

Exploring the Influence of Language Concordance and the Active Offer of French Language  
Physician Services on Patient Satisfaction Through a Northern Ontario Continuing Professional  
Development Initiative

by

Patrick Timony

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## Abstract

**Introduction:** Francophone minority populations across Canada experience poorer health outcomes. A lack of French language health services may be a contributing factor. Interpersonal communication between patient and physician is essential to providing quality health care and the legislative landscape in Ontario is evolving to become more responsive to Francophone communication needs. For instance, the passing of Bill 74 and the modernisation of the French Language Services Act (that was first passed in 1989) have created an expectation that health service providers will proactively offer services in French. The purpose of the present thesis was to develop and evaluate the effectiveness of a continuing professional development (CPD) program that teaches patient-centered communication through the active offer of French language services; to investigate the presence of the active offer in Northeastern Ontario; and to explore the influence of language concordance and the active offer on patient satisfaction.

**Methods:** A 3-phase CPD program was developed which included an assessment phase (comprising of physician, receptionist and patient surveys), an education phase (consisting of personalized reports and a workshop for physicians), and a reflective phase (consisting of a post-intervention physician survey).

**Results:** A comparison of physician surveys from the assessment and reflective phases suggest that the program successfully improved physicians knowledge (i.e., they more accurately defined the active offer), skills (i.e., they implemented several active offer strategies), and attitudes (i.e., they reported increased confidence in serving French-speaking patients). The pre-intervention physician and receptionist surveys suggest that the active offer was largely absent in physicians'

offices. The patient surveys from the assessment phase provided evidence that language concordance (i.e. when Francophones who prefer French regularly speak French with their physicians) and the active offer are associated with greater patient satisfaction.

**Conclusion:** The present findings suggest that providing health services in the patient's preferred language and practicing the active offer of French language services may be an effective way of improving the Francophone patient's experience. However, the general lack of active offer behaviours detected in the assessment phase suggest education is needed to teach physicians about the active offer and how to implement it. The present CPD program provides an example of how the active offer can be taught to practicing physicians.

**Key words:** Active offer, Continuing professional development, French language health services, Language concordance, Patient-centered communication, Patient satisfaction

## Résumé

**Introduction :** Les populations francophones minoritaires à travers le Canada connaissent de moins bons résultats en matière de santé. Un manque de services de santé en français peut être un facteur contributif. La communication interpersonnelle entre le patient et le médecin est essentielle à la prestation de soins de santé de qualité et le paysage législatif de l'Ontario évolue pour mieux répondre aux besoins de communication des francophones. Par exemple, l'adoption du projet de loi 74 et la modernisation de la Loi sur les services en français (qui a été adoptée en 1989) ont créé une attente que les fournisseurs de services de santé offriront de façon proactive des services en français. L'objectif de la présente thèse était de développer et d'évaluer l'efficacité d'un programme de développement professionnel continu (DPC) qui enseigne la communication centrée sur le patient par le biais de l'offre active des services en français ; d'étudier la présence de l'offre active dans le Nord-Est de l'Ontario ; et d'explorer l'influence de la concordance linguistique et de l'offre active sur la satisfaction du patient.

**Méthodes :** Un programme de DPC en trois phases a été élaboré, comprenant une phase d'évaluation (comprenant des enquêtes auprès des médecins, des réceptionnistes et des patients), une phase d'éducation (comprenant des rapports personnalisés et un atelier de formation pour les médecins) et une phase de réflexion (comprenant une enquête post-intervention auprès des médecins).

**Résultats :** Une comparaison des sondages des médecins de la phase d'évaluation et de la phase de réflexion suggère que le programme a réussi à améliorer les connaissances des médecins (c.-à-d. qu'ils ont défini plus précisément l'offre active), leurs compétences (c.-à-d. qu'ils ont mis en

œuvre plusieurs stratégies d'offre active) et leurs attitudes (c.-à-d. qu'ils ont signalé une plus grande confiance à desservir leurs patients francophones). Les enquêtes menées auprès des médecins et des réceptionnistes avant l'intervention suggèrent que l'offre active était largement absente des cabinets médicaux. Les sondages auprès des patients de la phase d'évaluation ont démontré que la concordance linguistique (c.-à-d. lorsque les francophones qui préfèrent le français parlent régulièrement en français avec leurs médecins) et l'offre active sont associées à une plus grande satisfaction du patient.

**Conclusion** : Les présentes conclusions suggèrent que la prestation de services de santé dans la langue préférée du patient et la pratique de l'offre active de services en français peuvent être un moyen efficace d'améliorer l'expérience des patients francophones. Cependant, le manque général de comportements d'offre active détectés lors de la phase d'évaluation suggère que l'éducation est nécessaire pour enseigner aux médecins l'offre active et comment la mettre en œuvre. Le présent programme de DPC fournit un exemple de la manière dont l'offre active peut être enseignée aux médecins en exercice.

**Mots clés** : Communication centrée sur le patient, concordance linguistique, développement professionnel continu, offre active, satisfaction du patient, services de santé en français

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## Chapter 1

### 1. Introduction

Although Ontario is home to Canada's largest Francophone population outside of Quebec (Ministry of Francophone Affaires, 2019), the majority of whom believe it is important to receive health care services in French (DPM Research, 2021), many Francophones experience an absence of French language health services (DPM Research, 2021). It has been suggested that such an absence may contribute to the health discrepancies observed in the Francophone population (Consultative Committee for French-Speaking Minority Communities, 2007; FCFA, 2001; French Language Health Services Working Group, 2005). Compared to the general population, Francophones are more likely to self-declare being in poorer physical (Bouchard, et al., 2009; Picard & Allaire, 2005) and mental health (Puchala, et al., 2013), experience higher rates of obesity (Gagnon-Arpin, et al., 2013), have a more inactive lifestyle (Imbeault et al., 2013), consume fewer fruits and vegetables (Batal et al., 2013), are more likely to smoke and consume alcohol (Batal et al., 2013) and are more likely to suffer from multiple chronic conditions (Bouchard & Desmeules, 2013) the most common of which include high blood pressure, asthma, back pain, heart disease and diabetes (van Kemenade et al., 2015) than the general population of Ontario.

Furthermore, since Franco-Ontarians living in a minority context will not demand their services in French (Forgues et al., 2014) for fear of being denied or experiencing longer wait times (Office of the French Language Services Commissioner of Ontario, 2016a), the active offer of French language services has been suggested as means of addressing gaps in the availability of

French language services (Office of the French Language Services Commissioner of Ontario, 2016a). The active offer is the proactive offer of services in French which are available at all times, clearly communicated, visible, easy to access, of equal quality and with similar wait times as those services being offered in English (Ministry of Francophone Affairs, 2014; Office of the French Language Services Commissioner of Ontario, 2016a). Thus, the active offer has the potential to improve the patient experience by ensuring health care is adapted to the linguistic needs and preferences of the Francophone population.

The poor health status of Ontario Francophones and the apparent lack of French language health services inspired me to conduct a series of studies exploring the availability and distribution of French-speaking physicians in Ontario. Using data from the College of Physicians and Surgeons of Ontario, we found that, although 15% of physicians self-declared as being competent enough to practice in French, the majority of these had located their practice in large urban centers of Southern Ontario, leaving the North comparatively underserved (Timony et al., 2013). Moreover, we also found that most French-speaking physicians had located their practice in communities where fewer Francophones reside. This study concluded that there was a maldistribution of French-speaking physicians. However, the presence of a French-speaking physician does not ensure the availability or the active offer of French language services. Furthermore, although the literature clearly shows an association between patient-physician communication and quality of care, patient health outcomes and patient experiences (Allenbaugh et al., 2019; Al Shamsi et al., 2020; de Moissac & Bowen, 2019; Korzh & Tsodikova, 2019; Matusitz & Spear, 2014; Stewart, 1995), to my knowledge, no previous study has examined the influence of language concordance

(i.e. when patients and providers speak the same language) or the active offer on patient satisfaction in Ontario's Francophone population.

My past work and current gaps in the literature surrounding Ontario's Francophone population and the potential for improving the Francophone patient experience through the active offer of French language services inspired the present thesis. My original objectives were to explore (i) the presence of the active offer in physicians' offices of northeastern Ontario, (ii) the influence of language concordance on physician-patient communication, and (iii) the effect of active offer on patient satisfaction.

A review of existing training resources on the active offer of French language services revealed certain limitations. Existing resources consist primarily of the *Carrefour de l'offre active*, an online directory of resources, tools and information compiled by the *Consortium national de formation en santé* and an online active offer training program titled "*The Active Offer of French Language Services: Why It Matters and How to Put It Into Practice*" developed by the *Réseau du mieux-être Francophone du Nord de l'Ontario*. However, these resources employ passive learning strategies (i.e., online modules and readings) and are intended for post-secondary students and health human resources in general, with no evidence that they lead to changes in active offer behaviours in practicing physicians. Therefore, I sought to develop and evaluate a Continuing Professional Development (CPD) program that uses experiential and practice-based learning strategies and adult learning principles to teach patient-centred communication to practicing physicians through the active offer of French language services.

The resulting CPD program, titled *Ici on parle! How to Actively Engage Francophone Patients. Tools for French- and English-Speaking Physicians*, was developed and implemented in

collaboration with the offices of Continuing Education & Professional Development and Francophone Affairs at the Northern Ontario School of Medicine (NOSM, now known as NOSM University). During the CPD program, a three-phase approach was used to improve physician communication with their French-speaking patients and to provide strategies that all physicians can use to actively offer French language health services, regardless of their ability to speak French. The first phase, an **assessment phase**, used a multisource feedback process to measure the physician's pre-intervention active offer behaviours through a series of physicians, receptionist and patient surveys. Based on results from the surveys, the second phase, an **education phase**, provided physicians with a personalised report highlighting gaps in their active offer behaviours and offering resources to help overcome these gaps. Physicians were also invited to participate in a workshop. During the workshop, they discussed barriers to serving Francophone patients and collaboratively developed strategies to implement the active offer in their practice. They also received constructive feedback from their peers, the host physician, and representatives from the *Réseau du mieux-être francophone du nord de l'Ontario*, the French Language Health Planning Entity for Northern Ontario. Finally, the third phase was a **reflective phase** in which physicians were provided with a post-intervention survey followed by a final progress report that identified improvement in active offer behaviour following the workshop. This CPD program was accredited by the College of Family Physicians of Canada for a total of 22 certified Mainpro+® credits.

Research was seamlessly imbedded within the CPD program with data being collected by way of physician, receptionist and patient surveys as well as during the workshop. The purpose of the present thesis is twofold. First, I intended to develop and evaluate the effectiveness of a CPD

program aimed at teaching the active offer to practicing physicians. Second, data collected during the CPD program allowed me to realise my original objectives to explore the presence of active offer in physicians' offices of northeastern Ontario, to explore the influence of language concordant physician-patient communication, and to explore the influence of the active offer on patient satisfaction. Moreover, the CPD program allowed me to explore the following research questions:

- 1) How does a CPD program teaching the active offer of French language services change physician communication behaviours in practicing physician's offices of northeastern Ontario?
- 2) To what degree are French language services actively being offered in physicians' offices of Northeastern Ontario?
- 3) To what degree do language concordant physician interactions influence patient satisfaction in a cross-sectional sample of Francophones living in Northeastern Ontario?
- 4) To what degree does the active offer of French language health services influence patient satisfaction in a cross-sectional sample of Francophones living in Northeastern Ontario?

Specifically, the post-intervention physician surveys in the **reflective phase** allowed me to evaluate the effectiveness of the CPD program by identifying improvements in the presence of the active offer, thus responding to the first research question. Physician feedback provided in the post-intervention survey and during the workshop was also assessed as indicators of the CPD program's potential effectiveness. It was hypothesized that active offer would improve after

participating in the CPD program in terms of physicians being more knowledgeable about the concept of active offer, provider more frequent active offer behaviours and being more confident in serving Francophone patients.

Next, in addition to identifying gaps in active offer behaviours, which were addressed in the workshop, the pre-intervention physician and receptionist surveys in the **assessment phase** provided a snapshot of the presence of the active offer in participating physician offices and addressed the second research question. It was hypothesized that French-speaking providers would report more active offer behaviours than English speaking providers. However, this analysis also allowed me to explore and identify active offer behaviours that were already common practice from those that were largely absent, regardless of the language spoken by the provider.

Finally, the patient surveys from the **assessment phase** included a patient satisfaction scale; this allowed me to address the third and fourth research questions. It was hypothesized that Francophone patients who receive linguistic concordant care would be more satisfied than those who receive discordant care from their family physician. In addition, it was hypothesized that Francophones who receive a greater active offer would be more satisfied than those who perceive fewer active offer behaviours from their family physician.

## Chapter 2:

### 2. Literature review

#### 2.1 Health status of Francophones in Canada and Ontario

French is an official language of Canada and is spoken by 22.7% of the Canadian population, with the vast majority residing in the province Quebec (Statistics Canada, 2019). In most regions outside of Quebec, the Francophone population is considered an official language minority, accounting for only 3.8% of the Canadian population. Although the Francophone population has been growing in most provinces, this growth has proportionately been outpaced by other linguistic minority groups resulting in a decline in the proportion of Francophones in Canada (Statistics Canada, 2019). Ontario is home to Canada's largest Francophone presence outside of Quebec. With a population of 622 415, Francophones represent 4.7% of the Ontario population with strong representation in eastern and northeastern Ontario, where Francophones account for 15.4% and 22.6% of the population respectively (Ministry of Francophone Affaires, 2019).

Research surrounding health status in Canada has revealed several health disparities between the Francophone minority and Anglophone majority populations (i.e., for those residing outside of Quebec) (Benoit et al., 2012; Bouchard et al., 2002; Bouchard et al., 2012a; Bouchard & Desmeules, 2013; Picard & Allaire, 2005). For instance, in comparison to Anglophones, Francophones are more likely to self-declare being in poorer health (Bouchard et al., 2009; Picard & Allaire, 2005) and having difficulties accomplishing daily activities due to their health status (Benoit et al., 2012; Picard & Allaire, 2005). They also experience higher rates of obesity (Gagnon-Arpin et al., 2013), have a more inactive lifestyle (Imbeault et al., 2013), consume fewer fruits and vegetables (Batal et al., 2013), and are more likely to smoke and consume

alcohol (Batal et al., 2013). Compared to the general population, Francophones are more likely to suffer from multiple chronic conditions (Bouchard & Desmeules, 2013), the most common of which include high blood pressure, asthma, back pain, heart disease and diabetes (van Kemenade et al., 2015). Francophones are also more likely to declare having poorer self-rated mental health (Puchala, et al., 2013), with 21% reporting high levels of emotional distress and 43% recalling a history of mental health problems in their family (Bouchard et al., 2018). Combined, addiction to drugs and alcohol along with other mental health disorders afflicts 38% of Francophones, compared to 34% of the general Canadian population (Bouchard et al., 2018). Finally, the Francophone population living in a minority situation is aging faster than the general Canadian population (Bouchard et al., 2015). In Ontario, 19.5% of the Francophone population is 65 years of age or older, compared to 16.2% of the general population (Ministry of Francophone Affairs, 2019), their advanced age being further associated with a greater prevalence of chronic conditions, obesity and a sedentary lifestyle (van Kemenade et al., 2015).

Despite a consistent tendency for Francophones to exhibit poor health outcomes, there is a general lack of research on the health status of Francophones outside of Quebec, with much of the research available being dated and relying on national survey data collected by Statistics Canada. The absence and lack of consistency in the way linguistic variables are defined and collected in national databases, a historic lack of dedicated funding for Francophone health research, and the small number of researchers in this field all contribute to a scarcity of up-to-date literature on the status of Francophone health (Bouchard & Desmeules, 2013). In 2019, l'Acfas commissioned a report by the Canadian Institute for research on Linguistic Minorities regarding the state of French language research in Canada (Acfas, 2021). The report found that

research in French is on the decline at all levels, with fewer funding applications being submitted in French for tri-council funding, lower success rates for funding applications submitted in French, and a decline in the number of French publications in scientific journals (Acfas, 2021).

Despite such limits in the available literature regarding their health status, Francophones also have a tendency to fair worse on other indicators of health. For instance, from a social-determinants of health lens, Francophones experience many barriers to realizing their full health potential. Francophone populations across Canada have historically been less educated, more likely to be unemployed, more likely to be living in poverty and more likely to live in a rural area than the general population (Gagnon-Arpin et al., 2013; Imbeault et al., 2013; Picard & Allaire, 2005), thus further compounding the health related issues described above. In Ontario, the 2016 census marked a turning point for Francophones in terms of educational attainment (Francophones were more likely to have a post-secondary education than the general population) and income (Francophones were less likely to have an annual income inferior to \$20 000 than the general population); however, higher unemployment rates persisted (Ministry of Francophone Affaires, 2019). Furthermore, a 2015 study found that Ontario Francophones continue to exhibit inferior literacy skills to their Anglophone counterparts (Bédard-Chagnon, 2015). The authors noted that, although Francophones have successfully reduced the literacy gap at a provincial level, regional variations can be observed, with rural Francophones, who also tend to be older and less educated, continuing to experience literacy challenges in comparison to their urban counterparts (Bédard-Chagnon, 2015). Finally, simply being a member of a linguistic minority group has been recognized as a determinant of health as these individuals have reduced access to linguistically concordant health and social services (Bouchard & Desmeules, 2013). Indeed, it

has been suggested that a lack of French language medical services may be a contributing factor to explaining the discrepancies observed in Francophones health (FCFA, 2001; French language health Services Working Group, 2005; Consultative Committee for French-Speaking Minority Communities, 2007).

## 2.2 Access to French language services in Canada

### 2.2.1 Availability of French-speaking providers

Research has found that living in a minority context leads to not only social inequality, but inequalities in terms of access to resources as well (Bouchard et.al, 2009). Anecdotal evidence from Ontario has suggested the existence of an overall lack of French language health services (FCFA, 2001; Gagnon-Arpin & Bouchard, 2011). A 2017 report from Statistics Canada investigated the use of the official minority language (i.e., English in Quebec and French in the remainder of Canada) by Canadian health care professionals using data from the 2001 and 2011 Censuses as well as the 2011 National Household Survey (Lepage & Lavoie, 2017). The health care professionals analysed consisted of registered nurses, registered psychiatric nurses and licensed practical nurses; general practitioners and family physicians; psychologists; social workers; pharmacists; ambulance staff and paramedics; and nurse aides, orderlies and patient service associates. In 2011, although 11.7% of Canadian health care professionals (outside of Quebec) were able to hold a conversation in French, only 5.1% used French regularly at work with 4.4% belonging themselves to the official-language minority. Furthermore, though the health workforce as a whole increased between 2001 and 2011, the proportion of professionals able to conduct a conversation in French or who used French regularly at work decreased (Lepage & Lavoie, 2017).

Similarly, in Ontario, 12.8% of health care professionals were able to conduct a conversation in French in 2011, yet only 6.1% used French regularly at work and 4.5% belonged to the Francophone minority group (Lepage & Lavoie, 2017). Although these percentages seem low, the number of health care professionals who were able to communicate in French, who regularly used French at work and who were members of the Francophone minority in 2011 increase by over 20% since 2001. From a regional perspective, northeastern Ontario, where the largest proportion of Francophones resides (Ministry of Francophone Affaires, 2019), also saw the largest increase in health care professionals able to conduct a conversation in French (a 26.9% increase). However, despite such increases, the report's authors concluded that the number of health care professionals able to conduct a conversation in French in 2011 was lower than expected based on the demographic growth of the minority population (Lepage & Lavoie, 2017).

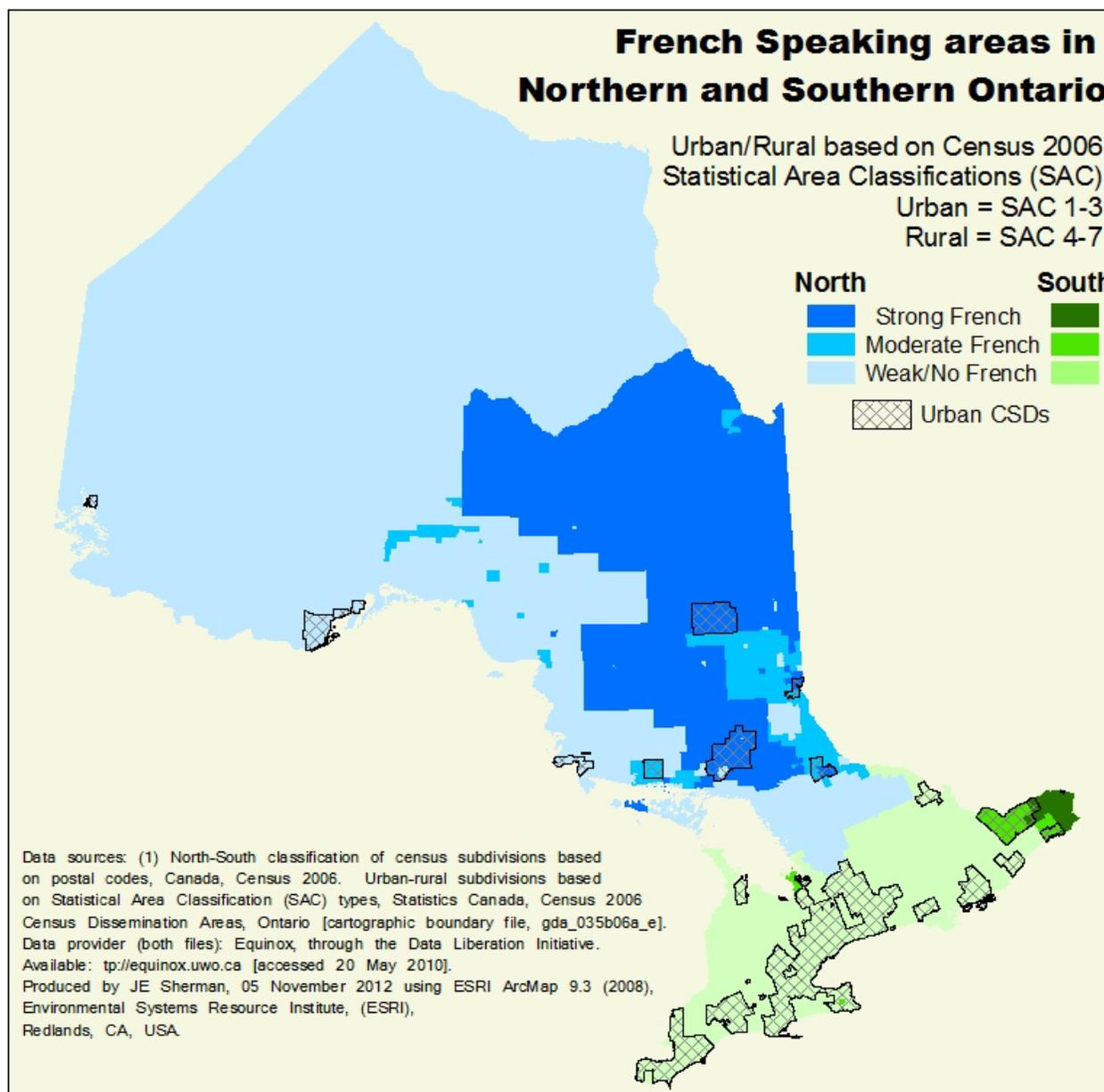
Indeed, the number of French-speaking providers is most meaningful when compared to the Francophone population. Past work has explored the availability and distribution of French-speaking providers compared to the distribution of the Francophone population in Ontario (Gauthier et al., 2012; Timony et al., 2013; Timony et al., 2022). Physicians and pharmacists who self-declared French as a language of competence on the publicly available College of Physicians and Surgeons of Ontario (CPSO) and Ontario College of Pharmacists (OCP) registries were considered French-speaking and ratios of French-speaking providers per 1000 Francophones were calculated. These studies found that the proportion of French-speaking physicians (15%) and pharmacists (7.2%) was considerably greater than the proportion of Ontario's Francophone population (4.7%) (Gauthier et al., 2012; Timony et al., 2013; Timony et al., 2022). Overall, there were 3.4 French-speaking physicians (Gauthier et al., 2012) and 1.5

French-speaking pharmacists (Timony et al., 2022) for every 1000 Francophones, ratios that were many times greater than the general physician and pharmacist to population ratio (which were both 0.9 per 1000).

Such promising ratios raised the question as to why Francophones perceive a lack of health care services in French (DPM Research, 2021). It was concluded that a geographic maldistribution of providers within the province was a likely explanation as the majority of both French-speaking physicians and pharmacists had located their practice in urban communities of Southern Ontario, leaving the rural and urban North comparatively underserved (Gauthier et al., 2012; Timony et al., 2022). However, such broad geographic categories do not determine whether these French-speaking providers practiced near Francophone populations. Therefore, follow-up analyses compared the availability of French-speaking physicians and pharmacists to the density of the Francophone population of the communities in which they practice. Specifically, a degree of Francophonie was calculated for every community (i.e., census subdivision) in Ontario whereby Strong French communities are those where Francophones represent 25% or more of the total population; in moderate French communities, Francophones represent between 10% and 24.9% of the population; and in Weak/No French communities, they represent less than 10% of the total population (as represented on the map in Figure 1). When the ratios of French-speaking providers to Francophones were once again calculated, the largest (most favourable) ratios were found in communities with the fewest Francophones, with 5.6 French-speaking physicians (Timony et al., 2013) and 2.2 French-speaking pharmacists (Timony et al., 2022) per 1000 Francophones in weak/no French communities. Conversely, the smallest ratios were found in communities with the largest Francophone populations, with 1.3 French-speaking physicians (Timony et al., 2013)

and 0.7 French-speaking pharmacists (Timony et al., 2022) per 1000 Francophones in strong French communities. No such differences were detected in the availability of English-speaking providers. Additional geographic analyses revealed that ratios were lowest in rural Francophone communities, many of which are located in northeastern Ontario (Timony et al., 2013; Timony et al., 2022), suggesting that several Francophones residing in these communities may not speak the same language as their health care providers.

A 2014 report to the Canadian Institute for Research on Linguistic Minorities, which surveyed Francophones living outside of Quebec, explored regional variation in access to French language services (Forgues et al., 2014). Despite the greater availability of French-speaking providers in communities with smaller Francophone densities (Timony et al., 2013; Timony et al., 2022), Francophones surveyed reported accessing fewer services in French as their proportions within the community decreased, suggesting that the favourable presence of French-speaking providers is not associated with a greater offer or availability of French language services. In fact, information regarding the availability of French language services was more likely to be advertised in communities with larger Francophone populations (Forgues et al., 2014).



**Figure 1: Map of Ontario by degree of francophony**

Through our previous work, we concluded that the distribution of French-speaking providers (physicians and pharmacists) does not parallel the distribution of the Francophone population and that gaps in the availability of French language services may be more a function of a maldistribution of providers than shortages in their total numbers (Timony et al., 2013; Timony et al., 2022). It is important to note that the ratio of French-speaking providers to Francophones within a community does not represent the actual availability of French language services for Francophones who reside in that community. Despite the relatively large number of French-speaking providers and favourable provider to Francophone population ratios in Ontario, these providers do not exclusively serve Francophone populations. In reality, French-speaking providers are also seeing non-French-speaking patients, and in many communities, Francophones only make up a small percentage of the patient population served (Timony et al., 2022). In addition, factors such as distance to providers, hours of availability and a lack of promotion of French language services can further limit access. Thus, even Francophones residing in a community with a larger French-speaking provider to Francophone population ratio may struggle to access a French language service if these services are not available near them or they don't know where to find them (i.e., if the French services that are available are not appropriately advertised).

### 2.2.2 Access to French language services from the patient's perspective

Barriers to accessing French language health services from the Francophone patient's perspective were further explored by Health Canada in 2020 (Leger, 2020, DPM Research, 2021). A combination of quantitative and qualitative approaches were used, including 1 125 surveys of Canadian adults (about half of which were Francophone), 28 interviews (20 in English and 8 in

French), and 26 focus groups. Overall, French-speaking family physicians were the health care provider in highest demand, with most respondents indicating that their services should be provided in the patient's preferred language (Leger, 2020). Nearly 9 of 10 respondents believe it is very important or somewhat important to receive health care services in their preferred language (Leger, 2020), with nearly three-quarters of Ontario Francophones in agreement (DPM Research, 2021). These Franco-Ontarians further explained that this preference is a function of communication and comprehension, with many reporting that they understand better in French, are more comfortable in French, and fear the risk of medical errors arising when communicating in English (DPM Research, 2021). The preference for French is also tied to their identity, as receiving health care services in French was considered essential to conserving their mother tongue (DPM Research, 2021). Furthermore, receiving services in one's preferred language is important as it was considered a question of safety in terms of understanding diagnoses, treatment instructions and medication use (e.g., storage, handling, dosage, and understanding adverse medication reactions) (Leger, 2020).

Despite preferences for health care services in French, only 34% of French-speaking respondents living outside of Quebec reported receiving such services from a health care provider during the previous 12 months (Leger, 2020). In Ontario, 60% of respondents reported a complete absence of French language services from all providers over the same time period (DPM Research, 2021). Such disparities in the reported access to French language health services are particularly concerning considering only half of these French-speaking respondents living outside of Quebec reported being confident in their ability to clearly communicate their health care needs in English (Leger, 2020), with 1 in 5 Franco-Ontarians reporting that they had little to no confidence in their

ability to communicate in English (DPM Research, 2021). Likewise, and equally concerning, only half of the respondents were confident in their health care providers ability to clearly understand their health needs in French (Leger, 2020), with nearly one quarter of Franco-Ontarians reporting that they had little to no confidence in their health care providers abilities to understand their needs when speaking in French (DPM Research, 2021). As a result, many Francophones experience a kind of paradox when accessing health care services whereby they lack confidence in their own ability to speak in English and simultaneously lack confidence in their provider's ability to understand them if they speak in French. Thus, in the presence of linguistic discordance (i.e., when French language services are not provided), Francophones have expressed feelings of discomfort and insecurity (Jutras et al., 2020). As a result, the health service seems more inaccessible, and the patients feel unable to adequately describe their health care needs and take charge of their own health (Jutras et al., 2020). Conversely, in the presence of linguistic concordance, Francophone patients express feelings of comfort, security, accessibility and confidence in their own abilities to manage their health conditions (Jutras et al., 2020).

Although 60% of Ontario Francophones reported a preference for being served in French, and two-thirds consider French language health care service to be fairly or very important, only 39% regularly ask to be served in French (DPM Research, 2021). According to a 2014 study, the vast majority of Francophones do not request services in French, with only 12% actively seeking out French language services in their community and 14% travelling outside their health region to access health care services in French (Forgues et al., 2014). Likewise, a 2010 study by Cardinal and Sauvé found that most Francophones do not use French language services even though they

are available and have a right to do so. Furthermore, habits such as requesting to be served in French and seeking out French language services were less common in Francophones who live in an extreme minority context (Forgues et al., 2014). However, we must be cautious when interpreting these results. The lack of demand and use of French language services does not necessarily represent a lack of desire or need for these services (DPM Research, 2021; Forgues et al., 2014). Rather, a type of learned helplessness has emerged whereby many Francophones who would prefer to be served in French have stopped seeking such services because they have been systematically denied in the past (DPM Research, 2021; Forgues et al., 2014).

Many barriers to obtaining, or even requesting health services in French have been identified. These include the perceived linguistic competencies of the health care provider, a lack of awareness of where French language services are available, an absence of offer of French language services, and fears of having to wait longer, that such a request will be in vain, or that the French language services will be of lesser quality (Cardinal & Sauvé, 2010; DPM Research, 2021; Forgues et al., 2014; Leger, 2020). When asked if their health care provider offered any type of accommodation when they could not themselves provide services in French, over three-quarters of Franco-Ontarians responded that none was offered, and 15% reported receiving a negative response after requesting to be served in French (DPM Research, 2021). Indeed, many Francophones do not feel comfortable asking to be served in French out of fear of being judged negatively by the service provider (Cardinal & Sauvé, 2010; Forgues et al., 2014; Leger, 2020). Rather than requesting services in French, these Francophones will accept services in English, as they do not want to create a problem or be inconvenient (Forgues et al., 2014; Leger, 2020). As a result, many physicians may fail to perceive a need to offer French language services. A 2016

study of family physicians located in Northern Ontario found that those who could speak French did not actively advertise themselves as being able to do so, while those who could not, often believed French was unnecessary, stating that their patients were “bilingual enough” (Timony et al., 2016, p.10). Thus, there exists a gap in Ontario between the patient’s values/needs and the physician’s perception. This gap may obstruct patient-centred care and may contribute to the poor health outcomes observed in Ontario’s northern Francophone population (Bouchard et al., 2012a).

### 2.2.3 The use of interpreters in the provision of care

One approach to meeting the communication needs of linguistic minority population is using interpreters. Numerous approaches to the provision of interpretation services exist throughout Canada, including: hospital or clinic-based; community-based health interpreters (where the interpreters follows the patient through various health encounters); generic professional interpreters (who are neither tied to an institution or a patient but rather provide broader interpretation services for various social, educational and legal services); telephone interpreters (who are available 24-hours a day to offer translation services in many languages and charge users on a per-minute basis); and the use of bilingual staff (who provide translation services on an ad-hoc basis) (Bowen, 2001; Sultana et al., 2018). Despite their existence, there is an underutilization of formal interpretation services in Canada, with most health care providers relying primarily on the use of family and friends or other untrained interpreters on an ad hoc basis, which poses a risk to patient safety and quality of care (Bowen, 2001; Papic et al., 2012).

While trained interpreters can help in the effective diagnosis, treatment, and management of various health conditions, the use of untrained interpreters is associated with a greater likelihood

of clinically significant errors, as well as higher rates of omissions and incorrect interpretations (Laher, 2018; Walji & Flegel, 2017). According to Wirral (2014), untrained interpreters, even those who are unknown to the patient and appear fluent in both languages, can lead to significant information loss during patient encounters. First, social desirability or fear of humiliation can compel the interpreter to filter out or edit statements they deem unnecessary or absurd (Cambridge, 1999; Wirral, 2014). For instance, the interpreter may choose not to convey that the patient used a home remedy to treat their ailment, believing these methods to be unfounded and concerned they may be judged poorly by the health care provider for even mentioning them. Alternatively, an interpreter who shares the patient's culture may be protective of their own traditional remedies and may fail to convey the message if the provider suggests discontinuing such remedies. In both instances, important information is lost, which can directly impact the patient's well-being. Second, although the interpreter may understand their role in the interview process, they may lack the technical vocabulary and medical training to understand medical concepts or the underlying reason behind a line of questioning (Cambridge, 1999; Wirral, 2014). As a result, the interpreter may not be able to explain a course of treatment properly or may slightly edit questions, which can hinder the history-taking process. Third, the inclusion of an interpreter in the doctor-patient encounter can break the natural feedback loop in linguistically concordant interactions (Cambridge, 1999; Wirral, 2014). When asking the patient a question, the message must first pass through the interpreter, then to the patient, then back to the interpreter before the provider can receive an answer. The same process occurs in the opposite direction for the patient. Thus, it becomes challenging for the provider to assess whether the patient accurately received the message and for the patient to determine whether their intentions were conveyed correctly. The risk of information loss or misinformation is even greater when the

interpreter is a family member or a friend (Rimmer, 2020). For instance, the family member may provide their own accounts and not those of the patient, the family member may find it hard to convey bad news and may edit or withhold information from the patient, and the patient may not want to share personal health information with their family member (e.g., a older parent may not feel comfortable sharing their sexual history if their son or daughter is translating for them) (Rimmer, 2020).

Similarly, using untrained interpreters, particularly family members, may be a risk to the ethical provision of care (Bowen, 2001). Beyond the need to share personal health information with a third party, Moloney (2017) argues that untrained interpreters can violate the Healthcare Consent Act (1996). According to the Healthcare Consent Act, providers must obtain valid informed consent before conducting a medical procedure (Healthcare Consent Act, 1996), which can only occur if the patient fully understands their condition and options (Moloney, 2017). However, the omissions, additions and alterations commonly occurring with untrained interpreters are a barrier to obtaining valid informed consent. Common characteristics of formal interpretation services include formal interpretation training (Rimmer, 2020; Sultana et al., 2018) and the unbiased, neutral, and passive provision of interpretation services (Rimmer, 2020), both of which are absent in an informal untrained interpreter. According to Rimmer (2020), the risks involved with an untrained interpreter may be greater than not having an interpreter at all. However, Rimmer (2020) adds that in an emergency where immediate care is required, a family member or an ad-hoc interpreter may be appropriate. Although interpreters are a viable solution to overcoming language barriers, the interpreter used by most providers is generally inappropriate. Thus, using interpreters should be one approach within a larger communication strategy.

