registered nurses, and nursing students came up with a number of strategies and means to bridge the gap and facilitate their day-to-day realities. All participants reported informal and formal strategies that they employed to optimize their care experience and offered several suggestions that would enhance the lived experiences of Francophone patients and their health care providers in Ontario. It must be said that strategies were rarely used independently or in silos. Patients and providers used multiple means to ensure that the health care interaction would take place effectively.

Implemented Strategies

At the time of the interview, study participants referred to strategies they had implemented. All touched on the value of clinical tools and resources in French. Many mentioned the use of technology in their day-to-day practice, while others talked about their recourse to interpretation and translation. Discussions took place about staff assignments and use of the interprofessional team, while others talked about non-verbal methods of communications. All participants valued health care education in French, though the needs and suggestions differed between patients and health care providers. Health care professionals spoke to the need for it as a resource to assist them professionally, while patients spoke to its importance to address the health needs of Francophone patients, and to bring light to issues pertaining to language as a determinant of health. Patients shed light on their own means of coping, which included accessing Francophone institutions, adapting to system inequities, and, furthermore, resisting the system. Beyond these strategies, participants also provided suggestions for systemic changes.

Clinical Tools and Resources

In terms of strategies currently in place, registered nurses and nursing students indicated that they had access to various clinical tools and resources, mostly in English although some in multiple languages depending on the workplace. However, resources in French were not consistently accessible and distributed, adding layers of complications to care provision. As RN03, RN09, and RN02, stated respectively:

> RN03: Resources we have… having our pamphlets in English and French.
>
> RN09: When I used to work at my other department, we had a little questionnaire that we had to go through with the patients, and we had it available in French and in English.
>
> RN02 : Les livrets des clients qui sont admis, ça aussi c'est disponible en français. Si jamais le client est Francophone, il va pouvoir avoir ces informations-là en français. Puis, aviser les clients qu'ils peuvent toujours verbaliser leur préférence [linguistique].

These three nurses indicate that resources do exist in their facilities in both official languages, pointing to pamphlets, questionnaires, and different patient information booklets. These include documents that health care staff can review with patients. RN02 also notes that patients can verbalize their linguistic preference. While these constitute basic resources for patient intake and some patient education, challenges emerge when the care must be individualized to meet patient needs. Patient participants previously mentioned that requesting services in French was a challenge. Nurses also realize that supporting patients with the proper clinical tools, even in the official language of their choice, is not a given. For example, RN03 states:

> Some of our resources we have in English and in French. So, like handouts and pamphlets and stuff. So sometimes I usually read them… like sometimes I'll actually provide them to the patient, but sometimes I just read them to get the information and learn the vocabulary . . . but it also just kind of slows you down, right? So yeah. I mean thankfully most of the teaching documents and stuff we have are bilingual, so I'll read it in English first and then read it in French before like giving it to them and going through the instructions with them and stuff.

In RN03's clinical context, although not all of the documents are available in French, those that are prove to be helpful to both the nurse and the patient. The nurse reads them over to enhance her own vocabulary in French before providing them to the patient. Challenges emerge with consistency, as the documents are not always available in French. Moreover, RN03 speaks of this process of reading them in French slowing down care. A health care provider who is not fluently bilingual now has to read the document in English, familiarize herself with the information in French, and then teach it to the Francophone patient as well. The strategy of reading the material in French and adjusting for French-speaking patients is viewed as a hindrance to the care process. Moreover, this process does not always take place, because sometimes the French language resources are not even available to the patient, as mentioned in RN03's quote. Thus, French language services and accommodations are not implemented systematically, but when done, they can be perceived as a hindrance that slows down care. NS09 adds to the conundrum:

> But you as a nurse, and as a student, you can meet a client that has a language [for which the] resource [exists] in another office and so on and so forth. You wonder, oh my goodness, how do I connect this? So, as nursing students, we just share how to get access to those resources. Sometimes we put it on drives, Google Drives for ourselves and then just distribute it among ourselves. Other times, people are able to find websites that are approved by [community agency] to use. And we just keep—compile those resources for ourselves. And we do share them with the nurses. And some of the nurses are already aware of, like, where to get some of these resources, so it's... it's also helpful.

In NS09's experience, clinical resources sometimes exist, but are not necessarily in the right place. In her clinical setting with multiple community agencies, different resources are available depending on the language of the typical clientele. As such, sometimes she knows that the resource exists in the required language, but it is not onsite with her when the patient is present in her clinic. As nursing students, seeing that this was a recurrent issue, they created an online drive to share resources electronically to bridge this all-encompassing dilemma. This also helps

them bank the information of other online resources, which they can then share with the nurses in their clinical agency. Yet, this is an example of the far-too-common reality where the existing structure of the health centre is not able to fully meet the needs of its clientele or staff. As such, care providers, including nursing students external to the agency, must come up independently with solutions to meet the daily needs of their client base. Such strategies, though they assist the immediate situation, mask the gaps in the system that face linguistic minority patients. RN02's agency also encompassed to knowledge mobilization and resource sharing:

> Sensibiliser le personnel, aussi, sur les ressources Francophones, parce qu'elles ne sont pas toujours nombreuses… Là où les clientes peuvent se diriger pour les affaires des soins, de counseling. On le sait, il y en a plus en anglais qu'en français. Pour ça, on garde, comme un petit journal. Par exemple, si on veut référer quelqu'un, même si c'est en privé ou au niveau du public pour des soins counseling. Puis on le sait, c'est où référer cette personne-là . . . Dans des cas comme ça, c'est canaliser les ressources, sensibiliser le personnel, pour qu'on puisse savoir où se trouvent ces ressources-là, et savoir comment est-ce qu'on peut référer le client a des ressources qui vont être adaptées à leurs soins.

RN02 indicates that there are only a few French language resources in comparison to those in English, which can be a challenge for continuity and transfers of care. Her agency keeps a journal that identifies resources in French that they have found. This includes private and public health care services, where they know that a patient will receive care in their official language of choice. While this informal means of collecting information is specific to this health care setting, it is beneficial to patients who know that their care needs will be linguistically congruent. However, this strategy also masks the need for the implementation of the systemic and sustainable solutions patients and health providers require. Instead of adopting strategies which could be beneficial systemwide, these strategies are only patchwork solutions at the individual and the health team levels, such that the problem is invisible to the organization.

Other Tools and Technologies

Participants list numerous means of meeting their own or their patient's linguistic needs. Acknowledging that some technologies were better than others, many improvised, and found that their cellphones yielded instantaneous help. For example, participants cite Google Translate as a key technology for their clinical sectors:

> NS01: I had my placement at the [hospital] in maternity. So, I had to take care of a patient who only spoke French. Didn't really understand much English. And like didn't really speak English at all. So, it was kind of difficult just because I used to speak French back when I lived in [ville/city], but you know, I haven't been able to practise it at all. So, I had to use Google Translate.
>
> RN09: Technology is also available, so using Google Translate, trying to translate to the patient or their families via that.

In this example, NS01 was practising in a complex care situation, providing care in the maternity unit to a Francophone patient who spoke no English, while she spoke very little to no French. In this case, the use of Google translate was the technology that she turned to for the care experience. RN09 notes that this tool is used to communicate with the families as well. These two participants highlight this tool as readily available technology for translation, which can support care "in real time." However, for some patients, the reality surrounding the use of Google Translate may be very different. For example, PT06 reveals the following:

> Mon mari avait enregistré… Quand le médecin nous donnait des prescriptions et des consignes à suivre mon mari a dû enregistrer pour qu'on l'écoute calmement à la maison… Il nous avait donné des brochures, un formulaire qu'on devait lire et compléter au cas où… quelque chose s'annonce à nouveau chez le bébé, ils ont écrit tout ça. C'était en anglais. Donc ce qu'on a fait c'était utilisé le Google translate, parce qu'il n'y avait personne pour nous aider.

PT06's quote reveals the process of receiving discharge instructions for the care for their sick child. Without Francophone or bilingual staff, they received their care and discharge

instructions in English. In the absence of French language support onsite, they audio-recorded the instructions. Using Google Translate was a means for them to understand the instructions that they had received in hospital, necessary because there was no one who could help them at the hospital in French.

While this strategy was adopted as an attempt to manage an urgent situation, it proves to be problematic at many levels. During a pediatric emergency such as the one above, families need to understand the discharge information provided to prevent detrimental outcomes. This French-speaking family did not get the opportunity for a suitable discharge experience. Instead, they audio-recorded the discharge information and left the hospital with the plan to listen to the recording calmly at home. Having to resort to such measures suggests that the environment in which they were discharged was not suitable for a Francophone family to receive, to integrate, or to understand the information provided to them. However, once they leave the hospital, they lose access to their health care providers, the very individuals who should be able to answer their questions, clarify their understanding, and confirm their preparedness and readiness for discharge. As such, though technology seems to help in some situations, it can be detrimental for the quality of care and safety of these patients. Other solutions using technology exist, as stated by RN02:

> Aux soins intensifs, je sais qu'ils ont des lits intelligents, qui sont capables par fois de traduire un petit peu . . . Ça ne va pas traduire une grande conversation là, mais, un petit peu à la fois, l'essentiel, les lits sont capables de faire un petit peu de traduction.

The nurse mentions the hospital-provided strategy of "smart" beds available in the intensive care unit. She notes that they can translate a few words, which has proven to be helpful in their clinical practice. However, these are localized to a particular clinical sector and not widespread throughout her institution. Even so, this technology helps bridge existing gaps in the delivery of language congruent care.

Interpretation and Translation

The use and access to interpretation and translation services in diverse care settings remained an issue of contention among participants. For example, access to professional interpreters and translation services varied vastly from one care setting to the next. Every participant described a different approach to the accessibility of translation services. For example, although NS01 notes that "They always tell us that there's a translator at the hospital available," she confesses to never using or needing access to those services. It is not clear whether professional services would be accessible anyway if she actually needed them, because earlier she had pointed to using either technology or other staff members to assist with translations, rather than the professional resources supposedly on hand.

Also addressing interpretation services, RN06 states that "On pourrait certainement demander un interprète si ce n'était vraiment pas possible que quelqu'un puisse parler en français." As a Francophone nurse, RN06 usually provides care in French to her own patients. She admits that obtaining professional French-language interpretation services is a stretch and reveals that the cultural norm for her sector is to find an individual onsite who can speak French. The question remains as to whether interpretation services are always accessible to participants requiring these services.

RN08 and RN09 state that their standard approach is to obtain translation from a French-speaking colleague:

> RN08: I will ask a co-worker to help me translate.
>
> RN09: In very few cases where let's say a French nurse isn't available and let's say I get this French-speaking patient, there are resources available in the hospital that we talked about previously, so the translation services . . . we have translation services… we've used them… so I used to work in a different department, and we definitely used it there before. Definitely not for French-speaking patients just because there were so many nurses

> available that spoke French but for other languages, we've definitely used it, I personally haven't but I know I've seen translators on the unit for sure.

In the case shared by RN08, one can question if translation and interpretation services are even an option, as the first choice suggested is to obtain the services of a colleague. Furthermore, RN08 does not suggest whether formal French language services would be sought by a health care professional or whether they would always use a colleague who speaks French. RN09 indicates that formal translation services do exist in her institution, although use varied per unit. However, she also indicates that for Francophone patients, the translation is usually done by one of the many French-speaking nurses. If a French-speaking nurse is unavailable, then translation services will be considered. As such, the practices surrounding the use of translation services appear to be reflective of contextual and staffing circumstances.

Both nurses and patients also described using families as informal translators. As RN02 notes :

> Des fois aussi, on met la famille dans le plan de soin… Si ça, c'est vraiment une barrière, par exemple, le grand-père [patient] peut parler juste en français, mais c'est l'infirmière [Anglophone] qui l'a. Ce sont des choses qu'ils peuvent faire pour essayer de switcher le patient ou essayer de… trouver quelqu'un qui peut donner l'information qui peuvent avoir à faire avec la sécurité du patient.

Francophone nurse RN02 is another participant who provides direct care to her patients in French. In her absence, especially at points of transition of care, she has seen families being integrated into the care plan as an option for helping the patient navigate their health care in an English majority setting. RN02 suggests this helps the transmission of important information related to the Francophone patient's health. However, as discussed before, such planning puts numerous pressures on the family, and raises concerns regarding confidentiality or agency for patients being able to choose who would be in their circle of care. Moreover, she is referring to

cases where the language is "really" a barrier. In cases where language may not be such a major barrier, additional planning and consideration may not be initiated by the care team, to the detriment of any patient who might be more comfortable receiving services in French.

PT06 shares her own experience with family interpretation and translation:

> J'étais obligée de demander qu'on écrive en détail, pour que quand j'arrive à la maison, mon oncle puisse le lire et m'expliquer… pour ne pas penser que j'ai compris. Parce que tu vois, avec les médicaments, il faut que tu saches vraiment c'est quoi qu'on a dit, comment il faut les prendre et tout…

PT06 was faced with a health care interaction where the providers did not speak French. At the time of discharge, she knew that she would need help to understand the information. Presented with no linguistic options from the health care providers, her plan was to ask them to write out the discharge information in detail so that she could ask her uncle to explain the instructions to her. She realizes the risks associated with discharge instructions, and the importance of understanding the guidance provided. However, we have no insight into her comfort level with sharing her personal health information with extended family, something that is not questioned or addressed by the health care professionals in this setting, either. Many health care providers may not see such questioning as their responsibility. Rather, it may be taken for granted that the patient's need for such detailed information to share with their family is her desire and preference. However, PT06 suggests that this is more likely done through necessity and desperation. No other options are provided by the health care setting, so the status quo persists.

Staff Assignment and Utilization of the Interprofessional Team

Registered nurses and nursing students mentioned several strategies which they have seen implemented to meet the needs of Francophone patients.

Hiring French-Speaking Staff.

> In terms of what already exists, there is clearly a trend of hiring more people who speak French which is good . . . All of our clerks have to be bilingual, so at least for registration and all of that, that will be done bilingually.

RN07 notes the trend towards hiring French-speaking staff, stating that in her facility, all the clerks need to be bilingual. Francophone patients can then be registered in the official language of their choice. However, it must be noted that the presence of bilingual clerks and administrative staff is not equivalent to addressing the lack of bilingual health care providers such as registered nurses. While registration in the patient's language of choice is an excellent and necessary start, the full care experience must be accessible in the patient's language, otherwise, care situations can be related to the idea of the unfortunate "good enough care," discussed earlier.

As RN04 notes with regard to staffing needs:

> Je ne pense pas qu'on devrait avoir des professionnels de la santé qui travaillent directement avec des patients et des familles qui ne peuvent pas communiquer en français. Je pense que ça, c'est vraiment la première étape c'est d'embaucher des professionnels de la santé qui sont compétents… dans les deux langues qu'on prodigue des soins.

RN04 reiterates the importance of linguistically congruent care in health care settings, affirming that the first step must be hiring bilingual health care professionals. While numerous patients mentioned the importance of having bilingual care providers, the idea arose less frequently with the health care professionals interviewed. Although the push to hire French-speaking administrative staff was mentioned, access to French-speaking health care providers was not always a reality. Any discussion among the health care participants became centered on making the most of the staff that they had, such as the language-based pairing of patients and providers.

Language-Based Assignments.

> L'infirmière-chef, elle va faire un effort supplémentaire pour s'assurer d'assigner des patients Francophones avec des infirmières qui sont bilingues. Mais des fois, comme sur l'unité où je travaille en ce moment, il y a très peu d'infirmières qui sont bilingues. Donc, ça fait en sorte que des fois je pense que l'infirmière-chef elle est limitée dans les choix qu'elle peut faire.

In this example, Francophone RN02 states that the charge nurse will usually try to design patient assignments so that French-speaking patients are paired with French-speaking nurses. Because there are few bilingual nurses on her unit, however, RN02 states that there are times when linguistic pairing cannot be achieved, making this strategy unreliable. RN07 talks about how this planning takes place in her facility:

> There is definitely a culture where [the hospital staff] kind of identify when [the patient/family] are Francophone and identify them to people, they know speak French . . . they will if they only speak French. Like if [the patient/family] speak French but they speak English then [the hospital staff] probably won't tell anybody, but if the family only speaks French, then they'll usually come let you know and kind of like pass the buck, but that's really helpful.

In RN07's workplace, there is a culture of sharing a patient's language status. If a patient is Francophone, they will be flagged as such, and paired with a French-speaking nurse. RN07 cautions that this takes place only for patients/families who speak only French. If a patient speaks French but can also speak some English, then the linguistic status will not be shared by the staff, and care will be delivered as usual (in English), regardless of whether the patient would have preferred to receive care in French. This strategy relies on the assumption that any level of English is good enough to receive care exclusively in English, and it does not give due consideration to challenges previously discussed regarding French patients who may get by in English, but still need their health care services provided in French.

NS04's experience as a nursing student suggests that pairing of patients also goes on for student assignments:

> A lot of the time they won't assign a student to a French, just a French-speaking person unless [the student] speaks French. Like a lot of the time will be like "Oh," like they ask, the clinical educators will ask us beforehand who speaks French and then if someone speaks French then they will go care for a patient that speaks French, to provide, like to give that patient their quality care that they deserve rather than sending someone who just, like me, who just speaks English where it would take more time and add a bit of frustration on the patient's part most likely that I wouldn't be able to understand what they are saying.

In NS04's experience during clinical rotations, French-speaking patients were not assigned to students who did not speak French. Students were asked prior to the patient assignment if they spoke French, and they could be assigned a French-speaking patient that day. NS04 asserts that this helps French-speaking nursing students provide the quality care that Francophone patients deserve. She also states that the presence of an English-speaking nursing student such as herself would be time consuming and frustrating for a patient. She suggests that the difficulty understanding what is being communicated could be an impediment to the care received by patients.

In RN10's health sector, language was one of the reasons she was placed in her particular clinical setting:

> When I was brought on, because I'm bilingual they wanted to keep me closer to [ville/city], sort of downtown because often the newcomers to Canada would live kind of more in that area. Same thing as [ville/city], they're more French-speaking patients. So, they would try to put an educator who was bilingual in that site. And then like I know we have a site out in [ville/city] and the educators that work out there don't speak French … so I guess by organizing where they have more French-speaking patients and they'll try and put an educator there that speaks French.

RN10 shares her experience as a bilingual nurse. After she was hired, she was requested to work in an area where more newcomers would need to access services. As many of those patients

speak French, her role as a nurse educator made her an asset to those sites. This allowed for meeting the needs of the patients in the community, based on the availability of staff who shared their language. Furthermore, such as strategy is optimal, as it is sensitive to local, social, cultural, and linguistic contexts of the patient population, allowing for a more targeted use of health resources and ensuring that patients, especially Francophone populations, receive the most appropriate level of care.

Collaborating With Colleagues.

As asserted by numerous nurses and nursing students, Anglophone and Francophone alike, when a French-speaking patient was not assigned to a French-speaking colleague in question, teamwork was the next best strategy in place. RN06 mentioned the importance of visual identifiers to point out French-speaking staff in the workplace:

> Certaines infirmières… comme mettons elles parlaient français, elles avaient comme un symbole sur leur carte d'identité qui disait qu'elles parlaient français, mais même à ça il fallait que tu le cherches, tu cherches pour le voir puis des fois... la carte d'identité n'est pas à vue, alors ce n'est pas idéal.

RN06 notes that French-speaking staff were identified with a symbol on their identification card. While this can be an important step, RN06 also cautions that these cues could be challenging to see, especially if the identification card was out of sight or not even on the person. This can be a challenge for both patients and colleagues who need to know this information. RN06 also adds that « On partage des tâches. Si quelqu'un m'a besoin en français je suis là puis quelqu'un peut faire quelque chose d'autre pour moi. » As the work is shared among RN06 and her colleagues, and if one of her colleagues needs a French-speaking individual, their strategy is to pull her, and in exchange, they will do something for her. Such a transactional exchange of French language services highlights the fact that linguistic support is a significant resource that has value. In the

health care setting, language services are a commodity that can be traded in exchange for help in other clinical tasks. As such, language support is recognized as extra labour, albeit disproportionally assumed by French-speaking nurses and with minimal recognition by the organization or health care system. This was the norm in many sectors, for registered nurses and nursing students. NS09 states:

> You can plan or schedule to go in with [French-speaking nurse] at least once or a couple times during the shift, depending on how their workload is. Sometimes, if you already know ahead of time where your patients are going to be and the [French-speaking] nurse is already on the floor, you can go and talk to them and be, like, "At this time and this time, are you able to come in with me and I'll help you out with what you need just to ease out your load as well" or during their lunch break, they can probably... I know this is terrible, they can probably step in for like ten minutes and help you out a little bit.

This type of transactional relationship between colleagues works to secure a few moments of French-language care provision. As NS09 states, time with a French-speaking colleague can be negotiated a couple of times during a shift and she then can help ease this colleague's workload by stepping in for them in exchange for their help with translation. However, she also addresses the challenging nature of nursing schedules, which means that sometimes the help is only available during a co-workers' lunch break, indicating that this strategy is not always convenient or fair. Working to provide linguistic services during a break also means that those break minutes are not paid. Francophone nurses may find themselves disproportionately in situations where they have to step in to do interpretation and translation work that is not only invisible to the organization, but also may be unpaid. This burden is not shared by unilingual Anglophone colleagues.

To become more resourceful in her care provision, RN09 took to asking her colleagues for more than just direct patient care:

> Because I do have such great access to all these French-speaking nurses, I would get them to say a few things in French or help me understand some things in French. That questionnaire that I was talking about earlier, I had a nurse sit with me while I read it and

> they helped me pronounce all the words correctly and things like that. Just so that once I'm going through that with the patients, they're able to actually understand what I'm saying. If I'm mispronouncing something, I'm able to know and get that feedback right away. Or even certain questions that we ask often, I was able to get those nurses to help me kind of learn how to say those things or understand the answers that the patients might say.

As a means of becoming more independent with her care provision, RN09 took to learning frequently used statements, reviewing questionnaires, and finding out how to properly pronounce words and communicate information from her French-speaking colleagues. This was a means of receiving feedback on her French language skills, a tool that she used regularly to become more proficient in dealing with her Francophone patients. However, as discussed above, while this strategy, which takes the form of informal tutoring, is beneficial for an eager English-speaking staff member, it has significant implications for the workload of the French-speaking health care providers. Regardless of whether this tutoring takes place during paid hours or on personal time, it remains invisible labour, unnoticed by the organization, yet disproportionately affecting the French-speaking staff members' workload. This is also another example of the informal, invisible, and unpaid work provided by French-speaking personnel that greatly benefits the care facility by allowing it to meet its objective of caring for linguistically diverse populations, but it does not address the issue systemically.

Delegating to the Interdisciplinary Team.

With few options for linguistically congruent care, communicating in French was often delegated to other members of the interdisciplinary team. These could even be health care providers who are external to the facility. For example, NS01 discloses that in one situation, "luckily, her midwife was actually a Francophone as well. So that made things a little bit easier . . . We got her midwife to kind of translate for us during our assessments." Here NS01 describes a Francophone midwife as the pillar for the patient care interaction. The Francophone midwife

interpreted for the health care providers during patient interactions. This strategy, once again, is not sustainable. While the midwife can sometimes accompany the patient, they are not always present, and yet other means of meeting the needs of this care interaction are not provided. RN07 offers more examples of the use of the interdisciplinary team:

> All of their prescriptions come out in English... I'm now realizing… So, for the administration of medication if they're taking meds at home… I actually usually just tell them to talk to the pharmacist to get all of the information because they are just not going to be able to get it all from the physician a lot of the times.

As RN07 describes it, in her facility all of the prescriptions are provided to patients in English. As such, regardless of the language of their care interaction, medication administration once at home can be a challenge. The strategy used by RN07 is to advise the patient to talk to their pharmacist to obtain information regarding the newly prescribed drug or therapy. This strategy is also used to bridge the gap created by the physician not providing full information to patients on their new medication. This strategy does not address the role of the nurse in education and safe patient discharge, a responsibility that needs to be fulfilled to meet the needs of all patients, including those in French-speaking populations.

While the strategy of referring patients to the community pharmacist may seem attractive to some providers, the challenge remains that the guarantee of accessing a Francophone pharmacist is as slim as it is for finding Francophone health care providers elsewhere. The strategy therefore amounts to passing the buck to another provider and leaving that provider with the task of ensuring the patient receives all the information that they need. However, it does not address the fact that the original facility neglected to provide safe discharge teaching and education of Francophone patients and families, ultimately leaving them to scavenge for the means to address their health care information needs on their own.

Non-Verbal Communication

Participants were willing to use many different means to understand and be understood. Non-verbal communication proved to be a frequently used strategy for nurses, nursing students, and patients enrolled in this study. For example, RN09 describes how gesturing serves as a complement to her efforts to engage verbally with French-speaking patients. "Sometimes we use a lot of hand gestures or hand motions trying to get the point across." Like many participants, hand gestures and motions – non-verbal means of communication – are used to "get the point across." NS04 notes that "the strategies that I usually use is just kind of using the knowledge I know on the whole and the non-verbal cues and using objects." And PT06 states, "s'il arrive que le soignant parle anglais, j'essaye de faire avec des gestes."

NS04 finds the use of props and non-verbal language a means to supplement for the linguistic barrier when verbal communication is ineffective. PT06 has adopted such a strategy when interacting with her Anglophone health care providers.

Other patients also reflected on these unfortunate experiences with the health care system. As a Francophone individual living in Ontario, PT08 contended that it is, in fact, her experience with the health care system that pushed her to learn more English.

> Je parle en anglais. C'est vraiment la chose qui m'a poussé à étudier l'anglais. Quand je suis malade, que je parviens à expliquer… Je ne peux pas lui expliquer dans des termes médicaux, mais j'essaie… Des fois je fais même des gestes pour essayer de lui expliquer ce que je ressens.

She affirms that she speaks English during her health care interactions; they are what pushed her to study and learn English. She was concerned with her ability to explain herself to health care providers and convey her needs in medical terms. She realized that hand movements and non-verbal communication were insufficient. Although just one patient experience, it points

to a systemic issue whereby the lack of organizational support and strategies to meet the needs of Francophone patients result in the patient adapting to the health care providers and the health care system and not the other way around. Unfortunately, such situations not only lead patients to settling for English even though their official language is French, but furthermore, it also perpetuates assimilation when their official language of choice is not a language that they can safely use within the health care system.

Health Care Professional Education

Patients, nursing students, and nurses were aware that many of the strategies in place were useful to address immediate needs but were not necessarily sustainable. Nurses and nursing students spoke to the strategies currently available for the education of health care professionals in the French language, pointing to important variations in linguistic resources across facilities and sectors. For example, RN03 states:

> I know that they had monthly like drop-in language groups, like you could just have discussions in French. Like they had a French working café group thing, and they do have courses. The [ville/city] … the [hospital] also has courses, and then [pediatric hospital] does too. I mean I've never done [pediatric hospital]'s courses. So, there are courses offered and they're usually free of charge, but you still have to have time to do them.

