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Abstract
Despite Canada's linguistic duality, French-speaking minority populations continue to face significant barriers in accessing equitable health care. Investigating two key research questions, this study explores: (1) What are the lived experiences of registered nurses and nursing students caring for French-speaking patients in Ontario? and (2) How do French-speaking patients navigate the health care system to access care in their preferred language? Using qualitative methodology informed by interpretive phenomenology, 31 participants were interviewed individually between 2018 and 2019, offering firsthand accounts of their experiences. Findings reveal a paradox of (in)visibility: French-speaking patients and nursing providers remain invisible when they adapt to systemic shortcomings but become highly visible when they advocate for equitable care. The study highlights the urgent need for the effective and consistent implementation of the strategic changes within health care institutions. Addressing these linguistic disparities is not only a matter of patient safety and quality care but also a fundamental step toward upholding Canada's bilingual commitments in health service delivery.

Keywords Qualitative approaches, Nurses, Students, Workforce issues, Patient safety

Official Language Minority Communities in Ontario: (In)visibility of Nursing Care

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Introduction

Although Canada is a bilingual nation, Francophone minority communities continue to perceive that they are receiving inadequate access to services in their language (Ombudsman Ontario, 2024). Inadequate access to health services in French may hinder the ability of Francophone minority communities to obtain timely and comprehensive access to the quality care that they seek (Savard et al., 2020b). Attributes of health care quality include care that is effective, safe, excellent, and that helps a person achieve their desired health goals and outcomes (Allen-Duck et al., 2017; World Health Organization, n. d.). The links between quality of care and language should be considered as social and cultural determinants of health (Bouchard et al., 2010; Bowen, 2001, 2015; Drolet et al., 2017; Showstack et al., 2019); however, numerous researchers contend that this standard of quality care is not upheld for Francophone minority patients.

With advancements in technology, individuals are expected to live longer and to require increasingly complex health care services (Canadian Institute for Health Information, 2011, 2017; Canadian Medical Association, 2016; Canadian Nurses Association, 2007; Cline, 2015). Meanwhile, trends in global mobility and migration indicate that low English proficiency populations are expected to increase around the world, including in Canada. Thus, individuals with different language and cultural needs are going to require health care services of increasing complexity, worldwide, and in Canada as well. With Canada attracting immigration of both English-speaking and French-speaking populations, the health care system must be prepared to respond to patients of all languages, and certainly to be ready and equipped to provide care in both official languages.

Growing numbers of studies have identified the importance of language concordance and the risks posed by language discordance within the health care system (L. Bouchard et al., 2024; Lee et al., 2024; Reaume et al., 2024; Seale et al., 2022). Studies in medicine have highlighted challenges with regards to inappropriate prescribing and lack of translation services within certain communities, affecting health equity and patient outcomes (Lee et al., 2024; Reaume et al., 2024; Seale et al., 2022). However, challenges with regards to access to linguistically concordant care for Canadian nursing is seldom explored within the literature.

While nursing is one of the largest professions in the health care system, few studies have focused on the experience of nursing professionals caring for French-speaking patients in a linguistic minority context. Moreover, given the aging population of the nursing workforce (Canadian Institute for Health Information, 2020; Chartrand et al., 2019; Kwok et al., 2016), and the exodus from the profession further complicated by the COVID-19 pandemic (Farahani et al., 2024; Martin et al., 2023), it is crucial to understand the perspective of patients, workers and learners navigating this complex health care landscape. Thus, this study examines Francophone minority communities with the aim to understanding the lived experiences of French-speaking patients and their nursing care providers.

Background

Languages and Health Care in Canada

The link regarding language concordance between patients and health care providers has been studied at length across the globe. Challenges concerning language concordance are reflected in Canada as well, especially in the wake of globalization and increased diversity of the languages spoken by individuals residing in Canada. For example, the impacts of language concordance between patients and physicians were recently examined in relation to the challenges of allophone ethnic groups who speak neither official language, nor share a common language with their physician (Ariste & Matteo, 2021; Seale et al., 2022). Language barriers were also examined, with some individuals indicating they were hesitant to access health care services due to language barriers. Some avoid the health care system altogether, while others choose to return to countries of origin to secure health care services (van Allen et al., 2021). Another example to consider is that of individuals belonging to Deaf cultural and linguistic minority communities, as they may also face decreased health literacy and poor health outcomes (Malebranche et al., 2020).

Impact of Language on Health Service Experience

Canada is a linguistically diverse country with two official languages, French and English. This bilingualism policy seeks to allow for Francophone minority communities and English-speaking minority communities to thrive in their respective languages. At the time of the 2021 Canadian census, 18% of Canadians indicated that they were bilingual, capable of conversing in French and English (Statistics Canada, 2023). Quebec hosts the majority of French-speaking Canadians, at 84.1%, or 7,074,328 people (Canadian Heritage, 2024). In Ontario, 533,560 people (or 3.8% of the population) boasts of French as their first official language. It is important to note that New Brunswick is the only bilingual province in Canada, with 30.3% of the population listing French as their first official language, representing 231,850 people (Canadian Heritage, 2024).

Numerous scholars have reviewed challenges to simply obtaining health care in Canada in one's official language. Though official federal languages in Canada are English and French, patients may face difficulties obtaining care in their official language, and thus find themselves having to accommodate the language of the health care provider, often to their detriment. The resulting challenges exist whether one is seeking care in a minority anglophone or francophone setting. For example, studies regarding official language minority populations in Quebec report that patients experience heightened anxiety when seeking health care services in their second language, for both physical and emotional/mental health presentations (Zhao et al., 2019). Also in Quebec, studies have demonstrated a heightened mortality risk for migrants belonging to the anglophone minority community (Lo et al., 2018). In certain regions of Canada, mental health services are less numerous and of lesser quality for Francophone minority and visible minority populations, a struggle identified in the youth and adolescent context of Saskatchewan (Firzly et al., 2021). Similarly, a study amongst international Francophone post-secondary students in Manitoba noticed that students also faced heightened risks to their mental health (Gueye et al., 2018), an issue further challenged by the inadequate access to health care services in their language.