## 2.3 Health system reform in Ontario

Although French is recognized as one of Canada's official languages, the struggle to acknowledge French language rights and receive services in French in Ontario has long been fought, with moments of victory and hardship. From Regulation 17 in 1912, which greatly restricted and almost eliminated French language education in Ontario schools to the 1997 threat of closing l'hôpital Montfort in Ottawa, Ontario's only French language hospital, numerous attempts have been made to assimilate and eliminate the Francophone language and culture in Ontario (Martel, 2005). However, official language rights, including the right to be served in French by the federal and provincial governments were gained with the passing of the Official Languages Act in 1969 (Official Languages Act, 1985) and the French Language Services Act (FLSA) of 1989 (French Language Services Act, 1990), respectively. Nevertheless, respecting French language rights and providing services in French in Ontario has been described as a policy of "overly prudent gradualism" (Cartwright, 1998, p.273). Rather than granting official language status to the French language, as was recommended by the Royal Commission on Bilingualism and Biculturalism in 1960s (Saywell, 1965), the government of Ontario decided to meet the demand for bilingual services when and where it arose. For instance, the FLSA only applies to designated geographic areas, where the Francophone population is large enough (French Language Services Act, 1990). I will next provide a review of the recent health system reform in Ontario and explore implications for the Francophone population.

### 2.3.1 Recent policy changes in Ontario

The gradual approach to providing French language services and the resulting inequitable availability of services in French is still seen today. For instance, shortly following a change in

the provincial government in 2018, from the Liberals to the Progressive Conservative Party (the PC government), a major cut to French Language services in Ontario was announced, namely the elimination of the office of the French language services Commissioner (Restoring Trust, Transparency and Accountability Act, 2018). Since 2007, the French language services Commissioner of Ontario had the mandate to ensure compliance with the FLSA, which is achieved by conducting investigations following complaints, making recommendations to improve the delivery of French language services, and advocating for the rights of Francophone populations (Office of the French Language Services Commissioner, n.d.). However, Bill 57, the Restoring Trust, Transparency and Accountability Act of 2018, abolished the position and office of the French language services Commissioner and transferred its mandate to the Ombudsman of Ontario (Restoring Trust, Transparency and Accountability Act, 2018). This decision was met with much criticism from the Francophone community as well as from the Minister of official languages and the Prime Minister of Canada (Leavitt, 2018; The Canadian Press, 2018; von Scheel, 2018), with many seeing this cuts as a threat to the vitality of French language services and French rights in the province (Laucius, 2018).

Such a cut give the impression that either French language services are of less importance to the current government or the current government believes Francophones are already adequately served and that improvements are no longer needed. However, between April 1, 2018, and March 31, 2019, the French language services Commissioner received 435 complaints or requests for information, 232 of which were admissible complaints (Office of the French Language Services Commissioner, 2019). These complaints often refer to an absence of services in French in locations where they are supposedly guaranteed (Office of the French Language

Services Commissioner, 2019). Furthermore, nearly one-fourth of all complaints were in regard to services from the Ministry of Health and Ministry of Long-term Care. This trend persisted in 2020-2021, as outlined in the new French Language Services Commissioner's annual report, which identified 351 complaints received between October 1<sup>st</sup> 2020 and September 30<sup>th</sup> 2021 (Office of the Ombudsman of Ontario, 2021). Although the majority of complaints received (27.4%) were in relation to cuts at Laurentian University, 15.4% of complaints were for services of the Ministry of Health (representing the most complaints of any organization/ministry) and an additional 4.7% of complaints were regarding a lack of services in French from designated hospitals (Office of the Ombudsman of Ontario, 2021). As the French language services Commissioner stated in his final report: "it is certainly worth asking how many Francophone citizens in similarly vulnerable circumstances do not file a complaint with the Commissioner's Office, and receive compromised and limited care as a result" (French Language Services Commissioner, 2019, p.23). Furthermore, health disparities between Ontario Francophones and Anglophones persist (Batista et al., 2019; Bouchard & Desmeules, 2013; Bouchard et al., 2018; van Kemenade et al., 2015). Concerns surrounding these health disparities are particularly relevant following another major change announced by the PC government, the provincial health care system reform.

### 2.3.2 Health system reform: the dawn of the integrated health care system

In January 2019, the Premier's Council on Improving Healthcare and Ending Hallway Medicine identified three key systemic challenges to Ontario's health care system (Premier's Council on Improving Healthcare and Ending Hallway Medicine, 2019). First, the system is complex, confusing, inconvenient and difficult to navigate, causing confusion for patients unable to access

the services they need in a timely manner. Second, the system, in its current form, cannot meet the growing demands of patients. A lack of beds, overcrowded hospitals, inappropriate use of emergency departments, long wait times, an inadequate mix of services, and limited use of digital tools all contribute to the current state of hallway medicine. These concerns will only grow as the population ages and their needs become increasingly complex. Third, the system is inefficient; care is often provided in silos, lacking coordination and communication between health care providers and services. As a result, patients receive fragmented care as they are forced to continually fill out duplicate forms and repeat their health history at each point of contact, increasing the likelihood of omitting important details. In turn, the provider often does not receive a complete medical history, which increases the probability of duplicating services and committing errors. Such inefficiencies are particularly dangerous when combined with a language barrier, as the patient's ability to properly provide a medical history is further hampered (Bowen, 2001).

In response to these observations, the PC government introduced Bill 74, The People's Health Care Act on February 26, 2019 (The People's Health Care Act, 2019). Schedule 1 of Bill 74 implemented the Connecting Care Act, which authorized the Ministers of Health and Long-Term Care to create a new Crown agency named Ontario Health (Connecting Care Act, 2019). This new super agency replaces the previous Local Health Integration Networks (LHINs). It has a broad mandate that includes overseeing the health care system by implementing strategies developed by the Ministries of Health and Long-term Care, informing and making recommendations to health care providers, measuring health system performance, and managing quality improvement and enforcing health system reform and integration (Connecting Care Act,

2019; Ministry of Health, 2019a; Ontario Medical Association, 2019a; The People's Health Care Act, 2019). Schedule 1 of Bill 74 also introduced the concept of Integrated Care Delivery Systems to the Ontario health care landscape, otherwise known as Ontario Health Teams (OHT). OHTs are “groups of providers and organizations that are clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined geographic population” (Ministry of Health, 2019b, p.6). Health Service Providers (HSP) who may join an OHT include, among others, hospitals, mental health facilities, long-term care homes, Community Health Centres, Family Health Teams, Nurse Practitioner Led Clinics, etc. (Ministry of Health and Long-Term Care, n.d.a; The People's Health Care Act, 2019). Although most funding agreements with HSPs will remain unchanged in the short term, Ontario Health will receive funding from the Ministry of Health and will provide funding to OHTs and HSPs through integrated funding envelopes, which will replace many current funding structures (The People's Health Care Act, 2019). Eventually, Ontario Health will become the primary source of funding for most HSPs, and their continued funding will depend on their level of integration within an OHT. The goal is for OHTs to offer the following services: hospital, primary care, mental health/addictions, home/community, long-term care home, palliative care, or any other prescribed services (Ontario Medical Association, 2019a; The People's Health Care Act, 2019).

The goal is to have a health care system that is interconnected and fully integrated with “all health services providers to eventually join or become Ontario Health Teams” (Ministry of Health, 2019b, p.2). Though no definitive definition of integrated care is found in the literature (Shaw et al., 2011), most view it as an organizing principle, which seeks to improve the patient experience through increased coordination of services, thus addressing fragmentation, reducing

inefficiencies, and improving continuity and quality of care (Ham & DeSilva, 2009; Lloyd & Wait, 2005; Shaw et al., 2011; Stein & Rieder 2009). The strategies used to achieve integration and their scope vary considerably. As such, integrated care is not a “one size fits all” model of care but rather a guiding principle that adapts to the health needs of the population being served and the availability of services within a geographic region. In Ontario, each OHT will be responsible for providing the full continuum of care for patients in the geographic region they serve (with the exception of the most specialized services such as transplants and neurosurgery) (Ministry of Health, 2019b). The goal is for seamless access to services that address the full range of health care needs provided by one interconnected group.

### 2.3.3 Challenges for the emerging Ontario Health Teams

The concept of integrated health care is not new in Ontario; the Local Health System Integration Act was an earlier attempt to improve the integration of services at a regional level (Local Health System Integration Act, 2006; Tsasis et al., 2012). However, the level of integration outlined in Bill 74 (i.e., the amalgamation of existing HSPs into new organizations), as well as its magnitude (i.e., community wide integration throughout the entire province under the supervision Ontario Health), is rarely seen (Shaw et al., 2011), and OHTs are likely to face many growing pains as they mature. Five main types of integration are discussed in the literature: systemic integration consists of coordinating and aligning policies; normative integration is achieved when values, culture and vision are shared across HSPs and organizations; organizational integration (also referred to as professional integration) involving the coordination of governance systems and alliances between HSPs; administrative integration (also referred to as functional integration) is the sharing of office functions, budgets and financial systems; and clinical integration consisting

of creating a single process for patients by coordinating information and services between HSPs (Lloyd & Wait, 2005; Shaw et al., 2011). The type of integration needed depends on the reason for integrating and the needs of the patient population being served (Goodwin et al., 2017).

However, it is expected that OHTs will incorporate many, if not all, of these types of integration, an act that is rarely seen in the literature (Shaw et al., 2011).

Furthermore, different levels of integration exist; from linkages (i.e., improving continuity of care through improved knowledge of existing organizations to better refer patients), to coordination (i.e., improving collaboration and sharing of information between existing organizations), to full integration (i.e., pooling resources to create a new organization offering comprehensive services) (Goodwin et al., 2017; Shaw et al., 2011). Integrated care systems typically move through the continuum as they mature but rarely achieve full integration (Shaw et al., 2011). However, the introduction of the OHTs is forcing existing HSPs to move directly to full integration, complete with new integrated funding models (The People's Health Care Act, 2019). Incorporating various types of integration and moving to full integration will undoubtedly be a challenge for OHTs.

Integrated care systems have been compared to Complex Adaptive Systems (Edgren, 2008; Edgren & Barnard, 2012; Tsisis et al., 2012). Much like an anthill, which requires all members to work in unison towards a shared goal, integrated care systems are most successful when members have a shared vision of reducing system fragmentation and improving patients' experiences and are intrinsically motivated to adapt to changing situations (Lloyd & Wait, 2005; Shaw et al., 2011). As a result, key features of a successful integrated delivery system, such as shared values and goals and a culture of teamwork and communication (Ham & DeSilva, 2009),

are unlikely to develop if integration is imposed. According to Bill 74, Ontario Health can order HSPs to integrate within an OHT, which is executed through new funding structures (The People's Health Care Act, 2019). Edgren (2008) warns against such top-down approaches to managing integrated care systems. A HSP who feels forced to integrate may view it as a risk to their professional autonomy and is unlikely to do so because they share the OHT's values. In situations such as these, HSPs may work together to coordinate services that give the impression of integration to satisfy funding requirements. However, if collaboration between HSPs is not improved (Lloyd & Wait, 2005), the services within the OHT will continue to appear fragmented from the patient's perspective. Thus, the goal of improving the patients' experience will not have been achieved. In Ontario, policies that encourage relationship building, sharing of information and self-management have been suggested to improve health system integration (Tsasis et al., 2012). These principles appear to be imposed by Bill 74 rather than encouraged, and it is yet to be seen if true integration will flourish under such pressures. Although the goal of Bill 74 is to reduce fragmentation and hallway medicine, there is also a focus on organizational reform to minimize duplication of services and achieve cost savings. It has been suggested that policies that seek to bring organizations together are less successful at improving the patient experience (Ham & DeSilva, 2009; Shaw et al., 2011). Given the funding power held by Ontario Health and their ability to order HSPs to amalgamate with other organizations, to transfer their operations to other organizations, to provide other types of service, or to cease operating all together (The People's Health Care Act, 2019, part 1 section 1), it is possible that HSPs in Ontario may focus more on pleasing the agency through organizational integration than improving the patient experience through clinical integration.

Another novel aspect of Ontario's integrated care system is the intended patient population. The OHTs will provide a full continuum of care to the entire patient population within a defined geographic region (Ministry of Health, 2019b). Effective integration occurs when HSPs work together to improve care coordination for individuals who are more likely to experience gaps in care that negatively impact their health (Goodwin & Smith, 2011). These are often older frail adults, those living with chronic illnesses, or those with complex medical or mental health needs (Goodwin & Smith, 2011; Goodwin et al., 2017; Stein & Rieder, 2009). It has been suggested that full integration is most appropriate when it is targeted to patients with complex care needs, whereas collaborations and linkages are more appropriate for serving a general patient population (Goodwin et al., 2017). Thus, the level of integration proposed in the OHT model may be unnecessary for the general patient population and too general to address patients with complex care needs adequately. The government of Ontario seems to have recognized these limitations and has been pivoting away from full integration to concentrate more on collaboration (Ministry of Health, 2020). It is possible that a hybrid between full integration and collaboration emerges whereby the majority of the OHTs will operate under a collaborative model when serving the general population, while those HSPs who provide specialty services to high-needs groups will fully integrate.

Furthermore, small population density and distance between population centers may pose additional challenges for the development of OHTs in rural and northern regions of the province. A critical mass of people is needed for system integration to function optimally (Ministry of Health, 2019b). Not only do rural and northern communities lack such a critical mass, but these communities are also often medically underserved and lack the health care provider complement

needed to provide the full continuum of care which the OHTs are intended to offer. It is yet to be seen how OHTs will develop in rural and northern areas and whether they will successfully address the needs of underserved communities.

### 2.3.4 Implications for Francophone: Opportunities

Although the OHTs are likely to encounter some challenges as they mature, they also provide opportunities to improve access to French language services. First, integrated care is a patient-centred approach that “imposes the patient’s perspective as the organizing principle of service delivery” (Lloyd & Wait, 2005, p. 7). The most successful integrated health care systems primarily address the patient’s holistic needs (Goodwin & Smith, 2011). The government of Ontario has acknowledged this important aspect of integration and indicated that the OHTs will place patient experiences and outcomes at the centre of care delivery (Ministry of Health, 2019b). Such patient-centeredness is achieved through a better understanding of the health care needs of the population they serve and the inclusion of patients in the OHT’s governance structures (Ministry of Health, 2019b). Such a commitment to the patient experience would presumably include an appreciation for linguistic and cultural needs, and it would be expected that Francophone patients should be included in patient engagement activities. To this end, the overarching Crown agency, Ontario Health, is leading by example by including a Franco-Ontarian member on its board of directors. Thus, the Francophone voice will have a place within Ontario Health and other individual OHTs are being encouraged to follow this example by including Francophones in their planning and management structures. A guidance document that was released in conjunction with Bill 74 states explicitly that OHTs are encouraged to create opportunities to improve care for Francophones and to demonstrate respect for the role of

Francophones in the planning, design, delivery and evaluation of the services they offer (Ministry of Health, 2019b).

Besides acknowledging the importance of the Francophone patient experience, Bill 74 provides further opportunities to improve French language services. For instance, Bill 74 effectively replaces the Local Health System Integration Act of 2006, which was amended in 2010 to appoint six French language health planning entities to collaborate with, and inform, the LHINs in the planning and implementation of French language services (Local Health System Integration Act, 2006; Ministry of Health and Long-Term Care, n.d.b). Although the LHINs will no longer exist, O. Reg. 211/21 of the Connecting Care Act (i.e., Schedule 1 of Bill 74) described the duty of Ontario Health to engage and collaborate with the French Language Health Planning Entities (O. Reg. 211/21, 2019). Thus, the French planning entities will continue to advocate for French language services by advising Ontario Health and the OHTs on the health needs and priorities of the French-speaking communities, the availability of and strategies to improve access to French language health service, the designation of French language health service providers, and the best methods of engaging with the Francophone population. Furthermore, Schedule 2 of Bill 74 amends the 1990 Ministry of Health and Long-Term Care Act to create “A French language health services advisory council to advise the Minister about health and service delivery issues related to Francophone communities”(The People's Health Care Act, 2019, Schedule 2).

The passing of the FLSA marked a critical milestone for French rights in Ontario (Office of the French Language Services Commissioner of Ontario, 2016b) by guaranteeing provincial government services would be offered in French. In the context of health care, the Local Health

System Integration Act recognized that, as agencies of the Ministry, the LHINs had to abide by the FLSA (Local Health System Integration Act, 2006). Although Bill 74 replaced the Local Health System Integration Act, an acknowledgement of the FLSA was maintained and somewhat strengthened. Not only does Bill 74 recognize that the public health care system should respect the requirements of the FLSA, but Part II, section 6 further affirms that one of the objectives of Ontario Health is to “respect the diversity of communities and the requirements of the FLSA in carrying out its objects” (The People's Health Care Act, 2019, Part II, section 6). The relevance of the FLSA was further affirmed in the government’s guiding document, which details that OHT candidates must adhere “to the requirements of the FLSA, as applicable, in serving Ontario’s French language communities” (Ministry of Health, 2019b, page 20).

### 2.3.5 Implications for Francophones: Challenges

Although such acknowledgements of French language rights are undoubtedly a good sign for the provision of French language services, the FLSA is somewhat limited, particularly in the context of health care delivery. In Canada, the planning and administration of health care falls under the jurisdiction of the provinces, which include government agencies and ministries. For instance, the Ministries of Health and Long-Term Care and the former LHINs are/were required to abide by the FLSA (Ministry of Health and Long-Term Care, 2017). However, due to outdated definitions of “government services” in the FLSA, the Act does not apply to some agencies in the realm of health care, such as public health units (Office of the French Language Services Commissioner of Ontario, 2016b). Furthermore, HSPs are not required to offer services in French under the FLSA (Farmanova et al., 2018). Public service agencies (including those providing health services) can voluntarily apply to be designated as French language service

providers under O.Reg. 398/93 of the FLSA (Farmanova et al., 2018; O. Reg. 398/93, 1990, Office of the French Language Services Commissioner of Ontario, 2016b; Ministry of Health and Long-Term Care, 2017). A designated agency must permanently provide services in French per the FLSA while maintaining French language service capacity and ensuring a Francophone presence on their board of directors and senior management positions. In return, the government recognizes the agency's competence to provide French language services, creating a quasi-constitutional guarantee that the agency will permanently provide such services. Thus, government funding is sustained as long as the agency maintains its French language service capacity (Office of the French Language Services Commissioner of Ontario, 2016b). However, it remains unclear what will happen when a designated agency joins an undesignated OHT, and there is a risk that designation may be lost if an agency is forced to integrate.

The provision of French language services by HSPs was previously regulated through Service Accountability Agreements with the LHINs (Ministry of Health and Long-Term Care, 2017). This responsibility will now fall under the mandate of Ontario Health. However, physicians were explicitly excluded from the definition of a HSP under the Local Health System Integration Act (Local Health System Integration Act, 2006) and there exists no legislative requirement for physicians to actively offer services in French in Ontario (Cardinal et al., 2018). Although physicians are not specifically named as HSPs under Bill 74 (Ministry of Health, 2019b), the government of Ontario, the Ontario Medical Association (OMA) and the Ontario College of Family Physicians (OCFP) recognize the important role physicians play in the long-term success of OHTs (Ministry of Health, 2019b; Ontario College of Family Physicians, 2019; Ontario Medical Association, 2019a). Both the OMA and the OCFP are advocating for physicians to take

on leadership responsibilities within OHTs. This position is logical given the role family physicians and general practitioners play as primary care specialists and gatekeepers to the health care system (Brown, 2018). Therefore, it would be reasonable for patients to make first contact with an OHT through their family physician. However, the voluntary nature of the offer of French language services by physicians (Cardinal et al., 2018), combined with the geographic maldistribution of French-speaking physicians in Ontario (who are predominantly located in communities with smaller concentrations of Francophones) (Timony et al., 2013) will pose a potential barrier to the offer of French language services provided by OHTs.

Furthermore, it remains unclear how the requirements for OHTs to comply with the FLSA as outlined in Bill 74 will apply to HSPs. According to Part IV, section 29(3),

“Any obligation, power or decision that, under this Act, applies to an integrated care delivery system applies to, and is binding on, each constituent person or entity of the integrated care delivery system to the extent necessary to make the obligation, power or decision practicable and effective” (The People's Health Care Act, 2019, Part IV, section 29(3)).

This section creates an expectation that OHT and their constituent HSPs, including physicians, would make French language services available in accordance with the FLSA (as outlined in Part II, section 6). However, such requirements would undermine physician autonomy (Ontario Medical Association, 2019b). Although physicians are not currently designated as HSPs under Bill 74, they are also not specifically excluded. According to the OCFP,

“The definition of a Health Service Provider in Bill 74 is open ended, allowing additional entities to be prescribed by future regulations. Entities defined as a Health Service Provider have significant requirements placed on them including possible directives issued by the Minister of Health and Long Term Care or Ontario Health on operational priorities” (Ontario College of Family Physicians, 2019, p. 8).

For this reason, the OCFP recommends amending the wording of Bill 74 to exclude physicians as HSPs. As long as physicians avoid being designated as HSPs, they will continue to be funded through existing channels (Ontario Medical Association, 2019a). As a result, under Bill 74, Ontario Health does not presently possess the funding power to order physicians to offer services in French or to relocate their practice, as they do with other HSPs under Part IV, section 33 (The People's Health Care Act, 2019). Therefore, it is unlikely that joining an OHT will change the way physicians serve their Francophone patients and thus, the offer of French language services at the first point of contact with the OHT (i.e., through family physicians and general practitioners) may be limited. Although neither the FLSA nor Bill 74 apply directly to the care provided by physicians, these legislative changes point to a shift in health care delivery to be more responsive to the needs of the linguistic minority population. It may be in the best interest of their Francophone patients and of the OHT they work with (particularly if they are in a leadership role) for physicians to take note of this shift and to adapt the care they provide accordingly.

Beyond the realm of health care delivery, the FLSA is further limited by only being applicable in 27 designated areas where the Francophone population is at least 5 000 or accounts for 10% of the total population (French Language Services Act, 1990). Furthermore, this Act had not

received any major revisions in 35 years, and there has been a lack of consistency in how various government agencies and ministries interpret the Act and define the Francophone population (Office of the French Language Services Commissioner of Ontario, 2016b). In 2009, the government of Ontario adopted the Inclusive Definition of Francophones, which expanded the previous definition to include “persons whose mother tongue is French, plus those whose mother tongue is neither French nor English but have a particular knowledge of French as an Official Language and use French at home” (Office of the French Language Services Commissioner of Ontario, 2016b, page 26). This new definition expands on previous definitions by allowing for the inclusion of immigrant populations who may not have been previously recognized as Francophone, but for whom French is the official language with which they identify. However, this definition is still not being used systematically (Office of the French Language Services Commissioner of Ontario, 2016b). In combination with the gaps in protected French language services in non-designated areas, the result is that the French language rights of many Francophones living in minority contexts in Ontario are not recognized. The pandemic highlighted further limitations of the Act, namely that public health units and several providers involved with screening and vaccinations are excluded (Office of the Ombudsman of Ontario, 2021). For instance, the 2019-2020 annual report of the French Language Services Commissioner of Ontario identified a lack of communication in French surrounding the COVID-19 pandemic as the top complaint received. Of note, media briefings from the Premier’s office and the Chief Medical Officer of Health, some government services and documents (notably a plan entitled *Keeping Ontarians Safe: Preparing for Future Waves of COVID-19*) as well as information provided by some local health units were only available in English (Office of the Ombudsman of Ontario, 2020). Although many of these complaints were eventually resolved, it

is clear that gaps exist in French language information surrounding the pandemic and in the extent to which various actors comply with the FLSA in emergency situations. Finally, there was also no directive in the Act that required French language services to be actively offered. Agencies must be able to serve French populations, but it has been the responsibility of the Francophone population to make the request (Office of the French Language Services Commissioner of Ontario, 2016b). However, important improvements to French language services were proposed by the government of Ontario in 2021, including a modernization of the FLSA.

### 2.3.6 The modernization of the French Language Services Act

In June of 2021, the Government of Ontario undertook six weeks of public consultations with Francophone populations across the province (Ministry of Francophone Affairs, 2022a). Over 950 people responded to an online questionnaire, and nearly 80 people participated in stakeholder roundtables (Ministry of Francophone Affairs, 2022b). According to the Ministry of Francophone Affairs (2022b), such high response rates clearly demonstrate the importance Francophones place on accessing French language services. These consultations revealed several challenges encountered by Francophones when accessing front-line services, which motivated the government to implement a new French Languages Services Strategy built on three pillars. Beginning with the third pillar, which focuses on **service planning and delivery**, the government intends to increase access to French language services by exploring novel service delivery models (e.g., mobile service delivery), implementing digital based options for both service delivery at the patient-level and access to training at the provider-level, simplifying the process for being designated as a French language service provider, and developing evaluation

tools to enhance accountability and assess the availability of government services in French (Ministry of Francophone Affairs, 2022a; Ministry of Francophone Affairs, 2022b). The second pillar centres on increasing the **Francophone and bilingual workforce** by making improvements to the training and recruitment of key occupations such as healthcare, and by creating a Francophone immigration corridor and professional certification recognition to recruit French-speaking skilled professionals from outside our borders. (Ministry of Francophone Affairs, 2022a; Ministry of Francophone Affairs, 2022b). Finally, the first pillar proposes a **modernized legislative framework**, including a modernization of the French Language Services Act (Ministry of Francophone Affairs, 2022a; Ministry of Francophone Affairs, 2022b).

In late 2021, the government of Ontario announced the first substantial review of the FLSA in over 35 years, which received royal assent on December 9th 2021 (Government of Ontario, 2021; Ministry of Francophone Affairs, 2022b). Notable revisions to the Act include: a greater emphasis on the rights of Francophones to receive front-line services in French; the ability to add designated points of services across the province, thus expanding the availability of French languages services beyond the previously designated regions; the addition of a new designated region under the Act, the City of Sarnia, which became Ontario's 27<sup>th</sup> designated region on December 13<sup>th</sup> 2021; and the addition of new requirements for Ministers to report annually on how they have implemented the Act and on the quality of the French services provided by their respective ministries (Ministry of Francophone Affairs, 2022b). However, the most notable revision is an amendment to section 5, which adds a new subsection regarding the active offer of services in French (French Language Services Act, 1990; Ministry of Francophone Affairs, 2022b). According to the new subsection, for every individual who has a right to receive front-

line services in French under the Act, the service provider is obligated to bring the availability of those services in French to the attention of the individuals (French Language Services Act, 1990). As a result, the modernized FLSA legislates the active offer of French language services, taking the onus to request services in French off the patient and placing it on the provider, who must clearly communicate the availability of service in French.

Despite the substantial improvements made to the FLSA, some important limitations have yet to be addressed. In the former French Language Commissioner of Ontario's annual report from 2016, a number of recommendations were made to modernize the FLSA (Office of the French Language Services Commissioner of Ontario, 2016b). Although some important recommendations have been implemented, notably the inclusion of the active offer in the Act, others remain relatively unchanged. First, the definition of a government service has not been expanded. As a result, municipalities and public service agencies (such a local public health units) remain excluded or partially excluded from the Act (French Language Services Act, 1990). Second, the Act does not specify how a Francophone is defined. As a result there is no guarantee that the Inclusive Definition of a Francophone will be used systematically when applying the Act, and some members of the Francophone population (i.e., those whose mother tongue is neither French nor English) may continue to be denied services in French. Finally, although efforts have been made to improve the number of designated areas and providers throughout the province, the former French Language Services Commissioner recommended that the entire province be designated under the Act (Office of the French Language Services Commissioner of Ontario, 2016b). As long as the designation of regions persists, many

Francophones living in non-designated regions will continue to have limited access to front-line services in French.

However, the addition of the active offer as a requirement of the FLSA is an important milestone in Ontario's long history of recognizing French language service rights. No longer will Francophones residing in designated regions need to request services in French, these services will be required by law to advertise their availability in French. Unfortunately, no such requirement exist in non-designated regions. The combination of Bill 74 and the modernization of the FLSA will also have important implications for French language health services. If under Bill 74, the OHTs must adhere "to the requirements of the FLSA, as applicable, in serving Ontario's French language communities" (Ministry of Health, 2019b, page 20), then they must also adhere to the changes to the FLSA, including the new legislative requirement to practice the active offer of French language services in the delivery of health care. However, the successful application of the active offer will require OHTs to properly understand what the active offer entails and have viable strategies for its implementation.

## 2.4 The Active offer of French Language Services

The concept of active offer of French language services originated in the public sector as a strategy for responding to legislative obligations set out by the FLSA. In their Framework for Action, the Ontario Public Service defined the active offer as the act of informing the public of the availability of services in French and ensuring access to such services (Ontario Public Service, 2006). More contemporary definitions consider the active offer as a proactive offer of services in French, which are available at all times, clearly communicated, visible, easy to access, of equal quality to and with similar wait times as the services being offer in English

(Ministry of Francophone Affairs, 2014; Office of the French Language Services Commissioner of Ontario, 2016a). An active offer is a verbal or written invitation to express oneself in the official language of their choice (Bouchard et al., 2012b). To be considered active, this invitation must precede the request, with the goal of offering services adapted to the linguistic minorities' culture to ensure Francophones feel comfortable when receiving services (Savard et al., 2014). Thus, the active offer is more than simply offering services in both official languages; it is an example of patient-centred communication that acknowledges the importance of culture and language (Lortie & Lalonde, 2012).

However, in Ontario, Francophone bilingualism can be a barrier to the offer of French language services. According to the 2016 census, 93% of Francophones in Ontario report also having knowledge of English (Statistics Canada, 2021). Given this high rate of bilingualism in their patients, some providers do not see the need to offer French language services (Timony et al., 2016). However, functional bilingualism is not an accurate representation of linguistic competence and, according to Bowen, "providers commonly overestimate their patients' ability to comprehend and communicate in a second language" (Bowen, 2001, p.57). Although many Francophones are able to hold a conversation in English they may lack the vocabulary and understanding of the English language to be able to describe their health needs and understand treatment instructions.

Research on Francophone patients in Ontario revealed that, even though these patients are capable of speaking in English, they often feel uncomfortable doing so with their primary care providers, leading to feelings of insecurity and an inability to follow self-care advice (Jutras et al., 2020). As a result, language barriers continue to threaten patient safety and health outcomes

throughout Canada (de Moissac & Bowen, 2019). Furthermore, many Francophones living in a minority context will not demand their services in French (Forgues et al., 2014), particularly if they believe that it will be difficult to do so, that wait times will increase or if the service had been previously denied (Office of the French Language Services Commissioner of Ontario, 2016a). In fact, linguistically appropriate services for Ontario Francophones have been described as having been “systematically denied” (Cartwright, 1998, p. 292), resulting in a form of learned helplessness and a refusal to continue to request such services (Société Santé en français, 2007). This leads to a vicious cycle in which providers are less likely to offer services in French if there is no demand, and patients are less likely to use service in French if there is no offer (Office of the French Language Services Commissioner of Ontario, 2016a). If this cycle remains unbroken, Francophone patients could continue to fall through the cracks, even in an integrated system. As we saw earlier, there exists a gap in Ontario between the patient’s needs and preferences to receive health services in French (DPM Research, 2021; Jutras et al., 2020; Leger, 2020) and the physician’s belief that their patients are bilingual and are content with being served in English (Timony et al., 2016).

The active offer of French language services has been suggested as a means of breaking this vicious cycle (Office of the French Language Services Commissioner of Ontario, 2016a). To be successful, the responsibility of the active offer must be shared with all levels of the health care system (French Language Health Planning Entities and French Language Health Networks of Ontario, 2015) and consider the health status of the Francophone population being served as well as the historical lack of French language services (Lortie & Lalonde, 2012). Considering the recent amendments to the FLSA, health service providers who join an OHT will be responsible

for proactively serving patients in French, understanding the particular needs of their Francophone patients, actively promoting French language services, and ensuring continuity of care in French when making referrals. The leadership of health care organizations can support the active offer by including Francophone members in their governance structures, developing policies on active offer, supporting the use of French in their internal culture (e.g., by encouraging French-speaking providers and staff to converse in French) and ensuring all staff receive active offer training. In turn, at the system level, Ontario Health can hold the OHTs accountable to the FLSA by including active offer standards in funding agreements. Though this strategy has yet to be implemented, recent amendments to the FLSA which require ministries, including the Ministry of Health, to assess and report on the quality of the French services they provide will likely trickle down to the front-line providers, and it is equally likely that OHTs will need to report regularly on their active offer approaches. Furthermore, the active offer provides strategies that both French-speaking and non-French-speaking providers can utilize to improve the offer of French language services. Such strategies include identifying the patient's preferred language of service, proactively welcoming Francophone patients in French, hiring bilingual health professionals and staff, developing a communication strategy that informs the general public of the availability of services in both official languages, and offering interpreter and translation services. (French Language Health Planning Entities and French Language Health Networks of Ontario, 2015; Ministry of Francophone Affairs, 2014; Reflet Salvéo, 2017).

According to the former French Language Services Commissioner of Ontario, it is vital that the active offer occurs at the first point of contact with an HSP (Office of the French Language Services Commissioner of Ontario, 2016a). This distinction is reflected in the Ministry of

Francophone Affairs' interpretation of the FLSA, which states that the "Active offer means that French language services are not only available but also brought to the attention of the client upon first contact" (Ministry of Francophone Affairs, 2022b, p. 11). This first communication sets the stage for the patient's expectation for receiving subsequent services in French. If the initial communication is in French, the patient will feel more confident that service will be received in French and will be more likely to engage with other service providers in French. However, if the initial communication is in English, the patient will expect all subsequent services to be offered in English and may refuse a French language service even if it is offered later on (Office of the French Language Services Commissioner of Ontario, 2016a). Therefore, if physicians will be the first point of contact with the OHTs, it will be important that they provide an active offer of French language services to ensure Francophone patients feel comfortable engaging with other members of the OHT in French.

With the growing acceptance of active offer as a patient-centred approach to delivering high-quality health care to linguistic minority populations and the legislation of the active offer in the FLSA, there is a growing expectation from patients that practicing health care providers be able to actively offer service in French. However, education and training will be required to prepare practicing providers to properly implement the active offer in their practice.

## 2.5 Importance of communication in health care

### 2.5.1 Influence of communication and language concordance on health outcomes and quality of care

If so much focus has been placed on the active offer of French language services in the context of health care delivery, it is likely because communication is recognised as an essential to the

provision of care. Interpersonal communication is at the heart of primary health care delivery and has long been considered the essential tool of primary care physicians (Ong et al., 1995).

Effective communication is vital for understanding medical information and coping with diseases (Nouri & Rudd, 2015; Ong et al., 1995). Furthermore, effective communication has been linked to a higher quality of care (Al Shamsi et al., 2020; Bensing, 1991; Matusitz & Spear, 2014) and improved health outcomes (Matusitz & Spear, 2014; Stewart, 1995). However, for many Franco-Ontarians, language barriers challenge the quality of this communication. In fact, a study of Canadian Francophones found that language barriers resulted in poorer quality of care and patient safety (de Moissac & Bowen, 2019).

The literature is rich with examples of how language barriers can negatively influence health outcomes and access to health-enabling resources at all levels of the health care system. For instance, belonging to a linguistic minority group has been found to be a barrier to initial access to health services and health information (Bowen, 2001). Language discordances are a barrier to fully benefiting from health promotion and prevention programs (Bowen, 2001) and health education (Ngo-Metzger et al., 2007). Patients whose first language is not English have been found to have reduced comprehension and compliance with physicians' instructions and experience difficulties understanding their own health conditions (Bowen, 2001; Wilson et al., 2005; Yeo, 2004). Furthermore, patients with limited English proficiency experience confusion about how to use medication and have trouble understanding medication labels (Wilson et al., 2005), which can lead to reduced medication adherence (Jacobs et al., 2006) and increased adverse medication reactions (Bowen, 2001; Wilson et al., 2005). A 2001 report on access and quality of care for official language minorities in Canada indicated that language barriers have

been associated with inequalities of prescribed medication, lower rates of optimal pain medication, and less adequate management of chronic diseases such as asthma and diabetes (Bowen, 2001). Additionally, strong evidence suggests that patient-physician language concordance is associated with better clinical outcomes (Cano-Ibáñez et al., 2021).