RN03 describes French language education options available in a few health care facilities where she has worked such as drop-in language groups that allow health care professionals to converse with each other in French. In addition to this, more formal French classes were available that were free of charge, making them more accessible to health care professionals. Nevertheless, health professionals do not necessarily use them, as both RN03 recounts and RN07 confirms "They are offering—they offer French lessons for free if you're a hospital employee. The only issue is that they're offered at rather inconvenient times for shift workers… but they are offered." Like the situation for RN03, RN07's facility also provides French lessons that are free of charge, but the

times at which they are offered are inconvenient for shift workers like many staff nurses who have variable schedules. RN08 adds to the discussion:

> The hospital has a . . . French language course that they offer I think it's every, like I think it's, it's every six months, there's one in the end of August/early September and one in February or something like that. The challenge with that is it's in the evenings and it can be at multiple, all kinds of campuses . . . I got an app that I like using once in a while just to play around . . . and see how, how my French is doing. . . but again that's on my own, my own time, with my own effort and like there's zero expectation for anyone to be accountable.

French classes are also available at her institution but in multiple different campuses. This can be a challenge for nurses trying to fit in a course between their shifts and personal obligations. While resources exist, they are unfortunately not well geared towards the needs of shift workers. Having courses offered at a different campus makes it more challenging to attend during breaks or immediately after or before a shift, especially if it involves a long commute.

However, still willing to enhance her French skills, RN08 uses a smart phone application that helps her practice her French. Even so, she does admit that a pitfall to progress is that this is done on her own time and due to her own desire. She also states that strategies such as courses and apps carry zero expectations in terms of accountability in the organization. Despite the significant efforts of this English-speaking registered nurse to enhance her care of Francophone patients, the work remains invisible to the facility although it is meant to benefit the organizations' clientele.

NS04 also describes how apps have supported her own education in French terminology:

> I have been like taking little apps and stuff like that to try to learn more [French] because I believe since it's such a big language in Canada and that's where I want to work, it's something that I need to look into a lot more...

She acknowledges that French is a significant and useful language to know in Canada and is smart phone applications as a strategy to learn and improve her French skills. Her drive to learn

French is not only driven by her clinical practice and patients' needs, but by her realization that if she wants to work in Canada, she will need to be more proficient in the French language. This further highlights the prevalence of French-speaking patients in the health care system and the importance of their needs in clinical settings. Patients and providers understand these needs, but they are not sufficiently addressed by health care organizations and the health care system. Individual patients and providers thus must work to ameliorate issues at the individual level although the problem remains systemic in nature.

Francophone Institutions

Considering the challenges experienced when seeking care in French throughout Ontario, many Francophone patients stated that finding care in Francophone institutions was an important strategy. Instead of gambling on the possibility of receiving care in their official language of choice, many preferred seeking out care in a place where they knew that both their linguistic and health care needs would be met. For example, PT04 states:

> Le centre de santé communautaire ici à [ville/city] en tout cas avec ses succursales s'est dédié exprès aux Francophones sans exclure, si un Anglophone y va, il va se faire soigner, mais le centre de santé communautaire, je pense que ça fonctionne. On en a un dans mon coin, succursale de centre de santé de la ville . . . je crois qu'il y en a un à [ville/city] aussi. Nous en avons au moins dans notre cas à [ville/city] et c'est d'ailleurs là que j'ai eu un médecin Francophone.

PT04 is pleased with having access to a French-language community health care centre, which has many branches throughout his region that provide care in both French and English. PT04 attests that this service works in meeting the needs of the French-speaking community, for example, by trying to provide him with access to a French-speaking physician. This type of format can meet the needs of Francophone patients without impacting care provision to English-speaking patients.

PT03 discusses an involved strategy for supporting access to Francophone care institutions:

> Je suis allée dans des organismes ici Francophones. J'ai été membre dans beaucoup d'organismes Francophones comme bénévole. C'est comme ça qu'en fréquentant ces organismes, j'ai compris qu'il y a quand même des gens qui se battent pour que le français soit maintenu. Pour que les services soient donnés en français. C'est comme ça même que le centre communauté santé a été créé : desservir la population Francophone qui n'arrivait pas à s'exprimer en anglais, les personnes âgées qui . . . ont déménagé du Québec et d'ailleurs qui n'ont pas, ou qui ont refusé d'apprendre l'anglais ou qui ont eu de la difficulté à vraiment maîtriser l'anglais. Il fallait que ces gens-là se fassent soigner… dans les études de faisabilité… on avait besoin de ça. Donc le centre s'est créé pour servir ces gens-là. J'ai fréquenté ces milieux-là pour que je puisse m'exprimer en français, et pour que je puisse aussi comprendre comment ça fonctionne ici.

PT03 became involved in the Francophone community, as a strategy to living her life in French, including accessing health care in French. She started seeking out Francophone institutions in her area and began volunteering in those groups. As she became more involved, she was able to connect with like-minded individuals who were supportive of the French language in Ontario. A community health centre was created in her area, meeting the needs of the Francophone population in the region. She became a patient at these institutions as well and was thus able to get her community health care needs met in French.

While at times such advocacy work and investment are done out of desire to support an important cause, it must be noted that PT03 went out of her way to engage herself in the French community activist movements and support Francophone health institutions. Such engagement requires a significant amount of time and effort. PT03 understands needing to join those who are "fighting" for French-language services to be maintained. Efforts of this nature are not a requirement for Anglophone patients to receive health care in Ontario but may be necessary for Francophone patients to demonstrate that there is a need and desire within the community to have access to such services. Such struggles and advocacy are also challenges to overcome for minority language communities in Quebec (Bourhis, 2018) and internationally (Roberts et al., 2010), from

both a policy and a political stance. Once health services in French are obtained, the fight to keep these services persists, as exemplified by the 1997 plans to close the Montfort Hospital (Perron Roach, 2015). Consequently, French-speaking patients may face significant challenges in their quest to receive better access to French-language health care services and to retain minority official language services within their districts.

Many of the patients interviewed spoke about the French-language community health facilities. However, health care needs extend beyond what community services can offer. NS10 shared her experience as a patient and as a provider:

> Je trouve que dans les milieux où il y a pas mal de Francophones, ils pourraient faire un hôpital complètement Francophone. Là c'est beaucoup demandé. Je sais qu'ils ne le font pas. Comme ici à [ville/city], il y a pas mal de Francophone, ils ont fait [hôpital Francophone]. Ça facilite les Francophones beaucoup beaucoup. Même les gens qu'ils engagent ils veulent qu'ils aient un élément en anglais, mais là les Francophones ils savent que dès qu'ils vont là ils vont être servis en français. Tout le monde va les comprendre. Ils ne vont pas les faire répéter sans arrêt pour les comprendre.

Participant NS10 understands the importance of having access to French-language hospitals, and she believes that a great benefit in her region is the presence of a Francophone hospital, greatly meeting the need of French-speaking patients in the community. The staff are also able to speak English and thus can also care for Anglophone patients. However, Francophone patients can have more confidence that they will be served in French, and that they will be understood. While NS10 highlights the fact that there are fewer repetitions due to language discordance, based on other accounts, there should also be fewer language-based delays in care. Despites these advantages, such designated health centres are not accessible to many patients in Ontario. In the absence of sufficient bilingual health care settings, participants shared numerous ways of coping and adapting to the circumstances, revealing challenging lived experiences.

Patients Adapting (Not Making a Fuss)

Knowing how challenging it could be to receiving care in French in Ontario, many participants found that the best strategy was to adapt to the context of an Anglophone majority and avoid making a fuss or causing any friction in their health care experience. To illustrate this point, many participants had similar strategies:

> PT08 : Je parle en anglais.
>
> PT01 : Pour faire sûr que je suis bien compris, je vais le dire en anglais.
>
> PT07 : Ce n'est pas facile. C'est difficile. Je faisais tout pour m'exprimer en anglais, mais . . . ce n'est pas facile… Je vais faire mieux pour expliquer, donc je vais me débrouiller en anglais, mais… je ne suis pas vraiment confortable avec ça.

To receive health care services in Ontario, most participants in the study stated that they ended up speaking in English. PT08 states point-blank that when she seeks health care services, she does so in English. PT01 states the same and asserts that he speaks in English to be sure that he will be understood. PT07 continues along this vein, stating that her strategy is to speak English as well. However, she also attests that this strategy is not one that comes easily for her, and although she does her best, this is not a strategy or a means that she is comfortable with. As discussed at length earlier, this strategy of complying with health care providers and the health care system is one that ultimately disadvantages the patients and heightens the risks of jeopardizing their safety.

PT09 further describes the challenges of this strategy:

> Je bricole. J'essaie de me faire comprendre en anglais. Mais ça demande un peu d'effort parce que… je pense en français… Je cherche les mots, puis je dis les mots, mais une langue ne traduit pas l'autre… Donc j'essaie de faire des efforts pour me faire comprendre puis je dis à la fin, « Regarde, je ne parle pas l'anglais. I don't speak English. »

PT09 tries her best to speak English and to be understood, but she acknowledges the difficulty that comes with this strategy. She thinks in French, and to communicate in English, a language that she is not comfortable in, she struggles to find words. Sometimes she says the wrong word. She also realizes that some words do not translate well from French to English, or the reverse. Despite her efforts to be understood in English, she realizes that this strategy is very difficult, and usually ends her struggles asserting that she does not speak English. Coming to a similar realization, PT06's previous experiences led her in a different direction:

> Je me dis… s'il arrivait qu'il tombe encore malade… si quelque chose de pire arrivait [à mon bébé]… Donc je pense que c'était quelque chose qui m'a aussi poussé à beaucoup m'exercer pour mieux comprendre… parler anglais et le comprendre aussi.

She acknowledges that what pushed her to learn to speak English were her encounters with the health care system. Having had a baby that needed medical care and knowing what it was like to not understand the care received, PT06 seeks to be prepared for future interactions by learning English so she can navigate health care encounters should her baby be sick again.

Participants had different means of adapting to the current state of the health care system. PT04 found solace in community:

> On a rarement quelque chose de tout à fait inédit que personne d'autre n'a jamais expérimenté dans le milieu conséquent. Donc il y a un partage communautaire d'information qui facilite quand on cherche des solutions et il y a parfois aussi des expertises dans le milieu, dans l'entourage…

Understanding that individuals are rarely the first or only person faced with a given health care problem or situation, PT04 states that sharing knowledge and experience about health care information in his community has been helpful to him. This has been a means of finding solutions to health care challenges and he has found that some individuals can even be experts in the health care field. These informal means of seeking French language health care support within the

community have been a strategy he has utilized to counter the void in appropriate and accessible French health care services.

Francophone participants felt that insisting on speaking in French could be perceived as abrasive in an Anglophone health care system. PT03 stressed the importance of being mindful of one's approach during interactions with non-French-speaking health care providers:

> Tu vas gentiment, ben oui. Je suis gentille avec les gens, je parle bien, malgré que je sois malade je blague toujours moi donc j'y vais, je m'exprime bien, j'essaie de m'exprimer et j'essaie de voir si on m'a bien compris. Si la personne, par exemple me répond et je vois que la réponse ce n'est pas ça, je dis « Je peux peut-être répéter », ce que je sens, ce que je vis je vais répéter, oui ou des fois elle me dit « Tu as dit ceci, ceci, cela », je dis « Oui », « Mais ça, ce n'est pas ce que tu viens de me dire ça, alors je pensais que peut-être tu n'as pas bien saisi ». Alors le temps qu'il m'explique comment lui il a compris, il dit « Ok », donc c'est ça. J'essaie d'être gentille.

She likens the process of improving her interactions as a Francophone patient when dealing with English-speaking health care providers to walking on eggshells. She speaks to the importance of being kind during interactions, of joking with the provider, of expressing herself carefully, and checking repeatedly whether or not she has been understood. She puts aside her own feelings of illness to manage the experience and perception of the Anglophone health care provider. She has certain ways of speaking, such as asking for permission to repeat herself if she realizes that she has been misunderstood. Her choice of wording is also cautious and apologetic: "*Maybe* I can repeat myself" or "*Maybe* you didn't *quite* understand," which weakens her position. She stresses again the importance of being a kind patient during this strategic process, which is revealing of the power dynamic at play and the risks for vulnerable patients. There is no space for her own frustrations and disappointments in such a subpar health encounter. The stress she places on not being a bad or problematic patient is palpable and is similar to what was conveyed earlier by PT03 when he stated that "with some [staff], you need to be delicate [about] this kind of thing." Such

accounts reveal how risky such encounters may be for Francophone patients, who sense that their request to be served in French may be perceived as offensive within an Anglophone context. The safest strategy for such patients is to forego their needs and nurture their relationship with providers through a subservient and unthreatening demeanour.

Patients Resisting (Making a Fuss)

While some Francophone patients affirmed the importance of adapting to unilingual English speakers as a strategy within the Ontario health care system, many expressed reluctance, dismay, or frustration for having to do so and shared their way of resisting care in English to receive safe care in French. PT05 states:

> Des fois je refuse de parler anglais quand… on ne me demande pas grossièrement, mais bêtement si je parle anglais, alors à ce moment-là je refuse. Alors bon, je passe en fait et ils vont chercher quelqu'un pour traduire . . . On me regarde, on me dit « Speak English » . . . à ce moment-là je ne parle pas anglais.

PT05 describes the frustrations that present when she is expected to speak English during her health care interactions. She attests that this interaction is not always pleasant or courteous. PT05 always asks for care in French but is more likely to resist English language care when it is imposed by the health care system. Her refusal to speak English appears to activate providers' efforts to locate someone for translation. PT09 has a similar approach:

> Ah oui, même s'il y a quelqu'un qui m'appelle ici à la maison pour d'autres services en dehors de la santé, je dis « Écoute si tu veux parler avec moi tu peux me parler en français. Si tu ne parles pas français, désolé, bye bye ». Alors la personne s'arrange s'il peut parler en français, ça va, sinon je dis bye bye.

PT09 also desires to receive her services in French. She uses the same approach for all services, health care and otherwise. For example, if someone calls her at home, she insists on her

exchanges being in French; otherwise, she hangs up the phone. In doing so, PT09 sets boundaries on how others can impose their own linguistic expectations on her. PT03 shares in the frustration:

> Oui, alors je me suis dit, moi je ne vais pas me mettre à l'école pour apprendre l'anglais, donc dans ma tête on m'a dit que je suis dans une ville ou on parle français donc je vais tout faire pour parler français, pour trouver des services en français.

PT03 also has the strategy of resisting services if they are not in her official language of choice. She stresses that she has no desire to going back to school to learn English, having moved to a country that is supposed to be bilingual and where she should be able to speak French. As such, her strategy is to speak French, and do what she can to find services offered in French in her region.

Participants had unique ways of resisting the Anglophone health care system. For example, PT04's strategy was as follows:

> On me parle en anglais, je fais l'âne pour avoir un Francophone. Je fais celui qui n'a rien compris, tu comprends, je fais répéter la question ou je fais « Ça veut dire quoi? Je ne comprends pas », etc., et il fait « Ah tu es Francophone? », « Oui », et puis on va me chercher un Francophone. Ça, ça m'arrive souvent à l'hôpital quand je vais pour un embêtement [problème de santé], ou pour une consultation, quand le médecin m'envoie à l'hôpital. Je pense que c'est une bonne tactique parce qu'il y a toujours des Francophones et des Francophones habituellement ils s'adressent à tout le monde en anglais parce qu'ils pensent que tout le monde est Anglophone, mais quand tu fais des difficultés, tu fais ton difficile, ils comprennent que peut-être ça serait mieux en français. Si la personne ne parle pas français, alors elle va trouver quelqu'un qui parle français. Ces derniers jours oui ça m'est déjà arrivé parce que j'ai été prendre des traitements à l'hôpital et puis à chaque fois, c'est deux ou trois traitements. Le premier traitement bon c'est là qu'on joue le jeu. Le deuxième, ils savent déjà que tu es Francophone.

When PT04 is addressed in English, he does everything in his power to obtain care in French. He resists by exaggerating the language barrier, acting as though he understands nothing and asking the provider to repeat himself. In doing so, PT04 pushes providers to locate someone to provide care in French, which he says is easy for them to do in that facility. He finds this strategy

useful, because many Francophones in the facility do not readily admit or display their ability to speak French. Discussed in earlier findings, the active offer seldom takes place, even among study participants. Going out of his way to stress that he is Francophone gets providers to adjust to him, rather than vice versa. PT04 is aware of how he may be perceived by providers when he implements this strategy, describing himself as acting "clueless" or "being difficult," but which does not appear to concern him. In his experience, this strategy has proven to be helpful, especially given the frequency of his medical appointments at the hospital.

Proposed Strategies

Participants shared at great lengths the strategies they used, both formal and informal, in their clinical experiences as patients, nurses, and nursing students. While some of those strategies were deemed to work well, others compounded the existing challenges or altogether masked the extent of the problems. Participants also proposed several measures that they believed should be implemented to meet the needs of Francophone patients in Ontario. Interestingly, many of these have already been proposed in numerous studies (as described in the literature review) yet they are not implemented as standard practice, to the detriment of Francophone patients. Patients underscored the importance of advocacy for the needs of the French-speaking community in Ontario. This involved proposals to raise awareness about the needs of French-speaking patients, to increase French-speaking human resources, to provide a full range of French-language clinical resources, to reinforce the educational systems for a better health care system in both official languages, and to keep the government accountable in enhancing the offer of health care services in French throughout Ontario.

NS04 reminds us that "when language becomes a barrier, it's like you really have to find ways around it and you have to look more as if it's a person and not a task to overcome." This

quote is representative of the lens required to take in the strategies and solutions proposed, as health care in Ontario must be accessible to patients in both official languages.

Advocacy and Raising Awareness

The necessity for continuing to advocate for French-speaking patients and for raising awareness of the community's needs was stressed by multiple participants, especially care recipients. These patients saw advocacy and raising awareness as a strategy for meeting the needs of the French-speaking patient population within Ontario. As PT04 contends:

> C'est à tous les niveaux, mais je crois qu'il y a aussi une question de mobilisation permanente des Francophones pour exiger d'être servi. C'est-à-dire si on ne demande pas de services, si on ne se bat pas pour les avoir, on ne les aura pas… C'est quelque chose qu'il faut continuer à revendiquer c'est clair parce que dès qu'on baisse les bras, tu vois, le système, tous les systèmes, c'est comme nous aussi, c'est comme les individus, ont tendance à pratiquer la loi du moindre effort.

PT04 outlines the mobilization and advocacy required at all levels of the health care system. He reinforces the importance of Francophones to also take part in the movement and to demand to receive their services in French. He states that if the Francophone community does not fight for this need and advocate for such services, then they may not obtain them as a community. He states that advocacy must be ongoing, because without the demand, the system will opt for the easier option and return to the status quo. In most cases, that status quo is providing services to everyone in English, regardless of the language that the patient requires. Unfortunately, that status quo and incessant need for advocacy also places a disproportionate stress and additional pressures on Francophone communities. Constantly needing to beg for access to care in their official language is a struggle that is not experienced in the same manner for Anglophone communities seeking English-language services in Ontario. Not only is access to health care for French-

speaking patients being compromised, but their linguistic rights are also consistently disregarded in the health care structure.

PT02 shares a similar opinion, also realizing the need for and importance of community advocacy: “Il faut que les gens se réveillent et puis poussent ça. Même moi je ne l’ai pas fait tellement puis là en parlant avec vous je réalise que c’est ça qu’il faut faire. C’est ça qui est mon opinion.” She understands that it is important for citizens to rise and to push for services in French, while admitting that this is not something that she has consistently done. However, participating in this study made her realize that this was key to maintaining access to the services that she requires.

PT06 also supports such a movement: “J’étais contente parce que c’était quelque chose qui était en moi. Maintenant j’ai la possibilité de m’exprimer et je sais que grâce à tes recherches, il pourra y avoir des solutions.” Here she shares her pleasure in seeing discussions taking place over French-language health care services and is pleased to be able to express herself and discuss her needs regarding French-language services. She is also hopeful that research (such as this study) can create and mobilize solutions that will benefit the Francophone community.

While PT06 speaks to the value of advocating and expressing herself through research, PT08 proposes another mechanism: “Quand les patients Francophones veulent se faire soigner en français, je pense que ça serait mieux… qu’il y ait des plaidoyeurs auprès des praticiens de la santé…” PT08 identifies a need for Francophone patients to seek and demand services in French when they meet care providers. If they do, more citizens can become involved in creating changes to support the wellbeing of French-speaking patients. As a health care provider, RN08 proposes that “having more workshops . . . for different cultures and for Francophone cultures” would be helpful. More workshops on different cultures, including Francophone cultures, RN08 suggests

would raise awareness of the needs of the French-speaking community. RN08 proposes these workshops to meet the needs of health care providers, but this would also be a means to reinforce and strengthen the offer of services to the French-speaking population. As a whole, PT08 stresses the importance of "promouvoir la langue française ici en Ontario." By stating the need to promote French language in Ontario, PT08's statement is putting the onus on all citizens to recognize and appropriately appreciate French as an official language spoken in Ontario.

Human Resources

Unanimously, patients, registered nurses, and nursing students contended that issues pertaining to human resources in health services had to be addressed to meet the needs of French-speaking patient populations in Ontario. When asked what was needed to see improvements in that respect, Anglophone and Francophone participants were clear. For example, NS01 and NS07, respectively share their desired strategy:

> NS01: Having more staff who speak French.
>
> NS07 : L'accès à des infirmières bilingues.
>
> RN06 : Quand on embauche les nouveaux, les nouvelles infirmières, les nouveaux membres d'équipes, on s'assure que ces gens-là puissent parler le français.

Francophone and Anglophone participants alike assert the need to increase access to French-speaking staff, and more explicitly, French-speaking nurses. While a health centre may not be able to make many changes regarding currently employed staff, RN06 suggests that when health care settings seek to hire new staff, they should ensure that these individuals can speak French prior to hiring them. NS07 continues along this vein:

> Si moi j'avais le pouvoir de changer ça, je pense que chaque emploi… chaque poste infirmier, je pense que ça devrait être bilingue… Que les soins [que les patients] reçoivent à l'hôpital soient accessibles dans les deux langues, dans un monde idéal.

NS07 suggests that a change that would greatly benefit patients in Ontario would be to ensure nursing positions are allocated to bilingual nurses, as a way to make health care services accessible in both official languages. As described earlier, the presence of bilingual, or French-speaking staff person, is an asset to the entire team, helping both patients and health care providers alike. NS08 concurs with this strategy:

> Si je pourrais changer les choses, je ferais que tous les hôpitaux… ben partout vraiment au Canada devraient engager du personnel soignant qui sont bilingues, donc qui peuvent prodiguer leurs soins à la fois en français et en anglais parce que je trouve que les patients seraient beaucoup, beaucoup plus confortables de cette façon-là. Les relations thérapeutiques… seraient meilleures, puis la sécurité des patients serait augmentée.

NS08 supports the strategy of hiring French-speaking health care providers throughout health care institutions as well. She suggests that this should be a necessity nationally. Such a large-scale change in human resources would have both provincial and federal implications. In addition to the benefits discussed by NS07, NS08 identifies patient safety and improved therapeutic relationships as additional important advantages to standardized bilingual care. PT02 denotes the importance of this strategy for medical staff, as well. “Alors moi, j’aimerais qu’on demande plus de médecins [d’aller faire les études en français], puisqu’il y a encore des gens qui ne connaissent pas les deux langues.” Participants reported their challenging experiences obtaining quality French language services with various health care providers. Such experiences lead participants, such as PT02, to desire to see more French-speaking physicians. She realizes that there are many physicians who do not speak both official languages. For reasons discussed at length, this is a detriment to patient care, and a significant opportunity for improvement throughout Ontario.

To improve access to French-speaking medical personnel, PT03 reiterates the need to build awareness the role staffing and health planning play in meeting the requirements of French-speaking patients:

> La sensibilisation dans les hôpitaux, c'est très important, oui. Il faut sensibiliser les infirmières, tous … les agents qui desservent les gens en santé... La sensibilisation dans les hôpitaux, ça veut dire, je ne demande pas qu'il y ait 50 % 50 %, ça serait l'idéal, mais si au moins 30 % des personnes qui parlent français dans chaque service et qui peuvent servir en français, ça aiderait.

PT03 argues that a minimum number of French-speaking staff for each health care sector could guarantee proper delivery of services, suggesting that 30% could be a target to aim for. For her part, NS10 emphasizes that the bilingual requirement must extend to all types of care services:

> Là je trouve que dans les milieux où il y a pas mal de Francophone il faut qu'ils donnent non seulement les soins de santé, mais d'autres soins que les gens octroient, il faut qu'ils mettent ça en français aussi. Il faut que ça soit des milieux complètement bilingues.

She speaks to the various services, beyond typical health services, that patients may need to access, all of which should be offered in French. Developing more Francophone health settings than exist in Ontario now could be a strategic approach to meet the holistic needs of the Francophone patient population.

Several participants also spoke to the importance of improving existing translation services and making them more accessible to staff. For example, RN03 suggests:

> I mean ideally, it'd be awesome if we had like an extra nurse on the floor who was just a translator helper nurse, but I know that'll never happen. I guess it'd also be nice if whoever was in charge always had to be bilingual, but I mean it also depends on how many — like most of our charge nurses are, but not all of them.

RN03 indicates that there is a need for both nursing help for general care tasks as well as for assistance with interpretation and translation. She proposes having an extra translator helper

nurse but at the very least, she believes that all charge nurses should be bilingual, in order to provide a bilingual resource for patients, families, and health care professionals on the unit. NS05 also emphasizes the need for translators, stating:

> We know the basic languages that they're going to come in and require translation for are French, Arabic, Chinese, Swahili, like those are the basic one, Spanish. [Translators] should be available to be there, like almost onsite.

In NS05's view, since there is a recurring need for translation for patients in several different languages, including French, planning for translation services is feasible. Health care organizations should be proactive in ensuring translators are readily available and onsite. Other nurses and nursing students suggested having the translator available by telephone, so as to enhance patient anonymity.

Clinical Resources

Not only was the presence of French-speaking colleagues important but so was being equipped with adequate resources. Registered nurses and nursing students, Anglophone and Francophone alike, emphasized that problematic access to French-language clinical resources had an impact on the quality of their care. They proposed numerous strategies that they believed would make a difference in their caregiving experience. To begin with, NS01 suggests "having signs around the [facility that are] bilingual." While the strategy of having bilingual signage throughout an institution may seem simple, it is not systemically implemented. Yet, bilingual signs would help Francophone patients know that services exist in French within the facility and would encourage them to ask for care in their official language of choice.

Participants considered numerous other strategies. For example, NS07 suggests that:

> S'assurer que toute la littérature, des fois on a des versions de la littérature, des pamphlets à donner à des patients suite à une chirurgie pour la réadaptation ou soit peut-être avant, quelque chose comme le électroconvulsivothérapie (ECT) en santé mentale, s'assurer que

> tous les pamphlets sont bilingues puis c'est facile à faire. D'un côté c'est en anglais puis là tu tournes de l'autre côté puis le document il commence en français. C'est vraiment . . . facile à faire… Que la littérature pour les patients soit accessible dans les deux langues.

NS07 supports the need for clinical resources and literature to be available in both French and English. Despite the importance of such documents, for example, in post-operative care or for mental health issues, patient information on certain conditions is not readily available in French. Pamphlets and brochures prepared for frequently needed resources are most often exclusively in English. French-speaking patients are thus less likely to have such critical information available to them in French. NS07 argues that this can easily be remedied, for example, by printing a document in English on one side, and in French on the other – a solution that remains seldom implemented according to participant accounts. Although this measure has been identified as a best practice and put forward in numerous studies, it has yet to become standard practice across the province. RN03 expands on the needs for such resources as a means to help both patients and staff:

> I'd like to have more language resources… when I worked at [hospital], we had language cards for… Mandarin and stuff like that, where it's a picture that explained like a shower and then had the word in English and the word in their language and you could just kind of point. I guess maybe they think too many people speak French, that we can always find someone, but a card like that would still be helpful for me because there are some things that I don't fully know. And I guess kind of having all of the resources we have in English also in French or even like having them integrated. I know it takes more paper, but sometimes if it has the English first then the French, it kind of lines up better, whereas the English and the French books sometimes don't even match up, you know what I mean? So, it'd kind of be better if it just had it line by line or paragraph by paragraph so then I can read it in English and then read it in French.