Linguistic Challenges in Nursing

While certain studies have reviewed the presence of visible minorities and language minorities in the Canadian nursing workforce (Premji & Etowa, 2014), there is a dearth of recent publications on official language minority communities with regard to their access to nursing care. Moreover, while some studies consider low English proficiency nursing students

(Choi, 2005; Skisland et al., 2018), no studies have recently examined nursing students caring for minority language patients in Canada. Our study is unique in that it examines the parallel experiences with registered nurses and patients, and provides a novel and timely perspective to an issue that requires further examination for the benefit of French-speaking patients, registered nurses, and nursing students in Canada.

Methods

Aim

The aim of this study was to examine the lived experiences of French-speaking patients, nursing students, and registered nurses with regard to French language health care services in the Canadian province of Ontario.

Theoretical Framework

This research was influenced by the Four levels of health care models, initially conceptualized as the “Four Levels of Change for Improving Quality” model (Ferlie & Shortell, 2001), later adapted by Reid et al. (2005) as the “Four-Level Model of the Health Care System.” The model by Reid et al. (2005) was represented by four concentric circles whereby the patient is at the centre of the health care experience, surrounded by the care team. The circles in this model then include the organizations, and lastly the environment. Both frameworks present different stakeholders to consider in the health care system, including patients, the health care team, the organization, and the environmental/systemic level, and thus provide important context to the sectors influencing the experiences of French-speaking patients and their health care workers. While this research was focused on the experiences of patients and their nursing care providers, the perspectives that were shared addressed all levels of the theoretical frameworks.

In addition to this theoretical framework, this work must be positioned by stating that the research was conducted by a Black Francophone registered nurse enrolled in a doctoral program in Ontario. The primary researcher had experience providing care for French-speaking patients, as well as helping family members navigate the health care system as linguistic minorities in Ontario. The first authors’ supervisors and research advisory committee also consisted of French-speaking researchers.

Design

A qualitative research design was used for this study, informed by interpretive phenomenology (Heidegger, 1962; van Manen, 1990). Given the complexity of the phenomena at hand, a qualitative research design would be indicated to explore the relative and multiple realities of research participants. As such, interpretive phenomenology, a qualitative research methodology with aims of understanding the essence and conveying the lived experience of a phenomenon, was well suited for this work. The phenomenological research questions explored in this study 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?”. By means of semi-structured interviews, participants elaborated on the supports, strategies, challenges and barriers encountered when receiving care as French-speaking patients, or when caring for French-speaking minority communities.

Participants

Using purposive and snowball sampling, study participants were recruited by means of invitations sent through the mailing lists and social medias of various organizations, including the Assemblée de la francophonie de l’Ontario, the Fédération des aînés et des retraités francophones de l’Ontario, the Réseau franco-santé du Sud de l’Ontario, the Réseau des services de santé en français de l’Est de l’Ontario, the College of nurses of Ontario, the Nurse Practitioners’ Association of Ontario, and the Canadian Nursing Students’ Association. The sampling strategy allowed for individuals with salient lived experiences to gain knowledge of the study, beyond the study teams’ original networks. Patients were invited using Francophone organizations across the province. Nursing professionals received invitations to take part in this study through their university and through student or professional associations. Participants were eligible for the study if they had received health care services in Ontario, or if they had been involved in the care of French-speaking patients in Ontario. All eligible participants were invited to contact the researcher by phone or by email, and were welcomed to take part in an interview in English or in French.

Data Collection & Analysis

This qualitative study was conducted in Ontario, Canada. Participant permission was requested for the interviews to be audio-recorded. All interviews were recorded but one, for which the participant consented to detailed notetaking. Reflexive notes were also taken throughout the data collection and data analysis period.

The individual interviews were transcribed verbatim, followed by thematic data analysis, as guided by van Manen (1990) and Braun and Clarke (2006). The data analysis was conducted individually for the three groups, registered nurses, nursing students, and patients. Following the analysis of the first interview for each set (MM), these findings were reviewed with an experienced qualitative researcher (AP). Each interview was transcribed, read and reread, and analysed individually, thereafter within the context of the participant group. Given that the interviews with nursing students, registered nurses, and patients were subsets of a larger study, following the preliminary analysis, all the interviews were reviewed for themes that emerged inductively, and which overlapped for the three subsets of participants. The thematic review was done to identify important similarities in the experiences of French-speaking patients and providers. The resulting themes were explored, discussed and agreed upon with all authors (MM, AP, JC). Numerous thesis advisory committee meetings were held, confirming consensus over themes.

Ethical clearance was obtained from the authors' institution of affiliation. All participants received a study information package, including an informed consent document, reviewed independently, and then reviewed with the researcher. Full and informed consent was provided by all participants. Only the primary researcher took part in the recording of interviews and had access to their personal information, as to assure participant confidentiality. Participant confidentiality was enhanced by allowing participants to take part in the interview over the telephone or in a private location in person, as per their preference. All collected data was stored in secure servers hosted by the University of Ottawa.

Results

Participants enrolled in this study shared their experiences regarding accessing and caring for French-speaking patients in Ontario. All interviews were conducted by the first author. Individual interviews were held in person or over the telephone, according to participant preference, between 2018 and 2019.