From a primary care perspective, a 2004 study from the United States found that patients with limited English proficiency visit primary care clinics less frequently, have fewer follow-up visits, spend more time with the primary care provider per visit and are subjected to more lab tests (Yeo, 2004). Patient-physician linguistic discordances have also been linked to inadequate chronic disease management, reduced diagnostic confidence and increased reliance on diagnostic testing (Bowen, 2001; Garra et al., 2010; Waxman & Levitt, 2000; Wilson et al., 2005). Such suboptimal access to primary care and health information in linguistic minority populations, in combination with a poor understanding of medication use, may be contributing to the increased risks of hospital admission and readmission (Bowen, 2001; Gallagher et al., 2013; Karliner et al., 2010), more frequent emergency room visits (Bowen, 2001, Gallagher et al., 2013; Yeo, 2004), and longer hospital stays (Douglas et al., 2014). Research from Ontario has found that limited English proficiency patients stay in hospital 0.7 to 4.3 days longer than their English-speaking counterparts (John-Baptiste et al., 2004) and are more likely to visit an emergency department and be readmitted to hospital within 30 days of being discharged (Rawal et al., 2019).

Furthermore, there is evidence that linguistic minority populations experience inequitable health services when in hospital. For instance, a 1996 study found that asthmatic patients with a language barrier in the United States were 17 times more likely to be intubated (LeSon & Gershwin, 1996). This study further recognised that the risk of intubation was higher for patients

with a language barrier than for patients with low education attainment or for patients who were active smokers (LeSon & Gershwin, 1996). A 2004 analysis of the U.S. National Trauma Registry for the American College of Surgeons confirmed that, upon arrival at a trauma center, Spanish-speaking patients were more likely to be unnecessarily intubated (Bard et al., 2004). A retrospective cohort study of home care recipients in Ontario found that Allophones (i.e., Ontario residents who are neither Francophone nor Anglophone) admitted to hospital experienced higher rates of harmful events, such as harm from general medical care (including medication administration), infections, patient accidents and harm from procedures (Reaume et al., 2020). Similarly, Francophone patients were more likely to experience harmful events when admitted to a hospital that was not legally required to offer services in both official languages (Reaume et al., 2020). An analysis of adverse events by the U.S. Joint Commission found that communication barriers were the root cause for 62% of adverse events between 2012 and 2014 (Carson, 2016). Additionally, between 2004 and 2014, communication issues were reported as being the principal cause in 81% of delays in treatment, 71% of medication errors, 63% of radiation overdose events, and 53% of Op/Post-op complications (Carson, 2016). In addition, a 2015 analysis of the Ontario Mental Health Reporting System revealed that, compared to English-speaking patients, French-speaking patients admitted to a mental health facility were one-third as likely to have daily contact with a psychiatrist (Tempier et al., 2015). In fact, language discordances are a considerable barrier to various mental health and counselling services (Bowen, 2001; Sentell et al., 2007, St Amant et al., 2018).

Language barriers have also been linked to suboptimal health care experiences across all age groups. Evidence from the United States suggests that, during birth, non-English-speaking

patients have a higher risk of experiencing obstetric trauma (Hines et al., 2014, Sentell et al., 2016) and high-risk deliveries (Sentell et al., 2016). Children from limited English proficiency Spanish-speaking families admitted to a pediatric hospital in the USA had an increased risk of experiencing a serious adverse medical event (Cohen et al., 2005, Lion et al., 2013) or unexpected occurrence involving death or serious injury (Lion et al., 2013). As a result, these children had longer hospital stays (Lion et al., 2013) and were more likely to be readmitted to an emergency department (Gallagher et al., 2013). Finally, a series of recent retrospective cohort studies in Ontario have shed light on the inequitable end-of-life care experienced by the aging Francophone population (Batista et al., 2019; Batista et al., 2021; Guérin et al., 2019; Riad et al., 2020; Reaume et al., 2021,). Compared to Anglophones, Francophones faced barriers to accessing home care services resulting in greater use of long-term care services (Guérin et al., 2019). Despite a preference by older Francophone Canadians to remain autonomous and to age-in-place (Bassett et al., 2007), a lack of French language home care services may be prematurely forcing Francophones into long-term care (Guérin et al., 2019). In addition, non-English-speaking home care recipients were less likely to visit an emergency room or be hospitalized when such hospital utilization was necessary (Reaume et al., 2021) and were more likely to die in hospital (Guérin et al., 2019). The authors attributed such inequitable hospitalizations to language barriers (Reaume et al., 2021). Linguistically discordant home care providers may fail to identify emerging health needs leading to delayed use of hospital-based health care services, which are more likely to end in death (Reaume et al., 2021). Alternatively, Francophones admitted to long-term care facilities in Ontario were more likely to experience: moderate to severe pain, worsening depressive symptoms, physical restraint, falls, administration of antipsychotic medication despite not having a diagnosis of psychosis, hospitalization, and

emergency department visits (Batista et al., 2019; Batista et al., 2021). The risk of these undesirable outcomes was particularly acute in facilities that were not legally required to offer services in French (Batista et al., 2021). Interestingly, being diagnosed with dementia had a protective effect on the influence of communication barriers (Riad et al., 2020). Francophones with dementia are more likely to communicate through a caregiver so are less likely to experience a language barrier than Francophones without dementia who communicate directly with long-term care staff, leading to an inadequate assessment of health status and an underreporting of symptoms (Riad et al., 2020).

Furthermore, communication barriers are also potentially costly to the health care system (Access Alliance Multicultural Health and Community Services, 2021). As we have seen, communication barriers can impact service utilization and health outcomes so that patients with limited English proficiency end up being more frequent users of the health care system (Bowen, 2001). It is difficult to estimate the actual economic impact that language barriers have on the health care system given that the indirect costs associated with reduced quality of care and poor health outcomes are intangible or hard to quantify (Bowen, 2001; Moloney, 2017). However, language barriers are commonly associated with costly practices such as reallocating staff time, a greater use of diagnostic tests, missed appointments and unnecessary procedures (Access Alliance Multicultural Health and Community Services, 2021; Bowen, 2001). A study of refugees seeking protection in Switzerland found that the care provided by a Swiss Health Maintenance Organization cost twice as much for those with language barriers (Bischoff & Denhaerynck, 2010). The added cost was largely attributed to the use of interpreters, who enabled the refugee to use more health care services. Thus, although the initial cost of

interpreters and greater use of health services may be more costly in the short term, in the long term, interpreters aid patients in attaining effective solutions sooner (Bischoff & Denhaerynck, 2010).

Much of the literature on the economic impact of language barriers has focused on the costs associated with interpreters (Bischoff & Denhaerynck, 2010; Bowen, 2001; Jacobs et al., 2001; Jacobs et al., 2004; Moloney, 2017; Sultana et al., 2018). Although informal untrained interpreters pose a threat to patient safety and the ad hoc use of bilingual staff often ends up being more costly than the use of formal interpreter services (for instance a nurse's hourly wage is more than the cost of an interpreter service, it also takes additional time to find a bilingual staff who must be pulled from caring for an other patient), these remain the most commonly used interpreters in Canada (Bowen, 2001; Papic et al., 2012). It is not surprising that informal/ad hoc interpretation is so commonly used given that the cost of formal interpreter services often outweighs the allocated budget. For instance, the estimated cost of providing interpretation for a Community Health Centre in Ottawa ranged from \$31,000 to over \$199,000 in 2016, however they had only budgeted between \$9,000 to \$20,000 for such services (Moloney, 2017). Although the initial cost of formal interpretation services is a barrier to their use, they may also represent substantial savings over time.

Research from Ontario agrees that formal interpretations services have the potential to reduce the financial burden that language barriers place on the health care system through indirect savings associated with avoiding delayed care, reduced complications and clinical errors, reductions in the number of unnecessary tests, reduced re-admission rates, and increases in preventive care (Moloney, 2017, Sultana et al., 2018). The overarching consensus is that the costs of providing

formal interpreters, and the associated costs of increased access to services in the short term, are more cost-effective than managing chronic diseases or avoidable long-term service utilization associated with linguistically discordant care (Bischoff & Denhaerynck, 2010; Jacobs et al., 2004; Moloney, 2017). In the absence of formal interpreter services, the use of informal/ad hoc interpreters should be kept to a minimum (Rimmer, 2020), with modern technology providing a solution to navigating linguistically discordant interactions. For instance, online translation software, such as Google Translate, improved quality of care, patient safety and patient and provider satisfaction (Al Shamsi et al., 2020).

In essence, communication can contribute to improved health and increased illness, and is essential to providing a quality health care service. This opinion is shared by the Royal College of Physicians and Surgeons of Canada who, in their CanMEDS framework, recognize that being a “communicator”, defined as the ability to effectively facilitate the patient-physician interaction, is one of the six roles of a medical expert (Frank et al., 2015). Furthermore, it could be argued that communication is essential to mastering the five remaining roles: being a collaborator, a leader, a health advocate, a scholar, and a professional (Frank et al., 2015). The notion that communication is essential when providing health care is far from novel. As Tumulty stated over five decades ago, “What the scalpel is to the surgeon, words are to the clinician ... the conversation between doctor and patient is the heart of the practice of medicine" (Tumulty, 1970, p.20).

### 2.5.2 Influence of communication and language concordance on patient satisfaction

In addition to being linked to health outcomes (Bensing, 1991; Stewart, 1995) and behaviours (Jacobs et al., 2006; Ong et al., 1995), physician communication has also been associated with patient satisfaction (Anderson et al., 2007; Clever et al., 2008; Crow et al., 2002; Pieper et al., 2009; Williams et al., 1998). For instance, Boissy et al. (2016) and Allenbaugh et al. (2019) concluded that patient satisfaction could be improved through provider communication training. This finding is supported by a 2002 review of literature on satisfaction surveys, which confirmed that the health service component that is most influential on satisfaction is the patient-physician relationship; particularly as it relates to communication (Crow et al., 2002). A 2019 study found that patient satisfaction was higher in patients who trusted their provider and when they judged their provider's communication skills to be of higher quality (Chandra et al., 2019). Furthermore, a 2019 literature review found that increased patient satisfaction is commonly associated with a patient-centred approach characterized by effective communication and high levels of trust (Korzh & Tsodikova, 2019). From a patient's perspective, in a 2007 qualitative study, patients reported that physician communication was among the essential qualities of health care influencing their satisfaction (Anderson et al., 2007). Communication was considered particularly influential when the physician listened to patient concerns, included them in the health care process, and provided adequate information (Anderson et al., 2007). Additionally, a 2019 study found a strong association between patient-rated physician empathy and patient satisfaction (Walsh et al., 2019). Though behaviours such as listening, providing information and being empathetic are not directly related to language, all would be limited in the presence of a language barrier.

Language barriers between patients and their health care providers are commonly associated with miscommunications and reduced patient satisfaction (Al Shamsi et al., 2020; Bowen, 2001). For instance, it is common for research from the United States to find that Spanish-speaking patients are more satisfied with their care when served by a Spanish-speaking provider than a non-Spanish-speaking provider (Dunlap et al., 2015; Flower et al., 2017; Haskard-Zolnierek et al., 2021; Lee et al., 2002). A 2019 literature review of papers about the Saudi Arabian health system found that many non-Saudi nurses have limited knowledge of their patient's language, culture and religion, resulting in poor communication, misunderstandings and poor patient satisfaction (Alshammari et al., 2019).

This association is further reinforced by studies demonstrating that patient satisfaction can be predicted by assessing physician communication behaviours (Batbaatar et al., 2017; Christen et al., 2008; Jackson et al., 2001; Hirsh et al., 2005; Schoenfelder et al., 2011; Sitzia & Wood, 1997; Yarnold et al., 1998). For instance, a post-visit survey of over 10 000 patients from 39 German hospitals revealed ten predictors of global patient satisfaction (Schoenfelder et al., 2011). Nurse and physician interpersonal skills were the second and third strongest predictors, and individualized care and discharge instructions were weaker yet significant predictors (Schoenfelder et al., 2011). Likewise, a 2008 study of satisfaction with gynecologists found that the strongest predictor was not physician gender (as one might expect) but rather patient-centred communication style (Christen et al., 2008). A 2017 systematic review of the literature further acknowledged that the provider's interpersonal quality of care is the most influential determinant of patient satisfaction (Batbaatar et al., 2017). Alternatively, a 2020 study of breast cancer patients in Germany found that waiting time is the strongest predictor of patient satisfaction and

that strong patient-centred communication neutralizes the dissatisfaction associated with long wait times (Lee et al., 2020).

Given the relationship between communication and satisfaction, it is not surprising that medical schools, certification bodies and health care organizations have employed patient satisfaction scales to assess physician interpersonal and communication skills (Duffy et al., 2004; Epstein et al., 2005; Greco et al., 1998; Greco et al., 2001). Since the quality of communication is subjective and dependent on those involved, it may not be appropriately assessed by a third party or an objective measurement tool, which cannot determine the communicator's feelings of understanding or being understood (Duffy et al., 2004). Since patients are directly involved in care provision, they have been described as an appropriate source for measuring this interpersonal process (Kazandjian, 1999). Many instruments developed to assess physician communication skills have relied on patient views and satisfaction scales (Flocke et al., 1998; Greco et al., 2002; Hall et al., 1999; Little et al., 2001; Mead et al., 2008; Ramsay et al., 2000; Roland et al., 2013). For instance, both the Doctors' Interpersonal Skills Questionnaire (Greco et al., 2002) and the General Practice Assessment Questionnaire (Mead et al., 2008; Roland et al., 2013) are comprised primarily of patient satisfaction scales and are considered to be reliable and valid measures of specific dimensions of primary care, including interpersonal and communication skills.

### 2.5.3 Link between patient satisfaction and quality of care

Patient satisfaction is also associated with quality of care. Positive patient experiences are linked to clinical best-practice procedures, better patient outcomes, and reductions in avoidable hospital utilization (Anhang Prince et al., 2014). Although there is no universally accepted tool for

measuring quality of care, patient satisfaction surveys are widely included as one indicator of quality and are often used to assess quality improvements (Dileep & Rau, 2010; Febres-Ramos & Mercado-Rey, 2020; Gill & White, 2009; Rashid & Jusoff, 2009; Säilä et al., 2008; Woodward et al., 2000). For instance, the SERVQUAL model conceptualizes satisfaction as the extent to which a service meets or exceeds the patient's expectations of that service (Parasuraman et al., 1988). As such, the SERVQUAL scale measures both patient expectations for services and their perceived experience with the service on five dimensions of quality: tangibles (i.e., the physical environment and personnel), reliability (i.e., service accuracy over time), responsiveness (i.e., timeliness of service), assurance (i.e., trust and confidence in the service), and empathy (i.e., patient-centeredness) (Parasuraman et al., 1988, Tripathi & Siddiqui, 2018). Thus, the SERVQUAL scale is a commonly used example of how patient satisfaction scales are used to measure quality of health care (Al-Neyadi et al., 2018; AlOmari, 2020; Pekkaya et al., 2019; Tripathi & Siddiqui, 2018). Some consider patient satisfaction to be the most important indicator of quality given the subjective nature of quality and the importance of the patient experience in developing patient-centred strategies (Faezipour & Ferreira, 2013; Gupta & Rokade, 2016; Naidu, 2009). Others criticize its validity because patient assessments can be emotionally affected and patients often lack the experience and knowledge needed to effectively evaluate clinical competencies such as diagnostic and therapeutic interventions (Gill & White, 2009; Naidu, 2009). However, patients are recognized as being the only source qualified to judge the physicians ability to communicate effectively with them (Agency for healthcare Research Quality, 2017), with many authors recognizing patient satisfaction scales as an appropriate method of measuring the interpersonal component of care (Gill & White, 2009; Rashid & Jusoff, 2009). As Donabedian suggests, "An expression of satisfaction or

dissatisfaction is also the patient's judgment on the quality of care in all its aspects, but particularly as it concerns the interpersonal process.” (Donabedian, 1988, p. 1746). Therefore, a patient’s evaluation of the quality of care, particularly the interpersonal component, is assessed through expressions of satisfaction and dissatisfaction.

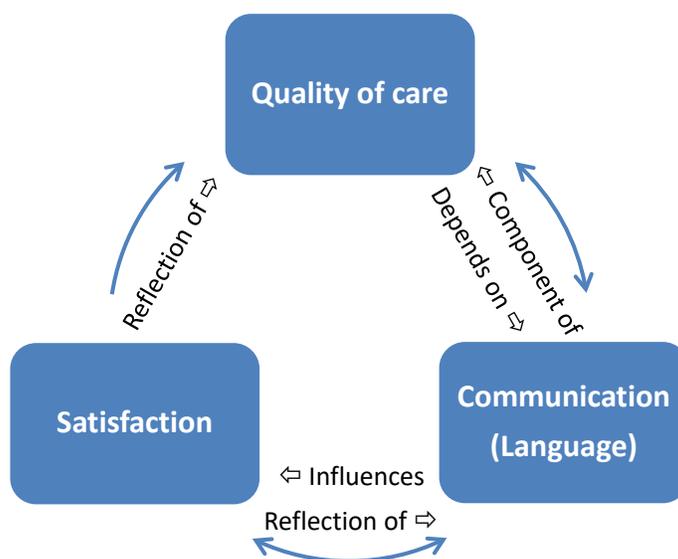
Furthermore, it has been found that understanding patient experiences (by using satisfaction scales) is vital to designing and delivering high-quality health services (Florin & Dixon, 2004; Woodward et al., 2000). Satisfied patients are more likely to continue seeing the health care provider, return for follow-up appointments, disclose crucial medical information, comply with medical recommendations and actively participate in their treatment (Aharony & Strasser, 1993; Westaway et al., 2003). Thus, it could be argued that satisfied patients are more likely to receive appropriate “upstream” preventative care rather than receiving a more costly reactive or curative “downstream” treatment (Canadian Public Health Association, website; Public Health Agency of Canada, 2009).

Naidu (2009) proposed a compelling explanation of the interplay between patient satisfaction and quality of care. According to Naidu, both the patient and the provider contribute to quality of care (Naidu, 2009). While the provider diagnoses, suggests treatment plans, prescribes medication and makes referrals, the patient must accurately describe their symptoms, undergo treatment, take their medication and attend referral appointments. As a result, quality of care depends on both provider competence and patient adherence, which combine to produce health outcomes. According to this model, patient satisfaction influences quality through loyalty to their provider (Naidu, 2009). As we have seen, it is largely accepted that patient satisfaction is associated with positive health behaviours, such as adherence to treatment plans, compliance

with medication and persistence with therapeutic interventions, which in turn encourages providers to prescribe more comprehensive treatment options, thus further improving the quality of care provided (Anhang Price, et al, 2014; Barbosa et al., 2012; Ivany & Lane, 2021).

Therefore, patient satisfaction is not measured to assess a provider's level of technical quality, but to determine the extent to which a provider's level of functional quality will influence the likelihood that patients will comply with the technical provision of care. As a result, barriers to the functional quality that negatively influence patient satisfaction, such as linguistic discordances, can in turn negatively influence the technical quality and patient health outcomes.

As we have seen in this review of the literature, communication is an essential component of a quality health care service. A lack of communication can lead to patients being dissatisfied with the care they are receiving, and patient satisfaction is both a reflection of physician communication and quality of care and is an important determinant of the patient's contribution to their quality of care. Therefore, if patient satisfaction suffers as a result of linguistic discordance, it may be indicative of a failure in communication and a lack in the quality of the health care provided (see Figure 2 for a Conceptual representation of this Rationale).



**Figure 2: Conceptual representation of background rationale**

Finally, language barriers may also pose a barrier to the Ontario health care system’s goal of achieving the Quadruple Aim (Access Alliance Multicultural Health and Community Services, 2021; Devlin, 2019). According to the Quadruple Aim framework, the health care system should be designed to achieve four overarching goals: improving the patient experience, improving health outcomes, reducing the cost of care and improving the provider experience (Access Alliance Multicultural Health and Community Services, 2021; Devlin, 2019). Although the Quadruple Aim has been described as “a compass to optimize health system performance” (Bodenheimer & Sinsky, 2014, p.573), language barriers can challenge all four goals. As we have seen in this review of the literature, language barriers in health care delivery are associated with reduced patient satisfaction (Al Shamsi et al., 2020; Bowen, 2001; Haskard-Zolnieriek et al., 2021), declined quality of care, patient safety and health outcomes (Bowen, 2001; de Moissac & Bowen, 2019) and increased costs to the health care system (e.g., through reallocating staff,

using more diagnostic tests, conducting unnecessary procedures and increased emergency department use) (Access Alliance Multicultural Health and Community Services, 2021; Bowen, 2001).

In addition, language barriers can challenge the provider experience. Research has found that providers are less satisfied with the care they provide to linguistically and culturally discordant patients compared to patients who share their own language and culture (Al Shamsi et al., 2020; Haskard-Zolnierek et al., 2021; Kamath et al., 2003). Specifically, satisfaction is lowest in the areas of disease prevention, chronic disease management and communication (Kamath et al., 2003), all of which have been found to be negatively influenced by language barriers (Bowen, 2001). Interactions with linguistically discordant patients are less rewarding, frustrating, emotionally draining and can leave the provider with a feeling of failure or helplessness (Haskard-Zolnierek et al., 2021; Olcoń & Gulbas, 2021; Turner & Madi, 2019). Such emotionally demanding patient consultations can lead to burnout (Olcoń & Gulbas, 2021), particularly if these interactions are frequent. As Olcoń and Gulbas (2021) revealed in a qualitative investigation of providers serving Spanish-speaking immigrants in Texas, providers who serve marginalized and vulnerable patients, such as linguistic minority populations, are at an elevated risk of experiencing work-related stress and burnout (Olcoń & Gulbas, 2021). In turn, physician burnout can further impede patient-provider communication and rapport building (Back et al., 2019; Robbins et al., 2019) while also increasing the odds of unsafe care, unprofessional behaviours, professional inefficiencies and patient dissatisfaction (Panagioti et al., 2018). Thus, language barriers, such as those experienced when serving Ontario's Francophone

population, are not only a risk to patient safety and satisfaction, but can also threaten the attainment of the Quadruple Aim.

## 2.6 Teaching patient-centred communication and the active offer to practicing physicians

The concepts of social accountability and patient-centred care have become increasingly prominent in medical education and health care delivery. While social accountability refers to a medical school's responsibility to provide education responding to the health concerns of the region they serve (Health Canada, 2001), patient-centred care, from the perspective of the physician, refers to the patient's involvement in the decision-making process regarding treatment and health management, and requires effective communication between physicians and patients (Care, 2010). Both concepts require an acute awareness of the needs and desires of the population being served (Boelen & Woollard, 2009). While medical schools are required to instruct students on the most common health needs of the general population, physicians must remain informed about the values, preferences and health goals of their patients (Barry & Edgman-Levitan, 2012). However, how do we ensure physicians remain accountable to their patients' needs once they are in practice?

### 2.6.1 Best practices in Continuing Professional Development

Undergraduate medical education and postgraduate residency training provide physicians with the skills and knowledge needed to begin practicing medicine; however, it is recognized that such early medical training is insufficient to ensure physicians maintain competencies over their professional lifetime (Filipe et al., 2016). Physicians must remain current in their knowledge, address gaps in their skills, and remain up-to-date on advancements in clinical best practices and

the changing needs of the population they serve. The process of lifelong learning can take the form of Continuing Medical Education (CME) and Continuing Professional Development (CPD). While participation in CME is intended to maintain and enhance medical knowledge and skills through the passive dissemination of information (e.g., readings or attending lectures, seminars and conferences), CDP addresses professional and personal development (Filipe et al., 2014; Filipe et al., 2016; World Federation for Medical Education, 2015). CPD expands upon the concepts learned in CME to focus on the competencies needed to provide quality medicine. For example, these include: managerial skills, professionalism, leadership, ethical conduct, patient safety and quality of care, information technology, interpersonal and communication skills and other educational domains set by professional societies (Filipe et al., 2014; Filipe et al., 2016; World Federation for Medical Education, 2015). In essence, CME ensures physicians remain knowledgeable, while CPD ensures physician professionalism and accountability. Effective CPD should address the physician's individual learning needs based on the practice standards set out by regulatory agencies and the needs of the population they serve (i.e., social accountability) and be free of commercial biases (i.e., organizations providing financial support should not be involved in the development, delivery or evaluation of CPD activities) (Filipe et al., 2014; Filipe et al., 2016; World Federation for Medical Education, 2015). Furthermore, unlike CME, which is intended to produce changes in knowledge, CDP is intended to produce changes in clinical practice behaviours while considering the physician's complex and multidisciplinary work environment (Filipe et al., 2014; Filipe et al., 2016; World Federation for Medical Education, 2015).

Filipe et al. (2014, 2016) describe a four phase CDP cycle consisting of: 1) the identification of learning needs; 2) planning learning activities 3) implementation; and 4) evaluation. In the first phase, learning needs are defined as a gap between current competencies or current population health status and the desired state (Filipe et al., 2014, 2016). Learning needs can be identified through personal learning plans or clinical audits. While personal learning plans are self-directed and initiated by the physician through a recognition of perceived needs (e.g., reflections on their own practice, direct patient care, interaction with colleagues and through non-clinical activities such as readings and attending conferences), audits are typically performed by a CPD provider or a licensing body and are suitable for identifying unperceived needs. According to Filipe et al. (2016), clinical audits follow a five-step process consisting of : 1) identifying a problem that needs to be addressed (e.g., addressing changing population health needs/status, implementing new best practice standards, or adhering to changing legal/licencing requirements); 2) setting practice standards (i.e., rooted in evidence-based best practice standards); 3) collecting data to identify practice baselines; 4) comparing practice baselines with intended practice standards; and 5) implementing an education intervention to bridge the gap (Filipe et al., 2016).

In the second and third phases of the CPD development cycle, CPD providers must design and implement education interventions that best respond to the learning gaps previously identified. CPD activities can come in various formats, from formal practice improvement activities (e.g., participating in workshops), to more informal independent professional development activities (e.g., clinical or surgical traineeship) and research or self-education activities (e.g., being a principal investigator on research project) (College of Family Physicians of Canada, 2019; Filipe et al., 2014; Filipe et al., 2016). For providers, formal CPD activities are most effective when

they reflect adult learning principles (Filipe et al., 2016; Merriam, 2018). For instance, adults are self-directed learners; thus, the role of the educator is to facilitate learning rather than dictating content (Filipe et al., 2016; Merriam, 2018). Adults are goal-oriented and are motivated by identified learning gaps (Filipe et al., 2016). They have lived experiences and knowledge, which should be considered by creating transformative learning activities that build on baseline knowledge (Filipe et al., 2016; Merriam, 2018). It is also beneficial to provide opportunities for learners to interact so physicians may learn from one another, thus acknowledging and respecting individual life experiences (Filipe et al., 2016). Finally, adults are practical/situational learners, compelling CPD providers to move learning outside of the classroom/boardroom and into real-world environments through interactive practice-based learning (Filipe et al., 2016; Merriam, 2018).

The final phase of the CPD cycle consists of evaluating the education program. Houlden and Collier (2018) from the Royal College of Physicians and Surgeons of Canada suggest that CPD assessments should be based on Dixon's (1978) four levels of evaluation. The first level is an assessment of **Perceptions and Satisfaction** and typically consists of a short questionnaire that asks participants to evaluate whether the education program addressed their learning gaps and met learning objectives. The second level is a **Competency Assessment of Knowledge, Skills and Attitudes**, which determines whether the CPD produces new learning by administering and comparing pre and post-intervention tests. The third level assesses whether the newly acquired knowledge, skills and attitudes have been translated to changes in behaviours through **Professional Performance Assessment**. Finally, the fourth level is a **Health-Care Outcome Assessment**, which ultimately measures whether participation in the CPD resulted in the

expected improvements in health outcomes in the patient population. However, the World Federation of Medical Education (2015) warns that participation in CDP rarely leads to tangible and measurable outcomes, and we cannot expect that participating in a single CDP activity will result in meaningful improvement in patient health outcomes. For this reason, Filipe et al. (2014) suggest it is important for CDP participants to have an opportunity to disseminate new learning with colleagues in their practice setting, thus allowing learnings to permeate within the profession and reinforcing what has been learned by sharing it with others. The limited impact of participating in a single CPD activity also speaks to the importance of the cyclical nature of CDP. Good CDP programs should build on previous learnings and evolve with each implementation by making improvements based on the post-education evaluation (Filipe et al., 2014; Filipe et al., 2016; World Federation for Medical Education, 2015). Furthermore, physicians must regularly participate in CPD activities. It is by continually updating ones knowledge and skills and repeatedly being sensitized to population health needs and best practice standards that one can make incremental changes to their practice, which over time, can have an impact on their patient's health outcomes.

Accreditation is also essential to ensure CPD programs are transparent, unbiased and designed to meet measurable, evidence-based learning outcomes while encouraging continued participation by physicians (Filipe et al., 2014; 2016). Accreditation is the evaluation of CPD by an external body to validate and legitimize educational events and award credits to those who participate (Filipe et al., 2016). In Canada, the College of Family Physicians of Canada (CFPC) is the professional organization that represents family physicians, establishes standards for post-graduate medical training (for family medicine) and certifies CPD programs (College of Family

Physicians of Canada, n.d.). The CFPC's Mainpro+® (Maintenance of Proficiency) program serves to provide CPD participation guidelines for physicians, enables physicians to track their CPD activities and provides accreditation for CPD programs through a peer-reviewed certification process (College of Family Physicians of Canada, 2019). To fulfill certification requirements under the CFPC, family physicians must acquire a minimum of 250 credits per five-year cycle, with at least 125 being certified credits and the remaining 125 being either certified or non-certified credits (College of Family Physicians of Canada, 2019). Certified credits are earned by participating in certified activities that have been reviewed and approved by the CFPC, while non-certified credits have not been formally reviewed, yet are recognized as providing professional learning opportunities (College of Family Physicians of Canada, 2019). Thus, the CFPC ensures CPD activities are accountable to the needs of Canadian physicians and responsive to the health needs of the Canadian population while also encouraging continued participation by physicians by awarding participation credits.

Finally, as mentioned earlier, CDP activities should serve to promote competencies established by professional societies. While the CFPC represents family physicians, the Royal College of Physicians and Surgeons of Canada (the Royal College) is the professional association that represents other specialist physicians and oversees specialty education in Canada (Royal College of Physicians and Surgeons of Canada, n.d.). However, in the early 1990's the Royal College also began developing a competency framework for specialty physicians (Frank et al., 2015). The resulting CanMEDs framework was introduced in 1996 and was updated in 2005 and 2015. Today the CanMEDs framework is used and adapted worldwide by various health care professions, including the CFPC, the Medical Council of Canada, the Canadian Medical

Association and Canada's medical schools, "making it the most recognized and most widely applied health care profession competency framework in the world" (Frank et al., 2015, p.5). According to the CanMEDs framework, a medical expert should possess the following competencies: they should be a professional, a communicator, a collaborator, a leader, a health advocate, and a scholar. Given that the present thesis pertains to the importance of communication and language in health care delivery, I will focus on the 'Communicator' competency, which is defined as the ability to "form relationships with patients and their families that facilitate the gathering and sharing of essential information for effective health care" (Frank et al., 2015, p.18). This competency refers specifically to communication between physicians and their patients (with communication between colleagues falling under the 'Collaborator' competency), and elucidates the importance of patient-centred communication and cultural safety. Therefore, if being a communicator is considered a CanMEDs competency, CPD programs addressing communication skills (such as linguistic concordance and patient-centered communication) should be developed when gaps in patient-physician communication are identified (such as the gaps in French language services identified in the present literature review).

### 2.6.2 Teaching medical communication skills

Medical communication, as with any effective communication, relies on verbal, non-verbal and paraverbal components (Ranjan et al., 2015). Verbal components include the content of what is being communicated and the selection of words; body language, facial expressions and spatial distancing make up the non-verbal components; and paraverbal components consist of the tone, pacing and volume of voice (Ranjan et al., 2015; Suojanen et al., 2018). Physicians must be self

aware of each of these components when communicating with patients. For instance, in a situation where two physicians are providing the same message, the physician who uses a common language, makes eye contact with the patient, speaks slowly and provides enough time for the patient to understand would be judged by the patient as being a better communicator than the physician who uses medical jargon, rarely makes eye contact and speaks quickly. Good communication skills are essential to the provision of patient-centred care, which requires the physician to foster an ongoing relationship with the patient built on trust, emotional support and a shared understanding of the patient's wants, needs and preferences (Levinson et al., 2010; Rao et al., 2007; Suojanen et al., 2018). Thus, patient-centred communication begins with a dialogue about the patient's individual needs and values, provides the information needed in an accessible language and invites the patient to participate in the decision-making process (Levinson et al., 2010).

Medical communication is often defined as a series of tasks that providers need to accomplish during a medical encounter, each of which requires a set of skills (Ammentorp et al., 2021; Aspegren & Lønberg-Madsen, 2005; Haq et al., 2004; Iversen et al., 2020; Levinson et al., 2010; Venktaramana et al., 2022). For instance, the Calgary-Cambridge Guide, developed by Kurtz and Silverman in 1996 (Kurtz & Silverman, 1996) and further refined in 2003 (Kurtz et al., 2003), defines a series of evidence-based skills needed at various stages of the patient interview and is used internationally as a framework for teaching and assessing medical encounters between patients and providers (Ammentorp et al., 2021; Iversen et al., 2020; Venktaramana et al., 2022). Various methods are used to teach and train communication skills to undergraduate and postgraduate learners. These methods typically begin with didactic teaching in which the

importance of communication in medical practice and basic communication skills are taught through readings, in class lectures and small group discussions (Ammentorp et al., 2021; Choudhary & Gupta, 2015; Deveugele et al., 2005; Haq et al., 2004; Suojanen et al., 2018; Venktaramana et al., 2022). Learners are then provided with an opportunity to observe encounters between patients and mentors/senior providers, either in person (during clinical placements) or through video recording (which provides an opportunity to see the difference between poor communication and proper communication) (Ammentorp et al., 2021; Choudhary & Gupta, 2015; Deveugele et al., 2005; Haq et al., 2004; Suojanen et al., 2018; Venktaramana et al., 2022). Finally, learners must be provided with an opportunity to practice and receive constructive feedback, first in a safe and controlled environment (e.g., through role play and with standardized patients), then in a real-world setting (e.g., conducting a patient interview while being observed by a mentor) (Ammentorp et al., 2021; Choudhary & Gupta, 2015; Deveugele et al., 2005; Haq et al., 2004; Suojanen et al., 2018; Venktaramana et al., 2022).

Although such strategies have been found to improve the learners' skills and confidence in communicating with patients (Aspegren & Lønberg-Madsen, 2005; Choudhary & Gupta, 2015; Deveugele et al., 2005), the literature also points out that communication skills are often overlooked during medical training (Back et al., 2019; Choudhary & Gupta, 2015; Haq et al., 2004; Levinson et al., 2010; Ranjan et al., 2015; Suojanen et al., 2018; Venktaramana et al., 2022), with a disproportionate emphasis being placed on the theoretical and practical understanding of diseases, diagnostics and treatment (Choudhary & Gupta, 2015; Levinson et al., 2010). There is a lack of consistency in the way communication is taught, integrated into the curriculum and prioritized by medical schools (Haq et al., 2004; Suojanen et al., 2018;

Venktaramana et al., 2022), and there is no consensus on best practices for teaching learners to be effective communicators (Suojanen et al., 2018). As a result, many communication skills are underdeveloped when learners transition into independent practice (Aspegren & Lønberg-Madsen, 2005; Suojanen et al., 2018).