RN03 suggests numerous resources to meet language needs. For example, the use of language picture cards could assist staff in easily translating activities of daily living and other such tasks. RN03 recalls these types of cards being used in a former place of work and finding

them useful in her care activities with French-speaking patients. Adding to the suggestion of NS07, RN03 also supports the use of bilingual discharge resources. This would help her read it in English, and understand it, and then proceed more confidently with reading the statement in French. RN03 further suggests that:

> It'd be nice to have educational videos and stuff that were in French. Like that we could just show a video to the parents. Like watch it with them, kind of explain through it. Like [pediatric hospital] doesn't really have a ton of educational videos.

According to this nurse, a range of formats must be included in translation efforts, citing visual material such as educational videos. While RN03 recognizes the widespread use of print material in routine care activities, translated multimedia resources can be a strategy to meet the needs of diverse patient populations, including those who have differing levels of health literacy. RN03 adds further that:

> It'd be better if they actually tailored the AVS [after-visit summary] to their preferred language, but I think a lot of physicians can't write in French and they don't have anyone to translate for them. Or like even if they can speak French, they're afraid of writing it in French because of the grammar and all the accents.

RN03 identifies a particular tool, the after-visit summary (AVS), as a way to ensure that discharge summaries are provided to patients in their official language of choice. However, she also believes that some providers' comfort level with writing discharge information in French remains a barrier. As a result, most patients end up receiving discharge summaries in English, regardless of their official language of choice or even in the language in which their health care interaction took place.

Educational Systems

Study participants highlighted the skewed perception of the value of French in Ontario. Patients, nurses, and nursing students alike were strong advocates for the need for comprehensive

education for health care providers. Suggestions were therefore provided to create system wide changes, advocating for increased French language promotion throughout elementary school, post-secondary education, and in the context of continuing professional development. As NS05 notes, "I think that . . . upstream promoting it to children that it is important to be bilingual. So, it starts at the bottom and works your way up." In Ontario, NS05's suggestion means early promotion of the importance of learning and remaining fluent in French. For children, this could start as early as elementary school, and continue into their post-secondary education. As she continues,

> I think it would be super essential and make a huge difference to require every nursing student if they are in English or if they are in French . . . to take the opposite language for a year of classes … a specific course that is tailored to teach you how to speak the language with your patients. I think that that would be super essential, and it would make a huge difference because at least people would have conversational French to be able to give care.

NS05's suggestion points to the normalization of learning French as a part of one's professional education in health care, to properly prepare future graduates to engage with French-speaking patients during health care encounters. This strategy is significant given the tendency identified in earlier findings to consider the ability to speak French as an exception or as a bonus. This strategy would ultimately build capacity in health care services across settings, as incoming nurses would be more confident providing care in both official languages. NS04 echoes this thought, saying:

> It'd be nice if there was some kind of course that they made you go through first year in the sense of, like you had to learn this amount of French . . . even if they were to go through just the basics and do different scenarios and test your knowledge to provide you with… that valuable information… to do that, would be really helpful but obviously that's not really a thing that is included in the curriculum right now.

In addition to what was proposed by NS05, NS04 adds that French language courses could be valuable to nursing students as early as first year, to learn the basics of the language and to work

through various care scenarios. In this case, students would be accountable for their learning through testing, solving an issue raised previously by participant RN08 about the importance of accountability to make such learning purposeful and effective. RN05 also supports this strategy, including the addition of scenarios and educative measures as a means of

> making sure that the issue stays in the forefront and that everyone can see French as a possible challenge and a patient safety issue, because right now I have the feeling from co-workers that it is more of a like "oh Francophones you know they know they are allowed to have it so they insist on it," that it is sort of like an added value thing . . . not a requirement because it can be dangerous or way too stressful.

RN05 encourages education as a means of building awareness, not only for nursing students but also for registered nurses. She stresses its importance because she realizes that many colleagues, fellow health care providers, believe that receiving care in French is a question of privilege. She believes that having such educational opportunities will awaken her colleagues to the potential dangers and safety issues that come with care being provided solely in English.

NS05 also suggests that:

> requiring at least like a year-long [French language course], that could be integrated into your clinical placement, you know, having a four-hour lecture lab… they have lecture labs, language labs available for other languages and I know they have it for French, I just think that it should be a requirement for your program especially because you are going to be providing health care to people, like you should be able to communicate with them . . . Because it is so common, like people are "Oh it's not that common." "Yes, it is." Like half of your patients in a day will be French."

NS05 further stresses the significance of this issue, reinforcing that she frequently encounters Francophone patients. While some may think that they will seldom need to speak French, NS05 asserts that half of her patients in a day will sometimes be Francophone. PT05 insists that starting this process with university education is pivotal:

> Le problème c'est que les universités on n'insiste pas sur la nécessité d'être un tout petit peu bilingue, vous savez… je reconnais l'effort de parler français. Mais si on me dit « Do you speak English? », « Non, c'est non, c'est non ».

PT05 states that universities do not do their part in insisting that students develop fluency in French. As a Francophone patient, she can recognize a health care professional's effort to speak French. However, she is not willing to have care imposed on her in English. Integrating linguistic requirements at the university level constitutes a key step to support care provision in French.

Numerous suggestions by patient participants were geared towards providers, from university students to seasoned nurses. For example, PT06 states the following.

> Pour les étudiants ou les gens qui sont en train d'apprendre, d'étudier en soins infirmiers par exemple, en médecine et toutes les autres personnes qui donnent des soins de santé en Ontario, il serait mieux qu'on leur montre cette utilité ou cette importance de connaître les deux langues afin qu'ils soient à l'aise à s'exprimer avec les patients. Je pense que c'est bien même s'il, au cas où on ne trouvait pas de traducteurs ou au cas où pour éviter des frais de plus, d'embaucher quelqu'un d'autre de plus, c'est mieux qu'on encourage à ce que les étudiants, les médecins, les infirmiers, tous, essaient de fournir un effort pour être complètement bilingues.

PT06's comment echoes those of NS04, NS05, and RN05 about professional programs, such as nursing and medicine, as key spaces where students could learn the value and importance of speaking some French to provide care to French patients. She argues that this would even be a financially beneficial strategy, as it can help reduce costs of translators in health facilities. While this approach may take more effort throughout the system and for individuals, PT06 believes that this will ultimately be best for patient care.

Numerous patients interviewed supported the need for continuing professional development, and for the French language to be taught to all providers who were not bilingual or capable of speaking in French:

> PT09 : À l'hôpital, ils peuvent donner des cours de français pour que tout le monde puisse savoir cette langue puis communiquer au moins avec les gens, donner les services.
>
> PT08 : Je pense que pour nous aider nous les communautés Francophones, ça serait mieux que le personnel de santé Anglophone aussi ait des formations en français, ne serait-ce que l'information élémentaire. C'est ça mon souhait.
>
> PT05 : Pourquoi ce n'est pas automatique qu'on leur donne des cours de langue?

PT09 proposes an initiative whereby courses are offered at the hospital. This would be a means to ensure that health care providers can communicate with their patients and help enhance patient care. PT08 adds that this is an important means of supporting the French-speaking community and adds that even beginner level French would greatly enhance the care experience. PT05 expresses surprise that French language courses are not automatically provided for health care providers who are not fluent in the minority official language.

Some participants agreed that there is a desire for such courses if support was given. RN08 suggests that a beneficial method would be "paying for our classes and offering a class that . . . worked with your schedule a bit more." Several nurses had previously contended that not accommodating shift work schedules was a hindrance to taking French language courses. As such, paid courses with consideration for the unique nature of nursing schedules would be strategic in terms of increasing enrollment in French language classes and ultimately building language capacity for French within an institution. NS07 further suggests that:

> Ça pourrait se faire ou même des lunchs and learn, des dîners-conférences. Je ne sais pas, des affaires comme ça pour aider à introduire des infirmières Anglophones à prodiguer des soins en français. Je pense que vraiment ça devrait être fait.

A lunch and learn series and other measures to introduce Anglophone nurses to French would help to make them more comfortable with offering care in French. RN05 again stresses the importance such education:

> Nurses do way more in terms of communication, as far as I'm concerned so I think for the biggest improvement for the patients and not just for the patient's experience but for their safety, all of the language training should be very heavily focused on nurses.

RN05 emphasizes the important role of nurses in the provision of patient care given their level of involvement in communication with patients, reiterating once more that communication without language congruence is not safe. She supports the idea that an effective strategy must emphasize the importance of increasing language training for nurses in health care settings.

Government Involvement

While participants eagerly provided ideas, suggestions, and strategies, they highlighted that these could not be limited to individual commitments and initiatives. Many patient participants advocated for change and action to take place at the government level. For example, PT10 states that « le gouvernement dit que l'Ontario … c'est une province qui est bilingue… Alors qu'il s'assure que tout le monde peut être capable de recevoir les soins dans la langue . . . qu'il connaît. » PT10 understands that the government of Ontario needs to ensure that everyone in Ontario can receive care in the language that they know best. For many patients in Ontario that language is French. However, although Canada is a bilingual nation, the province of Ontario is not officially bilingual. Despite this fact, many Ontario residents such as PT10 are bilingual and strive to receive their services and health care in Canada's minority official language. PT08 also supports the involvement of the government on this matter:

> Le gouvernement a des statistiques . . . souvent quand je fréquentais les centres de santé comme les hôpitaux et tout. On me demandait « est-ce que je me sentais à l'aise d'être servie en français ou en anglais », donc j'imagine que le gouvernement a toutes les statistiques des gens, des patients qui sont servis . . . Je pense que c'est le gouvernement qui est le mieux placé pour rehausser le niveau de français dans les centres de santé.

PT08 knows that statistics are collected by many organizations. Often when she accesses health care services, she is asked what her official language of choice is. As a result, she estimates that this data must be retained and should be valuable to the government, which then should be aware of the needs of the Francophone community, including the need for patients to know what is done as a result of collecting this data. They should also be able to assist in enhancing access to French language care, as well as offering French language services in health care organizations.

PT02 also suggests that there are political reasons for government to seek involvement with this cause:

> Ceux qui nous représentent, si on demande à eux ils peuvent le pousser pour nous autres… C'est au travers du gouvernement parce que c'est eux qui font les lois, c'est eux qui peuvent travailler pour ça, c'est eux qui nous représentent… c'est eux autres qui décident alors si beaucoup de gens poussent pour avoir plus de soins en français, [autrement], à la longue ils vont perdre des votes, [alors] ils vont travailler pour ça.

Highlighting her perspective on the decision-making power of the elected government, PT02 stresses that the government is responsible for many decisions that affect the population in general. She identifies government officials and members of parliament as key actors to advocate, move issues forward, and create laws. In her view, if many individuals advocate for health care in French, then the government needs to pay attention, otherwise it is at risk of losing votes, which then becomes an incentive to work for the cause of the linguistic minority. RN08 also sees the power of the government as a strategy for change. She states:

> The government, you know if the government offered . . . a French-language course for health care providers and said, "We're going to cover the costs but we're expecting that you're going to, you know, be fully committed." Like maybe have them sign a contract or something

RN08 believes that the government has the power to mandate its employees to take French classes and suggests a similar approach for health care providers. She suggests that buy-in from

the government could involve paying for language classes for health care providers. These classes would be fully covered and paid for by the government. To ensure that health care providers held up their end of the bargain, they could be mandated to sign a contract to this effect. PT08 also supports such a strategy:

> Il paraît qu'il y a une décision qui était sortie concernant les agents du gouvernement qu'ils devaient être bilingues et tout, ça a aidé parce que maintenant tu peux aller dans presque tous les bureaux du gouvernement il y a vraiment des services bilingues . . . Ça a aidé parce que, nous les Francophones ont se sent vraiment à l'aise surtout quand il faut parler de choses importantes comme la santé, les rapports, les documents officiels et tout donc c'est important. Si on pouvait faire ce genre de centre de formation surtout pour le personnel médical, ça serait vraiment intéressant.

PT08 draws on her experience accessing government services, which she sees as being transferable to accessing health care services. In Ontario's 26 designated regions, government officials must be bilingual as a condition of employment, making accessing help and services in these offices easier for Francophones in those areas. They can be comfortable addressing issues in their official language of choice. PT08 believes that a bilingualism training strategy could be valuable for medical and health care personnel, to increase their ability to comfortably serve French-speaking patients in their official language of choice.

Chapter 7: Discussion

The purpose of this study is to examine the health care experiences of Francophone patients and their nursing care providers in Ontario. The questions sought to assess the challenges and barriers encountered in offering high quality and safe care for French-speaking patients in Ontario. Numerous findings emerged, notably, the burden and disruptions for patients and health care providers, the lack of resources at the organizational level, and the health policy impacts on French-speaking patients' rights at the societal level. The study was also designed to reveal the supports, strategies, and opportunities that exist for improving care provision to French-speaking patients in Ontario. Participants in the study shared a number of strategies already implement that allowed patients and nursing professionals to cope with the current system, and they proposed other strategies to improve care for French-speaking patients in Ontario.

Using the data collected during the interviews with registered nurses, nursing students, and Francophone patients across Ontario, this discussion seeks to reconcile the existing data from the literature with the experiences of the study participants. The results are discussed with reference to the conceptual models used for this study, the "Four Levels of Change for Improving Quality" model (Ferlie & Shortell, 2001) and the "Four-Level Model of the Health Care System" (Reid et al., 2005). Moreover, as set out in the literature review, this chapter will also discuss the Framework for the Analysis of Health and Social Services Access and Integration for Official Language Minority Communities by J. Savard, Savard, et al. (2020) for its potential to make an important contribution to the issue at hand.

First, this chapter addresses the system paradoxes, notably the flaws in the system when it comes to French-language health care in Ontario. Thereafter, it will address the linguistic injustices faced by official language minority communities in the current health care landscape. The

discussion will then draw parallels with nursing practice and provide recommendations for health care administrators, health care providers, Francophone communities, and French-speaking patients. Finally, the chapter concludes with implications for nursing and directions to guide future research.

System Paradoxes: Flaws in the System

The Four Levels of Change for Improving Quality model (Ferlie & Shortell, 2001) and the Four-Level Model of the Health Care System (Reid et al., 2005) were the conceptual frameworks that guided this study. These models and this framework support initiatives to improve the quality of care and care outcomes at multiple levels in the health care system. This novel framework of J. Savard, Savard, et al. (2020) focuses on the unique needs of official language minority communities in Canada. It must be noted that the Framework for the Analysis of Health and Social Services Access and Integration for Official Language Minority Communities (J. Savard, Savard, et al., 2020) was published during the writing of this dissertation. The framework provides significant contributions to an understanding of health access for Francophone minority communities throughout the province of Ontario as it considers both Francophone patients and health care providers, and thus was a relevant addition for this thesis.

Although the health care system and its various levels are interdependent, J. Savard, Savard, et al. (2020) acknowledge that change in health care is often initiated at a single level of the framework, causing problems for sustaining meaningful and necessary changes system wide. This was also the pattern that emerged in the findings of the study. Analysis of participants' perspectives throughout the various sectors of the frameworks, from patients to the health care team, to organizations, and to the environment, results revealed that the health care system had flaws when it came to offering quality care in French to Francophone patients in Ontario.

Participants revealed that many of the efforts for change occurred at the individual level (for individual patients or for the nursing professionals) in lieu of a strategic approach that encompassed all facets of the broader health care system.

All authors of the conceptual frameworks mentioned in this chapter suggest that change can happen at multiple levels within the system. However, Reid et al. (2005) stress that individual level strategies alone are rarely effective if they remain in silos. Similar ideologies are shared by Ferlie and Shortell (2001) as well as with J. Savard, Savard, et al. (2020). These frameworks proved to be representative of the current health care landscape, its potential strengths as well as its shortfalls with regard to care offered to Francophone minority communities.

This section speaks to the (in)visibility of Francophone patients within the health care system, reviews the conflicted position of registered nurses and nursing students as health care providers, and provides an analysis on the legislative discourse and perplexing realities that display these conflicting priorities. Thereafter, we explore the sporadic application of existing solutions, and the problematic reality of local compensations for a systemic issue, before engaging in an examination of the challenges regarding the use of mostly individual level strategies for a systemic problem. This portion of the discussion stresses the importance of considering the interdependence of the various levels of the health care system to create meaningful, long-lasting changes for improving outcomes and enhancing the quality of care provided to Francophone linguistic minorities.

(In)visible Francophone Patients

While Canada is officially a bilingual country, patients speaking the minority language often notice gaps in their access to services. This has been the experience of several participants in this study. Though French is an official language in Canada, Ontario is not an officially bilingual

province. As such, despite legal requirements such as the FLSA, patients requiring care in the minority language can be invisible in systemic health care planning, and yet, stand out visibly as a system anomaly during their point of care experiences. This paradoxical (in)visibility places Francophone patients in a position of tension whereby the inequities that they face can be bolstered or ignored. Parry (2019), a social scientist scholar with expertise in political ecology, social vulnerability, social inequities, and health, argues that in light of such (in)visibility, poor access to health care services for marginalized populations can be perpetuated, while further rendering their health risks invisible.

The interviews with participants of this study revealed the visibility and invisibility of Francophone patients. This brought to light a conflicting paradox regarding their position within the health care system as patients seeking health care in the official minority language. This population appeared to go largely unnoticed at the systemic level, where their preoccupations with regard to health care are not always known or addressed. J. Savard, Savard, et al. (2020) identified the symbolic level within their framework, which points to values, beliefs, and social concerns of a health care structure. For example, the framework acknowledges the Government of Canada's commitment to linguistic duality, notably with the implementation of the *Roadmap for Canada's Official Languages* (Government of Canada, 2017a; J. Savard, Savard, et al., 2020). However, the participants in this research, as with participants in several other studies, indicate that provincial and federal values may not always have an obvious or direct benefit for patients, as evidenced by their health care experiences (Jutras et al., 2020; Kubina et al., 2018; J. Savard, Bigney, et al., 2020), especially the values speaking to Canada's stance on existing linguistic policies. This situation for Francophone patients touches on all aspects of the health care system, including political and regulatory structures, organizational structures, communities, health care

professionals, and patients, which are all interconnected according to the conceptual frameworks discussed in this thesis (Ferlie & Shortell, 2001; Reid et al., 2005; J. Savard, Savard, et al., 2020).

Several patient participants, who had the intent to speak French while seeking care, found their encounter with the health care system to be a shock especially when they realized that health care services would not be adequately offered in their language. To offset these situations, several patients went to great lengths to address the communication challenges inherent in their health care encounters. Some patients had to resort to technologies such as Google Translate and recording devices. Such efforts and troubleshooting are not a normal part of the health care experience and result in the patient being put to work (Unruh & Pratt, 2008), forced to take on an unforeseen burden in addition to the challenges brought on by poor health. Thus, these invisible Francophone patients find themselves doing invisible work, work that is seldom recognized or reported, such as preparing symptom lists, questions, and appropriate responses for their care provider in a language that is not their own (Jutras et al., 2020). Such tasks and expectations would not be expected from the majority Anglophone patient population in Ontario.

Certain patients who were aware of the inconsistent access to French language care would hold off on their visit until a family member, friend, or anyone in their network who was bilingual could accompany them. Several patients pointed to conflicts regarding whether or not to access health care services, and deliberated over which access point was reasonable. For example, PT04 admitted that going to the emergency department was tempting, as he knew that those health care providers were likely to speak French. However, he deliberated over this decision, pondering whether his health care concerns warranted the use of expensive, last resort health services. In evaluating the pros and cons of this option, this participant sought to determine the worth of his health and language needs. J. Savard, Savard, et al. (2020) would address this situation as a

problem across the trajectory of integrated services, as well as an issue of accessibility for linguistically congruent services throughout the care continuum. The care continuum speaks to the preventative, curative, and supportive health and social services required for patients and families (J. Savard, Savard, et al., 2020). In the example above, the availability of service in French at the primary health level was inconsistent, but was more reliable for care services available in the hospital. Such a flaw needs to be addressed, with strategies to rectify such inequities at all levels of the health care system (Ferlie & Shortell, 2001; Reid et al., 2005; J. Savard, Savard, et al., 2020), in order for them to be sustainable.

Bowen (2001) indicated that patients lacking proficiency in the official language may be more likely to avoid seeking health services, especially when interpretation may not be available. Language thus becomes a factor that adds undue stress to Francophone patients from minority communities that goes beyond their existing health concerns. Such stressors even cause some patients to avoid seeking health care altogether. Thus, access to health services can be compromised for official language minority communities (Government of Canada, 2020b), including those seeking health care in Ontario.

The health care challenges of Francophone patients are often invisible, and they are made more so by the extent of invisible work that patients do before and during the health care encounter to comply with the needs of the health care system. The patient needs to take on additional responsibilities to avoid being problematic during health encounters (de Moissac, 2016b; Jutras et al., 2020). This work adds to their burden and distress, even in the midst of navigating their illness.

However, Francophone patients can also stand out in the health care system especially when their health care provider is not able to communicate in French. Patients realize that their request to receive care in French usually means longer wait times and care delays. Longer wait

times and delays for official language minority communities are consistent findings outside of this study (Bowen, 2001; Drolet et al., 2014; Drolet, Bouchard, Savard, et al., 2017; Hien & Lafontant, 2013). Moreover, a study participant also spoke to the experience of being forgotten in a room after verbalizing his need for services in the French language. In such a case, this patient oscillates between visibility and invisibility. The patient stands out as a visible anomaly in the system, requesting services that the provider is unable to provide. However, the patient thereafter becomes invisible, forgotten in a room, and such an experience is interpreted as an isolated, exceptional event, invisible to the health care system due to it not being recorded in any shape or form.

Such a situation evokes concerns regarding discrimination and neglect of Francophone patients, concerns which resonate and should be considered by the various levels of the health care system. Moreover, these kinds of situations can also contribute to a decreased demand for services in the minority language. From a symbolic view, such an experience is not congruent with the values and beliefs Canada upholds around linguistic policies and linguistic duality. Moreover, they are harmful to the communities and individuals seeking and requiring services in their official language. These experiences can be problematic throughout the diverse structures of the health care system (Ferlie & Shortell, 2001; Reid et al., 2005; J. Savard, Savard, et al., 2020).

Thus, Francophone patients who require care in French are both invisible and visible within the health care system. Constantly navigating a system where patients do not fit in can be harmful and dangerous to the patient population. In these situations, the burden is placed on the individual patient to conform to the health care system, often at times when they are already ill and vulnerable. This experience points to inequities within the health care system which must be addressed. Francophone patients cannot be viewed as the problem; they need equitable access to health care

services. A systemic approach is required to see where changes can take place throughout the health care system to benefit patients throughout the province.

Tensions of (In)Visible Nursing Work

In the words of Star and Strauss (1999), "the workers themselves are quite visible, yet the work they perform is invisible or relegated to a background of expectation" (p. 15). Although American sociologists Star and Strauss (1999) were writing about computer-supported cooperative work (CSCW) that support the processes to enable group work, what they had to say resonates with nursing. The authors pointed to, the extensive informal tasks and background work required to make systems function, as well as to the overt regularly recognized work, acknowledging that there is a tension between the two extremes (Star & Strauss, 1999). Such was the reality of many participants in this study.

Bilingual registered nurses and nursing students in this study believed that speaking French was both a blessing and a burden in today's health care system. Speaking French was often considered an asset, or even a necessity, for employment, depending on the facility, city, or region in which they sought employment. However, they also reported that the ability to speak French could cause challenges. Their linguistic competencies often resulted in them having increased workloads in having to care for more patients. Though the nurses and nursing students are visible within the workplace and active in patient interactions, many aspects of their work with Francophone patients are unrecognized and undocumented, thus spurring the invisible nature of their work (Lydahl, 2017). This finding is supported by the literature, which depicts how nurses' work can be invisible or hidden, along with their moral and emotional concerns which can be easily dismissed (Bjorklund, 2004; Jackson, 1997; Lydahl, 2017; McQueen, 2000). In Canada, the Canadian Nurses Association acknowledged 14 years ago that the workload of bilingual, French-

speaking nurses can be significantly heavier in comparison with their Anglophone counterparts (Canadian Nurses Association, 2007); however, years later, this finding has yet to be properly addressed.

Regardless of the level of French-language proficiency in care providers, challenges and tensions exist with the provision of quality care to Francophone minority community patients. Anglophone nurses also face difficulties when their Francophone colleagues are not present or if they do not have French-speaking colleagues at all to assist with interpretation or translation. The reality in many institutions is that depending on a Francophone colleague is the go-to plan for serving French-speaking patients. In the absence of colleagues who speak the minority language, the linguistic barrier becomes more challenging to overcome, as providers find themselves scavenging for resources at their disposal or improvising new methods to bridge communication gaps. In such cases, according to Colombian nurse scholar Lopera-Arango (2018), several of the nursing efforts and tasks are invisibles both to the patients and to the administration, even as they benefit the care recipients or the organization. In this case of this study, this invisibility was evidenced in efforts of nurses to research French terms before a patient interaction, to arrange individual tutoring with nursing colleagues to be more competent at the bedside, or to use smart phone applications to enhance their French language proficiency.

As the health care system is currently structured, registered nurses and nursing students saw instances where care to French-speaking populations was frequently delayed or even avoided in order not to introduce an extra layer of difficulty in an already heavy workload. The visibility of Francophone patients demanding and requiring care in French causes nursing professionals to have to adapt within a system that is designed for Anglophone majority language patients. The arrival of Francophone patients and their need to receive health care in the French language is

reported to cause disturbances in the workflow, and most especially, to slow down the provision of care. Delayed care offered to French-speaking patients is discussed in the literature (de Moissac et al., 2011; Garcia et al., 2014; Hien & Lafontant, 2013), as are the challenges that can present when interpretation and translation services are required but not available (Munoz & Kapoor-Kohli, 2007).

Additional delays and challenges in the delivery of health services are problematic realities for several factors. J. Savard, Savard, et al. (2020) point to the importance of providing linguistically congruent access to care along the care trajectory, including making available preventative, curative, and support services for official language minority communities. However, this is not always the case, and the gaps throughout the system can be harmful. Garcia et al. (2014), an Ottawa professor specializing in quality of life and aging with dementia, found numerous potential delays in the pathway to diagnosing elderly Francophone adults with dementia in Ontario. For example, delays presented when patients and families desired a consultation with a French-speaking specialist (Garcia et al., 2014), a process that can be difficult and time consuming to secure. Such experiences are troubling given that delays in the diagnosis of dementia can cause additional challenges for patients and their families, as well as for the health care system.

To further illustrate this reality, participants in Hien & Lafontant's (2013) study pointed out that many Canadians cite long wait times as their greatest concern with regard to the health care system. However, Francophone patients contend that their wait time is extended beyond the already extensive wait times for official language majority patients (Hien & Lafontant, 2013). Northern Ontario participants in that study shared their distress after long wait periods, seeing their turn arrive but having to skip their turn as they waited for a Francophone health care professional

to be available to assist them (Hien & Lafontant, 2013). These anecdotes are similar to the lived experience shared by several participants in this doctoral study.