Overall, 31 participants were interviewed for this study, including 11 registered nurses, 10 nursing students, and 10 French-speaking patients, with interviews lasting approximately one hour in length. Most study participants were female, except for two male patients. French-speaking patients, registered nurses, and nursing students in the study had a mean age of 55 years old, 31 years old, and 22 years old, respectively. While most participants were Caucasian, seven patients identified as Black. Additional patient demographics and indicated in table 1.

Several results emerged from this study, represented by two key themes. The first theme featured in this article is a notion coined as "Good Enough Care," as the standard of care provided to French-speaking patients in Ontario: adequate for the time being, but not by any means the excellent quality level of care expected, desired, or preferred. The second

Table 1. Participants Sociodemographic Characteristics

	Francophone Patient (PT) n = 10	Registered Nurse (RN) n = 11	Nursing Student (NS) n = 10
	n (%)	n (%)	n (%)
Gender Identity	8 (80%) Female	11 (100%) Female	10 (100%) Female
Age	Average: 55 years old	Average: 31.7 years old	Average: 22.5 years old
Age Ranges	Range: 26-82 years old	Range: 24-42 years old	Range: 19-30 years old
Ethnicity	7 (70%) Black	9 (82%) White	7 (70%) White
Highest Level of Education	6 (60%) College/diploma/Bachelors	8 (73%) MScN	7 (70%) Undergraduate student
Language of Schooling	7 (70%) French	6 (55%) English Nursing School	6 (60%) French Nursing School
Mother Tongue	6 (60%) French	5 (45%) French	7 (70%) French and/or English
Preferred Official Language	9 (90%) French	7 (64%) English	5 (50%) French
City of Residence	Hornepayne, Ottawa & Sudbury	Ottawa, Sudbury & Toronto	Hamilton, Ottawa, Sudbury & Toronto

theme included the formal and informal adaptive strategies developed to overcome challenges accessing quality care given the linguistic minority context. For the presentation of participant quotes, registered nurses are referred to as RN##, French-speaking patients as PT##, and nursing students as NS##. Some quotes were translated from French.

Good Enough Care Theme 1.1: Delayed Access to French-Language Health Services

Individual patients were adamant in reporting poor access to French-language health services. Poor access was evidenced by experiences of delays in care, and the sentiments of being burdened and feeling like a burden when accessing health care services. At the individual level, patients also shared the socio-professional cost of barriers and the emotional impacts incurred.

In describing delays in care, French-speaking patients revealed difficulties in accessing health care services in French, notably pointing to concerns regarding potentially longer wait times. While it is already established that obtaining health care services can be lengthy, patients perceived that their visit was longer than other patients, since they incurred an additional wait time for care in French.

PT07 discusses this, revealing that: “Sometimes I request services in French, but it’s difficult. If you ask for someone who speaks French, it’s going to take a long time…” Many French-speaking patients in this study attested to starting their encounters already anticipating longer wait times, adding to the stress and distress of a challenging health care experience. However, some patients also described that despite having delayed access to services in their language, they would wait only to be advised that no one is able to service them in their official language of choice, thus having had to wait in vain.

Not only are holdups in care affecting individual French-speaking patients, but these delays have an impact on numerous actors in the health care system. For example, RN04 points to the extensive impacts of language discordance in the context of emergency services: “Let’s say we have a doctor who doesn’t speak French who is assigned to a French-speaking family… we have already lost time because we have just realized that the doctor cannot really communicate with the family. So, he leaves the patient room, and we must now find a nurse who speaks good French… we are wasting even more time. Next, the nurse must stop everything she is doing or he is doing to go in the patient room with this doctor. But let’s say that it’s me and that I was in the middle of doing something very important, the patient who is Francophone with a doctor who does not speak in French, continues to wait and wait and wait until, for example, I’m ready to go in the assessment room. It’s true that it really delays the care of this patient, but because it’s an emergency department, it means that it delays the care of everyone else in the emergency department that this doctor is assigned to see.”

In the quote above, RN04 vividly describes the ripple effect for patients, nurses, and the entire health care environment when French-speaking patients experience delays in their health care. Moreover, the entire health care team experiences disruptions in the services, as do other patients waiting on the same primary care provider. Meanwhile, the individual nurse is waited on for tasks that are not in her workload, which she is now expected to take on for the team.

Good Enough Care Theme 1.2: (In)visible Workloads

Numerous concerns were voiced from registered nurses and nursing students. A particularly insidious concern was the (In)visible Workloads that landed on both anglophone and Francophone nursing care providers, many of whom pointed to the overlapping, as well as the unique challenges which they faced. The term “(In)visible” workloads is indicated by parentheses to reflect the fact that the workloads are simultaneously visible and invisible. In reviewing (in)visible workloads, there were discussions elicited around student experiences, navigating studies and work in French, the particularities of anglophone nursing experiences, as well as the French-speaking nursing experiences. Nursing participants also discussed how they navigated preserving the therapeutic relationship, as well as the emotional impacts of caring for Francophone minority community patients.

For example, NS02 shares the following clinical experience caring for a Francophone family: “I was doing a clinical placement at [pediatric hospital] last year. I was a student with a patient and her mother who was also there. During the doctors round. . . they arrived in front of this patient’s door and all the doctors were talking, talking, talking. At the end they asked the mother ‘Do you have any questions? Then, she looked at me in a panic and she said, ‘I’m going to ask it in French because I don’t know, I don’t know how to say it in English.’ I was like, ‘It’s okay, it’s okay.’ So she asked the question. All the doctors looked at each other, like, ‘we don’t understand what she’s saying.’ So I said to myself, ‘It’s up to me to translate’ . . . The patient and the mother looked at me. Then I just translated the question. The doctors answered in English. I had to translate for the mom.’”