Furthermore, there exists many challenges and misconceptions to teaching communication for both learners and practicing physicians. For instance, communication is often devalued and considered by some to be unteachable, an unnecessary distraction from biomedical sciences, and best learned spontaneously through practice (Back et al., 2019; Choudhary & Gupta, 2015; Haq et al., 2004; Perron et al., 2015). Although some communication skills are spontaneously learnt, such as those common to most civil social conversations (e.g., remembering information, avoiding medical jargon and maintaining eye contact), others must be taught and practiced, such as those related to the process of conducting an effective medical interview (e.g., eliciting details, summarizing information, building a rapport, being responsive to the patient's emotional state, and allowing the patient to provide insight about how best to manage their own health) (Aspegren & Lønberg-Madsen, 2005; Perron et al., 2015). Learners must also contend with the "hidden curriculum", (i.e., the underlying beliefs held by educators that can undermine other educational efforts) (Perron et al., 2015; Suojanen et al., 2018). For instance, learners may conclude that communication is of little importance if they are paired with a preceptor who deemphasizes communication, uses a physician-centred communication style, does not demonstrate effective communication skills in practice, or does not provide constructive feedback when the learners practice the skills they were taught (Aspegren & Lønberg-Madsen, 2005; Haq et al., 2004; Perron et al., 2015; Suojanen et al., 2018). Such harmful attitudes are

likely to arise given that communication training is a relatively recent phenomenon in medical school, particularly the concept of patient-centred communication, and thus most practicing physicians have had to learn how to communicate on their own (Agency for healthcare Research Quality, 2017; Back et al., 2019; Levinson et al., 2010) with few educators (e.g., faculty and preceptors) having received formal communication training or feedback on their communication style, making them ill-prepared to teach communication to learners (Allenbaugh et al., 2019; Perron et al., 2015; Suojanen et al., 2018).

Such challenges are further amplified when attempting to teach communication skills to practicing physicians. The literature clearly acknowledges that communication skills can erode and be lost over time if they are not regularly practiced (Berkhof et al., 2011; Choudhary & Gupta, 2015; Perron et al., 2015; Rao et al., 2007; Venktaramana et al., 2022). Since practicing physicians are no longer in school and can choose the CPD programs they want to attend, participation in continuing education relies on the physician's desire to address self-perceived needs. However, most physicians have never received feedback on their interpersonal practices (Levinson et al., 2010; Perron et al., 2015) and are unaware of the plethora of communication skills that exist (Levinson et al., 2010). Physicians also have a tendency to overestimate their own communication skills, underestimate their patients' communication needs and are largely unaware of their patient's emotional state or ability to understand instructions (Back et al., 2019). In Ontario, the belief held by many physicians that French language services are unnecessary given that their patients are 'bilingual enough' (Timony et al., 2016, p.10) is another misconception that can hinder linguistically adapted communication training efforts. First, such belief can prevent physicians from attending such training initiatives, as they do not perceive

these as a need in their practice. Second, there is a risk that this misconception will be passed down to residents and junior physicians, who may also conclude that French language services are unnecessary in practice.

There is also evidence that the less formal communication training a physician receives, the more they are likely to undervalue communication training (Perron et al., 2015), with such deeply rooted misconceptions being difficult to change (Berkhof et al., 2011; Rao et al., 2007). As a result, they are less likely to participate in communication training once they achieve independent practice and the communication skills that were deficient in medical training and were expected to be spontaneously learned through practice remain absent (Aspegren & Lønberg-Madsen, 2005). Furthermore, the literature also suggests that too few CPD activities are dedicated to improving communication (Back et al., 2019; Levinson et al., 2010; Perron et al., 2015).

However, various methods and approaches have successfully taught communication to practicing physicians and improved communication skills. Such teaching methods include a combination of didactic and experiential learning environments such as small group sessions with lectures and discussions, reviewing case studies, observing videos that model desirable communication behaviours, and allowing physicians to practice while being observed and receiving feedback (Alexander et al., 2006; Allenbaugh et al., 2019; Ammentorp et al., 2021; Berkhof et al., 2011; Levinson et al., 2010; Rao et al., 2007). For instance, role play and use of standardized patients are common teaching methods as they provide the physicians with an opportunity to play the role of the patient, thus gaining a better appreciation for the patient experience while also practicing different communication strategies in a safe environment when playing the role of the physician

(Alexander et al., 2006; Berkhof et al., 2011; Levinson et al., 2010). Shorter sessions (e.g., a 2 hour or a ½ day workshop) have also been effective and more convenient for busy practicing providers (Agency for healthcare Research Quality, 2017; Allenbaugh et al., 2019; Levinson et al., 2010; Rao et al., 2007). Such training programs have been successful in improving the provider's confidence when interacting with and interviewing patients, expanding diagnostic capabilities, enhancing patient-centred communication skills (e.g., asking more open-ended questions, eliciting patient's concerns and expressing empathy), increasing job satisfaction and mental health and improving patient satisfaction (Agency for healthcare Research Quality, 2017; Alexander et al., 2006; Allenbaugh et al., 2019; Ammentorp et al., 2021; Levinson et al., 2010; Rao et al., 2007; Venktaramana et al., 2022).

Yet, CPD programs dedicated to communication must decide which communication skills they wish to address. As Levinson, Lesser, and Epstein (2010) explain: "Patient-centered communication is multidimensional. Any given intervention might have an impact on some but not all functions of patient-centered care" (Levinson et al., 2010, p. 1313). Most teaching interventions discussed thus far address the provider's interview skills, rapport building skills and information giving skills, yet, despite the importance of culture and language in health care delivery (Al Shamsi et al., 2020; Cano-Ibáñez et al., 2021; de Moissac & Bowen, 2019), cultural awareness and linguistic sensitivity training for practicing physicians is far less common, with most examples coming from the United States (Beach et al., 2005, Like et al., 2008; McGregor et al., 2019). For instance, a 2005 systematic review of cultural competence educational interventions for health professionals between 1980 and 2003 identified 34 studies, 29 of which were conducted in the United States, with 18 targeting physicians (Beach et al., 2005). Likewise,

a 2020 systematic review of articles between 2001 and 2017 only identified 11 studies that included an intervention to improve cultural competence in health care providers, 7 from the United States and only 4 targeting practicing physicians (Chae et al., 2020). The studies reviewed agreed that such interventions are effective in improving the provider's cultural knowledge (i.e., understanding the role of culture and ethnicity in disease incidence and prevalence), attitudes (i.e., understanding how cultural differences can influence a patient's values and behaviours) and skills (i.e., learning culturally sensitive communication strategies) (Beach et al., 2005; Chae et al., 2020; McGregor et al., 2019). However, evidence of the benefits of cultural competency training on patient health outcomes is scarce and inconclusive (Beach et al., 2005; Chae et al., 2020; McGregor et al., 2019) and many interventions are considered impracticable, leading to poor buy-in by providers (McGregor et al., 2019). Furthermore, other than providing strategies for dealing with language barriers or learning basic terms in a second language within the context of a larger cultural competency training (Beach et al., 2005; Like et al., 2008), few education interventions focus exclusively on serving linguistically discordant patients, and linguistic proficiency training in a language other than English is often absent from medical education curriculums (at least in the United States) (Ortega et al., 2019). In Ontario, physicians have identified a general lack of educational opportunities and professional development in French and, specifically, programs relating to Francophone patient needs as a barrier to serving Francophone populations (Timony et al., 2016). However, there is evidence that such interventions can be beneficial. For instance, a 2003 intervention in Switzerland, which trained physicians to communicate with linguistically discordant patients and work with interpreters, showed improvements in the quality of communication as perceived by the patients (Bischoff et al., 2003).

From a Canadian perspective, we have seen that the active offer of French language services is an example of patient-centred communication that acknowledges the importance of culture and language (Savard et al., 2014). The modernization of FLSA has legislated the active offer (Ministry of Francophone Affairs, 2022b) and the passing of Bill 74, the People Health Care Act, stipulates that Ontario Health Teams will be expected to adhere to the requirements of FLSA (The People's Health Care Act, 2019; Ministry of Health, 2019b). We have also seen the important role physicians play in setting the stage for the provision of French language services as the first point of contact with the OHT (Office of the French Language Services Commissioner of Ontario, 2016a). Given these recent policy changes, it would be beneficial for physicians in Ontario to familiarize themselves with the principle of active offer and gain strategies for its implementation.

There are primarily two services that provide active offer training resources in Canada. First, the *Consortium national de formation en santé* developed the *Carrefour de l'offre active*, an online directory of resources, tools and information pertaining to the notion of active offer. Providers seeking to learn more about the active offer and gain insight into its implementation can access reading material, videos, case studies and testimonials; while educators can access resources and educational tools to aid in the development of active offer training programs (<https://offreactive.com/enseigner>). However, the educational material available is primarily geared toward the training of post-secondary students and a provider seeking information on the active offer would need to peruse the site and may find it challenging to find the resources that best suit their needs. Furthermore, although the *Carrefour de l'offre active* is available in French and English, there are fewer resources available in English. Second, the *Réseau du mieux-être*

*Francophone du Nord de l'Ontario* developed an online active offer training program titled “*The Active Offer of French Language Services: Why It Matters and How to Put It Into Practice*” (<https://www.activeoffertraining.ca>). This program is fully available in both French and English and consists of six interactive modules which cover topics such as excellence in person-centred care, equity and safety, cultural competency, recruitment and retention of bilingual human resources, work environment and organizational culture, and community engagement for health equity. This program has the advantage of being freely available online; includes readings, videos, case studies and quizzes; and is certified by the CFPC and the Royal College to receive continuing education credits. However, the main limitation of these resources is that they are both passive learning tools, requiring the health care provider to read through the material themselves or observe video recording to model, but no practice-based or experiential learning strategies are employed. As a result, providers may learn about the concept of active offer while remaining unclear as to how to implement changes to their practice. There is little evidence that teaching strategies such as providing written information and modelling are effective at changing communication behaviours if not combined with group discussion, feedback from peers and an opportunity to practice (Berkhof et al., 2011).

## 2.7 Gaps in the literature (i.e., the problem under investigation):

In the present review of the literature, we have seen that language barriers continue to threaten patient safety and health outcomes throughout Canada (de Moissac & Bowen, 2019). Limited access to French language health services (DPM Research, 2021; Lepage & Lavoie, 2017) may be contributing to the various health disparities experienced by Francophones as compared to the Anglophone majority (Benoit et al., 2012; Bouchard et al., 2002; Bouchard et al., 2012a;

Bouchard & Desmeules, 2013; Picard & Allaire, 2005). We also saw that Ontario is home to Canada's largest Francophone population living outside of Quebec and, within the province, the northeast is home to many communities with large Francophone representations (Timony et al., 2013). Thus, physicians who choose to practice in the North must be prepared to encounter people who may prefer to receive services in French. As it pertains to patient-centred care, offering linguistically adapted health services is not only essential for effective communication, but demonstrates an awareness of patient values and linguistic preferences. However, an analysis of the registry data from the CPSO and the OCP revealed that most providers who are able to provide services in French are located in regions of Southern Ontario where fewer Francophones reside, leaving the more densely Francophone populated North comparatively underserved (Timony et al., 2013; Timony et al., 2022). Furthermore, Northern Ontario's Francophone residents who have family physicians who do not speak to them in French express feelings of discomfort, insecurity, stress, nervousness, and an inability to take charge of their own health (Jutras et al., 2020).

The main advantage of the CPSO and OCP data used in our past studies (Gauthier et al., 2012; Timony et al., 2013, Timony et al., 2022) is that it is collected on all Ontario physicians and pharmacists as part of their annual licensing requirements. However, this data is not without its limitations, the most problematic of which, in the scope of the present thesis, is the definition of a French-speaking provider. Although physicians are required to indicate all languages in which they are competent enough to conduct practice on their annual renewal survey (Timony et al., 2013), this self-assessed measure of competence is not an indication of the language in which services are being delivered, and having one's practice located in a French community does not

ensure a Francophone patient population. Given that French-speaking physicians are less plentiful in the North (Gauthier et al., 2012), where large concentrations of Francophones reside (Timony et al., 2013), it is of particular interest to identify whether those who are located in Northern Ontario are actually offering French language services.

Furthermore, we have shown that interpersonal communication is an essential component of a quality health care service (de Moissac & Bowen, 2019) and that the active offer of French language services has emerged as an example of patient-centred communication. Although poor communication can negatively influence health outcomes and patient satisfaction (Anderson et al., 2007; Matusitz & Spear, 2014; Walsh, et al., 2019), little is known about patient satisfaction or the extent to which linguistic concordance influences satisfaction in Ontario's Francophone population. In addition, although it is largely believed that the "active offer" of French language services can improve the Francophone patient experience, to our knowledge, no study has explored the impact of the "active offer" on patient satisfaction.

In addition, the legislative landscape in Ontario is evolving, with important implications for the offer of French language health services. Notably, the modernization of the FLSA has legislated the active offer of French language services for all government funded public services, taking the onus to request services in French off the patient and placing it on the provider, who must clearly communicate the availability of service in French. (French Language Services Act, 1990; Ministry of Francophone Affairs, 2022b). From a health services perspective, the passing of Bill 74, the Peoples Health Care Act has introduced a new integrated care delivery system known as Ontario Health Teams (OHT), which will be responsible for providing a full continuum of care to the population they serve (The People's Health Care Act, 2019). According to Bill 74, OHTs

must adhere to the FLSA, including the new legislative requirement to practice the active offer of French language services in the delivery of health care. Yet, few physicians report practicing in French (Lepage & Lavoie, 2017) with many failing to perceive a need for French language services in their patient population (Timony et al., 2016). Furthermore, although the use of appropriate interpretation services is a strategy that aligns with the principle of active offer (Reflet Salvéo, 2017), most providers rely primarily on family, friends or other untrained interpreters (Bowen, 2001; Papic et al., 2012), which can potentially be putting the patient at risk (Laher, 2018; Walji & Flegel, 2017). With the growing acceptance of active offer as a patient-centred approach to delivering high quality health care to linguistic minority populations and the legislation of the active offer in the FLSA, there is a growing expectation from patients that practicing health care providers be able to actively offer service in French. Therefore, it is clear that Ontario physicians who join an OHT and wish to comply with the FLSA will need to be educated on how to offer services that are adapted to the needs and values of their Francophone patients and on the notion of active offer and its implementation. In fact, physicians in Northern Ontario have identified a general lack of educational opportunities and professional development in French and, specifically, programs relating to Francophone patient needs as a barrier to serving Francophone populations (Timony et al., 2016).

Additionally, we have seen that continuing professional development programs should address learning needs based on the practice standards set out by regulatory agencies (Filipe et al., 2016). Since the CanMEDs framework considers being a communicator as a competency of a medical expert, CPD programs addressing communication skills should be developed when gaps in patient-physicians communication are identified, such as the language gaps identified in the

present literature review. However, although some active offer training resources are available (i.e., those developed by the *Consortium national de formation en santé* and the *Réseau du mieux-être Francophone du Nord de l'Ontario*), these often employ passive learning strategies (i.e., online modules and readings) with no evidence that they lead to changes in active offer behaviours. Since these training resources are intended for post-secondary students and health human resources in general, the concepts presented may be too broad for physicians to derive actionable changes they can bring to their practice.

## 2.8 Purpose and research questions:

Considering the gaps in the literature outlined above, the present thesis has four interrelated purposes, accompanied by four corresponding research questions.

**Purpose 1:** Given the limitation to the existing active offer training resources, the present thesis sought to develop and evaluate the effectiveness of a CPD program to improve active offer behaviours/skills of physicians in Northeastern Ontario using practice-based adult learning strategies.

**Research question 1: How does a CPD program teaching the active offer of French language services change physician communication behaviours in practicing physician's offices of northeastern Ontario?**

**Purpose 2:** Before meaningful recommendations can be made to policymakers and educators regarding the need for further active offer training efforts, it is essential to determine the current state of active offer being provided by Ontario physicians. Thus, the present thesis will explore

the active offer behaviours in a sample of physicians in Northeastern Ontario and identify behaviours/strategies that can be implemented to improve the Francophone patient experience.

**Research question 2: To what degree are French language services actively being offered in physicians' offices in Northeastern Ontario?**

**Purpose 3:** Although the link between communication and patient satisfaction is well established, little research has been dedicated to the impact of language concordance between physicians and patients in Northern Ontario's Francophone populations. Therefore, the present thesis will explore the influence of language concordances on patient satisfaction.

**Research question 3: To what degree do language-concordant physician interactions influence patient satisfaction in a sample of Francophones living in Northeastern Ontario?**

**Purpose 4:** In addition, although the active offer of French language services is believed to improve the Francophone patient experience, to our knowledge, the impact of the active offer on patient satisfaction has not been determined. Thus, the present thesis will also explore the influence of the active offer on patient satisfaction.

**Research question 4: To what degree does the active offer of French language health services influence patient satisfaction in a sample of Francophones living in Northeastern Ontario?**

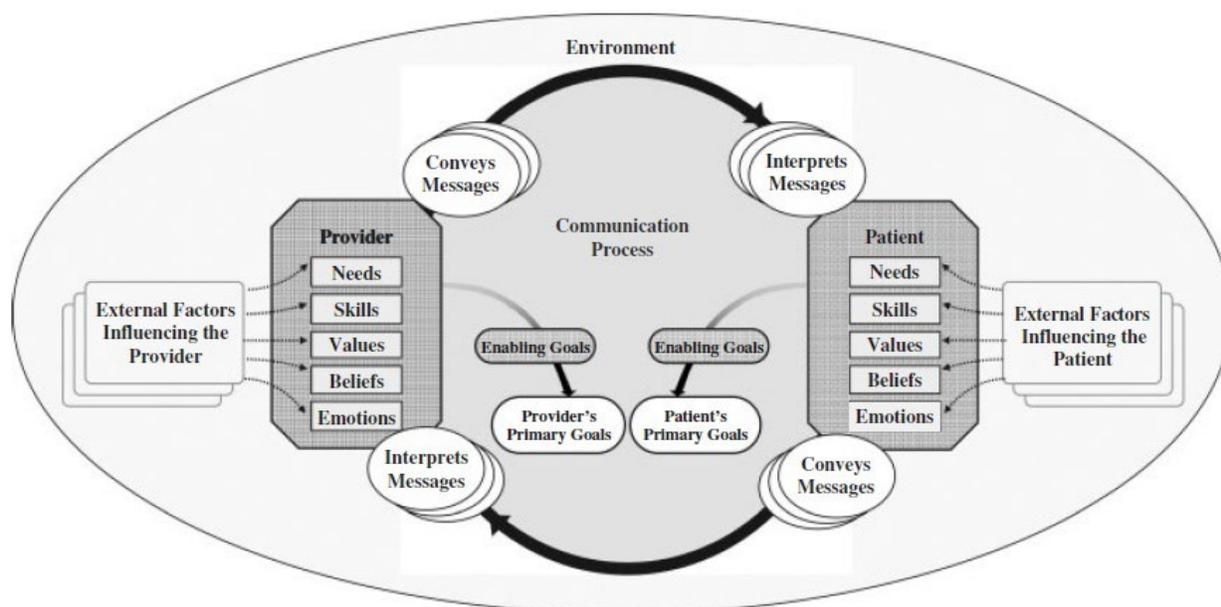
## Chapter 3

### 3 Conceptual framework

#### 3.1 The Framework for Patient-Professional Communication

All four research questions explored in the present thesis focus on physician language of communication. The first explores the effectiveness of a CPD program developed to improve patient-centred communication through the active offer of French language services; the second addresses the physicians tendency to actively offer French language services within their practice office, while the third and fourth address the influence of same language communication (i.e., language concordance) and active offer on patient satisfaction. The importance of clear communication in patient-physician interactions was explored in Feldman-Stewart, Brundage and Tishelman's Framework for Patient-Professional Communication (Figure 3) (2005).

According to this model: 1) communication is conceptualized as a cyclical process in which both participants involved are at once communicators and receivers of information; 2) communication between a physician and a patient serves primarily to address the goals (or objectives) of each participant; 3) the content expressed during communication is a function of each participant's attributes, or individual qualities (i.e., their needs, beliefs, values, skills and emotions); and 4), the environment (which consists of social, cultural, legal, and physical aspects) within which communication takes place is considered to be influential.



**Figure 3: Framework for Patient-Professional Communication, from: Feldman-Stewart, Brundage, & Tishelman, 2005, p. 803**

### 3.2 The ADAPTED Framework for Patient-Professional Communication

This framework is useful in understanding a patient-centred approach to communication as it acknowledges the equal role patients play in the health communication process and the fact that effective communication is bidirectional. However, although this framework recognizes that communication is performed within a cultural context, it does not fully explain how language discordance can influence the communication process. In fact, the authors of the Framework have acknowledged this potential limitation, explaining that core components of communication have been identified, yet suggesting that existing theories which focus on these distinct components are often required to apply the framework to a specific context (Brundage et al., 2010). Thus, to incorporate this model into a language discordant patient-physician interaction,

Gregg and Saha's Framework of Communicative Competence will also be considered to identify the communication **skills** needed by the provider (Gregg & Saha, 2007).

Research consistently shows that translation services are less effective than when physicians and patients speak the same language (Bowen, 2001; Laher, 2018; Ngo-Metzger et al., 2007; Walji & Flegel, 2017), suggesting that language is more complex than a simple understanding of words. Traditionally, language has been viewed as a system of grammatical rules; therefore, communication depends on a common understanding of these rules. However, sociolinguists suggest that language is multifaceted and context dependent (Hymes, 1974). According to this dimension of language, the meaning behind words is a complex interaction of body language, tone of delivery, context and social norms. Therefore, the Framework of Communicative Competence suggests that communication depends on both the physician's **linguistic competence** (i.e., the ability to produce grammatically correct sentences, essentially the ability to **translate** words from one language to the corresponding or comparable words in another language) and **communicative competence** (i.e., the ability to choose the appropriate sentences or expression in a given situation, essentially the ability to **interpret** the meaning behind the words used according to the patients cultural and social milieu) (Gregg & Saha, 2007). If we consider this **linguistic competence** and **communicative competence** to be among the physician's attributes described in the Framework for Patient-Professional Communication representing the physician's **skills**, then it stands to reason that a linguistic discordance would disrupt the entire patient-physician communication process. As the language between the patient and the physician becomes more discordant, a growing gap between the intentions of the message and its interpretation is formed, causing the quality of the communication to suffer and,

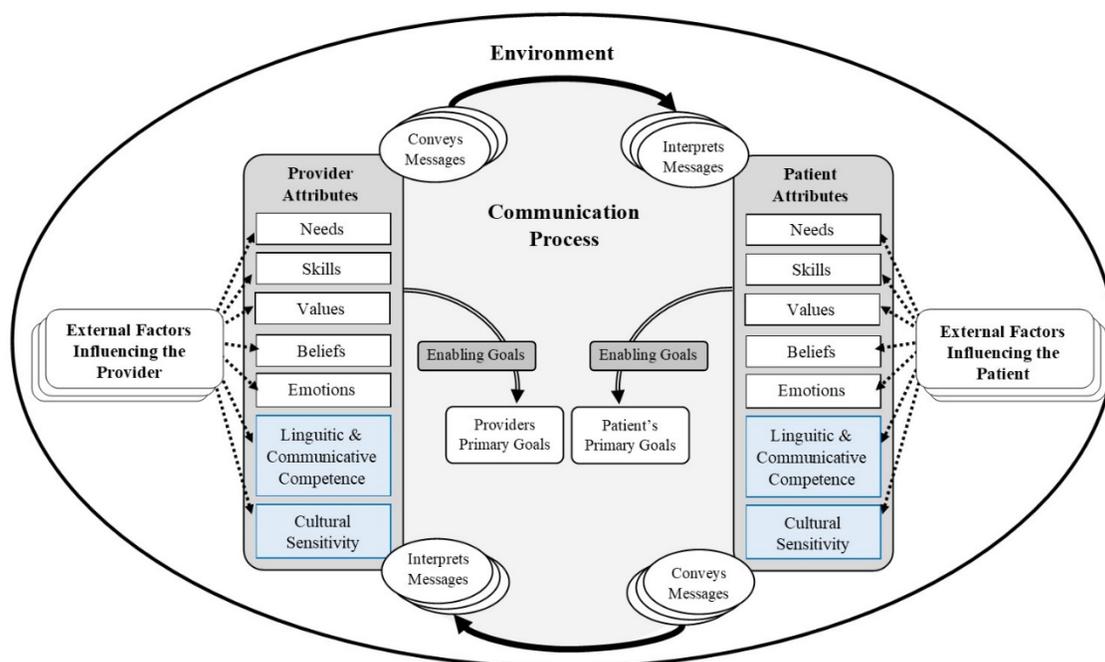
potentially, the patient's satisfaction with the physician to decrease. The Framework of Communicative Competence also explains how a physician can lack **linguistic competence**, (i.e., they do not speak the same language as their patient) but can still offer patient-centred communication through **communicative competence** (i.e., remaining aware of the presence of a language barrier and potential cultural differences between themselves and their patient and using strategies to ensure the patient understands and is understood).

Furthermore, given the Savard et al. definition of "active offer", which is offering services that are adapted to the linguistic minorities' culture (Savard et al., 2014), it may be argued that the active offer of French language services responds to the cultural dimension of communication described in the Framework of Communicative Competence (i.e., recognizing the cultural and social communicative needs of a patient and responding to them). When considering the Framework for Patient-Professional Communication, this conceptualization of **communicative competence** would thus represent the physician's **beliefs**, such as the belief that it is important to offer services in the patient's preferred language and **skills**, such as the ability to understand the cultural meaning behind patient communication. It would also represent the patient's **need** to understand and be understood and the **value** placed on being able to live their full health potential in French. However, the Framework for Patient-Professional Communication considers culture as existing in the external environment within which the communication is taking place, but it does not consider the importance of the cultural differences each participant bring to the process. For this reason, Dutta's (2007) Theory of Cultural Sensitivity can also be incorporated into the Framework. As Dutta has expressed, culturally sensitive healthcare requires that providers be aware of the cultural differences in their patient population. According to Jiang

(2000), language and culture are inseparable. Culture is learned through language and language is shaped by culture. As a result, the same word and expression can have a different meaning depending on the cultural background of the individual speaking it. It is therefore important to understand the cultural meaning behind words and expressions to accurately understand the patient. Thus, **cultural sensitivity** can be added to both the patient's and the provider's personal **attributes**. When interpreting messages from a patient, the physician must remain aware of the cultural lens through which these messages are conveyed and must make an effort to incorporate this cultural view in their return messages. Similarly, to properly interpret the physician's messages, the patient must also be aware that the physician may not be fully familiar with their culture. Thus, just as **linguistic** and **communicative competence** are important to the communication process, so too is **cultural sensitivity**.

Therefore, the present thesis proposes an adapted Framework for Patient-Professional Communication (Feldman-Stewart et al., 2005) which incorporates the concepts of **linguistic** and **communicative competence** from the Framework of Communicative Competence (Gregg & Saha, 2007) as well as the concept of **cultural sensitivity** from the Theory of Cultural Sensitivity (Dutta, 2007) (as depicted in Figure 4 below). This adapted framework will be used to interpret the findings from the present thesis, specifically, to understand and explain how various active offer strategies can improve communication between patients and physicians. If we agree that **linguistic** and **communicative competence**, as well as **cultural sensitivity**, are important components in a linguistically discordant patient-physician encounter and that the active offer addresses both linguistic and cultural aspects of communication, then describing the physician's "active offer" behaviours is an important step to fully understand patient-physician interactions,

specifically, interactions between Francophone patients and physicians in Northeastern Ontario. Furthermore, the adapted Framework for Patient-Professional Communication will also be used to explain how patient satisfaction can be influenced by language concordance between the patients and the physicians and by the physician's active offer habits.



**Figure 4: Adapted Framework for Patient-Professional Communication: combining the Framework for Patient-Professional Communication (Feldman-Stewart et al, 2005), the Framework of Communicative Competence (Gregg & Saha, 2007) and the Theory of Cultural Sensitivity**

### 3.3 Ontology, epistemology and philosophical perspective

Two main branches of philosophy are important to consider in the natural and social sciences (Crotty, 1998; Moon & Blackman, 2014). While ontology is the study of ‘what is’ or the nature of reality, epistemology refers to how knowledge is produced (Crotty, 1998; Moon & Blackman, 2014). A researcher’s ontological and epistemological stance will form their philosophical perspective, or the way they view the world and the underlining assumptions made when developing research questions, designing methodologies and interpreting results (Moon & Blackman, 2017).

From an ontology lens, I fall somewhere between realism (i.e. I believe that there are objective realities) and relativism (i.e., I also believe that these realities can be experienced differently between groups) (Moon & Blackman, 2014, 2017). For example, the cost of an uninsured health care service is objective, but the affordability of that service will depend on a variety of factors that differ from one group to the next (e.g., employment status, income status, and the presence of other health needs). In this respect, I would align more closely with bounded relativism, which, according to Moon and Blackman (2014), is the belief that “shared reality exists within a bounded group, but across groups different realities exist” (Moon & Blackman, 2014, p.4). In accordance with this ontological belief, my epistemology aligns closely with constructionism, which is the belief that reality is socially constructed (Crotty, 1998; Moon & Blackman, 2017). According to Crotty (1998), constructivism is not direct relativism, as constructivists believe a socially constructed reality is still real. Therefore, my philosophical perspective aligns with post-positivism, or the belief that no research method is perfect and that various methods are needed to explore a particular phenomenon from different perspectives (Moon & Blackman, 2014,

2017). For instance, I believe that certain quantifiable truths can be discovered through methods such as surveys; however, interviews may be needed to understand how individual's experiences these truths.

In the present context, I believe that language concordance/discordance can influence patient satisfaction, which can be objectively measured. However, the aspect of concordance that is most influential on satisfaction can vary. For some, it may simply be the fact that their provider speaks the same language as themselves, for others it may be that the provider takes the time to understand their individual linguistic needs and values. Various methods can be used to explore this phenomenon. For instance, a patient satisfaction survey can be used to determine the extent to which concordance influences satisfaction, as was explored in this thesis. However, patient interviews may be needed to further understand why concordance matters, which is outside the scope of the present thesis but may be the subject of a follow-up investigation.

Conforming to this philosophical perspective, various methods were used when exploring the present research questions. For instance, a quasi-experimental design was used when determining whether the CPD program was effective at changing physician behaviours (research question 1). Specifically, a pre and post survey design was used to measure changes in active offer behaviours following the CPD intervention. This quantitative analysis was supplemented with comments made on open-ended questions in the surveys and during the CPD workshop. Thus, a combination of quantitative and qualitative evidence were used to explore this question. Furthermore, a cohort design was used to explore the extent to which French language services are being offered in physicians offices (research question 2). The presence of various active offer behaviours were measured by surveying a small number of physician offices as an indication or

an example of the potential presences of active offer throughout the province. Finally, a cross-sectional design was used to measure the influence of language concordance and the active offer on patient satisfaction (research questions 3 and 4). Patient satisfaction was measured using surveys and compared between linguistically concordant and discordant groups. Different definitions of concordance were also explored to consider the realities of different groups based on their level of linguistic concordance with their family physician.

## Chapter 4

### 4 Methods

#### 4.1 Overview

The present thesis involved the development of a CPD program for physicians in Northeastern Ontario. The CPD program had two purposes, first to teach patient-centred communication through the active offer of French language services to practicing physicians using experiential learning strategies, thus overcoming certain limitations with existing active offer training resources. My first research question consists of an evaluation of the effectiveness of this CPD program. Second, the CPD program also allowed me to collect data regarding linguistic concordance, the presence of the active offer in physician's offices and on the patient experience (i.e., via a patient satisfaction scale). A series of physician, receptionist and patient surveys doubled as both a needs assessment, allowing to identify individual learning gaps and to personalize education to the needs of participating physicians, and as a means of collecting data which allowed me to address research questions 2, 3 and 4 (i.e., measuring the present availability of active offer in physicians offices, and exploring the influence of language concordance and active offer on patient satisfaction). This methods chapter will provide: 1) a detailed account of the CPD program, including the inclusion criteria and the recruitment strategies applied; 2) a description of the data collection tools used and how they were developed, and 3) a description of the data analysis plan for each research question, complete with hypothesis and operational definitions.

## 4.2 CPD program development and description

A CPD program was developed to encourage patient-centred care for Francophones in Northern Ontario by offering training on the active offer of French language services. The program, titled *Ici on parle! How to Actively Engage Francophone Patients. Tools for French- and English-Speaking Physicians*, used a three-phase approach (Table 1) to improve physician communication with their French-speaking patients and to provide strategies that all providers can use to actively offer French language health services, regardless of their ability to speak French. The goal was not to educate physicians on how to speak French, but rather to help improve the French-speaking patient experience by improving accessibility to linguistically adapted services and resources and by integrating French-speaking human resources in the delivery of care (e.g., offering patient education material in French, hiring bilingual staff, referring to French-speaking medical specialists).

**Table 1: Summary of CPD and available Mainpro+ credits**

Education Component	Activity		Possible credits earned	
			Scenario 1	Scenario 2
Personalized needs assessment	<b>Assessment Phase</b>	Complete Physician, Receptionist and Patient surveys	1 Non-certified credit	2 Certified credits <sup>1</sup>
Targeted education	<b>Education Phase</b>	Review survey results and read literature	1 Non-certified credit per hour <sup>2</sup>	2 Certified <sup>1</sup> credits per hour <sup>2</sup>
		Do Linking Learning to Assessment activity	5 Certified credits	5 Certified credits
		Participate in Workshop <sup>3</sup> & complete Reflective exercise		4 Certified credits
Patient feedback	<b>Post-education &amp; Reflective Phase</b>	Complete Physician		2 Certified <sup>1</sup> credits
		Review final report		2 Certified <sup>1</sup> credits per hour <sup>2</sup>
		Do Linking Learning to Practice activity		5 Certified credits
		<b>Total Mainpro credits earned</b>	<b>2+ Non-certified 5 Certified</b>	<b>22+ Certified</b>

1. All *Non-certified* self-learning credits earned are eligible for *Certified* group learning credits upon attending the workshop, otherwise they remain *Non-certified*.
2. These credits are earned on an hourly rate, 1 *non-certified* credit can be claimed for every hour of work.
3. This workshop meets the certification criteria of the College of Family Physicians of Canada and has been approved for 4 Mainpro + *certified* group learning credits.

The receptionist is an essential part of any physician's office, with responsibilities varying from administration to managing patient flow in and out of the waiting room. Receptionists describe their role as informal caregivers, patient advocates and healthcare brokers (Neuwelt et al., 2015). As the first point of contact for patients, the receptionist can be seen as the gatekeeper to the physician; thus, their ability to serve patients in their language of preference is essential to meeting the patient's linguistic needs when accessing care. Even a receptionist who is not fluent in French can learn a few words which would allow them to greet patients in French and initiate a conversation before switching to English to provide details. Furthermore, the receptionist can offer a perspective on the office environment that may not be seen by the physician (e.g., administrative and procedural components).

An analysis of the surveys collected from physicians (Appendix I), receptionists (Appendix L) and patient (Appendix O) identified weaknesses and strengths in each physician's practice, which were addressed during the second phase of the program. Thus, the surveys in the **assessment phase** represented a personalized needs assessment or an audit to determine the strengths and weaknesses of each participating physician (i.e., identifying learning gaps). In contrast to traditional general needs assessments, such as focus groups, interviews or observations (College of Family Physicians of Canada, 2010), this personalized needs assessment allowed me to more accurately identify the specific learning needs of physicians participating in the program (i.e., identify the presence and/or absence of various active offer behaviour) as well as the needs and values of their patients (i.e., determine the importance their patients place on language and the active offer), a vital component of patient-centred care (Barry & Edgman-Levitan, 2012).

In the **education phase**, physicians received a personalized report (Appendix P), which highlighted their performance in five areas of competence as identified by *The Active Offer of French Language Services in a Minority Context Measure* (Savard, et al., 2014):

1. Patient Interactions (e.g., asking patients in which language, French or English, they wish to communicate; greeting new patients in French);
2. Visual Cues (e.g., visual indicators (wearing a badge, signage) indicating the offer of French language services; availability of French pamphlets, magazines, newspapers, etc. in common areas),
3. Telecommunications (e.g., answering the phone in French, email signature in both French and English),
4. Workplace Culture, both written (e.g., bilingual letterhead and/or business cards, offering information in both official languages on the Website) and verbal (e.g., recruiting French-speaking staff, encouraging French-speaking employees to converse in French), and
5. Support & Referrals (e.g., offering patients the option to be directed to a French-speaking provider or Francophone organization, specifying the patients' language of preference on referral letters).