Once again, the values espoused by the Canadian government as revealed in the Framework for the Analysis of Health and Social Services Access and Integration for Official Language Minority Communities (J. Savard, Savard, et al., 2020) are of interest here. Although symbolic structures such as Canadian values for linguistic duality as well as policies and regulations such as the FLSA, should support the equity of services in both official languages, the reality falls short with regard to the experiences of French-speaking patients and their providers. Thus, invisible work is heightened at the individual and health care professional levels to ameliorate the point of care challenges. During such moments, the change in routine for the patient and provider are quite obvious throughout the clinical encounter, making the French-speaking patient stand out in the health care system interaction as a visible anomaly. However, this study's four-level frameworks suggests that substantial changes and improvements would result if the health needs of Francophone patients were recognized throughout the various levels of the health care system (Ferlie & Shortell, 2001; Reid et al., 2005).

The nursing staff interviewed, especially those who were bilingual, were aware of the problematic challenges facing linguistic minority patients in Ontario, realizing that this could ultimately compromise patient safety and even cause patient harm. Numerous scholars have expressed similar concerns for nearly 20 years, pointing to concerns for patient safety with linguistic minority communities (Bowen, 2015; Canadian Nurses Association, 2007; de Moissac & Bowen, 2019; H. Gauthier, 2016; H. Gauthier & Reid Triantafyllos, 2012; Wilson et al., 2005). However, knowledge of this issue did not necessarily result in advocacy among nursing professionals. Although health care professionals have a position of power over the patient in most

clinical encounters, nurses did not always push for needed change in the care of French-speaking patients throughout the organization. Some nurses pointed to the fact that there was little support for French language care among managers and organizational executives.

While supporting patient advocacy is often seen as an important role for nurses given their position in the health care system (Balwin, 2003; Tomaschewski-Barlem et al., 2016), many nurses find themselves lacking both support and power to advocate effectively. Lack of support and a feeling of powerlessness has been documented in the literature as a barrier to advocacy by nursing professionals. Contributing to this problem as well is the combination of time shortages and lack of time for sufficient or adequate communication with patients (Negarandeh et al., 2006). Furthermore, problems with advocacy also arise when the challenges and negative consequences are shifted from one individual to another. For example, those who persistently advocate for the needs of Francophone linguistic minority communities may find themselves labeled as troublemakers. This stigmatization can follow these health care professionals throughout their career in an organization. While advocacy may be a noble endeavour, in such situations it can yield negative consequences.

Conversely, recognizing the needs and rights of patients facilitated advocacy (Choi, 2015; Davoodvand et al., 2016; Negarandeh et al., 2006), but this once again becomes both a barrier and a reason for concern in the face of linguistic discordances between the patient and the health care provider. Studies point to the need for organizational cultures that support advocacy within their institution, as various clinical environments indicate that this is yet to be the case (Choi, 2015; Negarandeh et al., 2006). Furthermore, American nurse researcher Mahlin (2010) contends that while supporting individual patient advocacy is important, more work is required to address the

systemic inequities and disparities that persist within the health care system that disadvantage communities already marginalized and lacking proper health care access.

More often than not, nursing professionals seek to resolve presenting issues at the individual level, but this does not ultimately help address the systemic problem that exists throughout health organizations or throughout the provincial health care system. Utilization of nursing staff in this capacity masks the problem and contributes to the invisibility of Francophone patients' needs, while bolstering invisible nursing work. As the nursing staff compensate to meet the needs of patients, families, nursing colleagues, physicians, and ultimately, those of the organization and health care system, the need to systemically address the issue at the broadest level is further concealed.

The literature also suggests that such dynamics contribute to masking the presence of bilingual health care providers, as some do not disclose their bilingualism so as to avoid increasing their workloads (de Moissac, de Rocquigny, et al., 2012). For example, Timony et al. (2013, 2018) further suggest that some bilingual practitioners may be more inclined to practise in communities with a decreased French-speaking density, a troubling possibility which may be related to the increased workloads for French-speaking providers, especially in rural regions of Ontario. While such decisions can have a protective effect on the individual health care provider, they ultimately jeopardize the offer of care to French-speaking populations. Systemic strategies must be developed to address the issue (Ferlie & Shortell, 2001; Reid et al., 2005; J. Savard, Savard, et al., 2020). Such an endeavour would require ensuring that integrated health care services can be provided equitably across the continuum of required patient care services in both official languages, and systemically offering appropriate policies and incentives throughout the health care system to adequately support the care providers in their role. French Language Health Planning Entities are

valuable partners in supporting the interests of Francophone minority communities, all while partnering with health agencies that serve these populations (Ministry of Health and Long-Term Care, 2021a; Réseau des services de santé en français de l'Est de l'Ontario, n.d.).

Several problematic situations regarding the continuity of nursing care services for official language minority communities are already known. In this study, several nursing students pointed to the systemic issue that could also emerge with the lack of French-speaking clinical instructors, thus compromising a consistent and sustainable influx of Francophone nursing students. Studies have warned against a shortage of health care professionals, a stark reality for French-speaking health care professionals (P. Bouchard et al., 2009; de Moissac et al., 2015, 2017; Drolet et al., 2015; Lortie & Lalonde, 2012; Programme de soutien au système provincial, 2018), especially in specialty sectors (de Moissac, de Rocquigny, et al., 2012). This challenge was a great concern for students wanting specialty placements, such as mental health, where the importance of language, effective communication, and understanding are essential. When these placements are cancelled, it raises questions as to what possibilities remain for Francophone patients requiring care in these sectors.

Legislative Discourse and Conflicting Priorities

The right to French-language services is legally protected by the French Language Services Act (FLSA) (R.S.O. 1990). While this act supports French language services in public sectors, it is not thoroughly implemented throughout the health care system. For example, Ontario Health must provide services in both official languages (Ministry of Health and Long-Term Care, 2021c). Likewise, organizations fully funded by Ontario Health must provide services in both English and French (Ministry of Health and Long-Term Care, 2021c). However, organizations receiving partial government funding through Ontario Health are not subject to the same requirement, as their

designation obligations under the FLSA only apply to certain sectors or units of their institution. While the "health system should be guided by a commitment to equity and respect for diversity in communities in serving the people of Ontario," political considerations add considerable challenges to the successful offer of services to French-speaking communities in Ontario (Dumont & Doucet-Simard, 2013, p. 218).

French-speaking individuals may be able to advocate for their language rights with provincial and federal institutions and receive further support from the office of the Ombudsman of Ontario, notably with the Ombudsman or with the French Language Services Commissioner. However, challenges remain regarding the support for patient language rights in the health care system. For example, little support exists for patients who access services which are not under the jurisdiction of the FLSA. This includes the provision of French-language services at certain hospitals and long-term care homes, which can make the complaint and advocacy process more challenging for patients and families (Bureau de l'Ombudsman de l'Ontario, 2020).

Furthermore, while there may be laws that help reinforce French-language services in certain spheres of Ontario, there remains a conflicting discourse between laws in place and the political climate. For example, Franco-Ontarians, French-speaking Canadians, as well as advocates for official minority language community support were dismayed at the closing of the independent office of the French Language Services Commissioner of Ontario in 2019 (Bleytou, 2019; Office of the French Language Services Commissioner of Ontario, 2019). This decision happened in the wake of the financial restructuring by the Conservative government in power at that time. The services provided by the office of the French Language Services Commissioner of Ontario were merged with the services of the Ombudsman of Ontario. This caused great concern to the Francophone community, as it appeared that the unique needs for advocacy for French-

language health care services were getting lost among numerous provincial priorities (Office of the French Language Services Commissioner of Ontario, 2019; Radio-Canada, 2019; Star Editorial Board, 2018).

Such a climate for Francophones in Ontario does little to foster population trust, or to encourage the population to believe the discourse that the French language is a valued priority within the province. This reality is important to address in light of the conceptual frameworks referenced in this chapter, notably the Framework for the Analysis of Health and Social Services Access and Integration for Official Language Minority Communities (J. Savard, Savard, et al., 2020), which once again acknowledges the symbolic and political structures. While these are important components of the offer of linguistically congruent services in Ontario, challenges may present when the espoused values are challenged by conflicting political stances, as can happen with the change of ruling government authorities. Reid et al. (2005) speak to the environmental level pressures, as changes at this level impact various sectors of the health care system, touching on funding and existing policies. While change can occur, it is important for considerations at the various levels of the health care system to take place, especially when such decisions can compromise both health care access and health service provision.

Even within the nursing landscape, there is conflicting language regarding the value and prioritization of French language services in Ontario. Both the College of Nurses of Ontario (CNO) and the Registered Nurses Association of Ontario (RNAO) speak to the importance of supporting French language services. The CNO aims to protect the public, which includes Francophone patients in Ontario (College of Nurses of Ontario, 2020, 2021b). By means of advocacy and collaboration with nurses and the public, the RNAO reports the need to “advance individual and collective health” (Registered Nurses’ Association of Ontario, 2012, p. 32). In light of the

identified need to enhance French-language services to support health care provision, recommendations and resolutions were made to bolster these services (Registered Nurses' Association of Ontario, 2012).

Such decisions could be valuable to support and to advocate for nursing care providers serving French-speaking populations, and to promote quality of care to Francophones in Ontario. Yet, both of these organizations fall short with maintaining a sustained offering of services in French. This varies from the lack of satisfactory translation of their websites, to the sparseness of guidelines, and to the existence of resources that are not always accessible in both languages, as discussed by registered nurses and nursing student participants in this study. Moreover, following through on plans and resolutions is important, as French-language services can be initiated but may not be consistently maintained, or may present with concerning quality, especially in the face of interrupted funding and competing budgetary priorities.

A situation that troubled Francophone nursing students in this study was the decision of nursing professional licensing organizations to adopt the NCLEX-RN exam, replacing the previously validated examination required for nursing licensure in Canada, save Quebec. They were not the only concerned parties, as this decision caused concern even at the federal government level (Paradis, 2018) and even drew international attention (May & Singh-Carlson, 2019). Since the NCLEX-RN exam was implemented in 2015, student cohorts have seen a decline in success rates for the exam in French (as low as 40%) in comparison with English test results, which increased following the implementation of this new examination (Lalonde et al., 2020). Moreover, with the NCLEX-RN being an American-based exam, there was and continues to be a dearth of preparatory resources in French, especially in comparison to material available in English (Lalonde, 2019; McGillis Hall et al., 2016). Unfortunately, such a dire situation has led to

decreased choices to take the exam in French (Lalonde, 2019), and may even compromise students' choice to pursue their education in French (Lalonde et al., 2020).

The existing data demonstrates that the adoption of the NCLEX-RN by regulatory nursing bodies has been detrimental to certain French-speaking populations. However, the exam remains in place, including in Ontario (College of Nurses of Ontario, 2016). In such a situation, nursing professional organizations have a direct role in contributing to the success or demise of welcoming an influx of entry-level nurses to the profession. From a human resources perspective, such low pass rates, especially for French language exam writers, means that there is a reduction, or at very least, a delay in novice nurses entering the workforce (McGillis Hall et al., 2019). Moreover, this delay disproportionately affects Francophone populations. The decisions of implementing such an examination process can in turn be harmful for Francophone minority communities requiring services and an influx of human resources trained in French and capable of meeting their nursing needs (McGillis Hall et al., 2019). Furthermore, the potential decreases in French language enrolment and exam pass rates are harmful in light of Canada's linguistic duality, as well as its values of bolstering the vitality of its minority language communities (Paradis, 2018). As outlined in the three conceptual frameworks discussed in this chapter (Ferlie & Shortell, 2001; Reid et al., 2005; J. Savard, Savard, et al., 2020), decisions that are taken system wide, even at the environmental level, such as with nursing professional bodies, have a ripple effect throughout the health care system, affecting organizations and health care teams that require French-language trained nurses.

Thus, while plans to discuss lasting French-language services can be initiated, it is important to support their continuity, to equip nursing care providers and patients, and the overall community alike. The value and advocacy attributed to French-language services must once again

be considered by decision makers as well as by the nursing representative bodies, in order to support both French-speaking patients and their health care practitioners, symbolically, as well as with concrete actions, such that federal, provincial, and health systems values may concretely align (J. Savard, Savard, et al., 2020). Organizations such as the CNFS and SSF can be key allies in capacity building and supporting the successful implementation of such endeavours (Lortie & Lalonde, 2012; Société santé en français, 2019).

Sporadic Application of Existing Solutions

Numerous researchers and various organizations have studied issues regarding health care offered to official language minority communities for several years (Drolet, Bouchard, & Savard, 2017; Farmanova, Bouchard, et al., 2018; Kalay et al., 2013; Lacroix, 2006; Marmen & Delisle, 2003; Martin, 1992; Rukholm et al., 1991). However, evidence-based solutions are not always implemented with patients, as they are not consistently considered at the systemic level, nor fully acknowledged at the organizational level (Cardinal et al., 2018). Although a number of resources and suggestions have been identified for enhancing patient care to French-speaking populations throughout the province, their implementation is largely at the discretion of individual health care providers who draw on these resources sporadically. Furthermore, many health care providers in this study admitted to not being familiar with educational resources available to them, or did not have community services available to support health care providers and their linguistic minority patients, such as Société Santé en français, the Consortium national de formation en santé, or the regional French Language Health Services Networks.

Several resources and adaptive measures were voiced by patients and health care providers, indicating that there are various strategies that are feasible. Study participants pointed to a need for more French language clinical tools (from written to multimedia options), readily accessible in

the clinical settings. They also talked about the importance of appropriate interpretation and translation services to facilitate clinical interactions. Many participants, both patients and nursing professionals, deferred to miming and non-verbal communication in order to get their points across. Participants also pointed to the importance of hiring bilingual providers, a topic that has been well discussed in the literature as well (Prata & Tremblay, 2015; Regroupement des intervenantes et intervenants Francophones en santé et en services sociaux de l'Ontario, 2012). Given the challenges of attracting and retaining bilingual employees, it is important to outline needs regarding French and English language proficiency of individuals being recruited, and to be open to hiring individuals with diverse backgrounds and profiles, from internationally educated health care workers (Prata & Tremblay, 2015) to young professionals (P. Bouchard & Vézina, 2015; Prata & Tremblay, 2015; Regroupement des intervenantes et intervenants Francophones en santé et en services sociaux de l'Ontario, 2012).

Enhancing the education preparedness of educators was also widely discussed. The profile of health care providers is heterogeneous, and providers may not always be at ease in the minority language. In this study, though five registered nurses declared that their mother tongue was French, only three stated French as their preferred official language. Such factors can affect the language that one continues their education in, the language that they speak at work, and their ability to service French-speaking communities in their practice. As such, work needs to be done to ensure that all providers with a Francophone capacity are capable and confident to provide care in French, despite various linguistic backgrounds and preferences.

For point of care interactions, studies have outlined a number of strategies that could facilitate health care encounters, such as being proactive with the offer of French language services and, using name tags and badges that identify bilingual employees (de Moissac, de Rocquigny, et

al., 2012; Dumont & Doucet-Simard, 2013). Moreover, the use of bilingual signage, referring Francophone patients to French-speaking staff, or offering interpretation services remain strategies that could facilitate care to French-speaking patients (Forgues & Landry, 2014). Regardless of the linguistic proficiency of health care professionals, it is essential for them to be provided with tools and training to effectively implement the active offer and serve Francophone minority communities (Prata & Tremblay, 2015). The GReFoPS was proactive in creating "A self-assessment tool for healthcare [sic] and social service provision in French," in checklist formats that can be followed by organization managers to assess the needs and gaps within their facility as a means to enhance the offer of French language services and further equip their health care teams (GReFoPS, 2017; S. Savard et al., 2020).

Francophone patients in this study stated repeatedly that they must ask or suggest for their individual health care provider to accommodate them. It is only upon the French-speaking patients' request that health care professionals start advising them as to what resources are available and how these can be implemented, or what barriers prevent the provision of such resources and services. Thus, patients who are unable or uncomfortable to request language accommodations or resources at the time of their illness or health encounters cannot benefit from resources in their language if no one helps them access them. This is important for health care providers, health organizations, and for the health care system to note, as French-speaking minority community patients do not always initiate conversations or request for services to be offered in French (L. Bouchard, 2013; Dumont & Doucet-Simard, 2013).

Studies have demonstrated that patients may also refrain from asking for French-language services because they do not want to face longer delays for French services (Hubert, 2019; Jreige, 2018; Santé en français, 2016), they do not want to be bothersome (Hubert, 2019; Santé en français,

2016), or have only seen services offered in English, so no longer think to ask for services in French (Santé en français, 2016). Caregivers and families have even stated that they were "afraid she would receive negative care" (Office of the French Language Services Commissioner of Ontario, 2016b), speaking to concerns of asking for French-language services for a parent. The work of J. Savard et al. (2014) was highlighted in the Office of the French Language Services Commissioner of Ontario report that stated, "a vulnerable person may feel intimidated if they have to demand respect for their language rights; they may feel embarrassed and even afraid to request services in their language when resources are already limited" (2016b, p. 27). As such, Francophone patients and families are placed in a difficult position if they are expected to demand services in their language. They are placed in a bind, where there is no action that will produce a good result. This situation is further troubling, as studies demonstrate that when French language services are more frequently offered, patients are more likely to, in turn, request them (L. Bouchard, Beaulieu, et al., 2012; Farmanova, Bouchard, et al., 2018). Thus, initiative and proactive French-language service planning in health care must remain a priority in order to provide equitable services.

While it is sometimes witnessed by patients and colleagues, organizations rarely acknowledge the full extent of work that may be invested at the frontlines to sustain French language services. Many health care providers lack access to resources provided by their organization in their patient's language (L. Bouchard, 2011; de Moissac, 2013; S. Tremblay & Prata, 2011). Furthermore, health care administrators may not notice, consider, or account for the work that benefits their Francophone patients and their organizations. This reflects the environment that is rooted in the needs of the Anglophone majority, a culture that affects organizational cultures and the health care system. For example, nursing participants recounted

situations where they knew that a resource existed in the French language, but it was only available at a different site or in a different region. Without the appropriate support and resources within their organizations, health care providers are often ill-equipped, causing difficulty in successfully intervening with French-speaking patients. Similar situations continue to happen for official language minority community patients throughout the health care system (Kubina et al., 2018). Consistent services need to be offered systemically in clinical agencies rather than individual staff nurses or transient nursing students. Furthermore, a concerted approach towards developing French-language services must become the norm throughout the health care system, rather than remaining dependent on individual providers or organizations.

Local Compensations for a Systemic Issue

Considering the lack of resources provided to support French-language health care services, many participants resorted to local compensations for the systemic issue at hand. Such improvisations and adaptations were context-dependent strategies. They varied from one participant to another and from one facility to another. This included several improvisations to care provisions that made the unsustainable health care system slightly more manageable to participants in the study. Ad hoc strategies were implemented by health care providers and patients, as the situation would permit. Close to a dozen participants attested to using Google Translate regularly to facilitate patient-provider interactions, while others mentioned miming and hand gestures to get by. Nurses and nursing students in this study turned to bilingual colleagues and other French-speaking health care providers. Patients turned to family or friends or French-speaking individuals in the waiting room to help facilitate exchanges with their health care provider.

Some studies suggest that health care professionals see patients who speak the minority language as being responsible for providing their own interpreters (van Rosse et al., 2016). Problems related to the use of ad hoc or informal interpreters, such as children and other family members for interpretation, have been extensively documented in the literature, and the phenomenon continues to this day (de Moissac, 2016a; Flores, 2006; Flores et al., 2003, 2012; Munoz & Kapoor-Kohli, 2007). Moreover, though Google Translate and other such technologies are frequently referred to as options for bridging linguistic barriers, studies assert that the resource is "of limited benefit in emergencies or to address emotional distress, and inadequate for meaningful medical encounters" (de Moissac & Bowen, 2019, p. 29). Furthermore, a study by Patil and Davis (2014) found a 57.7% accuracy rate for medical translations, indicating that the tool is not adequate for high stakes communications, including conversations requiring consent (Patil & Davies, 2014). As such, the use of bilingual health care providers or qualified interpreter services remains the best practice for meeting the needs of linguistic minority populations (de Moissac & Bowen, 2019; Patil & Davies, 2014).

Very few patients mentioned having access to facility-provided interpreters or translators. Much training is required to optimize the use of interpreters with health care providers (Hsieh, 2015; Nailon, 2006). Nursing care providers exhibited a range of experiences with regard to interpretation services: some used them regularly, while others did not have access to them. Some found the service to be too slow and inconvenient, while others admitted that they had never inquired about their availability.

The literature also attests to this phenomenon, asserting that health care providers are ultimately the gatekeepers to interpretation services (Gerrish et al., 2004). The implications of such gatekeeping are especially significant for patients with low English proficiency who cannot

articulate their need for interpretation on their own (Gerrish et al., 2004). This remains problematic, given that language preference, and the language requested, does not always reflect the proficiency of an individual (Okrainec et al., 2014). Thus, a patient may be Francophone and not explicitly request or demand for services in French, though their proficiency in the official language is low.

Furthermore, when patients' official language does not match that of the health care system, their ability to consent is compromised (Schenker et al., 2007). Thus, the health care system must be ready to accommodate for the linguistic needs of patients, whether or not such services are explicitly requested. A systemic approach that integrates all levels of the health care system as outlined by Reid et al. (2005) is important to meet the needs of official language minority communities (H. Gauthier & Reid Triantafyllos, 2012).

Micro Strategies for a Macro Problem

Currently, French-speaking patients in Ontario find themselves in a situation where access to quality French-language health care services is rarely guaranteed. Consequently, patients cannot assume that their linguistic needs will be met in the same way as an Anglophone patient would in Ontario. A number of these individual, micro-level strategies further conceal the extent of the issue. It is important to reflect on matters regarding care to official language minorities system wide. Otherwise, the issues remain managed as though the individual (patient or provider) is the problem, instead of recognizing the numerous proven measures to address the problems which fail to be implemented throughout the health care system. Furthermore, such an outlook creates challenges for the higher-level implementation of strategies, such as firmer legislative support, action from regulatory nursing bodies, as well as higher-level advocacy within the community. Indeed, in trying to resolve the issue at the individual levels, patients and providers may

inadvertently contribute to making the issue undetectable to the organizations and health care system.

While this study focused on the experiences of Francophone minority communities and nursing care in Ontario, challenges accessing care are voiced by official language minority communities across Canada. For example, in this study, many participants did not know what the active offer was, including French-speaking nurses and nursing students. The active offer refers to proactively inviting a service recipient to express themselves in the official language of their choice (Consortium national de formation en santé, 2013). The active offer is a basic strategy that needs to be implemented systemically. Both nationally and internationally, the active offer has been demonstrated as an effective tool for improving quality and accessibility of services to minority official languages (L. Bouchard et al., 2021; Cooledge & Murphy, 2017; Drolet, Bouchard, Savard, et al., 2017).

To start, the active offer needs to be adopted throughout Ontario to meet the needs of patients accessing all health care services, with support of provincial government institutions and health authorities. Société Santé en Français (n.d.), a Canadian organization that is actively involved with advocating for equitable access to health services for Francophone and Acadian communities, supports the necessity of this method. It states that the active offer can serve to improve access to services in the official language of choice for minority communities (Société Santé en français & the French-Language Health Networks of Canada, 2017). However, they also assert that improved health care services in French cannot be achieved in silos. They point to five key partners who must be involved in successful French-language health care provision, notably "policy-makers, health-care [sic] administrators, health professionals, educational institutions and

communities" (Société Santé en français & the French-Language Health Networks of Canada, 2017, p. 8).

In light of the fact that accessing health care in their language can affect the quality of their care, it is urgent for the health care system as a whole to see which policy measures, administrative decisions, educational changes, practice modifications, and advocacy work can be adopted and implemented provincially to meet the needs of patients across Ontario, while addressing their language rights. This research emphasizes that many actors must take part in overcoming systemic issues regarding health services to French-language minority communities.

The Genesis of Linguistic Injustice

French-speaking patients and health care providers have witnessed a number of system inefficacies which hinder access to quality health care services. In examining the challenges in the health care delivery structures for this doctoral study, the participants' lived experiences revealed scenarios whereby patients and health care providers were seen to be the problem in the health care system, and used as the solution, further burdening both. For example, Francophone patient participants discussed difficult situations where they would arrive to the point of service, requesting French language services. When such services are not readily available, these patient requests become problematic. The patient is used as a solution when they are expected or asked to provide their own translation (e.g., present with family, be prepared to have someone outside of the health facility explain the information in their language, etc.).

The Anglophone providers who do not speak French are also seen as problematic. They are expected to increase their linguistic skills, to know which resources to access, and to do all of this with minimal support of the organization. When seeking to ease such situations, a French-speaking employee is called upon. It is problematic if this French-speaking employee is not readily

available (e.g., caring for their own patients), and thus, the French-speaking employee becomes both the problem and the solution. However, L. Bouchard, Beaulieu, et al. (2012) warn against the tendency to see the individual as the problem, and rather, to see the problem within the situation which needs to be rectified. This reality results in Francophone patients and their health care providers bearing an unsustainable emotional load, as described by participants in this study. Yet, maintaining the status quo results in the compromise of patient safety, as well as in sustaining inequities with regard to French-speaking patients' rights.

The health care system can only remain in its current state if Francophone patients and the community remain unaware of the extent of the issues. Such a reality lives on, not only if Francophone patients are resigned, but also when they internalize the issue as one that is their own to bear. The numerous shortcomings in the health care system result in the genesis of linguistic injustice. Ultimately, there is a need to address the complacency of the health care system, which has been a witness to the unfolding of injustices for official language minority communities.

Burdened Patients

French-speaking patients and their family/caregivers face a disproportionate burden of responsibility in securing their own access to care in their preferred language. Such a burden is not equivalent or equitable in comparison to individuals seeking health care in the majority language within the same province. French-speaking patients and their networks are burdened with organizing themselves to fit into an Anglophone health care system. As linguistic minorities in a system that is ill-equipped to care for them, obtaining quality care becomes an additional challenge to overcome. Certain patients may be disproportionately burdened, for example, individuals faced with chronic health issues, mental health challenges, or advanced neuro-cognitive diseases (e.g., disorders such as dementia). These individuals may have to access the health care system often,

thus, are more frequently exposed to the system's inadequacies for French-speaking patients. Such can be the case for elderly Francophone individuals living in a minority context.

While elderly individuals, regardless of the language, may be faced with more complex health issues, those who are Francophone may be less likely to have regular access to care in their language (L. Bouchard et al., 2015). Furthermore, a number of studies have demonstrated that individuals with dementia may be inclined to regress to their mother tongue (Aucoin, 2017; Carbonneau & Drolet, 2014; Papple, 2007). Thus, Francophone patients with dementia who speak English as a second language still require care in the language which they best understand. Further consideration is required for Francophone patients and families regarding palliative care and the end of life process, a process which is already difficult for many to navigate but becomes more difficult when services and care are not available in their language (Contant, 2014).