NS02’s example is relevant to the experience of Francophone nurses and nursing students, whereby the expectations of translating for the health care team may fall onto their shoulders, and be theirs to carry early in their career, even as a novice within the health care sector. The nursing student

shares of her numerous concerns with regards to this experience, notably the lack of training and preparation for such circumstances, and sharing in the distress of the parent in a delicate situation. While this work is valued by patients and by colleagues in the health care team, this work is not often acknowledged throughout the health care system, despite the fact that it is essential to satisfy patient care interactions.

NS05 shares her experience concerning the efforts required to care for patients well in the face of linguistic discordance, especially when their French language requirements have already been disregarded: "[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."

The previous quote shares the troubling experience of a French-speaking patient receiving care in English, despite limited proficiency in the language. The presence of the nursing student assists him in navigating and understanding the care received, before, during and after the procedure. The care also includes advocating for the patient by getting the surgeon to discuss with the patient again, this time allowing for the patient to provide proper informed consent to the operative plan. The extensive care provided was valuable for the entire health care team, but also required the student to stay beyond her assigned shift, work that is frequently invisible and unpaid.

Good Enough Care Theme 1.3: Disruptions in the Flow of Care

Furthermore, the findings of this study pointed to disruptions in the flow of care, as identified by both nursing and patient participants. The disruptions were evidenced by barriers speaking with and seeking health care providers, and with challenges pertaining to interpretation and translation. There was also an overarching concern that Francophones would be perceived as "difficult" patients, and overall, it was noticed that the disruptions incurred would certainly have an impact on care activities.

A frequently suggested solution with regard to language barriers is the use of interpreters. However, both patients and participants had numerous perspectives on interpreter use. As PT10 states, "The first time when I had the interpreter, I understood at least some English. At some point the interpreter... wanted to interpret what I didn't say. So I would stop him and then I would say 'No, that's not what I said'. So with that, it makes me question, 'Is the interpreter really going to make the doctor understand what my problem is? I had my doubts..."

PT10 shares concerns about miscommunication during the translation. While she can understand some English, her official language is French. During this interaction with the facility provided translator, she could understand how the translator was conveying her story, however, she was concerned to hear information she had not said being translated to the provider, as well. The interaction raised questions as to whether the provided translation would accurately convey her health needs to her physician, adding an extra layer of concern with her health care interactions. Several participants, patients and providers, noticed that interpretation services were important, but could also introduce additional difficulties.

Good Enough Care Theme 1.4: Lack of Resources

Unanimously, participants reflected on the lack of resources that plagued organizations in supporting French language health care services. There was discussion regarding the strengths and shortcomings of institutional designation, and concerns on the state of bilingualism in the organizations. Participants also addressed French language necessity, and considered managerial and organizational support for French language care. Study participants also discussed the state of clinical tools and resources existing to support French language health care.

On the matter of the lack of resources, reflections took place on a number of organizational strategies which could facilitate or hinder French language care, both for recipient and for providers. For example, several participants were aware of French language designated institutions, and many patients consciously sought those centres out. However, consistent offer of French language services could fall short in those organizations, as well. As RN07 shares, "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."

The nursing participant in question acknowledges working in a designated French language institution. However, she realizes that this organizational designation is not necessarily valued or respected by all of her colleagues. She sees this evidenced in the difficulty to make time or do the necessary efforts for the offer of French language services. As such, this can make the interaction more difficult for non-English speaking patients. A similar dismay was also shared by French-speaking patients, who realized that though institutional designation was an important step for organizations, it could still be difficult for them to receive the level of French language care required.

Good Enough Care Theme 1.5: Health Policy Impacts on Patient Rights

From an environmental level perspective, participants considered the health policy impacts on patient rights. Participants acknowledged that the current climate of health care services in Ontario affects how French-speaking patients can access care, and how health care providers can meet the needs of their French-speaking populations. Included in this theme were the lack of respect for French, hindered access, problems with regards to consent, the overall lack of consideration for patient safety, and the lack of quality care. They also drew parallels with the problematic situations regarding special patient populations (such as psychiatric pediatric or neurologically compromised patients) who experience disproportionate difficulties when systemically faced with language discordance. Participants considered language as a right, and what this meant for Francophones with regards to health care. Finally, considerations of good enough French and accommodations were explored, along with the state of the active offer and the lack thereof.

Concerning language as a right, participants were aware that the status quo was neither meeting the needs of health care system users, nor barely keeping up with the law. For example, PT03 states "It's still a right to be served in your language… when you consider it as a right, I think you have to make an effort. [An effort] from the government, [and an effort] from the [care providers] also to serve people in French." Here, PT03 indicates awareness of laws and patient's rights to French language services in Ontario, such as the French Language Services Act (Government of Ontario, 1990). The patient participant also points to the responsibilities for various actors of the health care system, including government and health care providers, to rectify the issues at hand, and to actively facilitate Francophones rights to receive and to be offered French language services. Such a reflection serves as a reminder that several individuals and structures influence their ability to receive the care and services within their rights.

This sentiment is echoed by other participants. In considering the way that the French language is treated in Ontario, RN06 shares, "I think we have to respect Francophones… By offering services in French, we show respect for the Francophone population. So it is necessary, it is really necessary to put these strategies in place." This participant links the importance of valuing French as an official language as a means of respecting Francophone individuals in Ontario. She also alludes to implementing strategies which can help meet the needs of French-speaking patients, in response to the linguistic needs of this population.