Survey results highlighted areas of competence in which physicians were already proficient as well as areas in which they could improve. Based on results from the pre-intervention physician and patient surveys, average scores for each area of competence were calculated and colour coded as green (indicating active offer behaviours they often or always practice), yellow (indicating behaviours they sometimes practice but where there is room for improvement), or red (indicating behaviours they rarely or never practice and could be added to their clinical practice).

The categorisation of these colour codes was selected based on the work of Savard, et al., (2014), who developed The Active Offer of French Language Services in a Minority Context Measure (described in greater detail below). The creation of this tool consisted of identifying common active offer behaviours from the literature and evaluating the relevance of each behaviours with a pan-Canadian Delphi survey of expert consultants. Therefore, the resulting items represent behaviours considered by experts to be essential to providing an active offer. In an ideal situation, each of these behaviours should be common practice, thus behaviours occurring Often or Always where colour coded as green and represent the goal providers should strive to achieve. Physicians received two sets of ratings, one from their own pre-intervention survey scores and a second from the surveys collected from their patients (thus providing two distinct perspectives on their own active offer behaviours). Furthermore, to allow physicians to compare themselves to their peers, the average ratings of all physicians who participated in the CPD program, as well as all patients who completed a pre-intervention survey as part of the CPD were also provided.

In addition, the report offered a number of online resources pertaining to the active offer, the majority of which referred to The *French Language Services Toolkit*, developed by the North East Local Health Integrated Network (Note: website no longer active). This toolkit consisted of videos and literature that described the importance of the active offer and provided strategies for its implementation. Although the NE-LHIN no longer provides this toolkit, many, if not all, of the resources are identical to those provided in the *Consortium national de formation en santé's* (CNFS) *Carrefour de l'offre active*, with a few links to CNFS resources also having been provided. The NE-LHIN resources were prioritized as the NE-LHIN would be recognized by providers as a reliable source of locally relevant information. All resources in the NE-LHIN's

toolkit were also available in both French and English. Each area of competence outlined in the report referred to specific sections of the toolkit allowing physicians to quickly and easily identify their weaknesses (by referring to their colour-coded scores) and refer to specific resources that directly address those individual competencies. Thus, the reports were tailored to each participating physician such that they not only identified individual gaps in services but also suggested components of the *French Language Services Toolkit* that best address these gaps.

Physicians were then invited to participate in a workshop hosted by a fellow physician and the Francophone Clinical Lead at the *Northern Ontario School of Medicine* (NOSM). Workshops began by reviewing the concept of active offer, which was presented by a representative from the *Réseau du mieux-être francophone du nord de l'Ontario*, the French Language Health Planning Entity for Northern Ontario. Next, the ratings from the previously described reports were reviewed in a small group discussion facilitated by the physician host. Each area of competence from the report initiated an open discussion in which the barriers to performing corresponding active offer behaviours experienced in their practice were discussed. Together, participating physicians brainstormed enabling strategies to implement the active offer based on their own experiences with constructive feedback from their peers, the physician host and the representatives from the *Réseau du mieux-être francophone du nord de l'Ontario*. Finally, each individual physician developed an action plan to implement the active offer within their practice and were encouraged to share the plan (along with other active offer resources) with colleagues and put the plan into action. In order to aid in this brainstorming exchange, all participating physicians were provided with a workshop package containing:

- a copy of the workshop consent form (Appendix Q),

- a copy of the slide deck presented by the *Réseau du mieux-être francophone du nord de l'Ontario*,
- a copy of the *Reference Framework – Training for the Active Offer of French-Language Services* document (ENGLISH version: [http://cnfs.net/wp-content/uploads/2015/06/Reference\\_Framework\\_CNFS\\_Training\\_for\\_active\\_offer\\_of\\_French-language\\_health\\_services.pdf](http://cnfs.net/wp-content/uploads/2015/06/Reference_Framework_CNFS_Training_for_active_offer_of_French-language_health_services.pdf), FRENCH version: [http://www.entitesante2.ca/fls-cop/wp-content/uploads/2020/09/5-OFFRE-ACTIVE-CNFS\\_pour\\_formation\\_offre\\_active\\_SSEF.pdf](http://www.entitesante2.ca/fls-cop/wp-content/uploads/2020/09/5-OFFRE-ACTIVE-CNFS_pour_formation_offre_active_SSEF.pdf)) developed by the *Consortium national de formation en santé*,
- an issue of *Research in FOCUS on Research* (ENGLISH version: <http://documents.cranhr.ca/pdf/focus/FOCUS15-A1e.pdf>, FRENCH version: <http://documents.cranhr.ca/pdf/focus/FOCUS15-A1f.pdf>) which summarizes two peer-reviewed papers discussing barriers and strategies to offering French language services in Northern Ontario,
- an example of bilingual signage (Appendix S),
- a workbook (Appendix R) presenting the average active offer scores along with examples of corresponding active offer behaviours and work space in which physicians could take note of the barriers they experience and practical strategies they can put into practice to implement the active offer (note, the workbook was private and was not collected as data),
- a PowerPoint presentation (Appendix T) was also prepared to help guide the discussion.

Finally, the third phase was a **reflective phase** in which the physicians were provided with a post-intervention survey (Appendix U) five months following the workshop. Physicians were asked once again to report on their current active offer behaviours and reflect on how they had incorporated the active offer into their practice. A five-month interval between the workshop and the post-intervention survey was chosen to provide an opportunity for physicians to make adjustments to their practice by implementing the strategies learned during the workshop. Furthermore, this interval provided enough time to reduce the possibility of a recall bias (i.e., the physician remembering how they answered the pre-intervention survey to inform how they should answer the post-intervention survey). The five-month interval also provided enough time to be able to identify active offer behaviours that persisted. Had the post-intervention survey occurred sooner (e.g., in the weeks following the workshop), any changes in behaviour reported could have been short-term changes which may erode with time. The changes that persisted after five months are more likely to represent long-term changes to the practice. The program ended with a final post-program report (Appendix W) that provided feedback and highlighted improvements physicians had made to their practice since participating in the workshop, thus allowing them to assess if the adjustments they made were effective.

This program was largely developed based on physician interviews, which identified several barriers to participating in CPD in the North (Timony et al., 2016). In addition to the shortage of educational opportunities surrounding Francophone health, physicians explained that those opportunities which do exist are seldom offered in the North and come at a cost, both financially (due to travel costs) and in terms of time away from their practice. To overcome these barriers, the program was developed to be free of charge and could be completed on the physician's own

time, at their own pace, with web-based options and without the need to leave their office. The only travel required was for the workshop, which was held in their home community or in a neighbouring community and could be attended virtually for those in more remote locations. To further address the time commitment issue, physicians were invited to participate in as much or as little of the program as they desired. The program was organized such that one could, for example, participate in the assessment surveys and review the reports and literature without having to attend the workshop or complete the reflective activity. However, it was to the physicians' advantage to participate in as many components as possible as each component was certified for Mainpro+ credits, awarded by the CFPC. For instance, self-learning activities such as completing surveys and reviewing literature were worth one non-certified credit per hour spent on the activity. There were also self-directed activities (the Linking Learning to Assessment and Linking Learning to Practice activities) that physicians could complete which were worth five certified credits each. Finally, the workshop was approved for four Mainpro+ certified group learning credits. Furthermore, upon attending the workshop, all non-certified self-learning credits earned were eligible for certified group learning credits. Thus, a total of 22 certified Mainpro+ credits were available for those who completed every aspect of the program (Table 1). Instruction on how to claim the Mainpro+ credits they had earned during the program were provided with the post-intervention survey (Appendix V).

#### 4.2.1 Inclusion criteria

All physicians with an unrestricted, independent practice license who were certified by the CFPC OR general practitioners (i.e., were neither certified by the CFPC nor Royal College) were eligible to participate in the CPD program, and by extension the study. To ensure the CPD

program was of particular relevance to participating physicians, only those whose primary practice was located in a strong French community of Northeastern Ontario (Timony et al., 2013) were invited to participate. Thus, a total of 260 family physicians and general practitioners were eligible. The choice to situate this thesis in Northeastern Ontario was motivated by the fact that 1) there is a high concentration of strong French communities within the Northeast; and 2) the distribution of French-speaking family physicians is less favourable in the Northeast (Timony et al., 2013). As a result, strong French communities of northeastern Ontario were considered a suitable location to launch the present CPD program as physicians were more likely to have a larger percentage of Francophone patients on their roster (given the Francophone population of the region) and were less likely to be offering French language services (given the relative shortage of physicians reporting French as a language of competence compared to other regions).

As part of the assessment phase of the CPD program, physicians provided a receptionist survey to their receptionist and 40 patient surveys to their patients. In the event that a physician had multiple receptionists, they were instructed to provide the survey to the receptionist who is most responsible for their patients or, if duties are shared equally by all, to the receptionist who had been working with them the longest. Physicians were also instructed to ask their front office staff to randomly distribute the patient survey packages to 20 Francophone and 20 non-Francophone adult patients who they judged to be legally competent to provide consent, to the extent that was possible. No further exclusion criteria were applied to patients.

### 4.2.2 Recruitment

The program was launched in January 2017 and was advertised through numerous channels, including email advertisements (Appendix B) sent out by the local medical school (NOSM) and health planning agencies (NE\_LHIN and the *Réseau du mieux-être francophone du Nord de l'Ontario*), and letters faxed directly to primary care offices. Of the 260 eligible physicians, 173 had a valid fax number posted on their profile on the CPSO website (with the majority without a fax number having indicated a hospital as their primary practice address), all of whom received a faxed recruitment letter (Appendix C) and poster (Appendix D). Awareness of this program was also created via electronic advertisements on websites, circulating posters (Appendix B), and presenting at conferences (Appendix A) where physicians were in attendance (e.g., the Northern Health Research Conference and the annual Northern Constellations Faculty Development Conference hosted by NOSM). Three advertisement cycles were conducted over the nine-month recruitment period (in January, April, and July 2017).

### 4.3 Data collection tools

As described above, in addition to the educational component, data collection was seamlessly incorporated within the CPD program. For instance, beyond informing CDP organizers about the physicians' learning needs, the surveys in the **assessment phase** also provided a snapshot of the prevalence of the active offer of French language health services presently being offered in the physicians' offices and its impact on patient satisfaction (allowing me to answer research questions 2, 3 and 4). In addition, the workshop in the **education phase**, as well as the post-intervention surveys in the **reflective phase**, provided both quantitative data as well as feedback from participating physicians, which can be used to evaluate the effectiveness of the program

itself (allowing me to answer the first research question). What follows is a detailed description of these data collection tools.

Upon agreeing to participate in the CPD program, physicians were sent survey packages consisting of: a letter with instructions on how to participate (Appendix E), 1 physician survey package, 1 receptionist survey package, 40 patient survey packages, 2 patient information posters (Appendix F) which the physicians could post in their waiting room, and 1 large postage paid business reply envelope in which all completed surveys could be placed and returned to the organizers. All survey packages (i.e., for physicians, receptionists and patients) included an information letter/instructions on how to participate (Appendices G, J and M), a consent form (Appendices H, K and N), a survey booklet (Appendices I, L and O) and a small postage paid business reply envelop. All participants were instructed to seal their consent form and questionnaire in the provided business reply envelop, thus insuring their responses remained confidential. The business reply envelop could then be placed in any out going postal box or handed in to the receptionist who would collect the small envelopes and place these in the large business reply envelop to be sent to the research team at a later date. All material was provided in both French and English (note, to save space, only the English versions have been included in the appendices) and a QR code and link were included on all survey booklets allowing respondents to complete an online version of the questionnaires and access electronic version of the information letter and consent form. A committee consisting of Francophone health researchers, French-speaking physicians, and health education experts from the offices of Continuing Education & Professional Development and Francophone Affairs at NOSM collaboratively developed and reviewed all CPD materials. This committee met and

corresponded by email regularly during the CPD development process to complete the Mainpro+ accreditation application, review surveys, develop the workshop material, review the physician reports and comment on the entire process. Each member of the committee reviewed and commented on all CPD materials (including adapting the questionnaires to the Northern Ontario context), comments were discussed during in person meetings and decisions were made based on consensus.

#### 4.3.1 Physician and receptionist surveys

Both the physicians and receptionists received nearly identical pre-intervention questionnaires (Appendices I and L), which began by determining the respondents' First Official Language Spoken and asking if they consider themselves competent enough to communicate with patients in French (with questions borrowed from the Canadian census (Statistics Canada, 2015) and the CPSO annual membership renewal survey). The receptionists were also asked if they consider the participating physician for whom they work to be competent in French. Physicians and receptionists were then asked to estimate the percentage of Francophone patients seen in the past week, as well as the percentage of patient interactions conducted in French. Anecdotal evidence from a previous qualitative study consisting of physician interviews (Timony et al., 2016) suggests that receptionists may be even more aware of the number of French patients than the physicians, making them an appropriate source for obtaining such information. The questionnaires also included a measure of the active offer of French language services.

As we have seen in the review of the literature, active offer is much more than simply ensuring linguistic concordance between patients and service providers. The active offer involves an organizational restructuring to ensure that leadership is sensitized to the needs of Francophone

patients, that the workplace culture encourages the offer of French language services, that highly qualified bilingual staff are recruited and retained, that efforts are made to ensure continuity of care in French when making referrals and that French services are clearly communicated, visible, available at all times and easily accessible (Ministry of Francophone Affairs, 2014; Regroupement des Entités de planification des services de santé en français de l'Ontario et Alliance des Réseaux Ontariens de santé en français, 2015). Each of these factors can influence patient satisfaction, in addition to the presence or absence of linguistic concordance. As a result, the physician and receptionist surveys in the present study included select questions from the *Active Offer of French Language Services in Minority Context Measure*, which measures the frequency in which providers perform various active offer behaviours on a four-point scale (i.e. Never, Rarely, Often and Always) (Savard et al., 2014). The development of this instrument began with a thorough literature review identifying all practices and behaviours associated with an active offer of French language services, the results of which were examined with a pan-Canadian Delphi survey of expert consultants, thus ensuring content validity (Savard et al., 2014). The items which were selected for the questionnaire were divided into categories and pilot tested by Savard et al. (2014) in a sample of 60 health care providers (e.g., physicians, nurses, social workers) who had recently graduated from a French language education program. The results from this pilot test provided evidence of an acceptable level of internal consistency (Cronbach  $\alpha$  ranging between 0.7 and 0.9) and showed signs of temporal stability in a modest sample of 22 individuals who completed a second questionnaire at a later date (Savard et al., 2014).

The *Active Offer of French Language Services in Minority Context Measure* is a two-part questionnaire which asks health care providers to first self-rate their own active offer behaviours and later rate the frequency of active offer efforts within their work environment (Savard et al., 2014). Each section of the questionnaire is further divided into sub-themes: 1) Reception and Patient Management, which asks about the use of French in the office environment and during patient interactions; 2) Interventions, which addresses the use of French informational or educational resources, screening tools and standardized instruments; and 3) Support and Referrals, which addresses referrals to French-speaking health care providers.

Given the current focus on communication and linguistic concordance as described in the Framework for Patient-Professional Communication (Feldman-Stewart et al, 2005), the Framework of Communicative Competence (Gregg & Saha, 2007) and the Theory of Cultural Sensitivity (Dutta, 2007), 24 items from the “Reception and Patient Management” sub-theme (12 of which represented self-reported active offer behaviours and 12 represented organizational efforts within the work environment) were included in both the physicians and receptionist questionnaires. Of particular relevance were items which assess the frequency of French interactions during patient visits, which are indicative of the physicians **linguistic** and **communicative competence**, as well as items which address active offer efforts within the office setting, which helps describe the **environment** in which the communication is taking place. Additionally, given the importance of continuity of care in French (Lortie & Lalonde, 2012) and the fact that physicians have identified referrals to French-speaking providers as a strategy to serving Francophone patients (Gauthier et al., 2015), the physician questionnaire also included four items from the “Support and Referrals” sub-theme (these questions were not

present on the receptionist survey, as receptionist do not typically refer patients to other services). According to the theory of cultural sensitivity: “culture is conceptualized as a collection of shared values, beliefs, and practices that are contained within a clearly defined community” (Dutta, 2007, p.307). Thus, linguistically concordant referrals can be considered indicative of **cultural sensitivity** as the physicians must be aware of and responsive to the patients **needs, beliefs and values**; which for Ontario Francophones would include the need, belief and value of being able to use their mother tongue (a protected official language of Canada) when accessing health care. Finally, the “Interventions” sub-theme was removed as those items may be outside of the physician’s control. For instance, physicians have identified a lack of educational or screening resources in French as a barrier to serving the Northern Francophone population (Timony et al., 2013). Furthermore, the “Interventions” sub-theme does not address patient-provider interactions, which may be linguistically concordant even in the presence of linguistically discordant instruments.

In the final questions, physicians were provided with open-ended questions that asked them to identify challenges to offering French language services in their practice and to define the active offer of French language services in their own words. These questions provided a baseline assessment of the physician’s knowledge about the active offer and challenges they may face when serving Francophone patients. Physicians also received a post-intervention questionnaire (Appendix U) in the **reflective phase** that was virtually identical to the pre-intervention questionnaire. Physicians received the same active offer questions from the *Active Offer of French Language Services in Minority Context Measure* and were asked once again to define the active offer (to see if their knowledge of the concept changed following the workshop). In a

series of open-ended questions on the post-intervention questionnaire, physicians were also asked to comment on the impact of the CPD program. For instance, they were asked to identify any changes they had implemented to their practice (in terms of both personal behaviour changes and general changes within their practice) and whether their level of confidence in serving Francophone populations had changed. In addition, if they did not find the program beneficial, they were provided with an opportunity to explain why. Finally, the survey data were supplemented with data pulled from the CPSO website. Specifically, the physicians' languages of competence, their gender, their primary practice address, undergraduate medical school and year of graduation were captured to provide descriptive statistics on the sample of physicians without the need to add additional questions to the questionnaires.

#### 4.3.2 Patient surveys

Like all research materials, the patient questionnaire was available in French and English and consisted primarily of close-ended questions that required respondents to select the most appropriate response (Appendix O). The questionnaire began by collecting demographic information such as age, gender, language spoken and home postal code. The influence of perceived health status on satisfaction was also controlled for by measuring self-assessed level of health (question taken from the Canadian Community Health Survey) (Statistics Canada, 2012). Next, patients were asked their language of preference when receiving health services, as well as the frequency in which they speak French with their family physician. Patient satisfaction was then measured with questions from the patient questionnaire of the 2006 version of the Physician Achievement Review (PAR) (Sargeant, 2006). The PAR was developed in late 1990's for the College of Physicians and Surgeons of Alberta in response to the growing number of complaints

related to patient-physician communication (Hall et al., 1999). The PAR is a multisource feedback program in which five sources rate physician performance: self, patients, medical colleagues, consulting physicians to whom patients are referred and non-physician coworkers (e.g., secretaries, nurses) (Hall et al., 1999). It has been suggested that two important dimensions of physician performance include clinical effectiveness and interpersonal effectiveness (Brook et al., 2000; Campbell et al., 2000; Donabedian, 1988), both of which are addressed in the PAR's rater-specific questionnaires (Hall et al., 1999;). Though the PAR in its entirety is considered a measure of quality of care, the patient survey focuses primarily on interpersonal skills (Lockyer et al., 2007) and may be considered a measure of satisfaction. Many of the PAR's patient survey questions resemble patient satisfaction surveys with primary care physicians (Hojat et al., 2011).

This version of the PAR was selected because it was developed for a Canadian physician regulatory body, the College of Physicians and Surgeons of Alberta, with the intent of assessing physicians and improving quality of health care; because it has been translated and validated in French; and because of its impressive reliability and validity indices, with a high level of technical reliability (Hall et al., 1999; Sargeant et al., 2003; Sargeant, 2006) and strong concurrent validity and inter-rater reliability (Hall et al., 1999; Sargeant, 2006; Violato & Hall, 2000). Furthermore, Lockyer, Violato, and colleagues (2007) examined the PAR's psychometric properties in their series of papers. First, a series of factor analyses were performed on the self, patient, coworkers, and medical colleague questionnaires. They then tested the reliability and validity of each questionnaire (Violato et al., 2008). Finally, they used factor scores to compare physicians based on the medical school they attended (Lockyer et al., 2009). Given the current interest in patient assessment, only the results from the patient surveys will be further described.

The factor analysis of the 40-item patient survey revealed four factors: professionalism and communication (24 questions), office personnel (6 questions), access to physicians (5 questions), and physical office (5 questions) (Lockyer et al., 2007). Each question asked patients to rate their physicians on a five-point scale, ranging from “Strongly Disagree” to “Strongly Agree”. An “Unable to assess” option was also available for each question. In a study of the instrument’s psychometric properties, each factor (group of questions) showed high internal consistency reliability (Cronbach's  $\alpha$  ranging between 0.98 and 0.89), stability over time (with a five year gap between testing periods) and construct validity (with questions having been conceptually placed together during the development of the questionnaire remaining grouped together during the factor analysis) (Violato et al. 2008). Given the link between communication and satisfaction explored in the current study, only the 24 questions of the PAR patient survey related to “professionalism and communication” were used.

Patients also rated their physician’s active offer behaviour using six items from the “Reception and Patient Management” sub-theme from the *Active Offer of French Language Services in Minority Context Measure* (Savard et al., 2014). Questions chosen related directly to patient interactions and asked patients to evaluate the visibility of French language services offered at their practice, the presence of French greetings, the frequency with which language of preference is asked, and the availability of French documentation. Each item was once again rated on a four-point frequency scale (never, rarely, often, always).

### 4.3.3 Workshop

In addition to imparting physicians with active offer implementation strategies, the workshop also provided an opportunity to speak with physicians and gain their insight on the effectiveness

of the CPD program. Participating physicians were asked what aspect of the CPD program, in general, they enjoyed and what could be improved. They were then asked specifically about the educational resources provided, namely the personalised reports and resources. Participating physicians provided their consent to having the workshops audio recorded. Their comments were used to supplement the quantitative data and were considered when interpreting the results. These comments provided insight into the effectiveness of the CPD program from the participating physician's point of view, thus contributing to answering the first research question.

#### 4.3.4 Formatting and administering data collection tools

In order to improve physician participation rates, receptionist response rates and patient response rates in the present study, the formatting and administration of data collection tools followed recommendations made by Don Dillman (Dillman, 1991; Dillman et al., 1998; Dillman, 2000). For instance, the assessment surveys in phase one of the CPD followed recommendations from Dillman's tailored designed survey method. This detailed approach for mail and web-based surveys promised a 60%-80% response rate when following the suggested survey packaging (e.g., the inclusion of a cover letter, university logos, a postage paid return envelope) and follow-up procedures (e.g., a precontact letter followed by a survey package and a set number of reminders) (Dillman, 1991; Dillman et al., 1998; Dillman, 2000; Hoddinott & Bass, 1986; Sudman, 1985). However, seeing as the present data collection method is incorporated within a CPD program, surveys were not randomly distributed to a sample of northern physicians (as is the assumption in Dillman's tailored designed survey method). Therefore, Dillman's recommendations were followed in recruiting physicians to the CPD program and formatting of the survey tools, when appropriate.

Further efforts made to help improve response rates, as suggested by Dillman, include keeping the questionnaires short to limit time commitments; detailing the professional relevance to participation in a cover letter; clearly describing the methods of protecting confidentiality; and including a link to an online version of the questionnaire, thus giving respondents an alternative mode of participation (Dillman, 2000). The questionnaire and supplementary materials were also shared with a consultative committee of relevant organizations and stakeholders (i.e., the NE-LHIN, the *Réseau du mieux-être francophone du Nord de l'Ontario*, the NOSM, and the *Consortium national de formation en santé*). One member from each organisation reviewed the material and provided feedback during an in person roundtable discussion. This committee reviewed the appropriateness of the instruments and facilitated recruitment through their networks. Such an endorsement increased the perceived validity and relevance of the study (VanGeest et al., 2007).

#### *Dillman's procedure for administering surveys*

As described above (under the 'Recruitment' heading), eligible physicians were recruited through various channels, one of which entailed a recruitment letter sent out by reputable organizations. As suggested by VanGeest, Johnson and Welch (2007), physicians are particularly attentive to letters received from medical peers or professional associations. For this reason, the NOSM, the NE-LHIN and the *Réseau du mieux-être francophone du Nord de l'Ontario* were approached and agreed to send a recruitment letter to their contact lists on my behalf. Seeing as the NOSM is the only medical school in Northern Ontario with faculty spread out across the northern territory, their mailing list included many northern physicians from most targeted communities (i.e., communities with a strong Francophone presence). Furthermore, at the time

the CPD program was launched, the NE-LHIN and the *Réseau du mieux-être francophone du Nord de l'Ontario*, were the primary health planning agencies in the region, with access to contact information from most healthcare providers. Therefore, these organizations allowed me to advertise the CPD program to most, if not all, eligible physicians. Furthermore, an endorsement from these organizations was particularly convincing of the study's importance.

Physicians who enrolled in the CPD program were provided with survey packages, as detailed above. As prescribed by Dillman (1991; 2000), the packages included the questionnaires (complete with logos from the Center for Rural and Northern Health Research (CRaNHR) and Laurentian University, the study title, a description of the study, instructions for participation and the option to drop out of the study, a personalized (by name and address for physicians only) cover letter printed on CRaNHR letterhead and signed by the lead researcher (i.e., me) and a postage paid return envelope, all inserted in a white business sized envelope with the Laurentian University crest and address. A series of reminder emails/faxes were sent three and seven weeks following the initial survey package mail-out with a final reminder sent out once the assessment phase was closed.

To help ensure the anonymity of respondents, it is suggested to avoid asking for names on the questionnaires. Alternatively, Dillman proposes including a unique identifier on each survey, allowing the researcher alone to identify the respondents (Dillman, 2000). In the present study, each physician was provided with a unique identification code upon enrolling in the CPD program. This unique ID was included on the physician, receptionist and patient questionnaires and acted as a password when completing the online version of the survey, thus ensuring

physicians could not be identified from the completed questionnaires yet allowing researchers to identify them from the data. Receptionists and patients were not asked to self-identify.

*Dillman's method for formatting the Paper-based survey*

As per Dillman's recommendations (Dillman, 1991, Dillman, et al., 1998; Dillman, 2000), all paper-based questionnaires (Appendices I, L and O) had a front and a back cover (devoid of questions), contained a short title for the study, displayed the Laurentian University and CRaNHR logos (on the front) and the researcher team's contact information (on the back). Questions were grouped in logical progression (typically following the grouping and order from the original tools), were easy to respond to, with primarily close-ended multiple choice question types, and questions within each survey followed a consistent answering convention. Finally, the survey was developed to be as short as possible, containing only essential questions, and printed on standard letter size paper (8 ½" x 11"). Questionnaires (both web- and paper-based) were formatted in a manner that is appealing to respondents encouraging participation (e.g., 13-point font, adequate space between questions, consistent and muted colour pallet) (Dillman, 1991, Dillman, et al., 1998; Dillman, 2000).

*Dillman's method for formatting the Online surveys*

All respondents could choose between paper-based or web-based versions of the questionnaires. Web-based questionnaires were created in Remark Web Survey Software (<https://remarksoftware.com/products/web-survey/>), a proprietary survey software which uses a common computer language compatible with all popular internet browsers and allows surveys to be opened and completed on any computer or device with an internet connection (i.e., a smart phone or a tablet), thus providing respondents with the freedom to participate in the web-based

survey using the method of their choice. Consistent with Dillman's principles (Dillman et.al., 1998), respondent-friendly formatting was employed. For instance, appropriate text size was considered. The average text size of a Google web search was applied. With the Remark Web Survey Software, as with most websites, the text size becomes larger when one "zooms" in. Therefore, the survey text size was compatible with each respondent's internet pre-sets and preferences. Furthermore, whenever possible, the number of questions per page was limited to those that fit within a standard computer screen (viewed at 100%), thus eliminating the need to scroll down to proceed to the "Next" page or question. Finally, questions on the web-based questionnaires followed a conventional format and a colour pallet, making them visually identical to the paper-based questionnaires.

#### 4.4 CPD compliance with best-practices

Although the CPD program was added to the thesis as a means of recruiting physicians, receptionists and patients, efforts were made to ensure the program was of the utmost benefit for participating providers. The goal in developing the present CDP program was to add to the existing active offer training resources by addressing some of the limitations with these existing programs. As we saw in the literature review, there are primarily two active offer training resources in Canada, the *Carrefour de l'offre active* developed by the *Consortium national de formation en santé* (<https://offreactive.com/enseigner>) and the online active offer training program developed by the *Réseau du mieux-être Francophone du Nord de l'Ontario* (<https://www.activeoffertraining.ca>). The main limitation of these existing resources is that they rely on passive learning by providing literature, videos, case studies and online modules that providers must review independently. These training resources are more akin to CME as they

aim to enhance knowledge and skills through the passive dissemination of information (Filipe et al., 2014; Filipe et al., 2016; World Federation for Medical Education, 2015). As a result, providers may learn about the active offer and discover strategies for its implementation, yet not know how to apply these strategies to their practice. To the contrary, the present CDP program intended to produce changes in active offer behaviours through practice-based and experiential learning strategies. In the following section, I will describe the best practice standards and adult learning principles that were considered when developing the program.

The present CPD program followed the four-phase CDP cycle described by Filipe et al. (2014, 2016) which consists of: 1) the identification of learning needs; 2) planning learning activities 3) implementation; and 4) evaluation. First, learning needs, which are defined as a gap between current competencies and a desired state (Filipe et al., 2014; 2016) were identified through a five-step clinical audit (Filipe et al., 2016). Step 1 involves identifying a problem that needs to be addressed, which I described in detail in the literature review. By and large, two ‘problems’ were identified in the literature, first there is a lack of French language health care services in Ontario (DPM Research, 2021; Leger, 2020; Lepage & Lavoie, 2017), particularly in the North (Timony et al., 2013, 2022), which may explain why Francophones experience poorer health outcomes compared to the general population of Ontario (Bouchard & Desmeules, 2013; Bouchard et al., 2018; van Kemenade et al., 2015). Second, recent legislative changes have placed a greater emphasis on the active offer of French language services, which has the potential to improve access to French language services. Of note, the modernization of the FLSA stipulates that French language services must be provided using an active offer (French Language Services Act, 1990; Ministry of Francophone Affairs, 2022b), while Bill 74 describes the responsibility of the

OHTs to provide care in adherence with the FLSA (The People's Health Care Act, 2019).

Although neither the FLSA nor Bill 74 apply directly to the care provided by physicians, these legislative changes point to a shift in health care delivery to be more responsive to the needs of the Francophone population. Therefore, the present CPD program sought to teach patient-centered communication through the active offer of French language services to physicians practicing in northeastern Ontario. Step 2 of the audit process involves setting evidence based best practice standards. Given that the active offer is a relatively new concept, particularly in health care delivery (French Language Health Planning Entities and French Language Health Networks of Ontario, 2015; Lortie & Lalonde, 2012), few best practice standards have been established. However, in developing the *Active Offer of French Language Services in Minority Context Measure*, Savard, Casimiro, Benoît, and Bouchard (2014) conducted a thorough review of the literature to identify all practices and behaviours associated with an active offer of French language services, the results of which were examined with a pan-Canadian Delphi survey of expert consultants. Therefore, the resulting items from the *Active Offer of French Language Services in Minority Context Measure* represent essential behaviours and were considered to represent best practices for the sake of this thesis. In Step 3 of the audit process, data was collected through the pre-intervention physician and receptionist surveys to identify the baseline presence of active offer. Step 4 consists of comparing baselines with intended practice standards, which was accomplished by providing physicians with a personalized report allowing them to compare the frequency of their own active offer behaviours against the standard set out by the *Active Offer of French Language Services in Minority Context Measure*. Specifically, best practice standards were colour coded in green, meaning they occur often or always. Physicians could compare their scores to these standards and thus identify areas needing improvement.

The final step of the audit process, which coincides with the second and third phase of the CPD cycle, involves designing and implementing an education intervention to bridge the gap identified in the audit (Filipe et al., 2014; 2016). According to the World Federation for Medical Education (2015), CPD providers must tailor education interventions to address gaps in competencies of participating providers. This was achieved in two ways. First, the personalized reports not only identified gaps in active offer behaviours, but also provided literature and resources to help implement/improve such behaviours. Second, active offer behaviours that were infrequently reported by participating physicians were addressed during the workshop, barriers to performing these behaviours were discussed, and strategies to implement the active offer were co-developed with participants. The World Federation for Medical Education (2015) also recommends that medical schools and physicians should be involved in the planning and delivery of CPD activities. To this end, the present CPD program was collaboratively developed by a committee consisting of Francophone health researchers, French-speaking physicians, and health education experts from the offices of Continuing Education & Professional Development and Francophone Affairs at NOSM. Additionally, the workshop was hosted by a French-speaking family physician and Francophone Clinical Lead at NOSM with a presentation from the *Réseau du mieux-être francophone du nord de l'Ontario*, the French Language Health Planning Entity for Northern Ontario.

Furthermore, formal CPD activities are most effective when they reflect adult learning principles (Filipe et al., 2016; Merriam, 2018), many of which were applied during the workshop. Since adults are self-directed learners (Filipe et al., 2016; Merriam, 2018), rather than only providing a didactic lecture about the active offer (which was provided in part by the *Réseau du mieux-être*

*francophone du nord de l'Ontario*), the majority of the workshop was dedicated to guided discussions that stimulated learning hosted by a fellow family physician (e.g., asking physicians about the barrier to providing the active offer in their practice, suggesting possible solutions to overcome these barriers, allowing physicians to adapt these solutions to meet their needs and providing constructive feedback). Since adults are goal-oriented and motivated by learning gaps (Filipe et al., 2016), the workshop addressed gaps identified in the physician's personalized reports based on the pre-intervention survey. The physician's lived experiences and baseline knowledge were also considered by focusing on identified gaps in active offer knowledge and behaviours rather than discussing active offer strategies that were already being performed by most (Filipe et al., 2016). The guided discussion provided plenty of opportunities for participating physicians to interact, thus not only respecting lived experiences, but also allowing physicians to learn from one another (Filipe et al., 2016; World Federation for Medical Education, 2015). Since adults are practical/situational learners (Filipe et al., 2016; Merriam, 2018), physicians were encouraged to implement the active offer strategies co-developed during the workshop in their practice, thus allowing for practice-based learning to occur before the final post-intervention survey was administered. In order to strengthen learning which occurred during the CPD intervention, physicians were also encouraged to disseminate new learning with colleagues in their practice (i.e., share active offer resources from the report and strategies discussed during the workshop) thus allowing learnings to permeate within the profession and reinforcing what had been learned by sharing it with others (Filipe et al., 2014). Additionally, various teaching methods that have been demonstrated to be successful in improving communication skills of practicing physicians were also applied (Alexander et al., 2006; Allenbaugh et al., 2019; Ammentorp et al., 2021; Berkhof et al., 2011; Filipe et al., 2014;

Levinson et al., 2010; Rao et al., 2007). These include a combination of didactic and experiential learning environments (i.e., learning could occur both during the workshop and in practice before being evaluated), small group sessions with lectures and discussions, interactive learning interventions (i.e., allowing physicians to interact and learn from one another), and reviewing case studies and observing videos that model desirable communication behaviours (which were provided as resources on the personalised reports). Finally, since shorter sessions have been found to be effective and more convenient for the busy practicing providers (Agency for Healthcare Research Quality, 2017; Allenbaugh et al., 2019; Levinson et al., 2010; Rao et al., 2007) the workshop was scheduled for two hours and occurred in the evening, thus allowing physicians to participate after office hours.

The final phases of the CPD cycle consisted of evaluating the education program (Filipe et al., 2014; 2016), which was accomplished based on Dixon's (1978) four levels of evaluation.