Moreover, additional challenges may confront individuals whose official language is French, but who also speak several other languages. As receiving health care services in one's mother tongue can be advantageous, certain populations (e.g., newly arrived immigrants) who speak French as an additional language in a linguistic minority context are further disadvantaged. They may speak little to no English, and thus rely on French as their best chance to receiving health care that they can understand (de Moissac et al., 2015; Santé en français, 2016). Thus, they may already be making concessions within the Canadian health care system, further compromising their health comprehension, and potentially, their health outcomes. Such considerations are significant, as it has been documented that immigrant populations see a decrease in their health status following immigration (Ng & Zhang, 2020; Zanchetta & Poureslami, 2006); the same is the case for Francophone minority immigrant populations (Ngwakongnwi et al., 2012). Thus, the health care system must be proactive in meeting the needs of vulnerable patient populations.

It is also important to consider the vulnerabilities faced by individuals whose health care problems simply cannot be addressed with only a physical evaluation (e.g., mental health issues). Language is an inherent component of the health assessment, and proper, timely communication is a core component of safe care (Bowen et al., 2006). This is true for individuals presenting with a physical health issue, but also for those experiencing mental health issues or distress. Safety is a heightened concern where stigmatization of mental illness remains a serious problem that complicates and hinders access to care. Moreover, certain Francophone populations, such as immigrant populations or indigenous individuals speaking the minority official language, may face greater difficulties accessing quality mental health services (L. Bouchard, Colman, et al., 2018; Tranchant et al., 2019), or sharing about such health problems (de Moissac et al., 2015; de Moissac, Graham, et al., 2020). Francophone individuals with low income, low education levels, as well as youth and elderly populations may also be more vulnerable with regard to access to mental health services (L. Bouchard, Colman, et al., 2018).

Thus, when mental health services are not accessible in their region, in their language, or in a manner that can assure confidentiality and non-judgmental care, patients may be less inclined to seek the help that they need (Van Kemenade & Forest, 2019). This can have dire consequences on an individual's health and wellness. J. Savard, Savard, et al. (2020) address the importance of the active offer and integrated services in French throughout the health care continuum, from preventative and curative care to supportive care in one's official language. However, if access to services is hindered for Francophone patients, they may not be able to access preventative services to the extent required or benefit from early intervention support options in their community (Van Kemenade & Forest, 2019). This can be problematic, especially given that timely access to preventative services can help prevent mental health illnesses from becoming more serious (Van

Kemenade & Forest, 2019). While these realities are difficult at the individual patient level, if a mental health illness that is preventable becomes an acute crisis, the costs to the individual and to the health care system are heightened.

Health care administrators and government authorities must facilitate and support access to the health care system for Francophone minority communities, rather than contributing to health care avoidance. Otherwise, to bear such a weight when accessing health care in French is not only unreasonable for many, but also unfathomable for most. The health care administrators and government officials must take note of the existing inequities burdening their French-speaking citizens. Rather than continuing the existing cycle of burdening the patients and their caregivers, health care leaders must recognize the issues at play systemically to improve the safety and well-being of Francophone patients within Ontario. Moreover, it is important for health systems leaders to acknowledge the integrated and complex nature of the health care system. Changes and improvements cannot only happen at one level of the health care system. The various levels of the health care system overlap and influence one another. Thus, solutions and improvements should not only be relegated to one level, but an important notion also to keep in mind to avoid burdening individual patients and health care providers.

Instrumentalization of Nursing

Within the current health care landscape, every level of the system has a potential contribution. Health care professionals in particular play a more visible role in patients' lives due to their direct care activities with patients. They are also tasked with operationalizing health policies at point of care. Registered nurses have been shown to implement discretionary decisions to safeguard the quality and safety of care when faced with challenges (Djukic et al., 2019). As such, they are a primary resource for compensating for the flaws of their organizations and of the

provincial health care system. Health care providers are faced with the reality of meeting the various needs of all of their patients, including French-speaking patient populations. Yet, this is often done with very little tools to facilitate their work and promote quality interactions.

While this is a challenging reality for most nursing care providers, the phenomenon is even starker among French-speaking nursing care providers (Canadian Nurses Association, 2007; S. Tremblay, 2015). In many jurisdictions, it remains difficult to recruit and to retain bilingual health professionals, nurses included (P. Bouchard & Vézina, 2015; de Moissac et al., 2014; Mercure et al., 2018; S. Tremblay, 2015). French-speaking nursing professionals may be called to assist Francophone patients and families who were not in their original workloads. They are also a key resource for non-French-speaking colleagues, including nurses, physicians, and others. They may be pulled from their work to different areas within their organization, and even used to provide at home interpretation services, as revealed by a registered nurse in this study. There can be challenges that present with such fragmented health care strategies, such as increased stress and fatigue in the face of an excessive workload, especially when supportive resources are lacking (Canadian Nurses Association, 2007).

Many nursing participants, both Anglophone and Francophone nurses and nursing students, voiced their ill preparation for the role, especially when this takes up a significant portion of their clinical experience and nursing shifts. The burden of responsibility placed on these staff members is a result of the health care system which is not serving the patients nor the providers. Rather, nurses become a means to an end, a tool that allows for the institutions and the health care system to operate at its status quo. The instrumentalization of nursing care providers leads to the cycle of masking the problem, to the detriment of all those involved in the equation.

Emotional Weight

Much work is required to improve the health care experience of French-speaking patients in Ontario. Otherwise, the repercussions of a health care system that does not meet the needs of Francophone patients are not without consequence. Rather, it leaves Francophone patients and their networks with an undue emotional weight to bear. As evidenced by the lived experiences of this study's participants, as well as in the work of Jutras et al. (2020), this struggle is exemplified at numerous points within their health experience. Great emotional stressors surrounding a medical appointment arise in anticipation of the health care encounter, at the time of the health care service, including during the care experience, as well as following the care experience, which affects patients' outlook of the health care system. Even once the health visit is complete, patients must navigate feelings of concern over their ability to access health or social services in their language, or if they were referred to the appropriate services and treatments given that their health care interaction happened in a language in which they were not confident communicating.

Patients in the study by Jutras et al. (2020) shared feelings of frustration, anger, embarrassment, and inferiority due to their difficult encounters with the health care system, which was similar to the complaints verbalized by the Francophone patients in this research. This burden is in addition to the episodic health challenges that the patient may already be facing. A study from de Moissac and Bowen (2019) affirms this, elaborating on the emotional weight that patients face with regard to language barriers, ultimately decreasing their confidence when interacting with health care professionals, increasing their overall stress, and also increasing their sentiment of inequity in the care received (de Moissac & Bowen, 2019). The emotional weight is heightened when the patient presents or must reveal issues causing distress but struggles to express themselves. For example, researchers describe the link between language, incongruent care, and

anxiety, which can cause emotional distress for both the patient and their families (Drolet et al., 2014; Zhao et al., 2019). Drolet et al. (2014) report that such "anxiety is felt especially by children and seniors and, by extension, by their caregivers and family members" (Drolet et al., 2014, p. 300). This is in addition to the reality that health care encounters can already be emotionally laden for health care recipients.

Health care providers may also struggle with a similar sentiment. Statistics Canada census data reveals that the percentage of nurses capable of conversing in French is decreasing nationwide (outside of Quebec), from 10.6% in 2001 to 10.1% in 2011 (Lepage & Lavoie, 2017). This is congruent with a decrease from 12.4% to 11.7% between 2001 and 2011 of overall Canadian health care professionals, excluding Quebec, who can converse in French (Lepage & Lavoie, 2017). In Ontario, though the number of health care professionals who can speak in French has increased (53,200 in 2011), the rate of increase is slower for French-speaking nurses (11,340 in 2011) (Lepage & Lavoie, 2017). This reality is felt within the workplace, especially as French-speaking health care professionals work to informally bridge the gaps. Health care providers may try to consider ways of meeting the needs of their patients at the time of the health care encounter. However, they can be left wondering about the continuity of care for French-speaking patients, especially at the change of shifts or with patient transfers to different facilities, since the receiving facilities may be equally ill-equipped to provide linguistically coherent care. As a whole, the emotional weight remains at the individual, micro-level, but this burden is unnoticed upstream.

Compromised Patient Safety

Currently, Francophone patients do not always know if French-language health care services will be available when they present to health facilities. When they are available, the quality of health care services can vary tremendously. Moreover, though language services may

be present on one day, the services may not be consistently present. Such a reality has become a norm for Francophone patients, and study participants acknowledged that their experiences were truly variable. At best, health services are inconsistently offered in French. As the provincial health care system is currently supported, French-speaking patients are stuck between the absence of French-language services and receiving good enough care in French. All too often, "good enough" care has become the norm. Care that would not be satisfactory in English (e.g., from linguistic discordances to lack of informed consent) is all that is available for French-language patients, and this is what they must settle for.

Such a reality is troubling, as it can compromise patient health outcomes. Patients cannot fully express their needs and concerns and may not be understood or understand their health care professionals. Patients become at risk for harm and declined health in such situations (Hien & Lafontant, 2013). They may also have to face the consequences of incorrect diagnoses and further medical errors (H. Gauthier & Reid Triantafyllos, 2012; Réseau des services de santé en français de l'Est de l'Ontario, 2016). And yet, their needs and rights are frequently referred to as preferences. Furthermore, discourse surrounding patient safety and quality of care is all too often confounded with patient satisfaction. Although these components are all important within the health care system, obtaining health care services in one's language is more than a component required for patient or caregiver satisfaction; it is also a necessity for quality of care and patient safety. Otherwise, patient safety for Francophone minority communities in Ontario falls by the wayside. H. Gauthier & Reid Triantafyllos (2012b) thus describe satisfaction as an indirect impact on the health care system.

Not only is the safety and satisfaction of Francophone patients compromised during the health care environment, but such concerns are also exhibited for other patients as well. For

example, in the case of bilingual nurses who are called upon to translate in support of other French-speaking patients in their organization outside of their care load, there may not necessarily be someone providing rigorous care for their own patients. If the translation duties prove to be extensive and lengthy, their own patients may be neglected for some period of time. For example, nurses in this study such as RN07 described spending three hours translating for a colleague's patient. Such use of nursing labour may result in secondary safety risks, consequently decreasing the satisfaction of more than one patient.

The World Health Organization defines patient safety as the aim "to prevent and reduce risks, errors and harm that occur to patients during provision of health care" (World Health Organization, 2019). Canadian and international scholars have identified the link between language and patient safety. Studies have already identified that linguistic barriers heighten a patient's risk for medical errors, care complications, as well as for adverse medical events (Bowen, 2015; de Moissac & Bowen, 2019). Health care providers cannot assume that a French-speaking patient can carry out a health care interaction in English because they are familiar with a few English terms (Doucet et al., 2019). Some bilingual Francophone patients further report decreased proficiency in English when faced with situations of stress, pain, or with the consumption of certain medications (de Moissac & Bowen, 2019). Patients with unique clinical considerations (e.g., a patient who is deaf, Francophone, and requires medical communication and information) present additional layers of complex needs (Drolet et al., 2014; Programme de soutien au système provincial, 2018). Given the state of knowledge of this issue within the health care system, many of these adverse events experienced by linguistic minority groups are preventable (Johnstone & Kanitsaki, 2006).

In more concerning cases, the presence of a language barrier may result in the omission of care altogether. For example, van Rosse et al. (2016) observed clinical units in Europe where double checks prior to medication administration and intravenous treatments were not performed, patient teaching regarding procedures such as fluid management did not take place, pain management assessments and protocols were not explained to patients, and telephone follow-ups were not completed due to the language barrier. Nonetheless, despite such glaring omissions care wise, documented as "successful" (van Rosse et al., 2016, p. 49), these situations further conceal poor or unsafe care processes for minority language patients. Furthermore, in case of adverse events, understanding the cause is made highly complicated by the recording of inaccurate information in patient charts. Some health care providers try to compensate for linguistic barriers by increasing the battery of tests and evaluations (Bowen, 2015). However, this results in increased exposure of patients to diagnostic evaluations and medical imagery, increased length of stays and hospital admissions, as well as risks of false positives, inaccurate diagnoses and unnecessary treatments (Bowen, 2015). Such practices do not compensate for the need of having trained interpreters, or better yet, a sufficient number of bilingual health professionals to meet the needs of presenting patients (de Moissac & Bowen, 2019).

Locally, organizations must support policies that "make it hard for people to do the wrong thing and easy for people to do the right thing" (Donaldson et al., 2000, p. ix). While health care professionals such as nurses are required to identify risks for patient safety and to act accordingly, organizational and systemic action is required to make this possible (Doucet et al., 2019). Ideally, health care providers would be empowered to implement the best practices, and patients would be supported to ask for services in the language in which it is required. Furthermore, organizations

should be accountable to official language minority patients and families engaged in service planning to ensure that minority language services are satisfactory (Johnstone & Kanitsaki, 2009).

All too often, the language of preference of a patient is not assessed; thus there is no documentation of patients' linguistic requirements (van Rosse et al., 2016). In order to improve quality of care and enhance patient safety, language-based data needs to be collected to obtain information on official language minority communities systemically (Réseau des services de santé en français de l'Est de l'Ontario, 2021). Such actions are required to ensure that equity, quality, and safety, remain at the forefront of health care for all patients.

Human Rights in Patient Care

International literature indicates that many health care providers lack knowledge about patients' human rights (Iltanen et al., 2012; Özdemir et al., 2009). For example, in a Finland-based study by Iltanen et al. (2012) surveying nurses and physicians, respondents acknowledged the importance of patients' rights, but admitted to having a weak knowledge of those legal rights. Health care providers need this knowledge to advocate for patients and assist them in obtaining the care that they rightfully deserve, in the official language of their choice. Özdemir et al. (2009) also surveyed health care professionals' awareness of legislation surrounding patients' rights, obtaining responses from nurses and midwives in Turkey. Although 75% of their respondents knew of the existence of laws surrounding patients' rights, 51% had never read the legislation, further raising questions regarding violations of patients' rights (Özdemir et al., 2009).

The Universal Declaration of Human Rights by the United Nations (1948) stipulates 30 human rights and freedoms that should apply to individuals across the globe, regardless of language. Article 25 of the Declaration stresses that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing,

housing and medical care and necessary social services" (United Nations, 1948, p. 7). As a result, it is important for nations, provinces, and regional health authorities to ensure that language does not become an impediment or barrier to the health and well-being of individuals in their jurisdiction. From a human dignity perspective, it is important to consider the limitations and shortcomings of the current health care system structures with regard to certain populations, as to not perpetuate inequities and infringement on the care that they rightfully deserve.

Cohen and Ezer (2013) state that "the concept of 'human rights in patient care' refers to the application of human rights principles to the context of patient care" (p. 7). The distinction of "human rights in patients care" and "patient rights" is significant, as many view patient rights through the lens of "consumer rights," which can undermine significant human rights considerations and violations (Cohen & Ezer, 2013). A patient seeking care should not be confronted by situations where their rights to informed consent, privacy, confidentiality are compromised (Beletsky et al., 2013; Cohen & Ezer, 2013; Peled-Raz, 2017; Talbot, 2013; Zopunyan et al., 2013). This includes the right for a patient to receive information about their health care in their language (Cohen & Ezer, 2013; Zopunyan et al., 2013).

Even nursing organizations nationally and internationally have recognized the significance of acknowledging human rights within health care, as a way to support the rights of the populations that they serve (Byrne et al., 2012; Canadian Nurses Association, 2018; McHale et al., 2001; Newham et al., 2021; Royal College of Nursing, 2012). However, while language rights in policy may be acknowledged, this does not translate into outcomes which benefit and improve the lived experiences of linguistic minority communities, nor the work of nursing care providers. Such a double standard stands out again when looking at decisions to not have fully bilingual websites, or to have communications only in the majority language of English, or to choose to implement

and maintain the NCLEX-RN registration exam in Canada with minimal resources for Francophone students that has had such significant negative repercussions for those taking the test in French.

However, participants in this study revealed that this can be a reality faced by numerous Francophone patients throughout the province. Not only is patient safety constantly in jeopardy for French-speaking patients in Ontario, but many of these patients' rights are undermined or even overlooked. In Ontario, several acts delineate some of these rights that have implications for health care provision. We turn the discussion to two such important acts: the French Language Services Act (FLSA) of 1990 and the Health Care Consent Act of 1996.

As previously discussed, the FLSA of 1990 was established to protect the legal rights of French-speaking citizens of Ontario. This act stipulates that French-speaking residents of Ontario have access to government services in French in designated regions of the province (Government of Ontario, 1990a). This act states that

> A person has the right in accordance with this Act to communicate in French with, and to receive available services in French from, any head or central office of a government agency or institution of the Legislature, and has the same right in respect of any other office of such agency or institution that is located in or serves an area designated in the Schedule. R.S.O. 1990, c. F.32, s. 5 (1).

This act considered the needs of Francophones across Ontario and led to the identification of 26 designated areas where government agencies and ministries must be ready to service their clientele in French (Government of Ontario, 2021a). As mentioned previously, the designated areas in Ontario are regions where at least 10% of the population, or over 5000 residents, is Francophone (Government of Ontario, 2016; Appendix A).

To further meet the needs of Francophone minority communities, along with the FLSA came the process of designation and identification of health organizations that receive government

funding (in part of in full). This was a means to protect the rights of Francophone minority communities to receive services in their language. An institution may become a designated facility or a partially designated facility, while other organizations may be identified as needing to provide services in French. Still others may not be identified or designated at all.

A designated institution is an organization that is permanently capable of offering French language services throughout its sectors, and is rooted in principles of the active offer of services to its clientele (Office of the French Language Services Commissioner of Ontario, 2018; Réseau des services de santé en français de l'Est de l'Ontario, 2013). The institution values the provision of French language services, such that those notions are imbedded in the organization's administrative documents. The organization has Francophone representatives in its board of directors to represent the French-speaking community of the area, and the senior management of the establishment is accountable to the Ministry of Health for ensuring that the services are consistently available. If an organization is not able to be fully designated, it may obtain partial designation for certain services that meet the standard of offering permanent, reliable services in the minority language. Designation (and partial designation) is not permanent. It is re-evaluated routinely and can be revoked (Office of the French Language Services Commissioner of Ontario, 2018).

The Ministry of Health and Long-term Care implemented a process of identifying organizations that were expected to become designated facilities to be capable eventually of assuring high quality French-language health services for the minority community within the area (Office of the French Language Services Commissioner of Ontario, 2018). While a number of facilities across Ontario have been identified as eligible to apply for the designation status for several years now, several have yet to undertake the steps required to fulfill the designation

requirements in part or in full (Office of the French Language Services Commissioner of Ontario, 2018). Other organizations may not have been identified, but can pursue the designation process voluntarily. All of these organizations are supported by Ontario Health services in order to effectively create the changes and implement best practices that will support their active offer of care for minority populations (Office of the French Language Services Commissioner of Ontario, 2018). Thus, though the French-Language Services Act has created a legal framework for French-language service provision, with further support from the French Language Health Planning Entities in Ontario (Ministry of Health and Long-Term Care, 2021a), it is of limited effect if health care facilities do not or cannot comply with some of its core requirements.

Of further consideration is the Health Care Consent Act of 1996. This act was created to protect the right of individuals to receive information and make decisions regarding their health care and treatment plans. Legally, the individual must receive and understand all the information required to provide free and informed consent. The Canadian Nurses Association defines informed consent as

> The process of giving permission or making choices about care. It is based on both a legal doctrine and an ethical principle of respect for an individual's right to sufficient information to make decisions about care, treatment and involvement in research (Canadian Nurses Association, 2017).

This term is also related to the notion of informed decision-making (Canadian Nurses Association, 2017). Yet, this right to informed decision-making, and the ability to provide informed consent, is compromised for French-speaking patients in Ontario. In order to make a voluntary decision to take part in a health care activity, the Health Care Consent Act requires that patients understand the language in which care-related information is provided. They need to be able to comprehend the procedure, risks, discomforts, and benefits of any procedures or treatment,

and to be abreast of options and alternatives (Usher & Arthur, 1998). They must also be able to ask any question regarding the treatment plan, with the opportunity to refuse or to revoke consent at their discretion (Usher & Arthur, 1998). Should a person withdraw their consent, or refuse to provide it altogether, they must know what the consequences of such a decision would entail (College of Nurses of Ontario, 2017a).

When French-speaking patients present to health care systems that do not offer care in their language, then their rights to provide free and informed consent and to fully take part in the decision-making process are jeopardized. Individual patients may not be aware of their rights under the Health Care Consent Act. While patients and caregivers cannot always be expected to know all the rights and regulations pertaining to their care, the lack of awareness of their rights can make them more prone to violations in their care. Also of concern is the fact that health care providers themselves may not be well versed with acts affecting their offer of health care services. This reality is problematic in the health care system, where attending to the linguistic needs of patients may be seen as a time-consuming task and burden, rather than a professional and legal responsibility. For example, the Health Care Consent Act (Government of Ontario, 1996) states the following:

> No treatment without consent
> 10 (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,
> (a) He or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent;
>
> Elements of consent
> **11** (1) The following are the elements required for consent to treatment:
> 1. The consent must relate to the treatment.
> 2. The consent must be informed.
> 3. The consent must be given voluntarily.
> 4. The consent must not be obtained through misrepresentation or fraud. 1996, c. 2, Sched. A, s. 11 (1).

> Informed consent
> (2) A consent to treatment is informed if, before giving it,
> (a) The person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and
> (b) The person received responses to his or her requests for additional information about those matters. 1996, c. 2, Sched. A, s. 11 (2).

The sections from the Health Care Consent Act (Government of Ontario, 1996) here clearly stipulate that treatment should not take place without consent. Several patient participants shared their lived experiences where reasonable steps such as securing an interpreter for care services did not occur. Though they were reasonable and capable, they were not given the opportunity to provide an informed consent. They did not receive an opportunity to ask questions or to obtain additional information. The information that they provided was often in the language of the health care provider, not their own. Except in specific circumstances (e.g., exceptional emergency situations), the consent of Francophone patients that is not obtained following a clear, comprehensive exchange of information is rendered meaningless under this Act, and is therefore considered invalid. While this is true for the consent act, patients have many other health rights to consider under numerous related acts, including but not limited to the Mental Health Act (Government of Ontario, 1990b) and the Canada Health Act (Government of Canada, 1985a).

Patients may not fully be aware of their rights in the health care system, especially given the variations that present occur in different jurisdictions, locally and globally (Dadashi et al., 2019; Mohammed et al., 2018). One factor that has allowed linguistic injustice to persist is the varying level of awareness of their rights that Francophone patients in Ontario face. Some patients do not realize the full extent to which their human rights and their safety as patients are compromised and undermined. Patients and families may be unaware of safety issues in care and the degree to which their rights are compromised, helping to explain the lack of pressure and

demands on the system to rectify the existing inequities. Furthermore, as stated earlier, patients seeking care services tend to be unwell and preoccupied with their health problems. They may not be attuned to the legalities of consent, and when shortcomings are identified, they may not have the energy necessary to invest in the fight for advocacy.

Individual level strategies mask the significance of this issue at the systemic level by offering fragmented, unsustainable contributions. While those may bridge a gap in the moment, the issue remains and needs to be addressed across Ontario to ensure that the human rights of Francophone patients in Ontario are respected and valued, in both official languages. The J. Savard, Savard, et al. (2020) framework points to the discordance between the various structures in the health care system, including the organizational, political, regulatory, and symbolic structures. Although the implemented laws and regulations are deemed to uphold the rights of Francophone minority community patients, if efforts do not take place to ensure that these meet the needs of patients, not only their safety is hindered but their rights as well. Patients cannot be expected to deal with their illness and their rights during patient care interactions. The health care system structures must integrate the needs and rights of all patients to be equitable for all.

Resignation and Internalization

While some French-speaking individuals may be unaware of the magnitude of problems regarding French-language health care services in Ontario, others may be more aware but have become resigned to the current situation. As the study participants revealed, several factors may contribute to this mindset, from having numerous priorities to consider, including their own health status and vulnerabilities, or from having concerns with jeopardizing the quality of their care should they be perceived as “demanding” or “difficult” by health care professionals. This is congruent with findings in the literature. For example, Charbonneau (2011), a political studies

professor at the University of Ottawa whose research interests include the state of Francophone minorities in Canada, notes that

> It takes a certain degree of courage for a perfectly bilingual Francophone to request services in French in majority English-speaking contexts, if only because the mere fact of asking for services in French in Canada outside Quebec can be perceived as a political act in majority English-speaking contexts (Office of the French Language Services Commissioner of Ontario, 2016b, p. 26).

The Office of the French Language Services Commissioner of Ontario (2009) was responsible for collecting examples of the difficulties Francophones had in receiving French-language health care services in Ontario. Notably, the commissioner's annual report highlights numerous stories of discouragement and resignation among Francophone patients and families, impacting both their wellness and safety. Resignation in the context of this discussion refers to patients and families giving up on necessary care or accepting substandard services due to language barriers. For example, the Office of the French Language Services Commissioner of Ontario (2009) reports the case of a mother of four children, one of whom needed psychological treatment; since this service was not available in French when the child was 6-years-old, the family were resigned to waiting for the child to learn English. Not until the patient was 21-years-old was treatment finally obtained (Office of the French Language Services Commissioner of Ontario, 2009). PT03 described another example of resignation: "Ils vont me parler en anglais, moi je ne comprends pas ce qu'il va me dire. Je vais m'acheter juste un petit Tylenol ou quelque chose comme ça." Her decision to not seek care points to the deliberations that patients can have over whether to visit the doctor or to resign themselves and settle for subpar options. Such realities are unacceptable and should not persist in the current health landscape. However, Francophone patients and families are routinely faced with the choice of receiving care in French with significant delays or receiving English language care that they may not fully understand.

Some participants' resignation grew after several years of advocacy which yielded minimal results, while others came close to assimilation after an extended period of time in an Anglophone environment. Several scholars argue that assimilation remains an immense threat to the Francophone minority of Ontario (L. Bouchard & Desmeules, 2013; P. Bouchard et al., 2009; Charron et al., 2018; Hien & Lafontant, 2013; Office of the French Language Services Commissioner of Ontario, 2009). This risk for assimilation is increased in regions where the population is aging and the remaining Francophone population declines (Charron et al., 2018). The reality of assimilation of official language minority communities is further exacerbated with the closure of Francophone or bilingual institutions in their region (Office of the French Language Services Commissioner of Ontario, 2009). As a result, the resignation of Francophone patients both results from and contributes to a reality whereby patients must accept care in English, or inconsistent, delayed, or insufficient care in French, and thus, settle for less within the current health care environment. Others may choose not to access health care and social services at all, which can entail serious consequences in the short- and long-term.

Along with being resigned to a subpar quality of health care, some official language minority community members may also internalize their status as being lesser than that of the majority population. As evidence, some may use English in public and relegate the use of French to private conversations, or informal spheres (Bourhis, 2008). This issue of status is also reflective of patients not asking for French-language services (e.g., used to services being unavailable or delayed in French, or concerned with being a bother to health care providers) (Santé en français, 2016), as though their language is not an official language in their country. Once an individual gives in to the minority identity, this relinquishing of power may result in the decreased incentive to advocate for oneself, leading to an exacerbation in existing injustices, in marginalization, and

in vulnerability, as well as in the oppression of the minority group (Baah et al., 2019). As a result, a cycle continues whereby there is minimal change, scarcity of resources, and few requests for improvement, which leads the health care system and health organizations to further perpetuate the notion that problems regarding access to French language health care throughout the province do not exist.