Strategies to Manage the Lack of Resources for French-Speaking Populations

The second major theme emerging from this study is the strategies to manage the lack of resources for French-speaking populations. In light of the perplexing situation with which participants were faced, patients, registered nurses, and nursing students had opportunities to reflect on numerous strategies. The strategies shared were considered to bridge the gaps existing within their health care environments, but were also voiced to suggest improvements to the status quo. The study participants discussed both the strategies that were implemented before, during, or after clinical encounters, as well as the strategies proposed to overcome the problematic situations which they routinely faced. It must be noted that these are strategies and recommendations raised by the participants, who speak to their lived experience of the phenomenon and voiced means to overcome some of their challenges.

Adaptive Strategies Theme 1.1: Implemented Strategies

Implemented strategies used to cope with the realities of providing and receiving care for Francophones in Ontario included suggestions concerning the use of clinical tools and resources. Participants reflected on the best use of other tools and technologies, as well as considerations on the state of interpretation and translation services. Several participants, nurses, nursing students, and patients alike, shared thoughts regarding staff assignment and utilization of the interprofessional team, the use of non-verbal communication, and on health care professional education. Participants also discussed how to best use Francophone institutions. Moreover, participants, especially patients, shared how they adapt to, challenge, or resist the lack of access to French health care services.

The breadth of experiences and strategies was extensive. For example, PT06 shares that "When the doctor gave us prescriptions and instructions to follow, my husband had to record him so that we could listen calmly at home… He had given us brochures, a form that we had to read and fill in case

something happened to the baby again. They wrote it all down. It was in English. So what we did was use Google Translate, because there was no one to help us." Here, PT06 reminds us once more of the extensive visible and invisible labour, tasks and toll that can take place for patients, especially in the context of linguistic discordance. Extra responsibilities include coming prepared to record the health care interaction, downloading and learning to use programs such as Google Translate, and extensive efforts to teach themselves what was required to safely care for their newborn baby at home. Such a recourse points once again to the inadequacies of the health care system, as once the patient and family are at home, they lose access to the health care professionals who should be able to validate their understanding, and respond to any questions or concerns. While technology comes with certain benefits, it is a strategy that cannot replace safe, quality care, including thorough patient education from health care professionals on site. Moreover, it certainly does not replace the important ability to ask and receive answers to questions, engaging the health care professional within the context of the therapeutic relationship. Nevertheless, these French-speaking patients and families demonstrate that this is how they must adapt.

Meanwhile, nurses and nursing students also find themselves improvising strategies to better meet patient needs when faced with linguistic barriers. As NS09 shares, "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... We just keep—compile those resources for ourselves... We do share them with the nurses... Some of the nurses are already aware of where to get some of these resources, so... it's also helpful." This nursing student shares of informal networks of information sharing, which indeed benefit other nursing students, registered nurses, and patients, in response to resources which may be scattered throughout their region. While this is a creative way to meet patients' and providers' needs, this points to structural issues within the health care system, whereby resources are not positioned strategically to meet the needs of patients and frontline workers. The strategy, optimized by nursing students, meets urgent needs of patients and staff, yet masks the inefficiencies of the organization, and the voids in care for Francophone populations.

In response to being consistently faced with challenges as a French-speaking patient, some choose to clearly express their boundaries in pursuit of French language health care services. According to PT05, "sometimes I refuse to speak English when... I'm not only rudely asked, but disrespectfully asked if I speak English, so at that time I refuse.... they will look for someone to translate. . . People look at me, they say "Speak English". . . at those times I don't speak English." PT05's response is an example of resisting the anglo-dominant health care structure in order to receive safe care in the patient's official language. The patient shares insight on what it can be like to be forced to speak in English, by the health care system. Despite asking for care in French, health care providers simply insist that she speaks in English. However, this participant has come to find that insisting on being served in French is an effective means of mobilizing health care providers to start seeking Francophone providers, or implementing the use of French language resources to safely care for her.

Adaptive Strategies Theme 1.2: Proposed Strategies

Participants shared both current strategies and proposed solutions to address the health care services of official language minority communities. As such, a number of proposed strategies were raised by the participants, including advocacy and raising awareness, human resources management, clinical resources use, involvement of educational systems, and considerations for government involvement.

Nursing students, registered nurses, and French-speaking patients unanimously echoed the importance of recruiting and retaining French-speaking health care providers throughout the health care system, in order to have sufficient numbers of bilingual health care professionals to meet the Ontario populations needs. Participants consistently spoke of the importance of having bilingual resources, in both English and French. NS07 shares that they "Make sure that all the literature, sometimes we have versions of the literature, pamphlets to give to patients after surgery for rehabilitation or maybe before, something like electroconvulsive therapy (ECT) in mental health... make sure all pamphlets are bilingual. It's easy to do. On one side it is in English, then you turn to the other side and the document is in French. It really is . . . easy to do... so that literature for patients is accessible in both languages." This participant points to a significant issue raised throughout the study, where many French-speaking patients struggled to access data and health information in their language. To consistently meet the needs of patients, and facilitate the experience of health care providers, systemically preparing resources in both languages, on the

same document, makes it easy for the health care providers to consistently equip patients with the appropriate information. Moreover, while this strategy seems intuitive, patients and providers alike indicated that this was not done systemically, although it could significantly help all those involved.

A number of participants pointed to the role of government in enhancing French language service structures. As PT08 shares, "The government has statistics. . . often when I went to health centers like hospitals and everything. I was asked 'did I feel comfortable being served in French or in English', so I imagine that the government has all the statistics of the people, of the patients who are served. . . I think the government is best placed to improve the level of French in health centres.'" Here, PT08 is frequently answering both facility and government surveys where she responds that French is her official language of choice. While this information is taken, patients do not always know how this data is utilized. However, with such data in hand, this patient believes that it would be wise for the government to consider this statistical data and thus help improve the language congruent care for health service facilities.