**Perceptions and Satisfaction** with the CPD program were evaluated to determine whether the education program addressed learning objectives (both with an open discussion during the workshop and with open-ended questions on the post-intervention survey). A **Competency Assessment of Knowledge, Skills and Attitudes** was accomplished by comparing pre and post-intervention surveys, specifically exploring whether definitions of active offer changes (reflecting a change in knowledge), whether changes were implemented to their practice (reflecting an improvement in skills), and whether physicians felt more confident in treating Francophone patients (reflecting a change in attitudes). A **Professional Performance Assessment**, which assesses whether the newly acquired knowledge, skills and attitudes were translated into changes in behaviours, was achieved by comparing pre- and post-intervention

active offer scores (i.e., determining whether active offer behaviours occurred more frequently as a result of participating in the CPD program). Finally, the fourth level of evaluation proposed by Dixon (1978) consists of a **Health-Care Outcome Assessment**, which explores improvement in health outcomes in the patient population. However, it was beyond the scope of the present thesis to conduct such an evaluation. As the World Federation of Medical Education (2015) suggests, participating in single CDP program rarely leads to meaningful improvement in patient health outcomes, which are more likely to occur after physicians have participated in a series of CPD activities over an extended period. Improvements in patient health outcomes are often incremental and only detectable through a longitudinal evaluation and it was not expected that measurable changes in Francophone health outcomes would occur as a result of the present CPD intervention.

I will end this section by addressing three final best practice suggestions, specifically, CDP activities should serve to promote competencies established by professional societies, be accredited and be free from commercial influences (Filipe et al., 2014; Filipe et al., 2016; World Federation for Medical Education, 2015). First, the present CPD program focuses on the communicator competency from the CanMEDs framework established by the Royal College of Physicians and Surgeons of Canada, which is defined as the ability to “form relationships with patients and their families that facilitate the gathering and sharing of essential information for effective health care” (Frank et al., 2015, p.18). Therefore, CPD programs addressing communication skills should be developed when gaps in patient-physicians communication are identified (such as the language gaps identified in the present literature review). The active offer addresses the communicator competency as it represents a patient-centered approach to

effectively communicate with Francophone patients (Lortie & Lalonde, 2012). Second, the program was accredited by the College of Family Physicians of Canada, with a maximum of 22 certified Mainpro + credits available to those who complete each aspect of the program. Third, although it was sponsored/financed by the Northern Ontario Academic Medicine Association (NOAMA), the NOAMA did not influence any aspect of the planning, development or implementation the CPD program, which was free from any other form of commercial sponsorship.

#### 4.5 Analyses and hypotheses

Data analyses began with a descriptive analysis of the sample who participated in the study. Demographic characteristics of physicians, receptionists and patients were derived from the pre-intervention surveys, with additional information about physicians being pulled from the College of Physicians and Surgeons of Ontario (CPSO) registry available online (<https://doctors.cpsso.on.ca/?search=general>). Table 2 contains a detailed list of information/variables collected from physicians, receptionist and patients. Each piece of information/variable is operationally defined and categories are provided when applicable.

**Table 2: Descriptive information collected from physicians, receptionists and patients**

Information/variable	Operational definition	Categories
<b>Physicians Information</b>		
Language of competence	The language in which physicians self-reported being competent enough to practice on the CPSO registry. Those who indicated French were considered French-speaking while those who did not were considered English-speaking, regardless of any other linguistic capabilities they may have identified	French-speaking physicians (FSPs) vs. English-speaking physicians (ESPs)
First Official Language Spoken (FOLS)	Derived by combining data on mother tongue, knowledge of Canada's two official languages and the language most often spoken at home as collected on the questionnaire. (Statistics Canada, 2009) (See: <a href="https://www.statcan.gc.ca/en/concepts/fig1">https://www.statcan.gc.ca/en/concepts/fig1</a> for a description of how FOLS is calculated)	Those with a FOLS classified as "French" or "French and English" were considered Francophone. All others were considered non-Francophone
Sex	Declared on the CPSO registry	Female vs. Male
Undergraduate school	Declared on the CPSO registry	Categorised as Ontario vs. outside of Ontario
Years since graduation	Calculated by subtracting the year of graduation declared in the CPSO registry from the year of the workshop	Continuous variable
<b>Receptionist Information</b>		
Language of competence	The language in which receptionists self-reported being competent enough to communicate with patient, pulled from the questionnaire. Those who indicated French were considered French-speaking while those who did not were considered English-speaking	French-speaking receptionists vs. English-speaking receptionists
First Official Language Spoken (FOLS)	(Same as above)	(Same as above)
<b>Patient Information</b>		
Age	As declared on the patient questionnaire	Continuous variable
Sex	As declared on the patient questionnaire	Female vs. Male
First Official Language Spoken (FOLS)	(Same as above)	(Same as above)
Physician Language of Competence	Patients with a physician who reported French among the languages in which they are competent enough to practice on the CPSO annual registry were considered to have a	French-speaking physicians (FSPs) vs. English-speaking physicians (ESPs)

	French-speaking physician. All other were considered to have an English-speaking physicians	
Service Language (FLS received)	The frequency with which the patients reported speaking with their family physician in French on the patient survey (Always (100% of the time), Often (50% of the time), Sometimes (less than 50%), Never (0%)).	Regularly (50% of the time or more) Rarely/Never (less than 50% of the time)
Language of Preference	The language in which patients reported they prefer receiving health care service on the patient questionnaire.	French vs. English

What follows is a detailed analysis plan for each research question, complete with the data sources, and hypotheses.

#### 4.5.1 Research question 1: How does a CPD program teaching the active offer of French language services change physician communication behaviours in practicing physician's offices of northeastern Ontario?

As part of the present thesis, a CPD program intended to improve patient-centred communication through the active offer of French language services was developed and implemented in a sample of family physicians from northeastern Ontario. The effectiveness of the program can be evaluated from various sources, including a comparison of the frequency of active offer behaviours as reported on the pre- and post-intervention questionnaires. Furthermore, participating physicians provided feedback on the education program on two separate occasions, first during the workshop and later on the post-intervention survey. Therefore, a combination of quantitative data and qualitative physician feedback will provide indicators of the program's success while also emphasizing its weaknesses.

For the present quantitative analysis, an active offer score was calculated by averaging physicians' responses to the active offer questions. This method accounts for missing data by

imputing a prorated scale score that fills in missing values with the individuals' average scores from all completed questions (Mazza et al., 2015; Shrive et al., 2006). This method is appropriate when data have lower percentages of missing values (Shrive et al., 2006), with a 20% cut-off point often applied (Mazza et al., 2015). Thus, active offer scores were suppressed if 20% or more of the active offer questions were unanswered. Four active offer scores were calculated in this manner. The first was a global active offer score, attained by averaging all 28 questions from the *Active Offer of French Language Services in Minority Context Measure* (Savard et al., 2014). Next, individual active offer scores were calculated for each subtheme, with two scores calculated from the 'Reception and Patient Management' subtheme (the first from the 12 self-rated questions and the second from the 12 work environment questions), with a final score being calculated from the four self-rated questions from the 'Support and Referrals' subtheme. Differences in active offer scores were compared between the pre-intervention survey from the **assessment phase** and the post-intervention survey from the **reflective phase** of the CPD program.

Ideally, I would have preferred to analyze this quantitative data using a series of paired sample t-tests. However, given that the sample size was too small (as will be described in detail in the Results chapter), and that many of the assumptions for a parametric test were violated, a series of non-parametric Wilcoxon signed rank tests were performed. The Wilcoxon test ranks differences between the pre- and post-intervention scores (from smallest to largest) and compares the average ranking of the positive differences (i.e., improvements) to the negative differences (i.e., decreases) to determine whether a significant difference is observed (Laflamme & Zhou, 2014). Descriptive analyses were considered when describing pre- and post-intervention differences.

Although descriptive analyses do not allow me to determine the presence of statistically significant differences, they nevertheless provided directional trends as an indicator of the program's potential effectiveness.

In addition to the quantitative analysis of active offer scores from the questionnaires, the effectiveness of the CPD program was also evaluated based on qualitative feedback from participating physicians. Advantages and disadvantages of the program were discussed based on physician responses to the open-ended questions from the post-intervention questionnaire and feedback provided during the workshop. More specifically, the definition of active offer from the pre- and post-intervention questionnaires were compared to see if knowledge of this concept improved. Specific changes to the practice reported on the post-intervention questionnaire were also explored, as were self-reported changes in the physician's confidence level when serving Francophone patients. Finally, comments shared during the workshop were considered, namely the discussion surrounding what participating physicians enjoyed about the CPD program and what could have been improved. A content analysis was conducted when analysing the qualitative data whereby the presence of common themes or concepts were identified and discussed in relation to the quantitative results.

It was hypothesized that active offer scores would improve on the post-intervention questionnaire, indicating changes in the active offer behaviours of participating physicians. I also expected physicians would express improvements in the way they define the active offer and in their level of confidence when serving Francophone patients.

#### 4.5.2 Research question 2: To what degree are French language services actively being offered in physicians' offices in northeastern Ontario?

In addition to serving as a personalized needs assessment, the physicians and reception questionnaires from the **assessment phase** also provided a snapshot of the presence of active offer in physicians' offices of Northeastern Ontario. Active offer scores from the *Active Offer of French Language Services in Minority Context Measure* were compared between French-speaking physicians, English-speaking physicians, French-speaking receptionists, and English-speaking receptionists. As with the previous research question, four active offer scores were compared: a global score, a score from the self-rated questions from the 'Reception and Patient Management' subtheme, a score for the work environment questions from the 'Reception and Patient Management' subtheme and a score from the 'Support and Referrals' subtheme. In addition, the present analysis sought to identify active offer behaviours that were already present in physician's offices as well as behaviour that were absent (or less frequent) and could be improved. Thus, physicians and receptionists (both French-speaking and English-speaking) were compared on all 24 items of the *Active Offer of French Language Services in Minority Context Measure* individually.

Ideally, I would have preferred to analyze active offer scores using a series of parametric analyses of variance and t-tests, however due to small sample sizes (which will be described in greater detail in the Results chapter) that violated several assumptions of parametric tests, non-parametric tests were performed. Specifically, the Kruskal-Wallis test was used when comparing physicians and receptionists (both French-speaking and English-speaking = 4 independent groups) on the global active offer score as well as on all scores derived from the 'Reception and Patient Management' subtheme (i.e., on the self-rated questions, the office environment

questions and on each individual question). The Kruskal-Wallis test allows us to compare three or more groups by ranking each individual's active offer scores from smallest to largest and comparing the average ranking of each group using a chi-squared analysis (Laflamme & Zhou, 2014). When a significant difference was found between groups, post-hoc Mann-Whitney U tests were performed to identify which groups differed from one another. Much like the Kruskal-Wallis test, the Mann-Whitney U test compares two groups based on the average ranking of their members (Laflamme & Zhou, 2014). The Mann-Whitney U test was also used to compare scores derived from the 'Support and Referrals' subtheme (both for the global sub-theme score and for each individual question), which appeared solely on the physician questionnaire. In addition to the non-parametric test, a series of descriptive statistics (i.e., the average score on each active offer question) were interpreted to compare active offer behaviour. Higher frequency behaviours and low frequency behaviours were identified and discussed. Descriptive analyses were also used to illustrate the frequency of French language services offered by physicians and their receptionists. The average percentage of Francophone patients was calculated, as well as the average percentage of patient interactions conducted in French.

It was expected that French-speaking physicians and receptionists would report more frequent active offer behaviours than their English-speaking peers. Thus, I hypothesized that French-speaking physicians and receptionists would have greater average global active offer scores and greater scores on each subtheme than English-speaking physicians and receptionists. I also expected that certain behaviours would be more common than others and that some groups may perform certain behaviours more often than others. For instance, some behaviours may be performed equally by all groups, some may be more common among receptionists, others more

common among physicians, while others may not be performed by anyone. However, given that this is an exploratory analysis, I am not aware of any previous study or theory that would allow me to make a specific hypothesis as to which behaviours were expected to be common and which were expected to be infrequent.

#### 4.5.3 Research question 3: To what degree do language concordant physician interactions influence patient satisfaction in a sample of Francophones living in northeastern Ontario?

The patient questionnaire from the pre-intervention survey was the primary source of data for answering research questions 3 and 4. Three indicators of linguistic concordance were considered to explore the relative importance of language on patient satisfaction. First, the language spoken by the patient (First Official Language Spoken) was compared to the language of competence of their physician (from the CPSO registry, as described in table 2). However, being able to practice in French does not ensure the provision of services in French. Therefore, the second indicator of linguistic concordance compared the patient's FOLS with the service language. Patients who indicated that they "Always, 100% of the time" or "Often, more than 50% of the time" speak with their physician in French were considered as regularly receiving French language services, whereas those who indicated "Sometimes, less than 50% of the time" or "Never, 0% of the time" were considered as rarely/never receiving such services. The third indicator of linguistic concordance considered the patients' language of preference (French vs. English) when receiving health care services and compared this preference to the service language. Each subsequent indicator of linguistic concordance is considered stronger than the last, with concordance between preferred language and service language being the strongest.

Patient satisfaction was calculated via the average score of the 24 PAR patient survey questions related to “professionalism and communication” appearing on the pre-intervention questionnaire. As described above, this method accounts for missing data by imputing a prorated scale score (Mazza et al., 2015; Shrive et al., 2006) and is appropriate when data have lower percentages of missing values (Shrive et al., 2006) with a 20% cut-off point often being applied (Mazza et al., 2015). Thus, satisfaction scores were suppressed if 20% or more of the PAR patient survey questions were unanswered.

The influence of each indicator of linguistic concordance (1: patient’s FOLS by physician’s language of competence; 2: patient’s FOLS by service language; and 3: preferred language by service language) on patient satisfaction was analyzed by conducting three independent multivariate analyses of variance (MANOVA) followed by three complementary multivariate analyses of covariance (MANCOVA) which controlled for the patient’s age (continuous variable), sex (dichotomous variable) and self-assessed health status (5-point ordinal scale ranging from Excellent to Poor, dummy coded for use as a covariate), each of which has been shown to independently influence satisfaction (Batbaatar et al., 2017; Rahmqvist, 2001). Fisher’s Least Significant Difference (LSD) post-hoc tests were performed when statistically significant interactions were observed (Laflamme & Zhou, 2014).

It was hypothesized that Francophones in the most linguistically concordant group would be more satisfied than those in the most discordant group. According to the Adapted Framework for Patient-Professional Communication described in Chapter 3, in the presence of a linguistic discordance between the patient and the physician, communication suffers, and so too does

satisfaction. As language becomes more concordant, communication becomes more coherent, and satisfaction is likely to improve.

#### 4.5.4 Research question 4: To what degree does the active offer of French language health services influence patient satisfaction in a sample of Francophones living in northeastern Ontario?

Much like the previous question, data used to evaluate the influence of the active offer of French language services on patient satisfaction was derived from the pre-intervention patient questionnaire. Once again, an active offer score was calculated by averaging these six items from the “Reception and Patient Management” sub-theme from the *Active Offer of French Language Services in Minority Context Measure* (Savard et al., 2014), with data suppressed if 20% of the corresponding items were missing. Patient satisfaction was once again considered to be the average score of the 24 PAR patient survey questions related to “professionalism and communication”.

A Pearson Correlation explored the relationship between patient satisfaction and the active offer of French language health services. If the active offer truly does improve the Francophone patient experience (Office of the French Language Services Commissioner of Ontario, 2016a), it was hypothesized that Francophones who receive a greater active offer (higher active offer score) would be more satisfied than those who perceive fewer active offer behaviours in their family physician (lower active offer score).

All analyses were conducted using IBM SPSS Statistics, version 24.

## 4.6 Sample size calculation

A power analysis was conducted to estimate the sample size needed to produce statically significant results. Given that the 3<sup>rd</sup> research question involves the most sophisticated inferential statistics, sample sizes were calculated based on the number of patients needed to detect a difference in satisfaction (as calculated by the 24 PAR patient survey questions related to “professionalism and communication”) based on the degree of linguistic concordance (as described above) using the G\*Power 3 analysis program (Faul et al., 2007). The G\*Power 3 analysis involved: 1) selecting the appropriate statistical test (i.e., since G\*Power 3 does not account for MANCOVA, ANCOVA was selected in the current study – a MANCOVA is essentially a series of ANCOVAs, thus the ANCOVA analysis was considered a conservative estimate of sample size); 2) choosing one of five types of power analyses (i.e., a priori, to compute the required sample size); and 3) providing the input parameters required for the analysis (i.e., the alpha level, the power, the number of groups and the effect size) (Faul et al., 2007). Given that three independent multivariate analyses of covariance were conducted in the current study, the alpha level was set to 0.0166 (in order to reduce the likelihood of committing a Type I error), the power was set to 0.95, the number of groups was set to 4 (as described above) and, based on the results of the Lockyer, Violato and colleagues study (2009) (specifically the average factor scores and standard deviations for the “professionalism and communication” factor), the effect size was estimated to be 0.1056. The sample size for the current study was thus estimated at 1470 respondents. Although the MANCOVA analysis would likely require a larger sample size than the ANCOVA (as calculated here), this sample is still considered overly generous given that there was little variability between groups in the Lockyer, Violato and colleagues study (2009). In their comparative study, Lockyer, Violato and colleagues grouped

physicians based on the medical school they attended (i.e., University of Alberta, University of Calgary and all Other Canadian universities). Though the University of Calgary curriculum focuses slightly more on interpersonal skills, it is not expected that the university where physicians were educated would substantially influence their communication skills (as measured by the PAR patient questionnaire, “professionalism and communication” factor). Furthermore, a sample of 1470 respondents may be unrealistic given that it represents nearly 1.5% of the total population of Strong French communities of Northern Ontario (Timony et al., 2013).

However, given that groups in the current study are divided based on linguistic concordance between physicians and patients, far greater variability between groups was expected than in the Lockyer, Violato and colleagues study. It was hypothesized that satisfaction would vary considerably between the most concordant groups and the most discordant groups and thus require fewer respondents to detect a significant difference. As a result, the effect size of 0.1056, calculated based on the Lockyer, Violato and colleagues' study, was modestly increased by 0.08 (to 0.1856), which yields a sample size of 480. In other words, if language concordance explains as little as 18% of the difference in satisfaction between the linguistically concordant groups, a sample of 480 respondents would be sufficient to detect such a difference. Such a sample should also be large enough to detect a correlation between patient satisfaction and the active offer.

For providers, to understand the current state of active offer in northeastern Ontario family physicians' offices and to provide all physicians with an opportunity to participate in the CPD program, I sought to recruit as large a sample as possible. However, given that physicians were asked to distribute patient surveys and that 40 patient survey packages were provided to each participating physician, it was estimated that a minimum of 12 physicians would be needed to

attain the patient sample size of 480 (i.e., 12 physicians x 40 survey packages = 480 patient surveys – assuming all patient surveys are distributed, completed and returned).

## 4.7 Ethical considerations

Ethical approval for this thesis was obtained from Laurentian University's Research Ethics Board (file number 6008383) (Appendix X), with all participants, including physicians, receptionists and patients providing informed consent. All efforts were taken to protect confidentiality and anonymity of respondents in all phases of this thesis. For instance, all paper questionnaires were stored in a locked filing cabinet located in a locked office of an access-controlled building, and all electronic data were stored on a secure server. The web-based version of the questionnaire was hosted on a secure server housed at Laurentian University, using proprietary survey software (Gravic's Remark Web Survey Software [Gravic, website]). Information transmitted via the web-based survey was protected by the security protocols of Laurentian University Computer Services.

Furthermore, all participants received an informed consent form that they could choose to sign and return (with those who chose to self-identify waiving their anonymity). Given the web/mail-based nature of the survey, all returned questionnaires were treated as having provided "implied consent", regardless of the presence of a signed consent form, thus further respecting the respondent's choice to remain anonymous. Unique identifiers (ID) were used throughout to identify individual questionnaires, and any identifiable information was stripped from the databases.

Furthermore, survey questions addressed physician interactions and were not personally sensitive or psychologically demanding for respondents. The number of questions was kept to a minimum

and was known to the participants from the onset (with participants being able to flip through the survey booklet for the paper-based questionnaires and a percent completed bar appearing on the web version of the questionnaire). Cover letters and consent forms stressed that participation was voluntary and that respondents could choose to withdraw at any time, with instructions provided (withdrawing from a web-based survey involved closing the internet browser whereas a paper survey could simply be discarded). Finally, anonymity was protected as respondents were not required to provide their names when participating in the study, and it was clearly stated that patients' and receptionists' individual responses would not be shared with the physicians (only aggregate results will ever be published or presented).

Likely the most sensitive ethical consideration arises in the patient surveys. For this questionnaire, family physicians must be identified and linked to the respondent's data, which may be of concern as this same questionnaire also has respondents revealing their level of satisfaction with the physician. The potential concern comes from the possibility that individual physicians may be seen in a negative light based on the patient surveys. In order to mitigate this possibility, physicians' names do not appear in the same data set as the patient satisfaction surveys. A unique identifier replaced the name in the data set. A codebook linking the names with their IDs was saved in a different location which only the lead researcher could access. The questionnaires completed by physicians, receptionists and patients were pre-stamped with the same ID, and identifiable information (including names) was never requested. Thus, it was impossible for anyone besides the lead researcher (i.e., me) to identify physicians from the survey data. Not even the lead researcher could identify receptionists or patients, making their

data completely anonymous. Therefore, it was impossible to link a physician's name to a patient's satisfaction survey by all but the lead researcher.

## Chapter 5

### 5 Results

#### 5.1 About the sample

Of the 260 eligible family physicians and general practitioners (i.e., those with an active primary practice located in a strong Francophone community of Northeastern Ontario), a total of 19 physicians joined the program (7%) with 13 completing the pre-intervention survey. Five physicians withdrew from the program after beginning the assessment phase, and two were lost to follow-up, meaning they agreed to participate yet never returned a survey or responded to follow-up communications. Six physicians participated in the workshop and, although five physicians participated in the post-intervention reflective evaluation, only three physicians completed enough of the questionnaire to be analyzed. A breakdown of physician characteristics who completed each phase of the CPD program is found in table 3. Nine out of the 13 physicians (69%) who participated in the pre-intervention survey reported being competent enough to practice in French on the CPSO annual renewal survey, a trend that remained relatively consistent in physicians who completed the phase 2 workshop and the phase 3 post-intervention survey. Seven (54%) physicians reported a First Official Language Spoken (FOLS) of French or French and English on the pre-intervention survey, while 67% of physicians who completed the phase 2 workshop and phase 3 post-intervention survey reported French as their FOLS. Likewise, seven (54%) women completed in the pre-intervention survey, with 5 (83%) participating the workshop and two (67%) completing the post-intervention survey. All but two physicians received their undergraduate education in Ontario, with one being educated elsewhere in Canada, and one being educated internationally. Although five of six physicians who

participated in the workshop were trained in Ontario, all were trained within Canada. Six physicians (46%) had been in practice (i.e., had completed undergraduate training and were registered with the CPSO) within the ten years preceding the CPD program, 4 (31%) had been in practice for between 11 and 30 years and three had been in practice for over 30 years (with 40 years of practice as the max).

**Table 3: Physician Characteristics**

		Physicians participating in CPD phases		
		Phase 1: completed pre-intervention survey	Phase 2: participated in workshop	Phase 3: completed post-intervention reflective survey
Sample count		13	6	3
Language of competence (CPSO)	French	9 (69%)	4 (67%)	2 (67%)
	No French	4 (31%)	2 (33%)	1 (33%)
First Official Language Spoken	French*	7 (54%)	4 (67%)	2 (67%)
Sex	Female	7 (54%)	5 (83%)	2 (67%)
	Male	6 (46%)	1 (17%)	1 (33%)
Undergraduate school	Ontario	11 (85%)	5 (83%)	3 (100%)
	Outside Ontario	2 (15%)	1 (17%)	0 (0%)
Years since graduation	≤ 10	6 (46%)	3 (50%)	1 (33%)
	11- 30	4 (31%)	2 (33%)	2 (67%)
	≥ 31	3 (23%)	1 (17%)	0 (0%)

\*Physicians with a FOLS of French include both those who were classified as French only and French and English

Although 13 physicians returned a completed pre-intervention survey, only seven receptionists did the same. Five receptionists did not identify French as their FOLS, however, all seven self-reported being competent enough to communicate with patients in French and will thus be considered as ‘French-speaking’.

A total of 245 patient surveys were received from 11 physicians who participated in the CPD program. Of these, ten surveys had over 50% missing data and were deemed invalid, thus 235

patient surveys were included in the analysis. Francophone patients represented 44% of the sample. On average, respondents were 54 years of age (range 15 - 87), and 68.4% were women, with negligible differences between Francophones and Anglophones. Although 62.6% of respondents had a physician who was competent enough to practice in French, only 17.2% reported regularly speaking in French with their physician, with more Francophones reporting regular French interactions than Anglophones (33% vs. 4.3%). When asked their language of preference when receiving health care services, 20.6% indicated that they prefer French. This preference was greater in Francophones than Anglophones (39.8% vs. 5%) (Table 4).

**Table 4: Patient Characteristics**

		Patient's First Official Language Spoken		
		French	English	Total
<b>Sample count</b>		103 (44.0%)	132 (56.0%)	235 (100%)
Age	Mean	53.6	54.6	54
	Min	15	20	15
	Max	84	87	87
Sex	Female	67 (65.7%)	93 (70.5%)	160 (68.4%)
	Male	35 (34.3%)	39 (29.5%)	74 (31.6%)
Physician Language of Competence	French-Speaking	66 (64.1%)	81 (61.4%)	147 (62.6%)
	English-Speaking	37 (35.9%)	51 (38.6%)	88 (37.4%)
Service Language (FLS received)	Regularly	34 (33.0%)	6 (4.6%)	40 (17.2%)
	Rarely/Never	69 (67.0%)	124 (95.4%)	193 (82.8%)
Language of Preference	French	39 (39.8%)	6 (5.0%)	45 (20.6%)
	English	59 (60.2%)	114 (95.0%)	173 (79.4%)

## 5.2 Research question 1: How does a CPD program teaching the active offer of French language services change physician communication behaviours in practicing physician's offices of northeastern Ontario?

Though participation and response rates to the later phases of the program were too low to allow for inferential statistical analysis, post-intervention survey results from physicians who completed the entire program suggest it was successful in changing active offer behaviours. Of note, all three physicians had improved global active offer scores (improving from an average score of 2.06 on the pre-intervention survey to 2.52 on the post-intervention survey) as well as on all three subthemes, improving from 1.86 to 2.14, from 2.00 to 2.78 and from 2.83 to 2.92 on the self-rated questions, the work environment questions (from the 'Reception and Patient Management' subtheme) and on the self-rated questions (from the 'Support and Referrals' subtheme), respectively.

A list of average pre- and post-intervention scores from each individual behaviour from the self-rated questions from the 'Reception and Patient Management' subtheme is available in Table 5. Behaviours that were most likely to improve from the self-rated questions from the 'Reception and Patient Management' subtheme, include those pertaining to the use of visual cues to advertise that the physician offers services in French (such as wearing some sort of identification (e.g., a pin or a badge) or displaying a sign in their office) and, to a lesser extent, those related to taking note of and delivering services in the patients preferred language (such as asking the patient their preferred language of communication and using expressions and a vocabulary used by the patient). Alternatively, behaviours that were performed infrequently on the pre-intervention survey and did not improve include those related to telecommunication (such as including a French message on their voicemail or a French signature on their email) and ensuring

the availability of French reading and entertainment options in the waiting room (such as pamphlets, magazines, newspapers, radio and television), which was actually rated worst on the post-intervention survey.

**Table 5: Reception and Patient Management: Physician self-rated behaviours. Comparison of pre and post-intervention survey scores (n=3)**

<b>Active offer behaviours</b>	<b>Pre-intervention</b>		<b>Post-intervention</b>	
	<b>Mean</b>	<b>S.D.</b>	<b>Mean</b>	<b>S.D.</b>
<b>Global subtheme score</b>	1.86	0.42	2.14	0.32
Wears an identification which indicates that they can offer services in French (e.g., badge/pin)	1.00	0.00	2.00	1.00
Asks patient in which language, French or English, they wish to communicate	2.67	0.58	3.33	0.58
Greets new/unknown patients in French first followed by English.	1.67	1.16	2.00	1.00
There are visual indicators in workplace demonstrating that they offer services in French or in both official languages. (e.g., a sign on door, in their office)	1.67	1.16	3.33	1.16
Sensitizes employer to the importance of promoting French language services which are available at workplace	1.33	0.58	2.00	1.00
Answers the phone first in French followed by English	1.67	1.16	1.67	1.16
Message on phone voicemail includes a greeting in French, as well as one in English.	3.00	1.73	2.00	1.73
Message on phone voicemail begins with a greeting in French, followed by one in English.	2.00	1.73	2.00	1.73
Signature on email appears both in French and in English.	1.00	0.00	1.00	0.00
Signature on email first appears in French.	1.00	0.00	1.00	0.00
Makes sure informative documents and entertainment options (e.g., pamphlets, magazines, newspapers, radio, television, games) are available in French in the common areas (waiting room or other).	3.00	0.00	2.33	1.16
Uses certain expressions and a vocabulary used by the patient so that (s)he feels comfortable speaking in French.	2.33	1.53	3.00	1.00

Average pre- and post-intervention scores from the ‘Support and Referrals’ subtheme are available in Table 6. On the post-intervention survey, physicians were more likely to indicate that they informed other providers or organizations of the patient’s linguistic needs and

preferences by specifying it on the referral form or transfer letter. Additionally, although behaviour such as consulting a list of providers and organizations who offer services in French and offering the patient the option to be directed to a specialist or follow-up services in French had not improved on the post-intervention survey, these behaviours were already reported as being regularly performed on the pre-intervention survey and had less room for improvement.

**Table 6: Support and Referrals: Physician self-rated behaviours. Comparison of pre and post-intervention survey scores (n=3)**

<b>When referring Francophone patients to another service provider:</b>	<b>Pre-intervention</b>		<b>Post-intervention</b>	
	<b>Mean</b>	<b>SD</b>	<b>Mean</b>	<b>SD</b>
<b>Global subtheme score</b>	2.83	1.18	2.91	0.58
Consults an updated list of providers and organizations who offer services in French.	2.33	1.15	2.33	0.58
Offers the patients the option to be directed towards a French-speaking provider or Francophone organization.	3.67	0.58	3.67	0.58
Specifies the patient's language of preference on the referral or transfer letter.	2.67	1.53	3.00	1.00
Verbally informs the provider or organization of the patient's language of preference, or has someone to do it for them.	2.67	1.53	2.67	0.58

Finally, average pre- and post-intervention scores from the general work environment questions from the 'Reception and Patient Management' subtheme are available in Table 7. Behaviours that were most likely to improve included those pertaining to advertising the availability of French language services (i.e., through enhanced visual cues, by supplying badges/pins, and by informing patients of the establishment's commitment to offering services in both official languages) and encouraging the use of French between employees. Additionally, although other improvements to the presence of French within the office environment were reported (such as offering information in French on the website, and providing magazines, booklets and other written resources in both official languages), no improvements were made to the availability of

French broadcast media options in the waiting room (e.g., radio or newspaper), and internal staff meetings were not more likely to be held in French, both of which were reported as rarely or never occurring. Finally, although behaviour such as displaying posters in French, recruiting French staff and printing letterhead and business cards in both official languages had not shown signs of improvement, these behaviours were reported as regularly occurring on the pre-intervention survey.

**Table 7: Reception and Patient Management: Physician rating of the work environment. Comparison of pre and post-intervention survey scores (n=3)**

<b>In the workplace, it is normal to...</b>	<b>Pre-intervention</b>		<b>Post-intervention</b>	
	<b>Mean</b>	<b>SD</b>	<b>Mean</b>	<b>SD</b>
<b>Global subtheme score</b>	2.00	0.00	2.78	0.48
display posters in French or in both official languages of Canada.	3.00	1.00	3.00	0.00
supply badges/pins or plaques indicating that services are available in both official languages of Canada.	1.33	0.58	2.67	1.53
advertise in a clear and visible manner, the availability of the services in French.	1.33	0.58	3.00	1.00
offer information in French or in both official languages of Canada on the Web site.	2.33	1.53	3.33	0.58
place at the patient's disposal magazines, booklets or other media which presents information in both official languages of Canada.	2.00	0.00	3.00	0.00
broadcast information in newspapers and on the radio in French.	1.00	0.00	1.00	0.00
recruit staff capable of offering services in French at all levels of service.	3.33	0.58	3.67	0.58
hold meetings in French or both official languages of Canada.	1.33	0.58	1.00	0.00
facilitate the use of French between employees.	1.33	0.58	3.33	1.16
inform the patient of the establishment's commitment to offer services of equal quality in both official languages of Canada.	2.33	1.16	4.00	0.00
converse in French between French-speaking employees.	2.00	1.73	2.67	1.16
print letterhead and business cards in French or in both official languages of Canada.	2.67	1.16	2.67	0.58

Despite improvements to many of active offer behaviours, we must interpret these results with caution. With only three physicians having completed the post-intervention survey, the sample size is too small for the non-parametric Wilcoxon Signed Rank Test to detect statistically significant differences. However, comparing descriptive results (i.e., mean active offer scores) from pre- to post-intervention does provide some indication of the program's success.

Besides quantitative data, open-ended comments from the post-intervention survey and the workshop provide additional evidence that participating physicians benefited from the CPD program in terms of improvements to both their knowledge about the active offer and its implementation. For instance, on both surveys, physicians were asked to define the active offer in their own words. While five physicians (38%) reported being familiar with the concept of active offer on the pre-intervention survey, none were able to accurately define the concept, with only a few providing examples of active offer strategies, such as offering services in French and English (both verbally and in the form of educational materials) and hiring bilingual staff. Alternatively, others defined the active offer in terms that contradict the principles of active offer, such as basing the offer of service in French on whether or not the patient has a French-sounding last name or speaks with an accent. However, all three physicians who completed the post-intervention survey accurately identified the proactive nature of active offer using strategies such as assuming each patient speaks French and offering services accordingly or initiating all patient interviews with a French greeting. Thus, physicians' knowledge of the concept of active offer had clearly improved, as all could identify one of the most important principles of active offer, namely being proactive rather than reactive (i.e., waiting for patients to request services in French).

Furthermore, when asked what specific changes they had made to their practice on the post-intervention survey, these physicians identified improvements such as increasing French signage, having French-speaking staff wear pins and greeting patients in French. One physician even indicated that they felt more confident in greeting patients in French after participating in the program. In doing so, this physician discovered that they had more French-speaking patients than they realized, a sentiment that was also shared by a second physician. Feedback from the workshop provided further support of the program's effectiveness. For instance, physicians appreciated that the education program was easy to participate in with surveys that could be completed at their practice. As one physician stated:

“I just wanted to say that we had our secretary hand out the questionnaires and it went quite well, she had a tally of French and English, she had a little bit harder time getting the French patients or identifying them, but she had them fill it out while they were waiting. I found that within a week it was done, I feel like it didn't take that long.”

(Participating physician)

Although participating in the program was relatively easy, in its present form, the assessment surveys were perceived by some as potential cumbersome for providers, front-line staff and patients:

“So our secretaries are English speaking, so I was doing it because I kind of knew which patients spoke French and which patients didn't” (Participating physician)

“I feel like the patients thought it was cumbersome because the patients come and see me for a medical issue and then I’m, I don’t want to use the word harassing but I’m like can you please fill this out for me” (Participating physician)

However, physicians did enjoy that the reports were quick and easy to read, with clear visual cues outlining their strengths and weaknesses and numerous resources to help improve their practice:

“I think it’s [the report] a good visual cue, like you’d look at it and quickly see if you’re doing well or not. I thought it was good.” (Participating physician)

Furthermore, while participating in the workshop, physicians exhibited several “aha” moments or moments of realizations of how they could apply the active offer, with many of these realizations leading to improvements in active offer behaviours, as reported on the post-intervention survey. For instance, one physician reflected on how they ask all types of questions when taking a medical history, yet rarely ask about language of preference or take into consideration that the patient may prefer a different language when speaking than reading, and when they do ask it of patients, they tend to forget what these preferences are. This physician suggested systematically asking patients their linguistic preferences and including this in their chart as a strategy to help remind themselves and others of the patient’s preferences:

“There’s an area on the left hand side, there’s no reason that I shouldn’t be putting speaks French, reads English or something along those lines for any patient that .... I sit there and I ask them about just about everything, but I don’t ask them if they prefer to speak French or English. Or often I’ll ask but I’ll forget by the time I go in. I can’t remember

French or English so I'm doing a lot of that, when really I should just be writing it down"  
(Participating physician)

Although there was no specific question on the post-intervention survey asking about how the patient charts may have been adapted, physicians reported that they often or always ask patients in which language they wish to communicate, a marked improvement from what was reported on the pre-intervention survey.