Systemic Complacency

The inequities facing official language minority communities in Canada have been problematic for several decades (P. Bouchard et al., 2009; GReFoPS, 2015). Patients speaking the minority language continue to report feeling like second-class citizens, as shared by a patient participant in this study and by those in others (Baron et al., 2016; Bernier, 2010; de Moissac & Bowen, 2019; Vastel, 2020). On a day-to-day basis, some issues may be ignored and forgotten; however, in times of crisis (e.g., global pandemics), these issues are exacerbated, and cause even greater concern to minority community groups who are left feeling more vulnerable and left behind by the actions (or lack thereof) by health authorities (Office of the Commissioner of Official Languages of Canada, 2020c; Trépanier, 2020). Such actions reveal the flaws that already exist in the health care system, but also demonstrate how the repercussions are amplified for Francophone minority communities, how the situation is even more problematically managed in times of crises and emergencies.

As a patient participant mentioned, the health care system is prone to following the path of least resistance. Presently, the position of Francophone minority populations is convenient for the health care system: they do not strongly advocate for their rights and offer little resistance to the status quo. Though some may complain over their concerns, at the individual level French-speaking patients usually do not raise their voice in the face of injustices they may face, injustices

that they may not even be aware of. At the health care professional level, some nursing students and nurses may try to address these issues on an ad hoc basis. However, as argued earlier, the patchwork of individual actions may mask the extent of a systemic problem. As such, these concerns rarely rise to the organizational level and even less to the environmental level (Ferlie & Shortell, 2001; Reid et al., 2005), contributing to complacency in the health care system. The health care system benefits from the resignation of Francophone minority communities that maintains the status quo. Yet, inaction can put patients at risk when considering the question of access to safe, quality care.

Without forcing these issues to be noticed at the systemic level, few remedies to the health care system will be found. The health care system is thus able to overlook these serious concerns. Such blind spots will persist unless communities unite and speak out consistently and urgently about these realities throughout the province and beyond. Awareness of the issues regarding care to language minorities must grow along with targeted efforts for improved equity and quality of care systemically. Otherwise, the Ontario health care system will continue to exist with inequities that disproportionately affect linguistic minorities. The health care system cannot maintain complacency with regard to the disparities in care for official language minority communities.

Limitations

Several limitations must be considered in this study, both with regard to its methodology (sampling and data collection), as well as with the researcher. For the methodological concerns, it is important to point out that this phenomenological research was conducted with a large number of participants (n=31), and a diverse sample (11 registered nurses, 10 nursing students and 10 patients) interviewed. The group was homogenous, in that it was largely female, with two male

patient participants. However, the socio-demographic profile of the patients and participants was quite heterogenous.

While interpretive phenomenology favours homogenous samples, such diversity was essential to adequately answer the research question and to provide a representative example of the experiences of French-speaking patients, nursing students, and registered nurses as authentically as possible. This diversity was also important given the heterogeneity of the Francophone minority population in Ontario as well as of the nursing profession. Moreover, the results of a qualitative phenomenological study are not meant to be generalizable, but to help us glean a better understanding of the problem.

Such diversity in the study's sample may be considered problematic when considering standards of data saturation. Although several themes from participant stories emerged repeatedly, indicating that there was cohesion in participant experiences, the data that could have been collected to elucidate the phenomenon at hand is infinite (van Manen et al., 2016). Thus we do not subscribe to concerns regarding saturation in the processing of the data and the results obtained (Garcia et al., 2014). More significant for phenomenology is gaining an understanding of and providing an interpretation of the participants' lived experiences. Although more data could have been collected and more insights could have been gained, the research question was answered.

Although the sample was already quite diverse, no nurse managers were recruited. They would have been eligible, but none came forward as participants. They were not an explicitly targeted group for the study, but their insights might have been useful with regard to their experiences, both positive and negative, of serving linguistic minority communities. Their input should be sought for future research in order to better understand the perspectives of management throughout the organizational structure.

Additionally, recruitment took place largely through community organizations, and thereafter, through informal networks with snowballing for key informants. Individuals who were not connected with the communities may not have been aware of the study when it was first advertised. Snowballing was important for participant recruitment especially as it allowed access to hard-to-reach participants, including unilingual Francophone participants who had extensive involvement with the health care system. However, future work should further leverage the role of informal networks in involving research participants. Furthermore, such additional efforts could be beneficial in reaching out to the 20% of Franco-Ontarians who do not live in the French designated areas of Ontario. Snowballing could have also been helpful to seek out the perspectives of more individuals from rural and remote communities, as only one (patient) participant identified as living in a rural area of Ontario.

Moreover, it is important to note that this study provided the perspectives of only two male participants, both patients. All other participants, including the nurses and nursing students, identified as female. No participants declared identifying to "other" gender groups, despite being provided with a blank field whereby they could. The responses received may have been different given a more gender-diverse participant group, for both patients and nursing providers alike. Moreover, it is important to consider my own personal bias as a cis-gendered Black Francophone female conducting nursing research, as a different researcher may have identified the under-/over-representation of certain groups and may have recruited differently. This is important, as different groups may experience different situations and injustices differently. For example, the experience of a Black, Francophone male presenting nurse may be quite different from a White, Anglophone female presenting nurse, as may their recognition of system shortcomings, or their patterns of

patient advocacy. Thus, consideration of intersecting identities with regards to experiences of patient care must be integrated in the planning and recruiting for future studies.

Additionally, the language in which the nursing participants pursued their education was not collected, but could have provided additional insights into the participant responses. Moreover, all study participants lived in French designated areas of Ontario. Interesting findings may have been obtained through interviews with nursing providers and patients living in non-designated areas of the province. As such, future studies may also benefit from targeting areas with differing Francophone population densities, as the experiences of these participants may also be unique.

Single interviews were the primary method of data collection and triangulation of data was accomplished through the use of field notes and journaling. While individual interviews provide in-depth, rich data, it is important to acknowledge that the information obtained was based on participants sharing their thoughts as well as they remembered. They referred to incidents and issues that spanned an expanded period of time that ranged from several weeks to several decades. As anticipated in interpretive phenomenology, research data is obtained based on participant recall, including how the participants experiences have been shaped and understood over time.

However, an additional layer to consider is the impact of participant self-selection and self-censoring. The interview participants were asked to share their thoughts on a sensitive topic that come from both personal and professional reflections. This requirement may have prevented some participants from volunteering for the study while those who did take part may not have wanted to divulge all of their lived experiences, perspectives, and practices. This tension is reflected in the choice of the one participant who refused to be recorded, which can occur with qualitative research (Afsana, 2004; Arceneaux, 2007; Basson, 2005). Others who were involved in the study may have consciously or unconsciously chosen to report socially desirable answers.

Another potential limiting factor is the primary researcher. Congruent with qualitative research methodology, the primary investigator is considered an instrument of research (Guba & Lincoln, 1981; Pezalla et al., 2012; Rubin & Rubin, 2011). The researcher mines the rich data and extensive findings and manually selects the quotes deemed significant to the study. Some data points may be outliers, but this process is also an inherent part of the interpretive phenomenological process. To support the reflections and thought processes throughout the data collection and interpretation process, the researcher collected field notes and undertook journaling to understand and to differentiate her own perspectives from those emerging from the participants. Furthermore, to balance that, the researcher worked closely with her doctoral supervisors who saw the extent of the data collected and spent more than a year parsing through the analysis and interpretation alongside the primary researcher.

Novelty of This Research

This timely research provides numerous contributions to nursing science and to patient care. This thesis unites the voices of registered nurses, nursing students, and Francophone patients in one study. While the experiences of Francophone minorities are usually relegated to largely Francophone spaces, the nursing participants were both English and French speaking, and aligned in revealing the problematic realities of nursing care provision to minority language populations. Such discourse further contributes to the dynamics of (in)visibility of Francophone patients within the health care system, as well as the similar phenomena of (in)visible work by nurses to bridge the systemic gaps.

Francophone patients can be confident in knowing that their voices were not only represented in this study, but that their realities are echoed by numerous allies. Moreover, this study used frameworks that examined individual, team level, organizational, and systemic

representations of the health care system. This allowed for the study to provide a current representation of all the levels involved for sustaining the status quo of minority language care. Using that systemic lens, this study also provides numerous suggestions from the perspective of patients and nursing care providers as to how to improve access to quality care in French, as well as care provision to these official language minority community patients in Ontario. These important discussions are at the forefront of considerations for Francophone patients and their nursing care providers.

This study provides numerous avenues to conquering the shortcomings of our health care system as it stands. While this study included a small subset of the population, with 31 participants, the rich quotes evidenced the severity of the problem, asserted by numerous participants, but also includes several solutions, many of which were shared by several participants. Though this problem has spanned decades, this thesis asserts that the state of care to linguistic minorities remains a current issue with ripple effects throughout the health care system.

Recommendations

Numerous results, strategies, and recommendations were elicited from this study. As a result of the insights provided by the participants in this research, it was important for this study to share the different paths for future action for patients in Francophone minority communities and for health care professionals, as well as for health care administrators. The following section provides recommendations that can benefit various actors within the health care system, not only to receive better care but also to provide improved quality of care that will contribute to more effective care delivery. While the recommendations may refer to nursing practice, the suggestions are transferable, and may benefit various sectors of the health care and social services system.

Recommendations for Patients, Caregivers, and Communities

- Ask for services in their official language, and denounce the situation when services are not available (e.g., submit a formal complaint with the health organization and government entities if the care cannot be provided in their official language)
- Seek education on their rights as Francophone patients.
- Participate in patient safety groups (community/hospital committees, national organizations).
- Engage in formal and informal forums regarding access to French language care in Ontario, both for personal benefits and for the improvement of health services.

Recommendations for Nursing Professionals

- Make an active offer to all their patients.
- Use the French language skills that they have: Speak in French and continue to stay up to date with their language skills.
- Wear labelling that identifies them as bilingual or French speaking.
- Advocate for official language minority communities by speaking out and reporting instances where the active offer cannot be successfully implemented (with themselves or colleagues).
- Consider pursuing continuing education opportunities in the minority language when available and relevant to their clinical area.

Recommendations for Schools of Nursing

- Integrate education on the needs of Francophone linguistic minorities consistently in their curriculums.

- Support the offering of minority language education by acknowledging language as a social determinant of health throughout the curriculum.
- Promote the importance of maintaining linguistic skills throughout the entire program, confirming these as essential supports for patient safety and access to health care for linguistic minority populations that the students will be serving.
- Encourage the eagerness of students in seeking out the linguistic competence that they require through their schools, colleges, and universities.
- Provide the foundations for political advocacy of the needs of Francophone minorities to students.
- Revise French immersion programs to offer more nursing courses (practice and theory) in the minority language such that students gain more exposure to clinical terminology.
- Provide educators with tools and resources to support advocacy and education about Francophone minority communities within the health care context.
- Leverage partnerships with agencies such as the CNFS, who have expertise in supporting post-secondary health education for Francophone minority communities across Canada.
- Continue partnering with groups such as the Canadian Association of Schools of Nursing to ensure that the voices of students are represented in education, research and policy regarding issues of minority language care and competency.

Recommendations for Health Care Administrators

- Encourage the active offer facility wide
    - Imbed the active offer in their policies and educate staff accordingly.

- Promote visible bilingualism: obtain materials to label health care professionals as bilingual; enforce the use of signs and visible resources encouraging French language services.
- Display signs encouraging patients to request interpretation and translation services (e.g., Saviez-vous que vous pouvez avoir accès à des services de traduction si vous en faites la demande?)
- Simplify and encourage the process for any hospital staff, including nurses, accessing translation, 24/7.
- Provide facility supported technologies to aid with point of care translation (e.g., translation devices or software programs dedicated to clinical staff).
- Provide clinical and educational tools in English and French (both official languages on the same resource), available in multiple formats (documents, multimedia/videos, etc.).

- French language recognition, education, compensation, and planning
  - Acknowledge and provide recognition for the work of French-speaking staff (e.g., provide financial incentives for bilingual staff to compensate for increased workloads).
  - Support French language courses and opportunities which are mindful of shift worker schedules across multiple campuses.
  - Provide compensation for health care professionals learning French online and through mobile applications (e.g., on their personal devices).
  - Count the number of Francophone and bilingual nursing care providers, and consider language in the daily staffing and clinical assignments

    - Hire bilingual candidates (from the bedside to management), and make language a significant hiring promotion criterion, especially with comparable applicants.
    - Support French-speaking clinical educators to mentor French-speaking students (clinical groups and preceptorships), especially in specialty sectors, to build capacity for French-speaking nursing care providers in those sectors.
- Promotion of quality French language services
    - Establish committees that address French language quality and ensure that all quality-based committees have bilingual standing members.
    - Conduct surveys throughout the organization to understand the challenges health care professionals face when meeting the needs of linguistic minorities within their care community.
    - Implement regular post-visit surveys about patients' French-language care experience, collecting both quantitative and narrative data (e.g., include questions such as: Did you receive care in your language? And anonymize the data such that there are no repercussions on their health care), returning the collected data to a French language quality improvement committee for the institution.
    - Recognize and validate the difficulties that can be generated by patients who seek but are unable to access health care in French in their establishment.
    - Count the number of Francophone patients who access the health service establishment (number of French-speaking patients and total number of visits) and update on a monthly and yearly basis. Document the preferred language of the patient (even if the patient is bilingual).

- Keep a count of Francophone or bilingual health care professionals, as a whole and by profession, in their establishment and update yearly.
- Continue encouraging designation of health care settings with the supports of the Réseau des services de santé en français de l'Ontario (financed by Ontario Health, Société Santé en Français, and Health Canada, supported by the Ministry of Health and Long-Term Care).

Implications

Registered nurses, nursing students, and Francophone patients shared insights from their lives and clinical experiences which can have an impact beyond the initial context. Considering the information revealed by study participants, numerous contributions of this study may be of significance in a number of nursing realms, including clinical practice, education, policy, and subsequent research. The following section discusses the potential implications stemming from this study.

Implications for Clinical Practice

Throughout this study, numerous opportunities to reflect on nursing practice and the status quo of care emerged. In the face of inequities of care to French-speaking minority communities, it is important for nursing professionals to consider their role with regard to the offer of care to language minority patients; they must consider their patients' human rights with the offer of linguistically congruent health care services. Supporting patients by extending them an active offer is a means to permit the patient to engage in the care interaction in the language of their choice. With inconsistent access to clinical tools and resources, the onus remains on nursing care providers to familiarize themselves with provincial and federal laws, for example, the French Language Services Act in designated health care facilities, or the Health Care Consent Act, to understand

what legal expectations apply to their patient at the point of care. Thus, it is important to consider principles of ethical care and their responsibilities to support patients in providing informed consent throughout their clinical encounters, especially when faced with a language discordance.

Implications for Education

This study revealed the significance of the linguistic duality within Canada, and how this duality, as a symbolic belief, can be upheld throughout the health care system, from government authorities to individual patients and health care providers. In order to provide quality services to the linguistic minority throughout the health care system, it is important to understand the value of education in upholding such values and fostering sustainability for the offer of French-language services. Participants in this study highlighted the importance of communities valuing and ensuring continuing education and training in the French language, encouraging proficiency and retention for students as early as primary school.

This information is valuable for nursing education, as there is a role for implementing the active offer as a notion in French and English nursing programs. Understanding the requirements of linguistic minority communities should be integrated into the nursing educational process rather than being left as an afterthought. Linguistic duality and awareness of minority language rights need to be integrated throughout nursing curricula, including lectures, clinical placements, and simulation cases. An example of recent endeavours to bridge this gap is the work of Giroux and Savard with interprofessional simulations for students enrolled in nursing, medicine, nutrition, and social service programs, which help improve student's clinical skills while supporting them in the implementation of the active offer (Consortium national de formation en santé, 2021; GReFoPS, n.d.-a).

Participants also talked about the added value that incorporating French language training and French language enhancement opportunities could provide to BScN university programs as mandatory or elective course components. Moreover, a linguistic and cultural competence approach to nursing education would be an added value for students, contributing to their understanding of the significance of the unique realities of linguistic minorities within and beyond the health care system, as they will eventually impact their career as registered nurses. To reinforce these notions, patient partners could be involved as linguistic minorities in the classroom, so that students can learn from their lived experiences. Such tools already exist, such as with the Consortium national de formation en santé (CNFS) toolbox for the active offer (Consortium national de formation en santé, 2013). However, since no study participants, including Francophone program nursing students, mentioned this resource, it would be worth actively promoting these tools in and beyond undergraduate student classrooms.

Throughout this study, it was also made evident that solely being bilingual was not sufficient to sustain the active offer of health services to minority communities. A concern of both individual patients and nursing care providers is the potential for assimilation and language loss, especially when French-language health services are seldom accessed, utilized, or offered. As a result, enhancing the visibility and promoting awareness of French-language support and French-language training opportunities available to health students and health care professionals are required. Such continued professional development needs must be considered by educational institutions as well as by organizations serving official language minority communities. As discussed in the conceptual frameworks used in this thesis, a systemic approach is most beneficial to create such long-lasting changes.

In nursing education, it is important to prepare and adequately support educators to share their insights and understanding with nurses and nursing students. The educational issues brought to light in this study should be addressed at several levels, as nursing educators can be found in numerous sectors from clinical settings to university lecture halls, and even within hospitals and community settings. These individuals also need to be well-informed on the active offer and how to best transmit this knowledge to their Anglophone and Francophone learners. Moreover, an understanding of how to best support the Francophone community needs to be emphasized in the education process, such as the value in matching French-speaking nursing providers with French-speaking patients when the opportunity arises, as well as how to best equip non-French-speaking nursing providers to navigate health encounters with Francophone patients. Such efforts could also be beneficial to build capacity with nurses, nursing students, and other health care professionals who are bilingual but not extensively involved in the provision of French-language services, such that they can remain competent and confident in their practice.

Implications for Policy

Numerous policies affect the provision and experience of accessing health care in Ontario. However, the results of this study demonstrate that policies may not always benefit patient and health care providers as intended. Policies that are implemented must be adequately funded, supported, and evaluated to assess their benefit to the intended population. As several sectors of the health care system, including federal, provincial, and community organizations, have a role in supporting the offer of French-language services, the following implications may be of value to several groups.

This study revealed the importance of providing adequate support for initiatives to increase bilingualism among health care professionals. While several tools exist to increase the capacity of

French-language services, the way that they are offered does not meet the needs of many front-line care providers. It is important to ensure that full financing and support of health care workers exists to allow them to enroll in educational opportunities. This includes providing them with appropriate time off or providing paid hours for education and for taking French-language educational opportunities. While such an endeavour may be difficult to implement on a large scale, strategic planning can take place to build capacity in regions where such linguistically congruent services are needed the most (e.g., regions where the ratio of French-speaking professionals does not meet the needs of French-speaking populations, or targeting for particular specialties where linguistically congruent services are pressing). Such a strategy could, for example, provide direct resources and initiatives to promote the recruitment and retention of bilingual staff in rural, northern, and remote communities, as well as in other regions where there may be a heightened need.

In the same vein, to support communities with the active offer of health services to linguistic minority communities in Ontario, it is important to integrate the language needs of French-speaking populations in systemic health care planning and evaluation. Patients in this study frequently noted that language-based data was occasionally collected but they seldom were told what the outcomes of this data collection were. In order to effectively mobilize the required changes, it is vital to include the presence of bilingual, French-speaking individuals at decision-making tables. Furthermore, to better implement best practice and proven recommendations, it is also imperative to seek involvement and expertise of Francophone organizations that already advocate for the needs of linguistic minorities (e.g., Société Santé en français, Consortium national de formation en santé, Réseaux des services de santé en français de l'Ontario).

A poignant finding of this research was the lack of awareness of the existing French-language advocacy networks and educational resources, even for French-speaking participants. This is important, as collaborating with such organizations can further empower patients, communities, and health care providers. It is essential to increase the visibility of these services and networks, be it with marketing/promotional campaigns to increase public awareness of these services, or with targeted awareness-building efforts with both the Francophone and Anglophone communities in Ontario to reach English-speaking health care providers as well. Such campaigns can be done concurrently with providing public information for official language minority communities regarding their rights, encouraging them to ask for services in French. Moreover, these sensibilization efforts can also be an opportunity to create resources in French for patients to know which service to access and when (e.g., preventive, curative, and support services; clinic and community provider use versus accessing the emergency department). To further assist Francophone minority communities in Ontario, it is also important to raise awareness for patients and communities regarding which facilities are designated Francophone facilities, and of the recourses to take when services are not provided in their language.

To support the offer of quality health care, system-wide support is crucial for health care providers. This means that policies that affect the health care team, health care organizations, and the overall health care environment must consider the individuals providing care. For one, nursing professional organizations need to develop and implement policies and resources to support the provision of care to linguistic minority patients, through bilingual resources addressed to patients and health care providers (from patient education to best practice guidelines). Evidence of such will have to be displayed throughout their organization, from the websites to the annual reports.

Directions for Future Research

As much as this study sought to understand the lived experiences of Francophone patients and their nursing care providers, the journey to understanding raised several questions and provided numerous directions for future research. While several studies have spoken to the challenges of linguistic minorities internationally and nationally, few have examined the realities of nursing practice. Moreover, the considerations of registered nurses, nursing students, and Francophone patients with regard to health care services for linguistic minorities in Ontario had yet to be examined. As a result, while this study provided a step forward in broadening the inquiry into patients and care providers lived experiences, questions regarding the active offer of French-language health care services throughout the organization and with regard to health management remain unanswered.

Future studies could assess the role and experiences of nursing management with promoting access to French-language nursing services, especially amid competing priorities. This would include conducting a similar study, while directly recruiting nursing managers and administrators to glean their perspectives on care provision to linguistic minorities in Ontario. Moreover, this study sampled participants in various regions of the province. Further understanding barriers for the implementation of the active offer of French language services for individual nursing community establishments would be valuable, especially with the opportunity to compare regions of Ontario with varying French-language density. Additionally, several participants questioned the value of the data that they provided in surveys asking them about their linguistic preferences. Organizational data regarding the impact of French-language awareness campaigns would be important and would help assess changes to access to French-language health services in individual health care organizations. Such data would be easy to collect in French-

designated organizations, especially as the Ontario Réseaux are now collecting French Language Health Services Reports through an online database called OZi (Réseau des services de santé en français de l'Est de l'Ontario, 2018).

With regard to the health care team, several nursing students, registered nurses, and patients mentioned the significant involvement of administrative staff. While they were frequently discussed, they were not included in this study. Future studies would be valuable to understand the experiences of administrative health team members, who are often called upon to provide health services including translation and interpretation especially if they are hired into a bilingual required role. Similar studies could be done including other nursing staff, such as registered practical nurses and nursing students, who may have a different linguistic profile in Ontario. Further research should also consider personal support workers and other unlicensed nursing staff, all of whom are increasingly relevant as we continue to see the population age with services for them provided in numerous sectors including nursing homes, home care, and alternate modalities of nursing service.

A topic that was mentioned but not sufficiently explored was the experiences of Francophone nursing students, their education in French and then their work in a bilingual clinical environment. They are also preoccupied with the National Council Licensure Examination for Registered Nurses (NCLEX-RN) and other examination processes. Furthermore, should change in active offer training take place in undergraduate nursing curricula, it would be valuable to compare the impact of active offer training in pre and post studies for nursing students in both the English and French language nursing programs.

The evidence provided by patients in this study demonstrated that their contact with French-language health care services happened at numerous levels within their lives: before, during, and after the health care interaction. This burden was further accentuated for particular

patient populations. For example, patients who had existing or ongoing health events which could lead to frequent access to the health care system were more vocal. This included patients requiring access to French-language services for chronic health issues, complex care problems, or other ailments requiring specialist services (such as mental health, obstetrics, or pediatric care). Patients also highlighted concerns around geriatrics and nursing care that will only increase with an aging population. The health care system needs to understand these concerns and nursing researchers must further delve into the preoccupations of these groups to further understand how to enhance their care experience. Many patients also spoke about the need to involve friends, patients, and other care providers in their communities to accompany them to access French-language nursing care services. Nursing would benefit from research enhancing understanding of patient and family-centred care to build capacity for Francophone families in this complex health care system.

Lastly, a surprising finding of this study, which was not addressed in the original research question or interview protocol, arose with the issue of compounding patient discrimination for linguistic minority patients who were also visible minorities, immigrants, and refugees. They shared heightened concerns with regard to their health care experiences. Future studies may benefit from exploring the challenges of patients who speak multiple languages, including the official minority language. An intersectional research lens may be optimal for providing valuable insights into this population and could be interesting given the need for supporting Canadian values of diversity and linguistic vitality.

Chapter 8: Conclusion

> Firstly, people need linguistic human rights in order to prevent their linguistic repertoire from becoming a problem or from causing them problems. Secondly, people need to be able to exercise language rights in order for their linguistic repertoire to be treated as, or to become, a positive, empowering resource (Kontra et al., 1999, p. 6).

Canada takes pride in its linguistic duality and boasts about the vitality of its population. However, this environment that strives to empower its communities and bolster linguistic and cultural competence is missing the mark with regard to the health care needs of its Francophone minority communities. An examination of the lived experiences of members of official language minority communities and their nursing care providers in Ontario provided significant insights into a problem that many do not acknowledge exists. “Why study the experiences of linguistic minority communities?” “Don’t all Francophones speak English as well?” These misconceptions remain present today, in and out of the health care system. However, when it comes to quality health care, equity and safety must remain at the forefront of the discussion. The experiences shared by registered nurses, nursing students, and Francophone patients in this study indicate that access to quality health care for Francophone minority communities in their language remains a difficult endeavour throughout Ontario, whether in the capital region or in rural and remote areas.

This qualitative phenomenological research sought to understand the lived experiences of providing and receiving care to Francophone communities in Ontario. The anecdotes shared demonstrate that the health care journey presents great difficulties particularly for Francophone patients and their care providers at the point of care. Participants discussed the hindrances that they faced from linguistic discordance to the active offer as well as the factors that could contribute to improving care.

As a resilient population, Francophone patients and the nursing participants shared the shortfalls they found in their health care encounters as well as the numerous means that they had created to try to ameliorate their concerns. However, these attempts at accommodation only keep the extent of the problems at the individual level. Such an approach is not sustainable and may instead be causing harm to the Francophone minority community and the nursing care providers. Lacking access to sustainable strategies, patients, nursing students, and registered nurses proved to be simply coping with their day-to-day situations. In trying to resolve the abundance of issues at the local level, patients and providers render the numerous problems undetectable to the organizations and health care system above them.

As a way to move forward, it is important for several actors to contribute to improving the health care system for patients and providers alike, so that they can focus on receiving and providing care rather than compensating for the gaps within. As demonstrated in the "Four Levels of Change for Improving Quality" model (Ferlie & Shortell, 2001) and the "Four-Level Model of the Health Care System" (Reid et al., 2005), as well as the "Framework for the Analysis of Health and Social Services Access and Integration for Official Language Minority Communities" (J. Savard, Savard, et al., 2020), change and improvement cannot take place in silos. If change planning is siloed, a problem that belongs to everybody can easily fall to the wayside and be addressed by nobody. The multiple levels of the health care system are intricately multifaceted and interconnected. Thus, it is important for approaches to successfully cross over the numerous levels and structures of the health care system along the hierarchy. For the implementation of sustainable change, planning must take into consideration the necessities of all members of the health care system. This must include the needs of the patients, their family members/caregivers, and health care providers. This also requires acknowledging the realities and constraints of the greater health

care environment. Simultaneously, such planning must respect the values of the community, which are not limited to political and symbolic values, but which ultimately require concrete measures and actions. Although this study focuses on the province of Ontario, many of the conclusions can be generalized to other provinces in Canada.This study provided numerous insights into the challenges facing Francophone communities in Ontario and their nursing care providers. It also delivers several measures for improving the health care system. With Canada being a bilingual country, receiving services in one's official language is understood to be a right. In order to improve the experiences of nursing care providers and Francophone patients, it is time to support and effectively implement these human rights, such that they become a systemic reality provincially and beyond.