Discussion

This study sheds light on the realities of the health care system concerning Francophone minority communities and their health care providers. Navigating a path laced with difficulties before, during, and even after the health care interaction, registered nurses, nursing students, and French-speaking patients provide numerous reflections on the problematic state of health care for official language communities. Such challenges include longer wait times, heightened workloads, difficulties with interpretation and translation, inadequate resources, and more.

The data collected also provides insights on how the problems are currently addressed, and strategies for their remediation. As the study participants share their complex realities, it becomes more evident that there is a dynamic of visible and invisible work which disproportionally affects some patients and providers at the individual level, and that may not be noticed or acknowledge systemically. Given their influence on quality of care, the (in)visible realities of French-speaking patients and nursing professionals requires further examination. The experience of participants demonstrates how the various levels of the health care system (Ferlie & Shortell, 2001; Reid et al., 2005) are actors involved in the challenging experience of seeking and delivering health care services to French-speaking communities in Ontario.

(In)visible Nursing Work

While there is an (in)visibility that was identified with French-speaking patients seeking health care, this reality also exists with health care providers to Francophone populations. Registered nurses and nursing students in this study displayed respective coping strategies in meeting the needs of their patients. As originally stated by 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). Such a dynamic is often the case within the health care system, as evidenced by how nurses and nursing students navigated complexities in providing quality care to the patient before them.

In this study, while both groups faced perplexing realities at the clinical front, the experiences of bilingual or French-speaking nursing care providers differed slightly from that of anglophone nurses. French-speaking nurses and nursing students frequently described how speaking French could be a workplace advantage and incur challenges. For example, certain facilities or sectors privileged hiring or promoting French-speaking nurses and nursing students. Moreover, this was an implicit advantage in being able to address the needs of their French- and English-speaking patients. However, these same nursing participants also pointed to the drawbacks of bilingualism, which was most often manifested in increased workloads and responsibilities. The same challenge has been echoed in the work of others (Canadian Nurses Association, 2007; Lydahl, 2017), with disparities causing some health care providers to even conceal their bilingualism. While their presence and ability to service both the English-speaking and French-speaking population was a visible asset, much of this work was invisible, in that it was unrecognized and undocumented, despite benefiting the patients, their families, the health care team (physicians, the interdisciplinary team), and the organization. Moreover, the weight of responsibility followed these providers beyond their shifts, some working overtime to meet the linguistic health care needs of patients, with many others remaining concerned about how patients' needs would be addressed in the health care facility, in referrals, and upon discharge.

English-speaking providers, nurses and nursing students alike, also acknowledged difficulties regarding care provision. They described a certain distress for not being able to meet the immediate language needs of French-speaking patients, and the risk for patient safety that could result. Invisible work is done to bridge the gap, from self-learning French using apps to meeting with colleagues for French tutoring using hospital handouts, is not acknowledged by the organization nor the

health care system, though it directly cuts into the personal time of the nurse or nursing students, as well as that of their helpful colleagues.

Within Canada, nursing institutions have analyzed the state of nursing for Francophone minorities. For example, the important work of the Canadian Nurses Association (2007) provided a synthesis report on the state of nursing in French, pointing to numerous inequities requiring improvement. Unfortunately, over 18 years since the release of the report, nursing professionals continue to perceive challenges in care, be they Francophone or be they caring for Francophones.

Despite policies and reports indicating that bilingualism is important, action is required to change the status quo, and to consider the various stakeholders who can take part in influencing the future and outcomes of nursing. Notably, action and contributions on the part of the health care system, government representatives, organizations, and health care institutions would be essential. The same expectations would apply to educational facilities, responsible for preparing and equipping working nurses, as well as supporting nursing students, who are already an integral part of the nursing workforce.

Limitations

With regards to study limitations, it must be noted that the study involved a large number of participants for a qualitative phenomenological study; this is because while there were three small samples (registered nurses, nursing students, and participants). As such, this paper presents the three subgroups of participants in the same dialogue as they provide insights as to how they have experienced the issue that they have in common. Resultingly, this study gains from having diverse perspectives of the phenomena in comparison to the data which could have stemmed from a more homogenous sample. Additionally, this study provided the perspective of two male patients, with no male nursing students or registered nurses. Future studies would benefit from targeted recruitment of men and gender diverse participants, which may experience receiving and providing care differently. Moreover, it is possible that the individuals who took part in this research already had a particular interest in official language minority communities, potentially affecting the study findings. Thus, interviews may have yielded different findings with a group of individuals who were less passionate about the phenomena.

Conclusion

Despite Canada's commitment to linguistic duality, French-speaking minority populations and their health care providers continue to face systemic barriers that compromise equitable access to care. Our study reveals that these challenges are not new but persist due to entrenched structural deficiencies that remain largely unseen and unaddressed. Participants' experiences underscore a troubling reality: while their adaptability and individual strategies mitigate some gaps, these efforts mask the deeper failures of the system and place the burden of linguistic accessibility on those least equipped to bear it.

Addressing these inequities requires a multilevel, coordinated response that moves beyond fragmented, siloed efforts. Drawing on both participant insights and existing scholarship (Ferlie & Shortell, 2001; Reid et al., 2005; Savard et al., 2020), this study highlights the necessity of action across environmental, organizational, team, and individual levels. Policies must go beyond symbolic commitments to actively embed structural, legal, and resource-based solutions that uphold the right to care in both official languages.

Ultimately, systemic reform is not optional but essential. Without significant investment and policy-driven change, French-speaking patients and their care providers will remain trapped in a cycle of invisibility—expected to function within a system that neither recognizes nor adequately supports them. Ensuring linguistic equity in health care is not just a matter of compliance; it is a fundamental issue of patient safety, professional well-being, and social justice.