Another example of a realization from the workshop that showed improvement on the post-intervention survey came from a discussion about referrals to specialists and other resources. As was evident from how frequently this behaviour was reported on the pre-intervention survey, participating physicians do typically give patients the choice of being referred to a French or English-speaking specialist or follow-up resource. However, one physician reflected on how they do not inform the specialist or resource of the patient's preference.

"I think it's very important to inform the provider, to ask the patient. If they would absolutely say I want a Francophone, that's fine, it's the patient's choice, I will always follow patient choice. But other than that I think your last statement, informing the provider the patient's language of preference I think is paramount... I think I will build it into one of our referral sheets and say patients preferred language of communication. I think that is a really relevant point and I think that's the big take home." (Participating physician)

This "aha" moment really demonstrates the type of learning we were hoping to achieve during the workshop. Specifically, after discussing a point or a component of the providers' practice and

presenting how the active offer can be incorporated into this component, the providers would develop actionable strategies that they can immediately apply to their practice. In the present example, the provider identified a gap in how they refer patients and identified and applied a strategy to overcome that gap in their practice. This is evident from the post-intervention surveys, where an improvement was observed on the item asking whether physicians specify the patient's language of preference on the referral or transfer letter.

The final realization or “aha” moment that I will address did not come in the form of an active offer strategy and was not a planned learning objective but rather the result of an unrelated discussion. One physician mentioned in passing that they had done their undergraduate training in French, to which an English-speaking colleague, who was also in attendance, was surprised to learn. In this small exchange, these physicians, who shared a practice and had been working side-by-side, suddenly realized that they were not aware of the linguistic capabilities of their colleagues and staff or of the potential capacity within their own office. They also realized that their assumption that their colleagues also did not speak French was incorrect. Furthermore, for the English-speaking physician, this realization also represented an immediate improvement in their access to French support.

### 5.3 Research question 2: To what degree are French language services actively being offered in physicians' offices in northeastern Ontario?

Thirteen family physicians and seven receptionists completed the phase 1 survey, the majority of whom were in the City of Greater Sudbury (77% of physicians and 100% of receptionists), the largest urban community in Northern Ontario with a large Francophone population. Nine physicians self-identified on the survey as being competent enough to communicate with patients

in French, henceforth referred to as French-Speaking physicians. The remaining four physicians will be referred to as English-Speaking physicians, having identified no such linguistic competence. All seven receptionists self-identified as being able to communicate in French, thus we cannot draw conclusions on the active offer behaviours of English-speaking receptionists. Furthermore, given such limited response rates, I am unable to draw generalized conclusions on the presence of the active offer in physician offices of northeastern Ontario. Rather, results from the pre-intervention physician and receptionist surveys provide an example of the active offer of French language services present in family physicians' offices, particularly in Sudbury.

My analysis began by comparing the estimated percentage of Francophone patients seen in the week preceding the completion of the pre-intervention survey, as well as the estimated percentage of patient interactions conducted in French. Comparisons were explored between French-speaking physicians, English-speaking physicians, and French-speaking receptionists (henceforth simply referred to as receptionists). Given the small sample size and the fact that survey responses were not normally distributed, a series of nonparametric tests were used. A Kruskal-Wallis test was used when comparing French-speaking physicians, English-speaking physicians and receptionists. A Mann-Whitney U test was utilized when comparing French-speaking and English-speaking physicians. Global active offer scores were compared as were scores on each of the subthemes from the *Active Offer of French Language Services in Minority Context Measure* (Savard et al., 2014), namely the self-rated and the work environment questions from the 'Reception and Patient Management' subtheme, and the self-rated questions from the 'Support and Referrals' subtheme. In addition, differences between French-speaking physicians, English-speaking physicians and receptionists on each question were considered

independently to identify gaps in active offer behaviours. Finally, the frequency with which each active offer behaviour was reported is discussed to identify behaviours that were commonly performed by all as well as behaviour that were rarely performed.

Although receptionists and French-speaking physicians reported having seen more Francophone patients in the week preceding the completion of the pre-intervention survey (41.4% and 36.3% respectively) than English-speaking physicians (23.8%), a non parametric Kruskal-Wallis test detected no significant differences ( $\chi^2 = 0.31$ ;  $p=0.857$ ). However, when asked what percentage of patient interactions were conducted in French, a Kruskal-Wallis test confirmed that French-speaking physicians and receptionists were significantly more likely to report more French interactions (30.6% and 31% respectively) than English-speaking physicians (0%) ( $\chi^2 = p.357$ ;  $p < 0.01$ ).

Generally speaking, French-speaking physicians reported performing more active offer behaviours than English-speaking physicians. The nonparametric Mann-Whitney U test confirms my hypothesis ( $U = 3.5$ ;  $p < 0.05$ ), whereby French-speaking physicians were more likely to have greater average active offer score ( $\bar{x} = 2.18$ ,  $SD = 0.30$ ) than their English-speaking counterparts ( $\bar{x} = 1.63$ ,  $SD = 0.36$ ). It should be noted that the global active offer score was calculated for physicians only as items from the “Support and Referrals” sub-theme were not present on the receptionist survey.

### 5.3.1 Reception and patient management: self-rated behaviours

Likewise, on the self-reported “Reception and Patient Management” questions, French-speaking physicians reported more frequent active offer behaviours ( $\bar{x} = 1.97$ ), followed by receptionists

( $\bar{x} = 1.45$ ) and English-speaking physicians ( $\bar{x} = 1.19$ ) as detected by a nonparametric Kruskal-Wallis test (statistically significant differences are indicated in Table 8). A Mann-Whitney U *post hoc* test confirmed that French-speaking physicians reported more frequent behaviours on the self-reported “Reception and Patient Management” questions than receptionist and English-speaking physicians, with no statistically significant difference detected between the latter. This was particularly noticeable in behaviours such as asking patients in which language they wished to communicate and using expressions and a vocabulary used by the patient. For both these questions, French-speaking physicians reported an average active offer score of 3.22 and 3.33, respectively (i.e., between often and always), compared to receptionists who had average scores of 2.00 and 2.71, respectively, and English-speaking physicians with an average score of 1.50 and 1.25, respectively. The *post hoc* analysis of these differences confirmed that French-speaking physicians were more likely to ask patients in which language they wished to communicate than receptionists and English-speaking physicians and that French-speaking physicians and receptionists were more likely to use expressions and a vocabulary used by the patient than English-speaking physicians. Other behaviours followed a similar trend, but to a lesser extent. For instance, French-speaking physicians reported average scores of 2.56 and 2.44 (i.e., between rarely and often) on including a French greeting on their phone voicemail message and making sure informative documents and entertainment options are available in French in the common areas, compared to average scores of 1.29 and 1.57 respectively for receptionists, and 1.0 and 1.50 respectively for English-speaking physicians. However, many active offer behaviours were infrequently reported by all providers. For instance greeting new patients in French, answering the phone in French followed by English, including a French signature on their email, posting visual indicators demonstrating that they offer services in French, wearing an

identification (e.g., badge or pin) indicating that they can offer services in French, and sensitizing their employer to the importance of promoting the offer of French language services all had average scores between 1 and 2 (i.e., between never and rarely).

**Table 8: Reception and patient management: self-rated behaviours. Comparison of pre-intervention scores from French-speaking physicians (n=9), English-speaking physicians (n=4) and receptionists (n=7)**

	French-speaking physicians		English-speaking physicians		Receptionist		Chi-Square	P
	Mean	SD	Mean	SD	Mean	SD		
<b>Active offer behaviours</b>								
<b>Global subtheme score</b>	1.97	0.37	1.19	0.22	1.45	0.16	10.43	< 0.01
Wears an identification which indicates that they can offer services in French (e.g., badge/pin)	1.00	0.00	1.00	0.00	1.00	0.00	0.00	1.00
Asks patient in which language, French or English, they wish to communicate	3.22	0.83	1.50	0.58	2.00	0.82	9.40	< 0.01
Greets new/unknown patients in French first followed by English.	2.00	0.87	1.50	1.00	1.57	0.79	1.59	0.451
There are visual indicators in workplace demonstrating that they offer services in French or in both official languages. (e.g., a sign on door, in their office)	1.67	1.12	1.50	1.00	1.71	0.95	0.21	0.899
Sensitizes employer to the importance of promoting French language services which are available at workplace	1.67	0.71	1.00	0.00	1.00	0.00	7.64	< 0.05
Answers the phone first in French followed by English	2.00	1.12	1.00	0.00	1.29	0.76	4.71	0.095
Message on phone voicemail includes a greeting in French, as well as one in English.	2.56	1.42	1.00	0.00	1.29	0.76	7.16	< 0.05
Message on phone voicemail begins with a greeting in French, followed by one in English.	1.56	1.01	1.00	0.00	1.14	0.34	2.13	0.344
Signature on email appears both in French and in English.	1.11	0.33	1.00	0.00	1.14	0.378	0.57	0.752
Signature on email first appears in French.	1.11	0.33	1.00	0.00	1.00	0.00	1.22	0.543
Makes sure informative documents and entertainment options (e.g., pamphlets, magazines, newspaper, radio, television, games) are available in French in the common areas (waiting room or other).	2.44	0.73	1.50	1.00	1.57	0.79	5.17	0.076
Uses certain expressions and a vocabulary used by the patient so that (s)he feels comfortable speaking in French.	3.33	0.71	1.25	0.50	2.71	1.11	8.68	< 0.05

### 5.3.2 Support and referrals: self-rated behaviours

The importance of continuity of care in French seems to have been recognized by both French-speaking and English-speaking physicians, with relatively high average active offer scores on the self-reported “Support and Referrals” subtheme, with French-speaking physicians reporting an average score of 2.64 and English-speaking physicians reporting an average score of 2.31 (between rarely and often) (Table 9). Of note, all physicians surveyed reported that they often or always offer patients the option to be directed towards a French-speaking provider or Francophone organization. Both French-speaking and English-speaking physicians also reported rarely or often specifying the patient’s language of preference on the referral letter and verbally informing the provider or organization of the patient’s language of preference. Finally, French-speaking physicians were slightly more likely to consult a list of providers or organizations who offer services in French when referring patients ( $\bar{x} = 2.67$ ) than English-speaking physicians ( $\bar{x} = 1.75$ ). However, a Mann-Whitney U test detected no differences in the frequency of “Support and Referrals” behaviours between French-speaking and English-speaking physicians.

**Table 9: Support and referrals: self-rated behaviours. Comparison of pre-intervention scores from French-speaking (n=9) and English-speaking physicians (n=4)**

	French-speaking physicians		English-speaking physicians		Mann-Whitney U	P
	Mean	SD	Mean	SD		
<b>When referring Francophone patients to another service provider:</b>						
<b>Global subtheme score</b>	2.64	0.72	2.31	1.01	13.5	0.503
Consults an updated list of providers and organizations who offer services in French.	2.67	0.87	1.75	0.96	8.5	0.148
Offers the patients the option to be directed towards a French-speaking provider or Francophone organization.	3.44	0.53	3.25	0.50	14.5	0.604
Specifies the patient's language of preference on the referral or transfer letter.	2.00	0.87	2.25	1.26	16.5	0.825
Verbally informs the provider or organization of the patient's language of preference, or has someone to do it for them.	2.44	1.13	2.00	1.41	13.5	0.503

### 5.3.3 Reception and patient management: work environment

Items that measured the active offer of French language services within the work environment reflected the active offer practices at the organizational level and thus little variability was observed between French-speaking physicians, English-speaking physicians and receptionists with no significant differences emerging from any of the non-parametric Kruskal-Wallis tests (Table 10). Only one organizational practice was reported as occurring often to always by all respondents, namely the recruitment of French-speaking staff. Five organizational practices were reported as occurring rarely to often including: facilitating the use of French between employees; displaying French posters; informing the patients of the establishment's commitment to offering quality French language services; displaying magazines, booklets, and other media in both official languages; and visibly and clearly advertising the availability of

services in French. Finally, four organizational practices were reported as never to rarely occurring including: offering French information on the website; holding meetings in both official languages; supplying badges/pins or plaques indicating the services are available in French; and broadcasting in newspapers and on the radio in French.

**Table 10: Reception and patient management: work environment. Comparison of pre-intervention scores from French-speaking physicians (n=9), English-speaking physicians (n=4) and receptionists (n=7)**

<b>In the workplace, it is normal to...</b>	<b>French-speaking physicians</b>		<b>English-speaking physicians</b>		<b>Receptionist</b>		<b>Chi-Square</b>	<b>P</b>
	<b>Mean</b>	<b>SD</b>	<b>Mean</b>	<b>SD</b>	<b>Mean</b>	<b>SD</b>		
<b>Global subtheme score</b>	2.24	0.40	1.85	0.46	1.86	0.57	3.89	0.143
display posters in French or in both official languages of Canada.	2.44	1.01	2.25	0.96	2.14	0.90	0.20	0.904
supply badges/pins or plaques indicating that services are available in both official languages of Canada.	1.44	0.73	1.25	0.580	1.14	0.38	0.86	0.650
advertise in a clear and visible manner, the availability of the services in French.	2.00	1.00	2.00	0.82	1.57	0.98	1.33	0.52
offer information in French or in both official languages of Canada on the Web site.	1.89	1.27	1.25	0.50	1.14	0.38	2.10	0.349
place at the patient's disposal magazines, booklets or other media which presents information in both official languages of Canada.	2.11	0.60	2.00	0.82	2.14	1.07	0.75	0.963
broadcast information in newspapers and on the radio in French.	1.33	0.50	1.25	0.50	1.00	0.00	2.67	0.963
recruit staff capable of offering services in French at all levels of service.	3.33	1.00	3.00	1.41	2.71	1.11	1.46	0.483
hold meetings in French or both official languages of Canada.	1.89	1.05	1.25	0.50	1.57	0.79	1.34	0.512
facilitate the use of French between employees.	2.89	1.17	2.00	1.41	2.43	1.27	1.66	0.436
inform the patient of the establishment's commitment to offer services of equal quality in both official languages of Canada.	2.33	1.11	2.50	1.29	2.20	1.11	1.11	0.573
converse in French between French-speaking employees.	3.22	1.09	2.00	1.41	2.86	1.07	2.67	0.271
print letterhead and business cards in French or in both official languages of Canada.	2.00	1.00	1.50	0.58	1.71	1.11	0.99	0.610

### 5.4 Research question 3: To what degree do language concordant physician interactions influence patient satisfaction in a sample of Francophones living in northeastern Ontario?

Data from the 235 patients who completed the pre-intervention survey were used to explore the influence of linguistic concordance on patient satisfaction. As previously described, three indicators of linguistic concordance were considered including: 1) concordance between the patient's first official language spoken (FOLS) and the physician's language of competence as publicly declared on the CPSO website; 2) concordance between the patient's FOLS and the service language, i.e., whether respondents reported as always/often speaking in French with their physician compared to rarely/never; and 3) concordance between the patient's language of preference and the service language. Differences in patients satisfaction, as defined by the average score of the 24 PAR patient survey questions related to "professionalism and communication" appearing on the pre-intervention survey, between linguistically concordant groups were evaluated by conducting three independent multivariate analyses of variance (MANOVA) followed by three complementary multivariate analyses of covariance (MANCOVA) which controlled for the patient's age (continuous variable), sex (dichotomous variable) and self-assessed health status (5-point ordinal scale ranging from Excellent to Poor, dummy coded for use as a covariate).

#### 5.4.1 Indicator of linguistic concordance 1: Patient's FOLS by physician language of competence.

Table 11 describes the distribution of patient satisfaction scores across the categories of the patient's FOLS and the physician's language of competence. Francophones with French-Speaking Physicians (FSPs) had the highest satisfaction scores ( $\bar{x} = 4.52$ ) followed by

Anglophones with FSPs and English-Speaking Physicians (ESP) ( $\bar{x} = 4.40$  each) and finally Francophones with ESPs, who had the lowest satisfaction scores ( $\bar{x} = 4.34$ ). A MANOVA found no main effect of the patient's FOLS ( $F_{(1; 209)} = 0.05$ ;  $p = 0.823$ ) or the physician's language of competence ( $F_{(1; 209)} = 0.630$ ;  $p = 0.428$ ) and no interaction between these two variables was observed ( $F_{(1; 209)} = 0.797$ ;  $p = 0.373$ ). Similarly, a MANCOVA found no main effect or interaction when controlling for the influence of age, sex and health status.

**Table 11: Distribution of patient satisfaction score across categories of patient's language spoken and physician's language of competence using MANOVA and MANCOVA**

Satisfaction score	Patient's First Official Language Spoken				
	French		English		
	Physician language of competence				
	FSP	ESP	FSP	ESP	
$\bar{x}$	4.52	4.34	4.40	4.40	<b>MANOVA <math>F</math> (<math>P</math> value)</b> 0.80 ( $p = 0.373$ )
(SD)	(0.51)	(0.76)	(0.80)	(0.90)	
$\bar{x}_{adj}$	4.52	4.34	4.41	4.47	<b>MANCOVA <math>F</math> (<math>P</math> Value)</b> 1.26 ( $p = 0.263$ )
(SE)	(0.10)	(0.13)	(0.09)	(0.11)	
95% CI	4.3-4.7	4.1-4.6	4.2-4.6	4.3-4.7	

#### 5.4.2 Indicator of linguistic concordance 2: Patient's FOLS by service language.

The distribution of patient satisfaction scores across the patient's FOLS and the service language category is described in Table 12. Francophone patients who regularly speak French with their family physician were the most satisfied group ( $\bar{x} = 4.65$ ), while those who rarely/never receive services in French were the least satisfied ( $\bar{x} = 4.37$ ), with satisfaction scores for Anglophones falling between the two. Caution should be used when interpreting satisfaction scores of Anglophones who regularly receive services in French, as only five respondents fell into this category. Once again, a MANOVA found no main effect of the patient's FOLS ( $F_{(1; 207)} = 0.32$ ;  $p = 0.857$ ) or of the service language ( $F_{(1; 207)} = 1.098$ ;  $p = 0.296$ ) and no interaction was observed

( $F_{(1; 207)} = 0.134$ ;  $p = 0.715$ ). Likewise, a MANCOVA found no main effect or interaction after controlling for age, sex and health status.

**Table 12: Distribution of patient satisfaction score across categories of patient's language spoken and service language using MANOVA and MANCOVA**

Satisfaction score	Patient's First Official Language Spoken				
	French		English		
	Service Language (FLS Received)				
	Regularly	Rarely/ Never	Regularly	Rarely/ Never	
$\bar{x}$	4.65	4.37	4.54	4.41	<b>MANOVA <math>F</math> (<math>P</math> value)</b> 0.134 ( $p = 0.715$ )
(SD)	(0.35)	(0.68)	(0.64)	(0.85)	
$\bar{x}_{adj}$	4.69	4.37	4.59	4.44	<b>MANCOVA <math>F</math> (<math>P</math> Value)</b> 0.192 ( $p = 0.661$ )
(SE)	(0.15)	(0.90)	(0.33)	(0.07)	
95% CI	4.3-5.0	4.2-4.5	3.9-5.2	4.3-4.6	

#### 5.4.3 Indicator of linguistic concordance 3: Patient's language of preference by service language.

Given that the largest differences in the previous analyses were observed between Francophones who were, and were not, receiving French services (i.e., had a FSP vs. ESP and were regularly vs. rarely/never receiving French language services), and that little variation was observed in Anglophones, regardless of their physicians language of competence or service language, only Francophones were considered in the following analyses. Table 13 shows the patient satisfaction scores across the language of preference and the service language categories. When observing the unadjusted means, Francophones who regularly speak French with their family physician were equally satisfied regardless of their language of preference ( $\bar{x} = 4.67$  for those who prefer French and 4.63 for those who prefer English), followed by Francophones who prefer English and rarely/never speak French ( $\bar{x} = 4.43$ ) and finally, Francophones who prefer French but rarely/never speak it ( $\bar{x} = 4.15$ ). A MANOVA found no main effect of the patient's language of

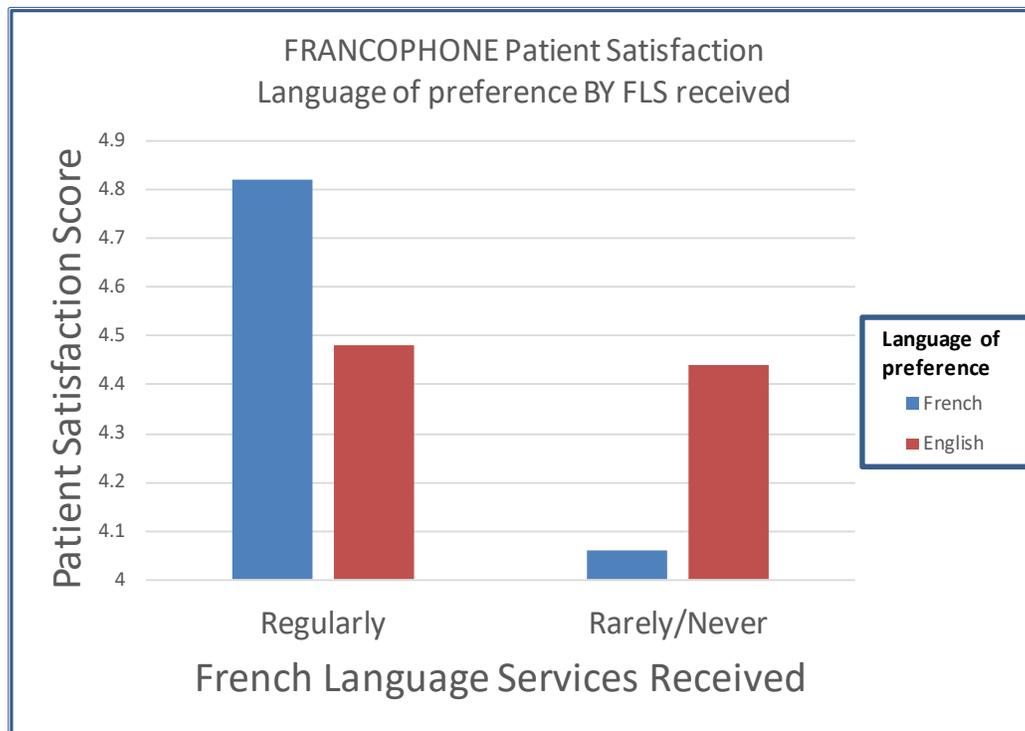
preference ( $F_{(1; 83)} = 0.786$ ;  $p = 0.378$ ). However, a main effect of the service language was observed ( $F_{(1; 83)} = 4.852$ ;  $p < 0.05$ ) with Francophones who regularly speak French ( $\bar{x} = 4.63$ ) being significantly more satisfied than those who rarely/never speak French ( $\bar{x} = 4.29$ ). The service language explains 6% of the variance in satisfaction. No interaction was observed in this MANOVA ( $F_{(1; 83)} = 0.817$ ;  $p = 0.369$ ). After controlling for age, sex and health status, a MANCOVA once again did not detect a main effect of patient's language of preference ( $F_{(1; 75)} = 0.015$ ;  $p = 0.903$ ). However, the main effect of service language persisted ( $F_{(1; 75)} = 2.194$ ;  $p < 0.05$ ) (Francophones who regularly speak French were once again significantly more satisfied,  $\bar{x}_{adj} = 4.65$  vs. 4.25) and a significant interaction between the language of preference and the service language was observed ( $F_{(1; 75)} = 4.995$ ;  $p < 0.05$ ). The main effect of the service language and the interaction explained 8% and 6% of the variance in satisfaction, respectively.

**Table 13: Distribution of Francophone patient satisfaction scores across categories of patient's language of preference and service language using MANOVA and MANCOVA**

Satisfaction score	Francophone patient language of preference				
	French		English		
	Service Language (FLS Received)				
	Regularly	Rarely/ Never	Regularly	Rarely/ Never	
$\bar{x}$ (SD)	4.67 (0.35)	4.15 (0.73)	4.63 (0.35)	4.43 (0.67)	<b>MANOVA <math>F</math> (<math>P</math> value)</b> 0.817 ( $p = 0.369$ )
$\bar{x}_{adj}$ (SE) 95% CI	4.82 (0.16) 4.5-5.1	4.06 (0.15) 3.8-4.4	4.48 (0.20) 4.1-4.9	4.44 (0.09) 4.3-4.6	<b>MANCOVA <math>F</math> (<math>P</math> Value)</b> 4.99 ( $p < 0.05$ )

The subsequent analyses of the simple effect indicate that the influence of language of preference is significant when Francophones rarely/never speak to their family physician in French ( $F_{(1; 75)} = 4.920$ ;  $p < 0.05$ ) but not when they regularly speak it. The post hoc analysis of

this simple effect shows that Francophones who prefer French but rarely/never speak it were significantly less satisfied than those who prefer English and rarely/never speak French ( $\bar{x}$  adj = 4.06 vs. 4.44 respectively). Additionally, the analysis of the simple effects of service language was significant for Francophones who prefer to receive services in French ( $F_{(1; 75)} = 11.950$ ;  $p < 0.001$ ), but not for those who prefer English. The post hoc analysis of this simple effect confirmed that Francophones who prefer French and regularly speak it were significantly more satisfied than those who prefer French yet rarely/never speak it ( $\bar{x}$  adj = 4.82 vs. 4.06 respectively). Therefore, the present analysis confirms the hypothesis that Francophones in the most linguistically concordant group (i.e., those who prefer French and regularly speak it with their family physician) would be more satisfied than those in the most discordant group (i.e., those who prefer French yet rarely/never speak it) (Figure 5).



**Figure 5: Graphical representation of Francophone patient satisfaction scores across categories of patient's language of preference and service language**

### 5.5 Research question 4: To what degree does the active offer of French language health services influence patient satisfaction in a sample of Francophones living in northeastern Ontario?

The pre-intervention patient surveys also allow me to explore the relationship between satisfaction and the active offer. A Pearson correlation between satisfaction, based on the 24 PAR patient survey questions related to “professionalism and communication” and active offer, based on the six items from the “Reception and Patient Management” sub-theme from the *Active Offer of French Language Services in Minority Context Measure* determined the presence of a weak yet significant correlation in the entire sample ( $r = .26$ ,  $p_{(\text{one-tailed})} < 0.01$ ). Thus confirming the hypothesis that patients become more satisfied as they perceive receiving a greater active offer of FLS (i.e., higher active offer scores). However, this correlation is insignificant when considering only Anglophone patients ( $r = .06$ ,  $p_{(\text{one-tailed})} = 0.35$ ), and becomes much stronger when exclusively considering Francophones ( $r = .49$ ,  $p_{(\text{one-tailed})} < 0.001$ ) (Figure 6).

Patient Satisfaction Score

Active Offer Score

**Figure 6: Scatter plot of the correlation between patient satisfaction and the perceived presence of active offer behaviours**

## Chapter 6

### 6 Discussion

As part of the present thesis, a continuing professional development (CPD) program was developed, which taught patient-centred communication strategies to family physicians practicing in Northeastern Ontario through the active offer of French language services. Throughout this three-phased program, consisting of an assessment phase (including physician, receptionist and patient surveys), an education phase (including a personalised report and a workshop), and a reflective phase (including a post-intervention physician survey and a final progress report), data were collected allowing me to explore a series of research questions. First, the pre and post-intervention physician survey plus feedback during the workshop provided some evidence that the CPD program may be effective in improving active offer habits of practicing physicians. Second, the pre-intervention physician and receptionist surveys provided a snapshot of the presence of the active offer in family physicians' offices of Northeastern Ontario. Finally, the pre-intervention patient surveys allowed me to explore the influence of linguistic concordance and of the active offer on patient satisfaction. In the following section, each of these results will be discussed in greater detail, followed by an interpretation of the findings through the theoretical lens of the Adapted Framework for Patient-Professional Communication (which combines the Framework for Patient-Professional Communication (Feldman-Stewart et al, 2005), the Framework of Communicative Competence (Gregg & Saha, 2007) and the Theory of Cultural Sensitivity (Dutta, 2007)

## 6.1 Practical interpretation

### 6.1.1 CPD as a means to improving French language services

Although the CPD program was evaluated through various channels (i.e., comparisons of pre- and post-intervention active offer scores, feedback during the workshop and reflections provided on the post-intervention survey), drawing hard conclusions on the effectiveness of the program is severely limited by the minimal participation rate to the later phases of the program. With only three physicians having completed the entire program, the sample size was not large enough to be able to definitely state that the program was successful. However, given that all three physicians who completed the program showed signs of improvements in terms of enhanced active offer behaviours (i.e., improved active offer scores on all three selected subthemes from the *Active Offer of French Language Services in Minority Context Measure* (Savard et al., 2014)), there is enough evidence to suggest that the program may be effective in changing active offer behaviours and to support further implementation of this or similar CPD programs. Furthermore, lessons learned from the first iteration of this CPD program provide insight on improvements that could be implemented in future offerings.

For instance, it is encouraging to see that all three subthemes selected from the *Active Offer of French Language Services in Minority Context Measure* (Savard et al., 2014) showed signs of improvement. Of note, behaviours that were most likely to improve were related to the physician's daily activities when interacting with patients (i.e., wearing an identification pin/badge, visually advertising the availability of service in French, regularly asking patients their language of preference, using words and expressions used by the patient and informing patients about the organization's commitment to offering services in French). Such

improvements were observed on both the self-rated and general work environment questions from the 'Reception and Patient Management' subtheme. Each of these behaviours are also directly under the physician's control and occur primarily during patient interaction, meaning they do not require organizational support to be implemented, and the benefits for patients are easy to understand and observe. Such results suggest individual level clinical behaviours may be more amendable to educational interventions for family physicians than broad practice-based improvements. Indeed, a 2015 evaluation of the impact of CPD activities on clinical practice found that education programs that target knowledge improvement are often unsuccessful at promoting clinical behavioural change (Légaré et al., 2015). It is possible that teaching active offer strategies that target clinical behaviours during patient encounters are directly applicable to practice and more likely to lead to changes in behaviours than general education on the importance of active offer within the primary care setting, which imparts knowledge without explicitly linking knowledge to practical application.

Therefore, it is understandable that not all behaviours evaluated in the present thesis improved (some even showed signs of decline) or that these behaviours were more likely to be related to the general office environment. For instance, little to no improvements were observed in telecommunication practice in French (e.g., answering the phone in French, including a French message on the voicemail box and including a French signature on emails). Such telecommunication strategies are both easy to correct and equally easy to overlook. A physician only needs to change their personal email signature once, likely does not need to change their personal voicemail message frequently, and is less likely to answer the phone than a receptionist. Therefore, it would be relatively easy to make such changes once and move on. The physicians

may not even notice the inclusion of French in their telecommunication practices, but the patients would. Telecommunication strategies are particularly relevant in a post-pandemic world where many primary care providers have moved to virtual care and continue to see patients virtually (Mohammed et al., 2021). Therefore, providers who wish to improve the Francophone patient experience when interacting with their practice should not overlook active offer strategies surrounding telecommunications. Other behaviours that showed little improvement included providing French reading and entertainment options, broadcasting French media (e.g., radio or newspaper) and holding internal staff meetings in French. Strategies such as these are not directly related to patient care and are more likely to fall under the responsibility of an office manager. It may not be the physician's responsibility and they may not have the capacity (in terms of time) to monitor the availability of French reading and entertainment material in common areas. Furthermore, it is understandable that meetings would not be held in French. If there is just one non-French-speaking individual at the meeting, it is only natural that the meeting is held in English, as it is a language commonly understood by all providers.

The fact that little to no improvements were made to behaviours surrounding telecommunication, the provision of French reading and entertainment options, and the use of French during staff meetings speaks to the need for an organizational policy or strategy detailing the practice's commitment to ensuring a minimum availability of French within the office environment. A lack of improvement in these behaviours does not necessarily indicate that the CPD program was ineffective at provoking changes but rather suggests that the right people must receive the right education for such changes to be implemented. Physicians are likely more motivated to improve behaviours surrounding direct patient care (as is evident by the improvement made to behaviours

that occur during patient interactions) and less motivated to make changes to the general office environment. However, an office manager, a receptionist or an executive director would be more motivated and better positioned to make changes to the office environment and implement active offer policies that would improve the patient experience when interacting with the clinic outside of physician interactions. Thus, future iterations of the education program should be provided to the entire team and deliver strategies tailored to the various roles within the practice (i.e., offer specific strategies for administrators, clerical staff and providers).

Furthermore, a lack of change in the work environment seems to indicate that physicians had little influence on improving the office setting, either because they did not share learnings and resources from the CPD program with colleagues or because there was little uptake from colleagues. However, stagnating and declining active offer scores in the work environment could also reflect improvements in physicians' knowledge about the active offer and its implementation such that, on the post-intervention survey, they were more aware of the shortcomings in their work environment. Thus, a negative change may not reflect a true decline in active offer behaviour, but rather a change in knowledge or increased self-awareness that invites the physicians to judge the work environment more attentively or from a new light. However, it is worth repeating that these results must be interpreted with caution. Again, it is not possible to draw firm conclusions based on the experience of only three physicians. Furthermore, post-intervention reactions from colleagues and patients would be needed to determine whether others also observed the improvements reported by physicians. Future iterations of the CPD program should include post-intervention evaluations from other sources (e.g., receptionists, colleagues, patients) to identify active offer improvements more accurately. Although the CPD

program was not successful at changing all behaviours, it is encouraging to see improvements in behaviours related to direct patient interactions. Therefore, the program may be effective at improving active offer knowledge and behaviours and supporting further implementations of this or similar CPD programs.

Beyond comparing pre- and post-intervention survey results, comments made during the workshop and reflections on the post-intervention surveys offer further evidence of the program's potential benefits. Of note, on the open-ended questions of the post-intervention survey, physicians demonstrated improved knowledge about the active offer (i.e., all were able to accurately identify the proactive nature of active offer as a critical component), noted several improvements to the active offer strategies they provide (e.g., increased French signage, providing identification pins to French-speaking staff and greeting patients in French), and stated having increased confidence in serving French-speaking patients. Thus the CPD program seems to have been effective at improving all three domains of Dixon's second level of continuing education evaluation of health professionals, namely improved knowledge (i.e., able to define the active offer accurately), skills (i.e., implementation of active offer strategies), and attitudes (i.e., increased confidence) (Dixon, 1978). Furthermore, several "aha" moments or realizations identified during the workshop show signs that learning occurred. The fact that many of these realizations led to corresponding improvement on the post-intervention survey suggests that this learning was incorporated into practice and sustained over time. For instance, one reflection made during the workshop that the physician does not systematically ask patients about their language of preference (both oral and written) led to a suggestion to include language preferences in the patient's chart. This change was reflected on the post-intervention survey as an

improvement to the frequency in which patients were asked in which language they wished to communicate. The importance of informing specialists and other resources of the patient's linguistic preferences is an example of another realization made during the workshop. A proposed solution included adding language preferences to the referral forms. The implementation of this solution was noticeable on the post-intervention survey, with an improvement observed on the question asking about referrals. Both these examples demonstrate how the present CPD program led to moments of realization or moments of increased self-awareness which were translated into changes in behaviours, thus supporting the notion that the program was potentially effective. Furthermore, both examples included solutions that supported the creation of policies on active offer that systematically incorporate linguistic preferences in existing tools (e.g., in the patient's chart and on referral forms). These strategies have the added benefit of encouraging physicians to discuss linguistic preferences with their patients, a practice that seems to be often overlooked, as suggested by the patient surveys. Although 63% of patients had a family physician competent enough to practice in French, only 17% reported speaking in French with their physician. Policies that systematically encourage a discussion surrounding linguistic preferences would raise awareness of such preferences and potentially increase the occurrence of linguistic concordant patient-physician communication.

Finally, the last notion discussed in the results arose unexpectedly when an English-speaking provider learned that a colleague was educated in French and thus could provide care in French. This notion sheds light on how infrequently providers discuss their linguistic capacities with colleagues. If the physician in question was wrong in assuming their colleague's linguistic capacities, it is equally likely that they are wrongly assuming some of their patients' linguistic

preferences. Once again, an organizational policy that encourages all staff to declare the languages they are comfortable speaking to patients would help create awareness within the office environment of the linguistic capacity available in-house and possible supports.