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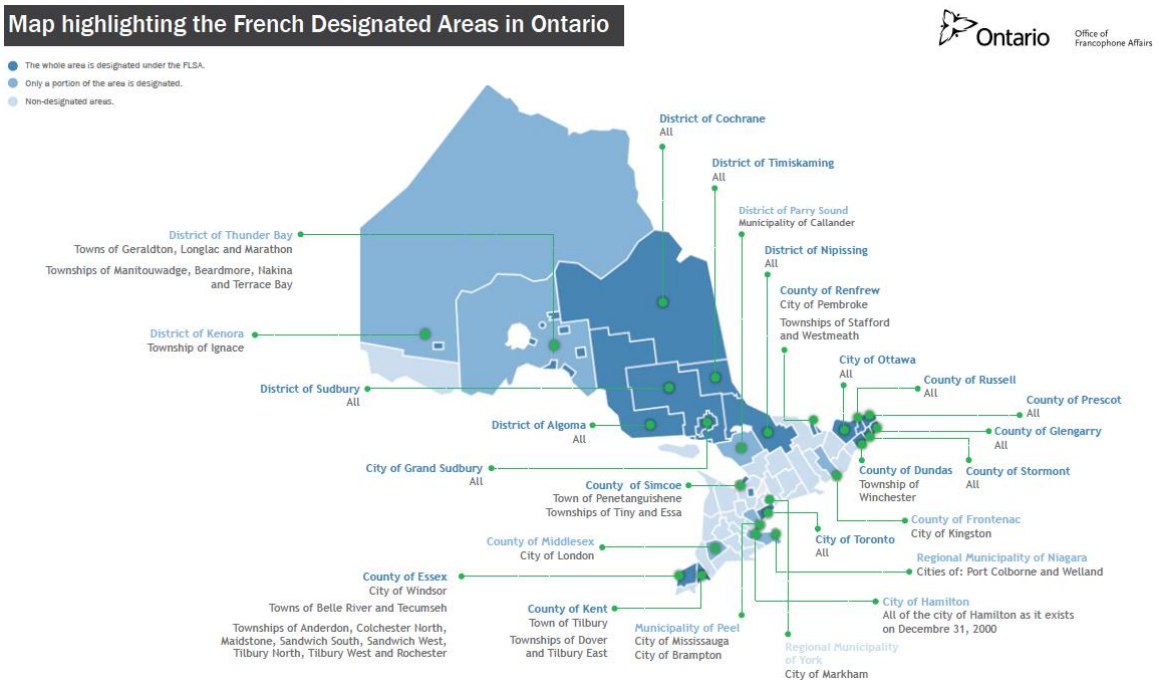
Appendix A: Map highlighting the French Designated Areas in Ontario

(Government of Ontario, 2016)



Appendix B: Four-Levels of Change for Improving Quality

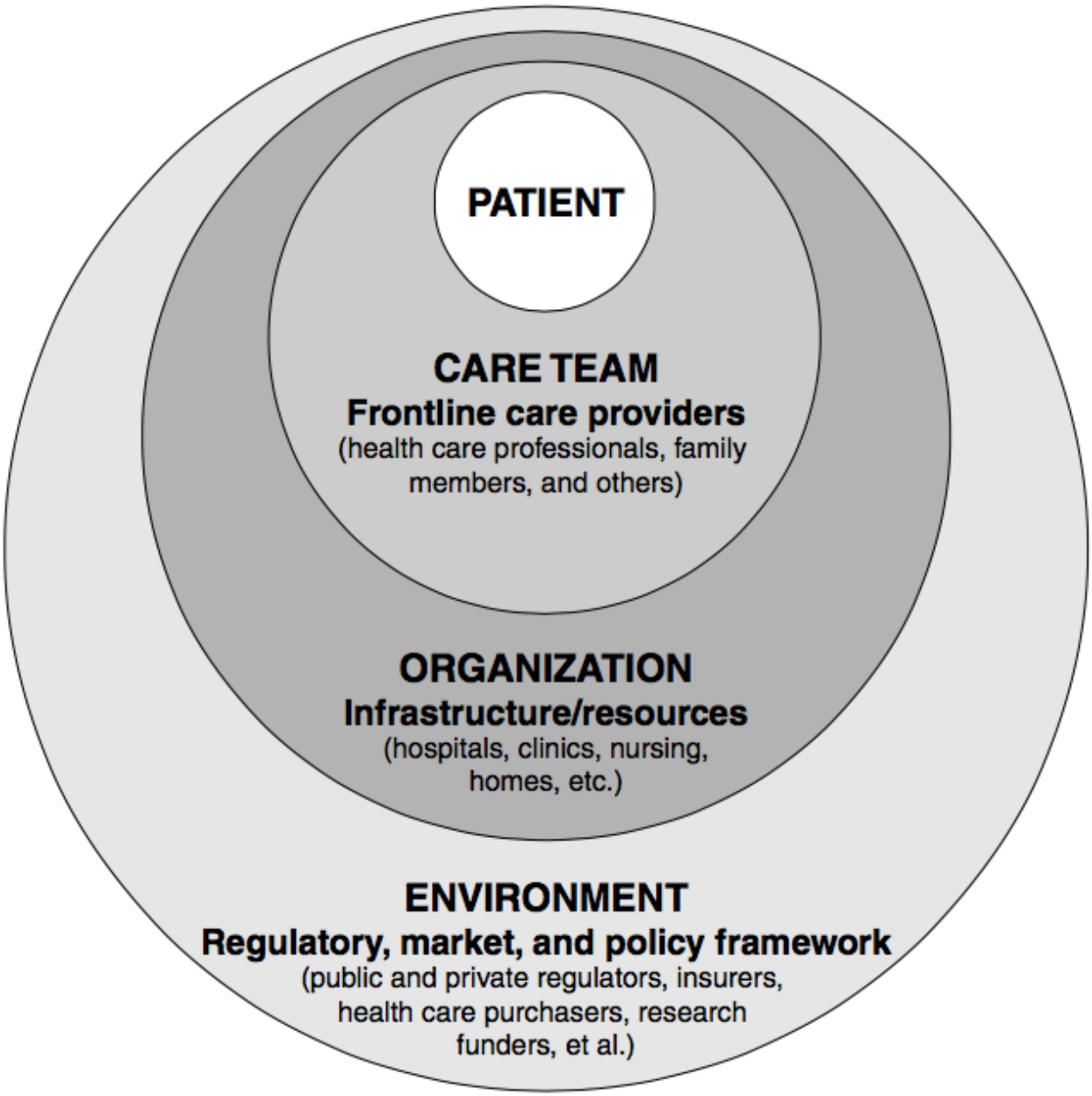
(Ferlie & Shortell, 2001, p. 284)

Four Levels of Change for Improving Quality

Levels	Examples
Individual	Education Academic detailing Data feedback Benchmarking Guideline, protocol, pathway implementation Leadership development
Group/team	Team development Task redesign Clinical audits Breakthrough collaboratives Guideline, protocol, pathway implementation
Organization	Quality assurance Continuous quality improvement/total quality management Organization development Organization culture Organization learning Knowledge management/transfer
Larger system/environment	National bodies (NICE, CHI, AHRQ) Evidence-based practice centers Accrediting/licensing agencies (NCQA, Joint Commission) Public disclosure ("report cards," etc.) Payment policies Legal systems

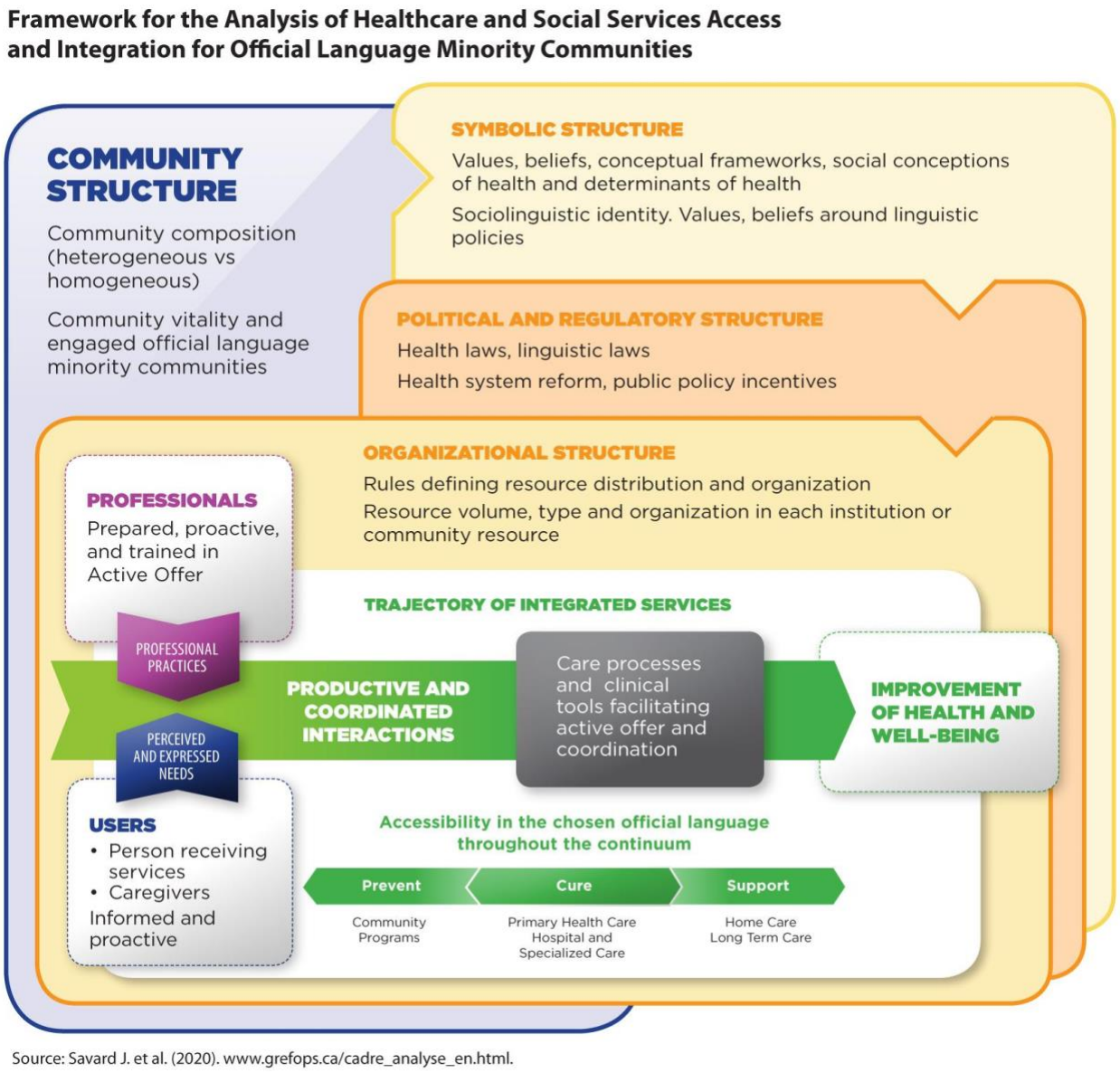
Appendix C: Conceptual Drawing of a Four-Level Health Care System

(Reid, Compton, Grossman & Fanjiang, 2005, p.20)



Appendix D: Framework for the Analysis of Health and Social Services Access and Integration for Official Language Minority Communities

(J. Savard, Savard, et al., 2020)



Source: Savard J. et al. (2020). www.grefops.ca/cadre_analyse_en.html.

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Appendix E: Research Ethics Boards (REB) Approval

27/06/2018

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE I CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	H-05-18-599
Titre du projet / Project Title	Official Language Minority Communities in Ontario: Understanding the Lived Experiences of Francophone Patients and their Nursing Care Providers
Type de projet / Project Type	Thèse de doctorat / Doctoral thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	27/06/2018
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	26/06/2019

Équipe de recherche / Research Team

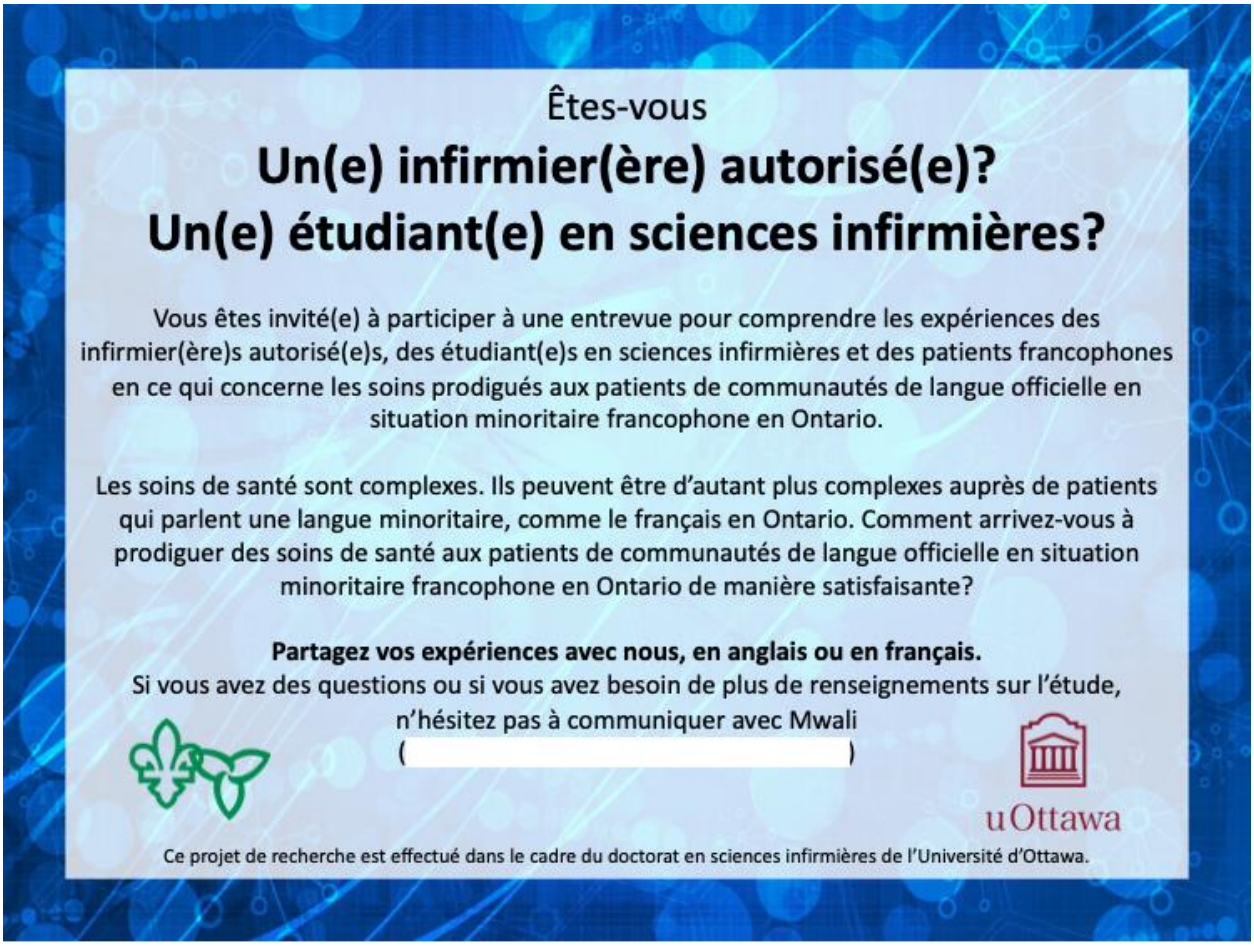
Chercheur / Researcher	Affiliation	Role
Mwali-Nachishali MURAY	École des sciences infirmières / School of Nursing	Chercheur Principal / Principal Investigator
Julie CHARTRAND	École des sciences infirmières / School of Nursing	Superviseur / Supervisor
Amélie PERRON	École des sciences infirmières / School of Nursing	Co-superviseur / Co-supervisor

Conditions spéciales ou commentaires / Special conditions or comments

550, rue Cumberland, pièce 154 Ottawa (Ontario) K1N 6N5 Canada
550 Cumberland Street, Room 154 Ottawa, Ontario K1N 6N5 Canada

613-562-5387 • 613-562-5338 • ethique@uOttawa.ca / ethics@uOttawa.ca
www.recherche.uottawa.ca/deontologie I www.recherche.uottawa.ca/ethics

Appendix F: Recruitment Posters


Êtes-vous
Un(e) infirmier(ère) autorisé(e)?
Un(e) étudiant(e) en sciences infirmières?
Vous êtes invité(e) à participer à une entrevue pour comprendre les expériences des infirmier(ère)s autorisé(e)s, des étudiant(e)s en sciences infirmières et des patients francophones en ce qui concerne les soins prodigués aux patients de communautés de langue officielle en situation minoritaire francophone en Ontario.
Les soins de santé sont complexes. Ils peuvent être d'autant plus complexes auprès de patients qui parlent une langue minoritaire, comme le français en Ontario. Comment arrivez-vous à prodiguer des soins de santé aux patients de communautés de langue officielle en situation minoritaire francophone en Ontario de manière satisfaisante?
Partagez vos expériences avec nous, en anglais ou en français.
Si vous avez des questions ou si vous avez besoin de plus de renseignements sur l'étude, n'hésitez pas à communiquer avec Mwali
(
)
uOttawa
Ce projet de recherche est effectué dans le cadre du doctorat en sciences infirmières de l'Université d'Ottawa.


Are you a
Francophone Patient?
You are invited to participate in an interview on the experiences of registered nurses, nursing students and Francophone patients regarding the care provided to French-speaking patient populations in Ontario.
Health care is complex. It can be even more intricate with patients who speak a minority language, such as French in Ontario.
How do you manage to access health care in a satisfying manner?
Please share your experiences with us, in English or in French.
For more information on this study, please contact Mwali
(
)
uOttawa
This research project is conducted in partial fulfillment of the requirements for the University of Ottawa doctoral degree in nursing.


Êtes-vous
Un(e) patient(e) francophone?
Vous êtes invité(e) à participer à une entrevue pour comprendre les expériences des infirmier(ère)s autorisé(e)s, des étudiant(e)s en sciences infirmières et des patients francophones en ce qui concerne les soins prodigués aux patients de communautés de langue officielle en situation minoritaire francophone en Ontario.
Les soins de santé sont complexes. Ils peuvent être d'autant plus complexes auprès de patients qui parlent une langue minoritaire, comme le français en Ontario. Comment arrivez-vous à accéder à des soins de santé de manière satisfaisante?
Partagez vos expériences avec nous, en anglais ou en français.
Si vous avez des questions ou si vous avez besoin de plus de renseignements sur l'étude, n'hésitez pas à communiquer avec Mwali
(
)
uOttawa
Ce projet de recherche est effectué dans le cadre du doctorat en sciences infirmières de l'Université d'Ottawa.

Appendix G: Sample Recruitment Emails

uOttawa

Université d'Ottawa
Faculté des sciences de la santé

École des sciences infirmières

University of Ottawa
Faculty of Health Sciences

School of Nursing

Official Language Minority Communities in Ontario: Understanding the Lived Experiences of Francophone Patients and their Nursing Care Providers

You are invited to participate in an interview for a study regarding the experience of registered nurses, nursing students and Francophone patients with respect to the services and health care provided to French-speaking official language minority communities in Ontario. We are looking for (registered nurses/nursing students) who have provided care to French speaking or francophone patients in Ontario.

We want to speak to nursing students who understand and speak in **English OR French**. Participants will be selected on a first come, first served basis. Your participation will consist of taking part in an interview, expected to be about one (1) hour in length. The interview may take place in person, over the phone, or by teleconference. The interview may be held in English or in French, whichever you prefer.

The interview will be guided by a list of questions and discussion items. You may skip any question that you do not want to answer. Participation in this study is strictly voluntary. This study will allow for greater understanding of the realities of health care provision to French-speaking minority patient populations in Ontario, looking at the perspectives of registered nurses, nursing students, and Francophone patients.

This project has received Research Ethics Board (REB) approval from the University of Ottawa (H05-18-599). If you have any questions or require more information about the study, please do not hesitate to contact the primary investigator, Mwali Muray , or her research supervisor, Dr. Julie Chartrand and Dr. Amélie Perron .

Thank you so much for your time and consideration.

Regards,

Primary Investigator
Mwali Muray, RN, BScN, MBA
PhD Candidate

Supervisor
Julie Chartrand, RN, PhD
Assistant Professor

Co-supervisor
Amélie Perron, RN, PhD
Associate Professor

☎ 613 562-5473
613 562-5443
451 Smyth
Ottawa ON K1H 8M5 Canada

www.uOttawa.ca

uOttawa

Université d'Ottawa
Faculté des sciences de la santé
École des sciences infirmières

University of Ottawa
Faculty of Health Sciences
School of Nursing

Invitation destinée aux patients francophones

Communautés de langue officielle en situation minoritaire en Ontario: Comprendre les expériences vécues des patients francophones et de leurs fournisseurs de soins infirmiers

Vous êtes invité(e) à participer à une entrevue dans le cadre d'une étude portant sur l'expérience des infirmières autorisées, des étudiants en soins infirmiers et des patients francophones en ce qui concerne les services et les soins de santé prodigués aux patients de communautés de langue officielle en situation minoritaire francophone en Ontario. Nous recherchons des patients francophones qui ont reçu des soins de santé en Ontario.

Nous voulons parler à des résidents de l'Ontario qui sont francophones ou bilingues et qui préfèreraient recevoir ou accéder à des services et des soins de santé en français en Ontario. Les participants seront choisis selon la règle du premier arrivé, premier servi. Votre participation consistera à participer à une entrevue qui durera environ une (1) heure. L'entrevue peut avoir lieu en personne, par téléphone ou par téléconférence, à votre convenance.

Lors de l'entrevue, la chercheuse aura une liste de questions et d'éléments de discussion. Nous vous invitons à répondre aux questions qui vous seront posées. Vous pouvez ignorer toutes les questions que vous ne voulez pas aborder. Votre participation à cette étude est strictement volontaire. Cette étude permettra de mieux comprendre les réalités de la prestation des soins de santé aux populations minoritaires francophones de l'Ontario, en examinant les points de vue des infirmières autorisées, des étudiantes infirmières et des patients francophones.

Ce projet a reçu l'approbation du Comité d'éthique de la recherche (CÉR) de l'Université d'Ottawa. Si vous avez des questions ou si vous avez besoin de plus amples renseignements sur l'étude elle-même, n'hésitez pas à communiquer avec la chercheuse principale, Mwali Muray , ou ses directrices de recherche, les Dres Julie Chartrand et Amélie Perron .

Nous vous remercions du temps et de l'attention que vous portez à cette recherche.

Cordialement,

Chercheuse
Mwali Muray, IA, BScInf, MBA
Candidate au doctorat

Directrice de recherche
Julie Chartrand, IA, PhD
Professeure adjointe

Co-directrice de recherche
Amélie Perron, IA, PhD
Professeure agrégée

☎ 613 562-5473
613 562-5443
451 Smyth
Ottawa ON K1H 8M5 Canada

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Appendix H: Sample Consent Forms

uOttawa

Université d'Ottawa
Faculté des sciences de la santé
École des sciences infirmières

University of Ottawa
Faculty of Health Sciences
School of Nursing

FORMULAIRE DE CONSENTEMENT

Communautés de langue officielle en situation minoritaire en Ontario: Comprendre les expériences vécues des patients francophones et de leurs fournisseurs de soins infirmiers

Votre participation à cette étude est volontaire. Veuillez lire ce formulaire de consentement attentivement avant de décider si vous voulez participer à cette étude. Posez autant de questions que vous le souhaitez à la chercheuse.

Chercheuse
Mwali Muray, IA, BScInf, MBA
Candidate au doctorat
École des sciences infirmières
Faculté des sciences de la santé
Université d'Ottawa

Directrice de recherche
Julie Chartrand, IA, PhD
Professeure adjointe
École des sciences infirmières
Faculté des sciences de la santé
Université d'Ottawa

Co-directrice de recherche
Amélie Perron, IA, PhD
Professeure agrégée
École des sciences infirmières
Faculté des sciences de la santé
Université d'Ottawa

Vous êtes invité(e) à participer à la recherche nommée ci-dessus qui est menée par Mwali Muray, sous la direction des Dres Julie Chartrand et Amélie Perron, dans le cadre de son programme de doctorat en sciences infirmières.

But de l'étude : Le but de l'étude est de comprendre les expériences vécues des patients francophones et de leurs fournisseurs de soins infirmiers en Ontario. Cette étude vise à interpréter les expériences vécues par les infirmier(ère)s autorisé(e)s et les étudiant(e)s en sciences infirmières qui prodiguent des soins à des patients de communautés de langue officielle en situation minoritaire en Ontario, tout en examinant les perspectives et les expériences des patients francophones qui reçoivent des services et des soins de santé en Ontario. Vous êtes invité(e) à participer à cette étude en raison de votre expérience avec ces services et ces soins.

☎ 613 562-5473
613 562-5443
451 Smyth
Ottawa ON K1H 8M5 Canada
www.uOttawa.ca

Participation : Votre participation consistera à effectuer une entrevue individuelle avec la chercheuse et à remplir un court formulaire sociodémographique (2 minutes). Pendant l'entrevue, on vous demandera de discuter de vos perceptions et de vos expériences relatives aux soins offerts aux patients de communautés de langue officielle en situation minoritaire francophone en Ontario. Vous n'êtes sous aucune obligation de répondre aux questions. Vous pouvez ignorer toutes les questions que vous ne voulez pas aborder. L'entrevue durera environ 1 heure et elle aura lieu dans un endroit et à un moment qui vous convient. Elle pourra avoir lieu en personne, par téléphone ou par téléconférence, selon votre convenance. L'entrevue sera enregistrée numériquement, à moins que vous refusiez (des notes seront alors écrites à la main). L'entrevue audio sera transcrite par la chercheuse, puis elle sera effacée. Toute identification mentionnée pendant l'entrevue sera éliminée pendant la transcription (noms de villes, de personnes, d'hôpital, etc.). Un nom d'utilisateur sera utilisé au lieu de votre nom pour identifier votre transcription d'entrevue.

Risques : Les risques encourus lors de votre participation à cette étude sont minimes. Toutefois, votre participation à cette recherche implique de discuter d'expériences personnelles, ce qui pourrait vous mettre mal à l'aise. Certains participants peuvent se rappeler d'évènements émotionnels ou psychologiques bouleversants. La chercheuse s'efforcera pleinement de minimiser ces risques. Vous pouvez sauter des questions, refuser d'enregistrer certaines parties de l'entrevue, ou vous désister de l'étude en tout temps. Vous pouvez contacter la chercheuse ou ses directrices de recherche par téléphone ou par courriel si vous avez des questions ou des inquiétudes. Vous pouvez aussi communiquer avec des services de crise tels que *Allo J'écoute* (téléphone: 1-866-925-5454 / www.allojecoute.ca) ou *le service 211* (téléphone: 211 / 211.ca/fr) pour de l'assistance confidentielle 24/7.