References

Allen-Duck, A., Robinson, J. C., & Stewart, M. W. (2017). Healthcare quality: A concept analysis. Nursing forum, 52(4), 377-386. https://doi.org/10.1111/nuf.12207

Ariste, R., & Matteo, L. di. (2021). Non-Official Language Concordance in Urban Canadian Medical Practice: Implications for Care during the COVID-19 Pandemic. Healthcare Policy, 16(4), 84-96. https://doi.org/10.12927/hcpol.2021.26497

Bouchard, L., & Lizotte, M. (2024). Les données linguistiques pour la recherche et la planification en santé : possibilités et limites pour l'étude des francophones en situation minoritaire. Minorités linguistiques et société / Linguistic Minorities and Society , 22. https://doi.org/https://doi.org/10.7202/1110621ar

Bouchard, L., Savard, J., & Dumond, M. (2024). La santé en contexte francophone minoritaire au Canada : 20 ans de recherche : introduction. Minorités linguistiques et société / Linguistic Minorities and Society , 22. https://doi.org/https://doi.org/10.7202/1110619ar

Bouchard, P., Vézina, S., & Savoie, M. (2010). Rapport du dialogue sur l'engagement des étudiants et des futurs professionnels pour de meilleurs services de santé en français dans un contexte minoritaire: formation et outillage, recrutement et rétention. Formation et outillage. Recrutement et rétention, 1-47.

Bowen, S. (2001). Language barriers in access to health care. https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-accessibility/language-barriers.html

Bowen, S. (2015). Impact des barrières linguistiques sur la sécurité des patients et la qualité des soins. Société Santé en français. https://savoir-sante.ca/fr/content_page/item/429-impact-des-barrieres-linguistiques

Canadian Heritage. (2024). Statistics on official languages in Canada. https://www.canada.ca/en/canadian-heritage/services/official-languages-bilingualism/publications/statistics.html

Canadian Institute for Health Information. (2011). Health care in Canada, 2011: A focus on seniors and aging. https://publications.gc.ca/collections/collection_2011/icis-cihi/H115-15-2011-eng.pdf

Canadian Institute for Health Information. (2017). Canada's seniors population outlook: Uncharted territory. https://www.cihi.ca/en/infographic-canadas-seniors-population-outlook-uncharted-territory

Canadian Institute for Health Information. (2020). Nursing in Canada, 2019: a lens on supply and workforce. https://www.cihi.ca/sites/default/files/document/nursing-report-2019-en-web.pdf

Canadian Medical Association. (2016). The state of seniors health care in Canada. https://www.cma.ca/state-seniors-health-care-canada

Canadian Nurses Association. (2007). Projet soins infirmiers en français: synthesis report.

Chartrand, J., Vandyk, A., Beké, É., Balasa, R., Loranger, C., Muray, M., Chartrand, M., & Baker, C. (2019). La pénurie de professeures de sciences infirmières au Canada et ses effets sur les programmes de formation en sciences infirmières offerts en français. Minorités Linguistiques et Société, 11(11), 95. https://doi.org/10.7202/1065214ar

Cline, D. D. (2015). Complexity of care: A concept analysis of older adult health care experiences. Nursing Education Perspectives, 36(2), 108-113. http://doi.org/10.5480/14-1362

Deschamps, S. (2024, septembre 26). La langue officielle du patient figurera sur la nouvelle carte de santé du Manitoba. Radio-Canada. https://ici.radio-canada.ca/nouvelle/2107400/sante-francais-document-offre-active-manitoba

Drolet, M., Bouchard, P., & Savard, J. (2017). Accessibility and active offer: health care and social services in linguistic minority communities. University of Ottawa Press. https://doi.org/https://doi.org/10.2307/j.ctv5vdcxc

Farahani, M.A., Nargesi, S., Saniee, N. et al. Factors affecting nurses retention during the COVID☐19 pandemic: a systematic review. Human Resources for Health, 22(78), 1-20. https://doi.org/10.1186/s12960-024-00960-7

Firzly, N., Linares, N. N., Jones, G., & Aubry, T. (2021). La mise en œuvre d'une évaluation des besoins pour un conseil scolaire minoritaire : Interventions psychologiques centrées sur les enfants et les adolescents et basées sur des données probantes. Canadian Journal of Community Mental Health, 40(1), 129-134. https://doi.org/10.7870/cjcmh-2021-006

Government of Canada. (2017). Horizontal initiative - roadmap for Canada's official languages 2013-18. https://www.canada.ca/en/canadian-heritage/corporate/publications/plans-reports/departmental-results-report-2016-2017/roadmap-official-languages-2013-2018.html

Government of Ontario. (1990). French language services act, R.S.O. 1990, c. F.32. https://www.ontario.ca/laws/statute/90f32

Government of Ontario. (2021a). Modernized French Language Services Act receives Royal Assent. https://news.ontario.ca/en/release/1001316/modernized-french-language-services-act-receives-royal-assent

Government of Ontario. (2021b, avril 29). O. Reg. 398/93: Designation of public service agencies. https://www.ontario.ca/laws/regulation/930398

Gueye, N. R., de Moissac, D. L., & Touchette, A. (2018). Profils ethnolinguistique et de santé mentale de jeunes étudiantes et étudiants d'un établissement d'enseignement postsecondaire francophone en contexte minoritaire dans l'Ouest canadien. Canadian Journal of Community Mental Health, 37(1), 13-28. https://doi.org/10.7870/cjcmh-2018-004

Heidegger, M. (1962). Being and time. Harper and Row.

Kwok, C., Bates, K. A., & Ng, E. S. (2016). Managing and sustaining an ageing nursing workforce: identifying opportunities and best practices within collective agreements in Canada. Journal of Nursing Management, 24(4), 500-511. https://doi.org/10.1111/jonm.12350

Lee, S. H., Gibb, M., Karunananthan, S., Cody, M., Tanuseputro, P., Kendall, C. E., Bédard, D., Collin, S., & Kehoe MacLeod, K. (2024). Lived experiences of palliative care physicians on the impacts of language and cultural discordance on end-of-life care across Ontario, Canada: a qualitative study using the intersectionality-based policy framework. International Journal for Equity in Health, 23(1), 229. https://doi.org/10.1186/s12939-024-02312-2

Lo, E., Tu, M. T., Trempe, N., & Auger, N. (2018). Linguistic mortality gradients in Quebec and the role of migrant composition. Canadian Journal of Public Health, 109(1), 15-26. https://doi.org/10.17269/s41997-018-0023-z

Lydahl, D. (2017). Visible persons, invisible work? Exploring articulation work in the implementation of person-centred care on a hospital ward. Sociologisk forskning, 163-179.

Malebranche, M., Morisod, K., & Bodenmann, P. (2020). Deaf culture and health care. Cmaj, 192(50), E1809. https://doi.org/10.1503/cmaj.200772

Martin, B., Kaminski-Ozturk, N., O'Hara, C., & Smiley, R. (2023). Examining the impact of the COVID-19 pandemic on burnout and stress among US nurses. Journal of Nursing Regulation, 14(1), 4-12. https://doi.org/10.1016/S2155-8256(23)00063-7

Ombudsman Ontario. (2024). 2023-2024 Annual Report of the French Language Services Commissioner of Ontario. https://www.ombudsman.on.ca/sites/default/files/Media/ombudsman/ombudsman/resources/Annual%20Reports/2023-2024/Ombudsman-FLS-Annual-report-2024-EN-WEB-FINAL-s.pdf

Premji, S., & Etowa, J. B. (2014). Workforce utilization of visible and linguistic minorities in Canadian nursing. Journal of Nursing Management, 22(1), 80-88. https://doi.org/10.1111/j.1365-2834.2012.01442.x

Province of Manitoba. (2024). Health Card Information and FAQ. https://www.gov.mb.ca/health/mhsip/health-card-information.html

Reaume, M., Peixoto, C., Pugliese, M., Tanuseputro, P., Batista, R., Kendall, C. E., Landry, J.-R., Prud'homme, D., Chomienne, M.-H., Farrell, B., & Bjerre, L. M. (2024). The impact of patient-facility language discordance on potentially inappropriate prescribing of antipsychotics in long-term care home in Ontario, Canada: a retrospective population health cohort study. BMC Geriatrics, 24(1), 889. https://doi.org/10.1186/s12877-024-05446-8

Savard, J., Bigney, K., Kubina, L. A., Savard, S., & Drolet, M. (2020b). Structural facilitators and barriers to access to and continuity of French-language healthcare and social services in Ontario's Champlain region. Healthcare Policy, 16(1), 78-94. http://www.doi.org/10.12927/hcpol.2020.26289

Savard, J., Savard, S., Drolet, M., de Moissac, D. L., Kubina, L.-A., Van Kemenade, S., Benoit, J., & Couturier, Y. (2020). Framework for the analysis of health and social services access and integration for official language minority communities. https://www.grefops.ca/uploads/7/4/7/3/7473881/framework_description_en_april2020.pdf

Seale, E., Reaume, M., Batista, R., Eddeen, A. B., Roberts, R., Rhodes, E., McIsaac, D. I., Kendall, C. E., Sood, M. M., Prud'Homme, D., & Tanuseputro, P. (2022). Patient-physician language concordance and quality and safety outcomes among frail home care recipients admitted to hospital in Ontario, Canada. Canadian Medical Association Journal, 194(26), E899-E908. https://doi.org/10.1503/CMAJ.212155

Showstack, R., Santos, M., Feuerherm, E., Jacobson, H., & Martínez, G. (2019). Language as a social determinant of health: An applied linguistics perspective on health equity. AAALetter (AAAL's newletter). https://www.aaal.org/news/language-as-a-social-determinant-of-health-an-applied-linguistics-perspective-on-health-equity

Star, S. L., & Strauss, A. (1999). Layers of silence, arenas of voice: The ecology of visible and invisible work. Computer supported cooperative work (CSCW), 8(1), 9-30. https://doi.org/10.1023/A:1008651105359

Statistics Canada, 2023. Census in Brief, English–French bilingualism in Canada: Recent trends after five decades of official bilingualism Census of Population, 2021. https://www12.statcan.gc.ca/census-recensement/2021/as-sa/98-200-x/2021013/98-200-x2021013-eng.pdf

van Allen, Z., Dogba, M. J., Brent, M. H., Bach, C., Grimshaw, J. M., Ivers, N. M., Wang, X., McCleary, N., Asad, S., & Chorghay, Z. (2021). Barriers to and enablers of attendance at diabetic retinopathy screening experienced by immigrants to Canada from multiple cultural and linguistic minority groups. Diabetic Medicine, 38(4), e14429. https://doi.org/10.1111/dme.14429

van Manen, M. (1990). Researching lived experience: Human science for an action sensitive pedagogy. Althouse Press.

World Health Organization. (n. d.). Quality of care (Last accessed on September 28, 2021). https://www.who.int/health-topics/quality-of-care#tab=tab_1

Zhao, Y., Segalowitz, N. S., Voloshyn, A., Chamoux, E., & Ryder, A. G. (2019). Language barriers to healthcare for linguistic minorities: The case of second language-specific health communication anxiety. Health Communication, 36(3), 334-346. https://doi.org/10.1080/10410236.2019.1692488

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