Ceci est une étude indépendante. L'information discutée avec la chercheuse ne sera pas partagée avec des professionnels de la santé ou des gestionnaires. Elle ne sera pas utilisée pour vous évaluer. Parce que votre nom ne sera pas utilisé et parce que vos propos ne seront pas partagés, votre participation n'affectera pas votre capacité à utiliser des services de santé, ni votre relation avec des professionnels soignants.

Bienfaits : Il n'y a aucun avantage direct à participer à ce projet. Toutefois, votre participation à cette recherche vous permettra de partager vos expériences et vos opinions relativement aux soins de santé aux personnes francophones en Ontario. Ce processus pourrait contribuer à une sensibilisation des besoins des patients francophones et de leurs fournisseurs de soins.

Confidentialité et anonymat : Vos propos resteront strictement confidentiels. Les données recueillies seront utilisées uniquement aux fins de cette recherche. Les seules personnes qui auront accès aux données de recherche sont la chercheuse et ses directrices de recherche.

Toutes les informations recueillies dans le cadre de cette étude seront anonymes. Toutes les informations qui pourraient vous identifier seront éliminées. Votre nom et toute autre information qui pourrait vous identifier ne seront pas divulgués dans des publications. Des citations directes de votre entrevue pourraient être utilisées dans des publications ou des rapports de recherche; cependant, ces extraits seront modifiés afin de protéger votre anonymat.

Votre information lors de cette étude sera assignée à un nom d'utilisateur. Le lien entre votre nom et vos données personnelles et le nom d'utilisateur seront conservés en lieu sécuritaire à l'Université d'Ottawa, séparés de vos données de recherche. Les publications ou présentations résultantes de cette étude ne contiendront qu'un pseudonyme et aucun autre identifiant personnel.

Conservation des données : Les dossiers de recherche, y compris les enregistrements audio des entrevues, les transcriptions des entrevues et les notes de recherche seront conservés pendant cinq (5) ans (jusqu'en mai 2023) dans un fichier crypté à l'Université d'Ottawa. Les copies papier des documents de recherche (formulaires de consentement, questionnaires sociodémographiques) seront verrouillées et archivées dans un cabinet protégé à clé et un bureau barré à l'Université d'Ottawa. Après cinq ans, les documents et les dossiers de recherche seront détruits.

Compensation : Aucune indemnisation ne sera versée.

Participation volontaire : La participation à cette étude est entièrement volontaire. Vous n'êtes aucunement obligé(e) de participer. Tous les participants ont le droit de se désister de l'étude à tout moment, sans avoir à justifier leur décision. Vous pouvez refuser de répondre à toute question selon votre volonté. Si vous choisissez de quitter l'étude, toutes les données recueillies jusqu'au moment de votre retrait seront éliminées de façon sécuritaire.

Consentement

Ayant lu ce formulaire de consentement, je, _____ (*nom en lettres moulées*), accepte de participer à cette recherche menée par Mwali Muray, candidate au doctorat à l'École des sciences infirmières de la Faculté des sciences de la santé de l'Université d'Ottawa, sous la direction des Dres Julie Chartrand et Amélie Perron. Pour tout renseignement additionnel concernant cette étude, je peux communiquer en tout temps avec la chercheuse ou ses directrices de recherche.

Pour tout renseignement sur les aspects éthiques de cette recherche, je peux m'adresser au Responsable de l'éthique en recherche, Université d'Ottawa, Pavillon Tabaret, 550, rue Cumberland, pièce 154, 1-613-562-5387 ou ethics@uottawa.ca.

Il y a deux copies du formulaire de consentement, dont une copie que je peux garder.

Je consens à participer à cette étude intitulée ***Communautés de langue officielle en situation minoritaire en Ontario: Comprendre les expériences vécues des patients francophones et de leurs fournisseurs de soins infirmiers.***

J'accepte d'être enregistré(e) sur bande audio : oui ☐ non ☐

J'accepte que mes propos puissent être cités de manière intégrale (mon identité ne sera en aucun temps révélée) : oui ☐ non ☐

Signature du participant: _____ _____
(*Signature*) (*Date*)

Signature de la chercheuse: _____ _____
(*Signature*) (*Date*)

FORMULAIRE DE CONSENTEMENT VERBAL

Ce formulaire sera utilisé si l'entrevue est effectuée par téléphone ou par téléconférence, dans le cas où le participant est incapable ou préfère ne pas imprimer, numériser et renvoyer le formulaire de consentement signé. L'information complète sur l'étude et la feuille de consentement seront envoyées au participant par courriel avant le jour de l'entrevue. Le tout sera discuté au téléphone entre Mwali Muray et le/la participant(e) avant de procéder à l'entrevue.

Avant de commencer l'entrevue, j'aimerais confirmer ce qui suit:

- Vous comprenez qu'on vous demande de participer à une recherche sur les expériences vécues par les patients francophones et leurs fournisseurs de soins infirmiers en Ontario.
- Vous avez lu, ou l'on vous a lu, chaque page de ce formulaire de consentement.
- Toutes vos questions ont été répondues à votre satisfaction.
- Si vous décidez plus tard que vous souhaitez vous retirer de cette étude, vous pouvez le faire n'importe quand.
- Vous acceptez volontairement de participer à cette étude.
- Vous recevrez une copie de ce formulaire de consentement signé (par courriel).

Déclaration du chercheur

J'ai soigneusement expliqué cette étude au participant. J'ai donné au participant la chance de poser des questions et exprimer toute inquiétude qu'il pourrait avoir concernant cette étude. J'ai répondu à toutes les questions du participant. À ma connaissance, le participant comprend la nature, les exigences, les risques, les avantages et le caractère volontaire de cette étude. Le participant a consenti verbalement à une participation volontaire à cette étude.

Signature de la chercheuse: _____ _____

(*Signature*) (*Date*)

uOttawa

Université d'Ottawa
Faculté des sciences de la santé
École des sciences infirmières

University of Ottawa
Faculty of Health Sciences
School of Nursing

PARTICIPANT INFORMED CONSENT FORM

Official Language Minority Communities in Ontario: Understanding the Lived Experiences of Francophone Patients and their Nursing Care Providers

Participation in this study is voluntary. Please read this Participant Informed Consent Form carefully before you decide if you would like to take part in this study. Ask the study team as many questions as you like.

Primary Investigator
Mwali Muray, RN, BScN, MBA
PhD Candidate
School of Nursing
Faculty of Health Sciences

Supervisor
Julie Chartrand, RN, PhD
Assistant Professor
School of Nursing
Faculty of Health Sciences
University of Ottawa

Co-supervisor
Amélie Perron, RN, PhD
Associate Professor
School of Nursing
Faculty of Health Sciences
University of Ottawa

You are invited to participate in the abovementioned research study conducted by Mwali Muray, under the supervision of Dr. Julie Chartrand and Dr. Amélie Perron, as part of her PhD in nursing program.

Purpose of the Study: The purpose of the study is to understand the lived experiences of Francophone patients and their nursing care providers in Ontario. The aim of the study is to interpret the lived experiences of registered nurses and nursing students providing care to French-speaking patient populations in Ontario, and to truly understand the realities of health care provision, while gaining an understanding of the perspectives and experiences of Francophone linguistic minority patients in who access and receive health care in Ontario. You are invited to participate in this study because of your experience with these services and care.

☎ 613 562-5473
613 562-5443
451 Smyth
Ottawa ON K1H 8M5 Canada
www.uOttawa.ca

Participation: Your participation will consist of taking part in an individual interview with the primary investigator and completing a short socio-demographic form (approximately 2 minutes). During the interview, you will be asked to discuss your perceptions and experiences as a registered nurse regarding the care provided to patients in official language minority community patients in Ontario.

You are under no obligation to answer any questions. You may ignore or skip any question that you do not want to answer. The interview will last about one (1) hour and will take place at a time and place that is convenient for you. The interview may be conducted in person, by telephone or by teleconference to, depending on your convenience. The interview will be audio-recorded, unless you refuse the digital recording (alternatively, notes will be written by hand). The audio recording will be transcribed by the researcher, then the audio-record will be deleted. Any identification mentioned during the interview will be eliminated during the transcript (names of cities, people, hospitals, etc.). A username will be used instead of your name to identify your interview transcript.

Risks: The risks incurred during your participation in this study are minimal. However, your participation in this research involves discussing personal experiences, which could make you feel uncomfortable. Some participants may be reminded of some emotionally and psychologically upsetting events. The researchers will make every effort to minimize these risks. Participants may skip questions, refuse to record certain parts of the interview, or may quit the study if they choose to do so at any time. Participants may contact researchers by phone or email should they have questions or concerns. Participants may also contact crisis services such as Good2Talk (Telephone: 1-866-925-5454 / www.good2talk.ca) or the 211 help line (Telephone: 211 / www.211.ca) for 24/7 confidential assistance.

This is an independent study. The information discussed with the researcher will not be shared with patients, other nurses or managers. It will not be used to assess or evaluate your work performance. Since your name will not be used and your statements will not be traced back to you, your participation will not affect your relationship with your employer.

Benefits: There is no direct benefit to participating in this project. However, your participation in this research will allow you to share about your experiences and opinions regarding health care for Francophone people in Ontario. This process could contribute to an awareness of the needs of Francophone patients and their caregivers.

Confidentiality and anonymity: The information shared by participants will remain strictly confidential. The data collected will be used only for the purposes of this research. The only people who will have access to the research data are Mwali Muray and her research supervisors.

All information collected as part of this study will be anonymous. Information that could be used to identify the participants will be eliminated. Participant names or other identifying information will be excluded from any publications. Direct quotes from participant interviews may be used in publications or reports from this study; however they will be modified so as not to reveal any identifying information.

The study information of each participant will be assigned a username. The link between your name and contact information and the username will be stored securely and separate from your study records at the University of Ottawa. Publications or presentations resulting from this study will only contain a pseudonym and no other identifiers.

Conservation of data: Research records, including the audio versions of the interviews, the interview transcripts, and research notes will be kept for five (5) years (until May 2023) in an encrypted file at the University of Ottawa. Hard copies of research documents (such as consent forms and socio-demographic questionnaires) will be locked and filed away in a key protected cabinet and office at the University of Ottawa. After five years, the research documents and files will be destroyed.

Compensation: There will be no compensation.

Voluntary Participation: Participation in this study is completely voluntary. Individuals are under no obligation to participate. You can withdraw from the study at any time, without having to justify your decision or rationale. Participants can refuse to answer any questions. If a participant chooses to withdraw from the study, all data collected until the time of withdrawal will be securely disposed of and eliminated for this participant.

Consent

Having read the participant informed consent form, I, _____ (*print name*), agree to participate in the above research study conducted by Mwali Muray, doctoral candidate at the University of Ottawa, Faculty of Health, School of Nursing, researching under the supervision of Dr. Julie Chartrand and Dr. Amélie Perron. If I have any questions at any point throughout the study, I may contact the researcher or her supervisors.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5 (Telephone: 1-613-562-5387 / ethics@uottawa.ca).

There are two copies of the consent form, one of which is mine to keep.

I consent to participate in this study titled ***Official Language Minority Communities in Ontario: Understanding the Lived Experiences of Francophone Patients and their Nursing Care Providers.***

I agree to audio-recording this interview: yes ☐ no ☐

I accept that my words be quoted integrally (without revealing my identity): yes ☐ no ☐

Participant's signature: _____ (*Signature*) _____ (*Date*)

Researcher's signature: _____ (*Signature*) _____ (*Date*)

VERBAL PARTICIPANT INFORMED CONSENT

This form will be used if the interview is being conducted by telephone or teleconference, in the event that the participant is unable to or prefers not to print out, scan, and return the signed consent form. The full study information and consent sheet will be sent to the participant by email and reviewed over the phone with the primary investigator (PI) Mwali Muray.

Prior to beginning the interview, I would like to confirm the following:

- You understand that you are being asked to participate in a research study about the lived experiences of Francophone patients and their nursing care providers in Ontario.
- You have read, or have had read to you, each page of this Participant Informed Consent Form.
- All of your questions have been answered to your satisfaction.
- If you decide later that you would like to withdraw your participation and/or consent from the study, you can do so at any time.
- You voluntarily agree to participate in this study.
- You will be sent a copy of this signed Participant Informed Consent Form (by email).

Investigator Statement

I have carefully explained the study to the study participant. To the best of my knowledge, the participant understands the nature, demands, risks and benefits involved in taking part in this study. I have also provided the participant with opportunities to ask questions and to address any concerns they may have about the study. The participant has verbally consented to voluntary participation in this study.

Researcher's signature: _____ _____

(*Signature*) (*Date*)

Appendix I: Sociodemographic Questionnaire and Interview Guides

Interview Protocol Project: Care of Francophone Minority Patients
Time of Interview:
Date:
Place:
Interviewer:
Interviewee Identifier:

The purpose of this project is to explore the experiences of registered nurses, nursing students and Francophone patients regarding the care provided to French-speaking patient populations in Ontario. **This form is for nursing students.**

Gender Identity	
Age	
Ethnicity	Asian / Oriental / Pacific Islands Black / African / Caribbean Caucasian / White Hispanic / Latino Middle Eastern / East Indian Native / Aboriginal Other
Status	BScN Student Year 1 BScN Student Year 2 BScN Student Year 3 BScN Student Year 4 BScN Graduate Other
Highest Level of Education (in Nursing or another discipline)	Undergraduate nursing student College or Diploma _____ Bachelor's degree in _____ Master's degree in _____ Doctorate degree in _____ Other
Language of Nursing School Program	French English French and English Other
Mother Tongue	French English Other
Preferred Official Language	French English

Thank you for your participation in this interview. Anonymity and confidentiality of your responses and data will be protected throughout the research process, with utmost respect of your privacy.

Projet : Soins aux patients Francophones en situation minoritaire
Heure de l'entrevue :
Date :
Endroit :
Identifiant du chercheur :
Identité du participant :

Ce projet a pour but d'explorer les expériences des infirmiers, des étudiants en sciences infirmières, et des patients francophones qui ont reçu ou prodigué des soins de santé dans le contexte minoritaire francophone de l'Ontario. **Ce formulaire est pour les étudiants en sciences infirmières.**

Identité sexuelle	
Âge	
Ethnicité	Asie orientale / Asie Pacifique Noir / Africain / Caribéens Caucasien / Blanc Hispanique / Latino Moyen-Orient / Indien Autochtone Autre
Statut	Première année du BScInf Deuxième année du BScInf Troisième année du BScInf Quatrième année du BScInf Finissants du BScInf Autre
Le plus haut niveau d'éducation (en soins infirmiers, sciences infirmières ou dans une autre discipline)	Étudiant au BScInf Collège/diplôme/technique en _____ Baccalauréat en _____ Maîtrise en _____ Doctorat en _____ Autres
Langue du programme de sciences infirmières	Français Anglais Français et Anglais Autre
Langue maternelle	Français Anglais Autre
Langue officielle préférée	Français Anglais

Merci de votre participation à cette étude. Soyez assuré que votre anonymat sera respecté et que nous protègeront la confidentialité de vos réponses et de vos données personnelles tout au long du processus de recherche.

Interview Protocol Project: Care of Francophone Minority Patients
Time of Interview:
Date:
Place:
Interviewer:
Interviewee Identifier:

Questions

Opening question: Could you describe your experiences providing care to French-speaking patients in Ontario?

1. Is your nursing education preparing you (or did it prepare you) for the provision of culturally competent and linguistically competent nursing care? How so?

2. What challenges or barriers do you encounter in the provision of nursing care to French-speaking patients?

3. How do you communicate with French-speaking patients?

4. Do you consider language to be a determinant of health or a factor in accessing health care?

5. What strategies or opportunities exist for providing quality care to French-speaking patients within your typical nursing clinical placement? What organizational or managerial support exists (in your programme of study or in clinical settings where you do your placements) to support care to French-speaking patients? Is there anything you would like done differently?

6. To whom should I talk to find out more about the experience of caring for French-speaking patients in Ontario?

Thank you for your participation in this interview. Anonymity and confidentiality of your responses and data will be protected throughout the research process, with utmost respect of your privacy.

Projet : Soins aux patients Francophones en situation minoritaire
Heure de l'entrevue :
Date :
Endroit :
Identifiant du chercheur :
Identité du participant :

Questions

Question d'ouverture : Pouvez-vous décrire vos expériences de soins prodigués aux patients qui parlent en français en Ontario?

1. Est-ce que votre formation en sciences infirmières vous prépare (ou vous a préparé) pour la prestation des soins linguistiquement et culturellement compétents? Comment?

2. Est-ce que vous êtes confrontés à des défis ou des obstacles lors de la prestation des soins infirmiers aux patients francophones? Comment?

3. Comment communiquez-vous avec les patients francophones?

4. Percevez-vous qu'une barrière linguistique entre le patient et le professionnel de la santé est un déterminant de la santé ou un facteur de risque lors de l'accès aux soins de santé?

5. Quelles stratégies ou opportunités existent pour fournir des soins de santé de qualité auprès de patients francophones dans le cadre de vos stages cliniques lors d'une journée typique? Quels soutiens organisationnels ou de la part de vos gestionnaires cliniques (dans votre programme d'études ou dans les milieux cliniques là où vous faites vos stages) existent pour soutenir la prestation des soins de santé offerts aux patients francophones en Ontario? Selon vous, y a-t-il quelque chose qui devrait être fait différemment?

6. À qui devrais-je m'adresser pour en savoir plus sur l'expérience des soins prodigués aux patients francophones en Ontario?

Merci de votre participation à cette étude. Soyez assuré que votre anonymat sera respecté et que nous protègeront la confidentialité de vos réponses et de vos données personnelles tout au long du processus de recherche.

Interview Protocol Project: Care of Francophone Minority Patients
Time of Interview:
Date:
Place:
Interviewer:
Interviewee Identifier:

The purpose of this project is to explore the experiences of registered nurses, nursing students and Francophone patients regarding the care provided to French-speaking patient populations in Ontario. **This form is for registered nurses.**

Gender Identity	
Age	
Ethnicity	Asian / Oriental / Pacific Islands Black / African / Caribbean Caucasian / White Hispanic / Latino Middle Eastern / East Indian Native / Aboriginal Other
Employment	Casual Part Time Full Time Unemployed Other
Nursing Membership	General class (Registered Nurse [RN]) Extended class (Nurse Practitioner [NP])
Years as an RN / Year as an NP	
Highest Level of Education (in Nursing or another discipline)	RN Diploma Bachelor's degree in _____ Master's degree in _____ Doctorate degree in _____ Other
Language of Nursing School Program	French English French and English Other
Language of Work	French English French and English Other
Mother Tongue	French English Other
Preferred Official Language	French English

Thank you for your participation in this interview. Anonymity and confidentiality of your responses and data will be protected throughout the research process, with utmost respect of your privacy.

Projet : Soins aux patients Francophones en situation minoritaire
Heure de l'entrevue :
Date :
Endroit :
Identifiant du chercheur :
Identité du participant :

Ce projet a pour but d'explorer les expériences des infirmiers, des étudiants en sciences infirmières, et des patients francophones qui ont reçu ou prodigué des soins de santé dans le contexte minoritaire francophone de l'Ontario. **Ce formulaire est pour les infirmiers.**

Identité sexuelle	
Âge	
Ethnicité	Asie orientale / Asie Pacifique Noir / Africain / Caribéens Caucasien / Blanc Hispanique / Latino Moyen-Orient / Indien Autochtone Autre
Emploi	Travail occasionnel Temps partiel Temps plein Sans emploi Autre
Désignation infirmière	Catégorie générale (infirmier autorisé [IA]) Catégorie spécialisée (infirmier praticien [IP])
Années en tant qu'IA / Années en tant qu'IP	
Le plus haut niveau d'éducation (en soins/sciences infirmiers ou dans une autre discipline)	Collège/diplôme/technique en _____ Baccalauréat en _____ Maîtrise en _____ Doctorat en _____ Autre
Langue du programme de sciences infirmières	Français Anglais Français et Anglais Autre
Langue utilisée au travail	Français Anglais Français et Anglais Autre
Langue maternelle	Français Anglais Autre
Langue officielle préférée	Français Anglais

Merci de votre participation à cette étude. Soyez assuré que votre anonymat sera respecté et que nous protègeront la confidentialité de vos réponses et de vos données personnelles tout au long du processus de recherche.

Interview Protocol Project: Care of Francophone Minority Patients
Time of Interview:
Date:
Place:
Interviewer:
Interviewee Identifier:

Questions

Opening question: Could you describe your experiences providing care to French-speaking patients in Ontario?

1. Did your nursing education prepare you for the provision of culturally competent and linguistically competent nursing care? How so?

2. What challenges or barriers do you encounter in the provision of nursing care to French-speaking patients?

3. How do you communicate with French-speaking patients?

4. Do you consider language to be a determinant of health or a factor in accessing health care?

5. What strategies or opportunities exist for providing quality care to French-speaking patients within your typical workday? What organizational or managerial support exists (in your work place) to support care to French-speaking patients? Is there anything you would like done differently?

6. What professional development or educational opportunities exist for improving the provision of French language health services?

7. To whom should I talk to find out more about the experience of caring for Francophone patients in Ontario?

Thank you for your participation in this interview. Anonymity and confidentiality of your responses and data will be protected throughout the research process, with utmost respect of your privacy.

Projet : Soins aux patients Francophones en situation minoritaire
Heure de l'entrevue :
Date :
Endroit :
Identifiant du chercheur :
Identité du participant :

Questions

Question d'ouverture : Pouvez-vous décrire vos expériences de soins prodigués aux patients qui parlent en français en Ontario?

1. Est-ce que votre formation en sciences infirmières vous a préparé pour la prestation des soins linguistiquement et culturellement compétents? Comment?

2. Est-ce que vous êtes confrontés à des défis ou des obstacles lors de la prestation des soins infirmiers aux patients francophones? Comment?

3. Comment communiquez-vous avec les patients francophones?

4. Percevez-vous qu'une barrière linguistique entre le patient et le professionnel de la santé est un déterminant de la santé ou un facteur de risque lors de l'accès aux soins de santé?

5. Quelles stratégies ou opportunités existent pour fournir des soins de santé de qualité auprès de patients francophones dans votre milieu de travail lors d'une journée typique? Quels soutiens organisationnels ou de la part de vos gestionnaires cliniques dans votre milieu de travail existent pour soutenir la prestation des soins de santé offerts aux patients francophones? Selon vous, y a-t-il quelque chose qui devrait être fait différemment?

6. Quelles opportunités de développement professionnel ou de formation continue existent pour améliorer la prestation des services en français?

7. À qui devrais-je m'adresser pour en savoir plus sur l'expérience des soins prodigués aux patients francophones en Ontario?

Merci de votre participation à cette étude. Soyez assuré que votre anonymat sera respecté et que nous protègeront la confidentialité de vos réponses et de vos données personnelles tout au long du processus de recherche.

Interview Protocol Project: Care of Francophone Minority Patients
Time of Interview:
Date:
Place:
Interviewer:
Interviewee Identifier:

The purpose of this project is to explore the experiences of registered nurses, nursing students and Francophone patients regarding the care provided to French-speaking patient populations in Ontario. **This form is for Francophone patients.**

Gender Identity	
Age	
Ethnicity	Asian / Oriental / Pacific Islands Black / African / Caribbean Caucasian / White Hispanic / Latino Middle Eastern / East Indian Native / Aboriginal Other
Highest Level of Education	High School _____ College or Diploma _____ Bachelor's degree in _____ Master's degree in _____ Doctorate degree in _____ Other
Language of Schooling	French English French and English Other
Language of Work	French English French and English Other
Mother Tongue	French English Other
Preferred Official Language	French English

Thank you for your participation in this interview. Anonymity and confidentiality of your responses and data will be protected throughout the research process, with utmost respect of your privacy.

Projet : Soins aux patients Francophones en situation minoritaire
Heure de l'entrevue :
Date :
Endroit :
Identifiant du chercheur :
Identité du participant :

Ce projet a pour but d'explorer les expériences des infirmiers, des étudiants en sciences infirmières, et des patients francophones qui ont reçu ou prodigué des soins de santé dans le contexte minoritaire francophone de l'Ontario. **Ce formulaire est pour les patients francophones.**

Identité sexuelle	
Âge	
Ethnicité	Asie orientale / Asie Pacifique Noir / Africain / Caribéens Caucasien / Blanc Hispanique / Latino Moyen-Orient / Indien Autochtone Autre
Le plus haut niveau d'éducation	École secondaire _____ Collège/diplôme/technique en _____ Baccalauréat en _____ Maîtrise en _____ Doctorat en _____ Autre
Langue de votre formation scolaire	Français Anglais Français et Anglais Autre
Langue utilisée au travail	Français Anglais Français et Anglais Autre
Langue maternelle	Français Anglais Autre
Langue officielle préférée	Français Anglais

Merci de votre participation à cette étude. Soyez assuré que votre anonymat sera respecté et que nous protègeront la confidentialité de vos réponses et de vos données personnelles tout au long du processus de recherche.

Interview Protocol Project: Care of Francophone Minority Patients
Time of Interview:
Date:
Place:
Interviewer:
Interviewee Identifier:

Questions

Opening question: Could you describe your experiences receiving French language health care in Ontario?

1. Do you wish to receive health care in French? If so, do you request to be served in French? Why or why not?

2. What are your expectations with regards to receiving French language health care in Ontario?

3. What challenges or barriers do you encounter in receiving French language health care?

4. How do you communicate with your health care providers to make your needs known/understood?

5. Do you perceive language to be an issue for your health care?

6. In your opinion, how could we ensure quality care to French-speaking patients?

7. Do you know of services and resources dedicated to supporting the provision of care to Francophone patients? What would you like done differently with respect to the delivery of health care services for to French-speaking patients in Ontario?

8. To whom should I talk to find out more about the experience of Francophone patients in Ontario?

Thank you for your participation in this interview. Anonymity and confidentiality of your responses and data will be protected throughout the research process, with utmost respect of your privacy.

Projet : Soins aux patients Francophones en situation minoritaire
Heure de l'entrevue :
Date :
Endroit :
Identifiant du chercheur :
Identité du participant :

Questions

Question d'ouverture : Pouvez-vous décrire vos expériences lorsque vous avez cherché à accéder aux soins de santé en français en Ontario?

1. Souhaitez-vous recevoir des soins de santé en français? Si oui, est-ce que vous faites la demande de recevoir des soins en français? Pourquoi, ou pourquoi pas?

2. Quelles sont vos attentes en ce qui concerne la réception de soins de santé en français en Ontario?

3. Est-ce que vous êtes confrontés à des défis ou des obstacles lors que vous cherchez à accéder aux soins en français? Comment?

4. Comment communiquez-vous avec vos soignants pour faire connaître vos besoins et être comprise?

5. Trouvez-vous que la langue est un problème pour votre accès aux soins de santé?

6. Selon vous, comment pouvons-nous assurer des soins de qualité offerts aux patients qui cherchent à obtenir des soins en français en Ontario?

7. Connaissez-vous des services et des ressources dédiés à la prestation de soins aux patients francophones? Selon vous, y a-t-il quelque chose qui devrait être fait différemment pour ce qui a trait à la prestation des soins de santé des patients francophones en Ontario?

8. À qui devrais-je m'adresser pour en savoir plus sur l'expérience des patients francophones en Ontario?

Merci de votre participation à cette étude. Soyez assuré que votre anonymat sera respecté et que nous protègeront la confidentialité de vos réponses et de vos données personnelles tout au long du processus de recherche.