### 6.1.2 The active offer of French language services in northeastern Ontario

The intention behind the second research question was to estimate the state of active offer of French language services in family physician offices of Northeastern Ontario. If primary care providers are expected to actively provide care in French, it is essential to understand the current presence of active offer to provide recommendations for its improvement. Once again, the limited sample size prevents the drawing of broad conclusions. The 13 physicians and 8 receptionists who completed the phase 1 survey are too few and lack the diversity needed to be considered representative of their peers. However, results from these physicians do provide an example of the state of active offer. Therefore, these results should be interpreted as an approximation of behaviours that are likely also occurring (or not occurring) in other physicians' offices. Comparing French-speaking physicians, English-speaking physicians, and receptionists has also allowed me to identify differences in active offer behaviours between groups, thus allowing for more targeted recommendations.

It was hypothesized that French-speaking physicians would provide more active offer of French language services (as measured by the *Active Offer of French Language Services in Minority Context Measure*). As expected, French-speaking physicians had higher active offer scores than English-speaking physicians, with receptionists often falling between the two. For instance, on the self-reported "Reception and Patient Management" subtheme, English-speaking physicians reported fewer active offer behaviours, such as advertising that they can offer service in French

(either with a visual indicator or by wearing a badge/pin), answering the phone in French or using French expressions and a vocabulary used by the patient. Although it is understandable that language barriers would challenge these behaviours (i.e., one cannot be expected to advertise that they can offer services in French if they cannot speak French), many active offer behaviours measured by the *Active Offer of French Language Services in Minority Context Measure* do not require a high level of linguistic competence and can be performed by all providers. These include asking patients their language of preference, including a French signature on their email, sensitizing others to the importance of French language services, making sure informative documents and entertainment options are available in French and greeting patients in French, which even the most novice French speaker can achieve by learning a few basic words. However, many of these behaviours were infrequently reported, even by French-speaking physicians and receptionists. For example, all respondents reported never or rarely including a French signature on their email or sensitizing others to the importance of French language services. Although French-speaking physicians and receptionists tended to score slightly higher than English-speaking physicians on behaviours related to greeting patients in French or advertising the availability of French language services, all reported these types of behaviours as never to rarely occurring. Such behaviours are required for a provider to adhere to the most basic active offer principle, namely proactively informing patients about the availability of services in French (Ministry of Francophone Affairs, 2014; Office of the French Language Services Commissioner of Ontario, 2016a). The infrequency of these behaviours points to a general lack of active offer in physicians' offices of Northeastern Ontario, thus organizational policies could and should be implemented to ensure patients are proactively being greeted in French. From the receptionist's perspective, policies regarding individual behaviours could

include wearing an identification (e.g., badge/pin) indicating that they speak French, greeting patients in French in person or including French telecommunication strategies. Any French-speaking receptionist can perform such behaviours with little disruption to their regular work habits, yet these behaviours were reported as never to rarely occurring. Likewise, policies to improve the active offer behaviours of French-speaking physicians could include wearing an identification indicating they can offer services in French and greeting new patients in French. Furthermore, behaviours already being performed, such as asking patients their language of preference and using expressions and vocabulary used by the patients, should be further encouraged.

No differences were observed between French-speaking and English-speaking physicians on questions from the Support and Referrals subtheme, which is not surprising as these referral practices can be performed regardless of one's linguistic ability. Of note, all physicians seemed to be already offering patients the option to be directed to a French-speaking provider (reported as often or always occurring). However, policies could be developed to encourage further behaviours, such as specifying the patient's language of preference on referral or transfer letters and verbally informing the provider of the patient's language of preference. As we have seen in the results from the first research question, a strategy to systematically include the patient's language preferences on referral letters was proposed during the workshop and led to noticeable improvements on the post-intervention survey.

Finally, although it is promising to see that practices that participated in this CPD were actively hiring French staff, a French-speaking hire is of little benefit if structures are not in place to facilitate the use of French in the work environment. Most behaviours measured in the work

environment questions of the Reception and Patient Management subtheme were reported as rarely to never occurring. Organizational level policies could be implemented to support the offer of French language services by ensuring that behaviours, such as informing the patients of the availability of French services (both visually and verbally), providing French documents and entertainment options and encouraging the use of French between staff members, are acknowledged as important and occur more frequently.

Therefore, the present analysis revealed that, among select physician offices in Northeastern Ontario (i.e., those who participated in the CPD program), although French-speaking physicians and receptionists tended to report more frequent active offer behaviours than English-speaking physicians, few active offer strategies were reported overall by all respondents (i.e., many behaviours were rated as being infrequent or nonexistent). It is encouraging to see that some active offer strategies were already in place and regularly performed by most respondents (e.g., asking patients in which language they wish to communicate, offering the option to be referred to a French-speaking specialist and recruiting French-speaking staff). However, strategies that proactively inform the patient about the availability of French language services or encourage the use of French within the work environment (e.g., providing French reading and entertainment options, broadcasting French media or holding meetings in French) occurred far less frequently. Organizational policies encouraging such active offer strategies have been suggested and should be considered by any family physician's office wishing to conform to the principles of the active offer of French language services. Furthermore, the fact that many behaviours infrequently reported on the pre-intervention survey improved on the post-intervention survey as a result of the CPD program (as described in the interpretation of research question 1), suggests active offer

can be learned, further supporting the continued implementation of this or similar CPD programs.

### 6.1.3 Language concordance and patient satisfaction

The third research question explored the influence of linguistic concordance on patient satisfaction using data collected from the phase 1 patient surveys. As hypothesized, there was a consistent trend for patient satisfaction scores to be higher when language concordant patient-physician interactions were stronger. Although differences may not have been statistically significant when considering the weakest indicators of concordance (i.e., the patient's FOLS by the physician's language of competence and the patient's FOLS by the service language), there was a clear tendency for Francophones with French-speaking physicians and Francophones who reported regularly speaking in French with their family physician (i.e., linguistic concordance) to be the most satisfied. In contrast, those with an English-speaking physician and those who rarely/never speak in French (i.e., linguistic discordance) were consistently the least satisfied. Statistically significant differences in satisfaction were not observed between Francophone and Anglophone patients, which is understandable as all Anglophones were receiving linguistically concordant care thus, it would be expected that they would be equally satisfied as Francophones who experience linguistically concordant care. As we saw in tables 11 and 12, Anglophones were slightly less satisfied than Francophones who receive linguistically concordant care and slightly more satisfied than Francophones who receive discordant care. However, when exploring the strongest indicator of linguistic concordance (i.e., the language of preference by the service language) in Francophones alone, those who prefer French and regularly speak it (linguistic concordance) were significantly more satisfied than those who prefer French yet

rarely/never speak it (linguistic discordance). These tendencies are consistent with research on the Spanish-speaking population in the United States (Dunlap et al., 2015; Flower et al., 2017) and provide further evidence that language discordances are a barrier to patient satisfaction. However, this is the first time such differences in satisfaction have been found in Ontario's Francophone population.

Results from this study provide evidence of the importance of linguistic concordant interactions and the active offer of French language services on patient satisfaction and may provide insight into the quality of care provided to French-speaking patients. Given the maldistribution of French-speaking physicians throughout the province (Timony et al., 2013), linguistic discordant patient-physician interactions are more likely than linguistic concordant interactions.

Consequently, it is possible that many Francophone patients in Ontario are less satisfied with their care. Given the relationship between patient satisfaction and quality of care (Hekkert et al., 2009, Naidu, 2009; Woodward et al., 2000), these findings may help explain the poorer health outcomes observed in Ontario Francophones. As Naidu (2009) suggests, patients who are satisfied with the functional quality of care (e.g., the interpersonal component) are more likely to comply with the technical provision of care by continuing to see their health care provider, returning for follow-up appointments, disclosing important medical information, complying with medical recommendations and actively participating in their treatment (Aharony & Strasser, 1993; Westaway et al., 2003). Thus, it could be argued that satisfied patients are more likely to receive appropriate "upstream" preventative care, while dissatisfied patients receive a more costly reactive or curative "downstream" treatment.

Furthermore, results from this thesis suggest that simply increasing the number of French-speaking physicians in Ontario would be insufficient to improve the Francophone patient experience (i.e., no differences in satisfaction were observed when considering the weakest indicator of concordance, the patient's FOLS by the physician's language of competence). It was both the provision of care in French and being responsive to the patient linguistic preferences that produced the most significant differences in satisfaction. This is important as it is more challenging to increase the number of French-speaking physicians within the province, which can only be achieved through the recruitment of internationally trained physicians and by enrolling more Francophones in medical schools, two strategies included in the government of Ontario's French Languages Service Strategy (Ministry of Francophone Affairs, 2022a; Ministry of Francophone Affairs, 2022b) than it is to provide active offer training to the existing physician workforce. Through the active offer, physicians would be proactively offering services in French, thus respecting linguistic preferences and implementing strategies that increase the availability of French language services. It must be stated that physicians do not need to be fluent in French to ensure French language services are rendered, they simply have to remain aware of their patient's communication needs, values and preferences and adapt the care they provide to respond to these needs, which should occur naturally if they are providing patient-centred care/communication. For instance, all physicians can ask their patients in which language they would prefer to receive care. In the presence of a linguistic discordance, a physician with limited ability to converse in French can use strategies such as: learning some basic words to greet their patient in French; having French and English handouts, thus allowing the patient to follow the conversation using the French materials; using translation services when severe language barriers present themselves; using digital translation tools, such as Google translate or MediBabble,

which have been found to improve patient satisfaction, quality of care and patient safety (Al Shamsi et.al., 2020); and asking patients to repeat instructions in their own words to verify comprehension. Such linguistically and culturally sensitive strategies would help establish a relationship in which the patient feels that their language is welcomed and respected.

Furthermore, the more physicians uses these strategies, the more they will become part of their standard practice thus allowing physicians to gain confidence and proficiency in the provision of French language services.

#### 6.1.4 Active offer and patient satisfaction

Finally, the fourth research question explored the relationship between the active offer and patient satisfaction. Although the underlining belief is that the active offer of French language services can improve the Francophone patient experience, to my knowledge, this is the first study to demonstrate an association between the active offer and patient satisfaction, such that Francophone patients became more satisfied as they perceived receiving a greater active offer. Additionally, since no such correlation was detected in Anglophone patients, I can surmise that the implementation of active offer strategies in primary care does not harm the Anglophone patient experience yet has the potential to improve the Francophone patient experience.

## 6.2 Theoretical interpretation

### 6.2.1 Research questions 1 and 2

The first two research questions pertain primarily to the active offer of French language services, with the second research question seeking to understand the present state of active offer in

physician offices and the first developing a CPD program intended to improve patient-centred communication through the active offer. The Adapted Framework for Patient-Professional Communication is used here to explain how the active offer can enhance patient-physician communication. Based on the analysis of the first two-research questions, five areas of competence (i.e., broad categories of active offer behaviours) emerged from the questions selected from the *Active Offer of French Language Services in Minority Context Measure* (Savard et al., 2014). These areas of competence include, 1) self-directed behaviours during **patient interactions**, 2) proactively informing patients of the availability of French language services using **visual cues**, 3) including French in **telecommunications**, 4) Supporting the use of French within the office, indicative of **workplace culture** , and 5) ensuring continuity of care in French through **support and referrals**. The Adapted Framework for Patient-Professional Communication helps explain how each of these active offer strategies can help improve communication between the patient and the physician.

When considering the active offer and the present CPD program through the lens of the Adapted Framework for Patient-Professional Communication, we must first acknowledge that the CPD program is an external factor that can influence the physician's attributes (i.e., their needs, beliefs, values, skills, emotions, linguistic competence, communicative competence and cultural sensitivity). The improvement of active offer behaviours on the post-intervention survey suggests the CPD program successfully modified certain physician attributes. Many self-directed active offer behaviours during patient encounters are the results of physicians' attributes responding to the individual patient attributes. For instance, the fact that physicians incorporated active offer strategies into their practice suggests changes to their **Beliefs** (i.e., the belief that

there is more they could be doing to serve their Francophone patients and that not all Francophones are “bilingual enough” (Timony et al., 2016, p.10) to be served in English exclusively) and **Values** (i.e., that communication is vital to providing high-quality care). It also indicates **Cultural Sensitivity** (i.e., being responsive to their Francophone patients' cultural and linguistic needs). The adoption of active offer strategies also responds to the patient’s attributes, namely their **Needs, Beliefs, Values and Emotions**. First, Francophones (like all patients) have a **need** to understand and be understood as well as a **need** to have French language services proactively offered. As we have seen, Francophones have learned to not request services in French (DPM Research, 2021; Forgues et al., 2014). Second, nearly 75% of Ontario Francophones **believe** it is important to receive health care services in their preferred language (Leger, 2020). Third, francophones **value** the ability to fully live their lives in French, for these individuals receiving health care services in French is a question of identity, and is considered essential to conserving their mother tongue (DPM Research, 2021). Finally, from an **emotional** perspective, Francophone patients who do not receive health care services in French have expressed feelings of discomfort, insecurity, inaccessibility, and an inability to properly describe their health care needs and take charge of their own health (Jutras et al., 2020). Specific examples of self-directed active offer behaviours include: asking the patient in which language they wish to communicate, which is a physicians **skill** that is respectful of the patient’s **needs** and **values**; greeting patients in French and learning some basic French as needed to allow for French greetings is indicative of **linguistic competence** (i.e., producing grammatically correct sentences); and using words and expressions used by the patient is an example of **communicative competence** (i.e., choosing the appropriate sentences or expression in a given situation), both of which also fall under the physician’s **skills**. In addition, asking patients in

which language they wish to communicate will also sensitize providers to their patients' **needs** and allow providers to identify gaps in their **skills** and their own **needs** for further support and education. Furthermore, strategies generated during the workshop, such as taking note of the patient's linguistic preferences in their chart, periodically verifying if and how these preferences may have changed and using their preferred languages, all demonstrate **cultural sensitivity** (i.e., respecting the patient's **needs** and **values**).

From another angle, proactively informing patients of the availability of French language services, including French in their telecommunications strategies, and supporting the use of French within the office (e.g., conversing in French between French-speaking employees, or providing French reading and entertainment), all address the **Environment** in which communication is taking place. By enhancing the visibility and availability of French within the office environment, providers are creating a space in which Francophone patients feel safe and comfortable. When exposed to a Francophone environment, patients will feel more welcomed and encouraged to express themselves in the language they are most comfortable, thus allowing them to truly experience and express their health status without the fear of being persecuted (DPM Research, 2021; Leger, 2020) or having to translate their experiences in what ends up being a watered down or incomplete medical history. Research exploring the experience of Ontario Francophones when accessing physician services finds that patients often feel uncomfortable accessing services in an anglo-dominant environment, that the service seems more inaccessible, and that the patient lacks confidence in both their own ability to properly explain themselves in English and in the provider's ability to understand them if they speak in French (DPM Research, 2021; Jutras et al., 2020; Leger, 2020).

From the patient's perspective, strategies to improve the visibility of French in the office setting will help improve the perceived availability and accessibility of services in French within the **environment**. However, we have seen that, even in the presence of French services, Francophones will often choose to use the service in English (Cardinal & Sauv , 2010; Forgues et al., 2014). As Forgues, Landry and Long (2014) explain, after years of being denied services in French, Francophones may believe they do not have a legitimate right to be served in French and default to English even when provided with the option to be served in French. As we have seen, this has led to a vicious cycle in which providers are less likely to offer services in French if there is no demand, and patients are less likely to use service in French if there is no offer or if the offer is not sustained (Office of the French Language Services Commissioner of Ontario, 2016a). Therefore, the implementation of active offer strategies is not lost even if the patients do not select to use the French services when they are first offered. The more patients are asked in which language they prefer to communicate and are exposed to French in the medical environment, the more they will feel that French is both safe and welcome and the more they will be likely to use French services in the future. Language preferences are also very situational. According to Economidou-Kogetsidis (2010), the choice of language used in a particular situation depends on several factors, including familiarity, social power, and imposition. Therefore, it is understandable why so many Francophones choose to use English services given that the language one prefers when accessing health care depends on the familiarity with the health care provider (past experiences, both positive and negative, sets their expectations for the language of care provision), the power dynamic between patient and physician (as the physicians hold the power, they control the choice of language to be used), and the degree of imposition (Francophone patients often feel that requesting services in French would inconvenience

physicians (Forgues et al., 2014; Leger, 2020)). However, the more the patient sees French being used in the medical office **environment** through active offer strategies, the more they will feel comfortable and confident in speaking in French in that environment, thus increasing their familiarity with receiving services in French and changing the perceived degree of imposition associated with using French language services.

Furthermore, although physicians have little influence on the availability of French language services outside their office, ensuring continuity of care in French and informing specialists and follow-up services of the patient's linguistic preferences will help sensitize other providers to the importance of linguistically concordant care and allows these specialists and services to prepare to serve the patients in French and make the necessary adaptations to their own work **environment**. Therefore, according to the Adapted Framework for Patient-Professional Communication, any effort to adapt the office to the patient's linguistic needs (i.e., ensuring the visibility and availability of French services) will create an **environment** that is conducive to higher quality communication by making the patients comfortable and encouraged to communicate in their preferred language.

Finally, by truly internalizing the importance of the active offer, physicians may see their communication goals expand from receiving a medical history, reaching a diagnosis and providing treatment to also ensuring the highest possible quality of communication and improving the patient experience. To this end, it is worth mentioning that the active offer strategies discussed to improve the Francophone patient experience can also be applied to improve patient-centred communication with other groups for whom communication is

compromised, such as other linguistic minority groups, the hearing impaired or those who are mute.

### 6.2.2 Research questions 3 and 4

While the Adapted Framework for Patient-Professional Communication was used to understand how the active offer of French language services could improve patient-physician communication in research questions 1 and 2, when interpreting research questions 3 and 4, it is used to explain how same-language communication (i.e., linguistic concordance) can influence the patient experience. The Adapted Framework for Patient-Professional Communication considers communication to be a **cyclical process** that serves primarily to address **the goals** (or objectives) of each communicator. Therefore, any obstruction to the communication cycle that prevents the conveying and interpretation of a message from one party to the next can prevent the communicators from achieving their goals and thus negatively influence the patient experience. Language barriers are an example of such an obstruction that can provoke discordances in many patient and physician **attributes**. For instance, in the presence of a linguistic discordance, there are discordances in the participant's linguistic **skills**, as patients may lack the vocabulary needed to describe their condition and understand physician instructions. Additionally, there may be deficits in the physician's **linguistic and communicative competencies** required to interpret messages from the patient and provide instructions in a linguistically and **culturally accessible** manner. Furthermore, linguistic discordances can also indicate discordances in **beliefs, values and cultural sensitivity**, as the physician may be unaware of how the patient's culture influences their health habits. For example, suppose a Francophone patient visiting a physician to discuss their recent cancer diagnosis and available

treatment options is spoken to exclusively in English. They may have difficulty understanding the severity of their condition and the possible treatments. Thus their goal of receiving clarity and selecting a treatment plan that best meets their needs will not have been achieved, and they would likely be dissatisfied with the encounter.

In the present thesis, I hypothesized that as linguistic concordance becomes stronger, communication is richer and more effective, and patient satisfaction is improved. Thus, the first indicator of linguistic concordance considered in the present thesis (i.e., concordance between the patient's first official language spoken (FOLS) and the physician's language of competence), is considered the weakest. Although patients and physicians may share a **skill** (i.e., the ability to speak French), physicians may not be serving the patient in French. Thus **linguistic and communicative competence** may remain discordant ( as we saw in the Lepage and Lavoie (2017) report, less than half of the providers who could conduct a conversation in French in Ontario reported using French at work) and **culturally insensitive** (if the physician is unaware of the patient's linguistic preferences and needs, they are likely equally unaware of how the patients culture may influence their health). As a result, communication can suffer, resulting in lower satisfaction, as was observed in the present results. Although Francophones who had a French-speaking physician did have higher satisfaction scores than those who had an English-speaking physician, this difference was not statistically significant until I considered the language in which services were being received. This suggests that being able to speak the same language as their family physician is of little benefit if the physician is not actually providing services in French. Nearly half of the participating Francophones who had a French-speaking provider rarely/never received services in French. For these Francophones, communication can suffer

which can prevent the patient from achieving their communication goals and negatively influence satisfaction.

The second indicator of linguistic concordance between the patient's FOLS and the service language (i.e., whether they regularly vs. rarely/never receive services in French from their family physician) is considered a stronger indicator of concordance. In this instance, patients and physicians not only share a **skill** (the ability to speak French), but by providing services in French, the physician is also demonstrating **linguistic competence** and potentially **communicative competence**. As hypothesized, when considering this stronger indicator of concordance, Francophones who regularly speak French with their family physician were significantly more satisfied than those who rarely/never speak French.

The third indicator of linguistic concordance between the patient's language of preference and the service language is considered the strongest. By providing services in French, physicians are demonstrating concordant **skills**, **linguistic competence** and **communicative competence**. By considering the patient's language of preference, they are also responding to the patient's **values** (honoring their patient's linguistic preferences) and **emotions** (by providing services in French they are creating an environment in which patients feel safe and comfortable), thus demonstrating **cultural sensitivity**. As a result, considering this indicator of linguistic concordance, communication is likely the most effective and, by extension, the ability for patients to achieve their communication **goals** is largely unhampered. Thus, patient satisfaction should be highest. Indeed, results from this strongest indicator of concordance confirm that Francophones who prefer French and regularly speak it with their family physician were significantly more satisfied than those who prefer French yet rarely/never speak it. Furthermore,

the differences in satisfaction between groups were largest when considering this indicator of linguistic concordance (compared to differences observed in the weaker indicators of concordance). This difference was also statistically significant. Therefore, the Adapted Framework for Patient-Professional Communication, which suggests that as patient and physician attributes become more concordant, communication is more effective and communication goals are more likely to be achieved, thus producing greater patient satisfaction was supported by the present thesis.

Finally, the previous interpretation of research question 1 and 2 explained how the active offer has the potential to improve communication by ensuring providers **attributes** (i.e., their **skills**, **linguistic competencies** and **communicative competencies**) are responding to Francophone patient **attributes** (i.e., their **beliefs** and **values** that services should be received in French, which is indicative of **cultural sensitivity**) and care is being offered in an **environment** in which Francophone patients felt comfortable interacting in French. The theoretical relationship between active offer and patient satisfaction suggested by the Adapted Framework for Patient-Professional Communication was supported by the analysis of the final research question. As hypothesized, Francophone patients became more satisfied as active offer behaviours were perceived to be occurring more frequently, suggesting communication was also more effective, and patients were better able to achieve their communication goals. According to Naidu (2009), satisfied patients (i.e., patients who receive linguistic concordant care and perceive an active offer of French language services according to the present findings) are more likely to contribute to their own quality of care (by accurately describing their symptoms, undergoing treatment,

taking their medication and attending follow-up appointments) and experience improved health outcomes.

### 6.3 Situating results in the current political and health reform landscape

Although the research questions posed in this thesis and the methods used for collecting data were developed before 2019, when the current health system reform was announced (as described in detail in the literature review), the implications of the present findings are arguably more relevant today than they were when I started my thesis research. For instance, the FLSA received its first substantial revision in December of 2021 (Ministry of Francophone Affairs, 2022b; Government of Ontario, 2021). Among other changes, the modernization of the FLSA included a new subsection which legislates the active offer of French language services by stipulating that for every individual who has a right to receive front-line services in French under the Act, the service provider is obligated to bring the availability of those services in French to the attention of the individuals (French Language Services Act, 1990). As a result, since Bill 74 defined the requirements for the OHTs to comply with the FLSA, they will also be expected to comply with the recent revisions to the Act, including the need to actively offer services in French. The findings from my thesis, particularly the association between the active offer and patient satisfaction, supports such a requirement for OHTs to practice the active offer. As I have demonstrated, linguistic concordant care and the active offer of French language services are associated with improved patient satisfaction in a sample of Francophone patients from Northeastern Ontario. These findings support the French Language Services Commissioner's position on the role of the active offer in improving the Francophone patient experience (Office

of the French Language Services Commissioner, 2016a), with higher active offer scores associated with greater satisfaction.

Furthermore, although physicians are not explicitly named in Bill 74 and will not be obligated to join an OHT, they will play a vital role in the long-term success of the OHTs (Ministry of Health, 2019b; The People's Health Care Act, 2019). Given that family physicians are recognized as primary care specialists and gatekeepers to the health care system (Brown, 2018), it is reasonable to expect that physicians will be the first point of contact with an OHT. In fact, the Ontario Medical Association and the Ontario College of Family Physicians have advocated for physicians to take on leadership responsibilities within OHTs (Ontario College of Family Physicians, 2019; Ontario Medical Association, 2019a). Although neither the FLSA nor Bill 74 apply directly to the care provided by physicians, these legislative changes point to a shift in health care delivery to be more responsive to the needs of the Francophone population, a shift which physicians would be wise to take note of. Results from this thesis suggest that it is in the best interest of their patients and the success of the OHT for physicians to also incorporate the active offer in their practice. Furthermore, implementing the active offer will allow physicians to fulfill the CanMEDS role of being a communicator, with active offer strategies also being applicable to other linguistic minority populations.

In the present thesis, results from research questions 3 and 4 indicate that linguistically concordant care and the active offer of French language services have the potential to improve the Francophone patient experience. Furthermore, results from research question 2 suggest that, although French-speaking physicians had greater active offer scores than English-speaking physicians, overall many active offer behaviours were relatively infrequent. Finally, despite only

three physicians having completed the entire CPD program, the findings from research question 1 suggest that active offer strategies can be learned through continuing education. The current period of health system reform marks an ideal opportunity to introduce active offer strategies to the OHTs, thus ensuring adherence to the FLSA, encouraging linguistic concordant interactions, and contributing to the overall goal of improving patient experiences.

In addition, I would suggest that the Ministry of Health or Ontario Health to begin monitoring the state of active offer in medical offices of Ontario using tools such as the *Active Offer of French Language Services in Minority Context Measure* (Savard et al., 2014). Since integrated care is a patient-centred approach which “imposes the patient’s perspective as the organising principle of service delivery” (Lloyd & Wait, 2005, p. 7), Ontario Health and the OHTs should also periodically evaluate the influence of the active offer on patient experiences and health outcomes in their Francophone patients. This suggestion aligns well with both the government of Ontario’s recent French Languages Service Strategy and with the modernisation of the FLSA. While the French Languages Service Strategy intends to develop evaluation tools to enhance accountability and assess the availability of government services in French (Ministry of Francophone Affairs, 2022a; Ministry of Francophone Affairs, 2022b), a recent addition to the FLSA will require Ministers (including the Minister of Health) to report annually on how they have implemented the Act and on the quality of the French services provided within their respective ministries (Ministry of Francophone Affairs, 2022b). Finally, when insufficiencies are detected in the presence of active offer, the Ministry of Health or Ontario Health should invest in active offer training programs. As we have demonstrated in this thesis, such education programs have the potential to improve active offer behaviours, which, in turn, will improve the patient

experience. Furthermore, enhanced active offer behaviours would not only be beneficial for Francophone populations, but can also be applied to improve patient-centred communication with any patient with whom communication is compromised (e.g., other linguistic minority groups or the hearing impaired). This suggestion also aligns well with the government of Ontario's French Languages Service Strategy to implement digital-based options for training health care provider (Ministry of Francophone Affairs, 2022a; Ministry of Francophone Affairs, 2022b).

Furthermore, I would argue that implementing the active offer of French language services will also contribute to achieving the Quadruple Aim (Access Alliance Multicultural Health and Community Services, 2021; Devlin, 2019). First, as we have seen in this literature review, language barriers can threaten patient safety and **health outcomes** (De Moissac & Bowen, 2019). The active offer will help improve access to linguistically appropriate services for Francophones, which can improve clinical outcomes and reduce errors, inappropriate testing, and emergency department use (Access Alliance Multicultural Health and Community Services, 2021). Second, we saw how language barriers can be costly to the health care system and provoke inefficiencies, with the associated reallocation of staff time, greater use of and reliance on diagnostic tests, more missed appointments, more unnecessary procedures and greater patient readmission to hospitals (Access Alliance Multicultural Health and Community Services, 2021). Although there will certainly be a cost associated with implementing some active offer strategies, many require little to no cost to implement (such as greeting patients in both official languages, hiring bilingual staff, asking patients in which language they would prefer to be served, etc.) and others which do have a cost associated (such as the use of professional

interpreters) may decrease the undesirable consequences of language barriers and lead to **lower costs of care** over time (Moloney, 2017). Third, we saw how language barriers can challenge the **provider experience**, leading to less rewarding, more frustrating, and emotionally draining patient interactions, which can leave the provider with a feeling of failure or helplessness (Haskard-Zolnierek et al., 2021; Kamath et al., 2003; Olcoñ & Gulbas, 2021; Turner & Madi, 2019). Through active offer training, providers would better appreciate their own minority language skills and how these can be optimally utilized to build a better rapport with their patients, thus improving patient/provider communication and leading to more satisfying patient interactions. Physicians rated as good communicators have higher job satisfaction, are less stressed and are less likely to suffer from burnout (Suojanen et al., 2018; Venktaramana et al., 2022). Additionally, implementing the active offer in an integrated care model, such as an OHT, would include a better understanding of their colleague's capacities to practice in French, which would support providers in the delivery of care by improving collaborations with French-speaking colleagues. Finally, my thesis has demonstrated how the active offer can **improve the patient experience**, with more active offer being linked to greater patient satisfaction. Given that the OHTs will operate under an accountability framework and must achieve "improvement against a standard performance measurement framework" (Ministry of Health, 2019b, p.24) reflecting all aspects of the Quadruple Aim, it would be in the OHTs' best interest to implement active offer strategies.

Finally, the implementation of the active offer can also contribute to Health Quality Ontario's (2017) Quality Matters Framework. The active offer addresses many dimensions of quality

health care (Health Quality Ontario, 2017). For instance, as we have seen, practicing the active offer will ensure that care is:

- **safe**, linguistic concordant care is associated with fewer medical errors, more appropriate testing and reduced hospitalizations (Access Alliance Multicultural Health and Community Services, 2021),
- **effective**, linguistic concordant care is associated with greater patient adherence and improved patient confidence (Bowen, 2001; Jutras et al., 2020; Wilson et al., 2005; Yeo, 2004),
- **patient-centered**, the active offer is an example of patient-centered communication that allows patients better understand their health status and actively contribute to the decisions making process,
- **efficient**, asking patients in which language they would prefer to receive care and ensuring such preferences are included in patient charts and on referral forms would allow follow-up care to prepare to provide services in the patient's preferred language, and
- **equitable**, equitable access to linguistically appropriate care can be achieved through the proactively offer of care in both official languages.

## 6.4 Limitations and future considerations

Although efforts were made to maximise physician and patient participation by embedding data collection within a CPD program, thus incentivizing participation from physicians and providing a means of recruiting patients (i.e., through their family physician's office), nevertheless my thesis was subject to low participation rates. Furthermore, although I attempted to follow as

many best practice standards as possible when developing the CDP program, the program could be improved in several ways. In the following section, I will discuss some of the limitations of the provider surveys, the patient surveys and the CPD program in general. I also present suggestions for future work.

#### 6.4.1 Limitations with the physician survey participation rates

Likely, the biggest limitation of the present thesis is the limited participation rate from physicians, particularly in the later phases of the CPD program. There were too few physicians who completed the entire CPD program (n=3) to be able to conclude on the effectiveness of the program, as was intended with the first research question. However, what little evidence I was able to collect (from the pre/post intervention surveys, workshop comments, and post-intervention open ended survey questions) suggests that the program may be effective at changing active offer behaviours as I was able to observe improvements in knowledge (physicians were better able to define the active offer after participating in the program), skills (practical examples of active offer strategies implemented within the practice were provided on the post-intervention survey), attitudes (physician reported being more confident in serving Francophone populations after participating in the program) and behaviours (numerous improvements were observed on various items of the *Active Offer of French Language Services in Minority Context Measure*). Also, with only 3 physicians completing the post-intervention survey, not only is it impossible to make broad generalizations about the effectiveness of the program, but it was also not possible to conduct a comparative analysis to determine what behaviours were more likely to improve in English-speaking vs. French-speaking physicians. This information would allow us to better tailor future iterations of the program to individual

needs of participating physicians. For instance, English-speaking physicians may benefit more from learning simple strategies to conversing in French (e.g., learning basic words and colloquial expressions to use with the patient and aid in the interpretation when taking a medical history) whereas French-speaking physicians may benefit from learning strategies to systematically and continuously take account of their patient's linguistic preferences rather than assuming they know what language their patients prefer from past interactions (Timony et al., 2016).

Furthermore, there were too few physicians participating in the pre-intervention survey to allow me to make broad judgements on the larger workforce. Thus, the goal of the second research question, of determining the degree to which French language services are actively being offered in physicians' offices of Northeastern Ontario, could not be achieved. Results from the 13 physicians who completed the pre-intervention survey are likely not representative of the presence of active offer in all of Northeastern Ontario, yet provide an approximation of behaviours that are likely also occurring, or not occurring, elsewhere. These results suggest a general lack of active offer within family physicians offices in Northeastern Ontario (with generally low average active offer scores observed on all subtheme of the *Active Offer of French Language Services in Minority Context Measure*). Thirteen respondents also provide little variability in participating providers and there is reason to believe that physicians who participated in the CPD program may be different from the average northern physician. I recognized certain physicians from having participated in past research surrounding Francophone health and/or from having previously attended linguistic sensitivity training hosted by the NOSM. Unfortunately, with a smaller pool of professionals working in the north (i.e., there are only 260 physicians with an active primary practice located in a strong French

community of Northeastern Ontario, representing only 2.6% of the entire workforce), we tend to see the same small groups of providers participating in research and other activities hosted by the medical school. Given their continued involvement with these types of activities, these individuals are likely already highly sensitized to the importance of French language services and it would be expected that they would be more aware of the concept of active offer, why it is important and how it can be implemented. Their knowledge of the value of offering French language services may have motivated them to participate in the CPD program and improve their own active offer behaviours. Therefore, it is likely that the active offer behaviours (i.e., average active offer scores) would be even less frequent in the general northern family physician's office. The present results suggest there is still work to be done to improve the availability of active offer in the north and likely throughout the province, thus supporting further implementations of the present CPD program or of similar continuing education activities surrounding the active offer.

However, before implementing any further continuing education interventions surrounding the active offer, we must address participation rates, why they were so low in the present CPD and how they may be improved. Although data could not be collected from physicians who did not participate in the CPD program, the literature provides possible explanations for why physicians may not have participated. For instance, Aizen's Theory of Planned Behaviour (1991) has been used to understand why physicians may not participate in certain continuing education programs (Gagnon et al., 2007). According to the Theory of Planned Behaviour, a change in behaviour depends on the individual's **intention** to perform the behaviour, which in turn is explained by the individual's **attitudes** towards the behaviour, the **subjective norms** in their environment and

their perception of being able to **control** their behaviour (Aizen, 1991). Each of these factors can help explain why so few physicians chose to participate in the present education program.

For instance, when considering **attitudes**, in order for a physician to participate in a continuing education program of this nature, they must first believe there is an advantage to doing so. With many physicians in Northern Ontario believing that French language services are unnecessary given that their patients are bilingual (Timony et al., 2016), the low participation rate could be explained by such an attitude. Furthermore, as was discussed in the literature review, physicians often devalue communication skills and the importance of communication training, believing communication to be largely unteachable and learned through practice (Back et al., 2019; Choudhary & Gupta, 2015; Haq et al., 2004; Perron et al., 2015). Such negative attitudes towards communication training are particularly likely if the physician does not perceive communication as being an issue with their patients (i.e., if they are unaware of their own communication shortcomings). Given that many learn communication skills through on-the-job observation of senior physicians (Agency for healthcare Research Quality, 2017; Back et al., 2019; Levinson et al., 2010), it is clear that the common attitude in Ontario, that French is unnecessary since Francophones are bilingual, will continue to be a barrier to implementing and teaching the active offer to practicing physicians.

From the perspective of **subjective norms**, physicians have identified the dominance of the English language in the medical profession as a barrier to serving French-speaking patients (Timony et al., 2016). The fact that most physicians in Ontario were educated in English, that the medical literature they receive is predominantly in English and that English is the language of choice when communicating with colleagues perpetuates a belief within the medical community

that the language of practice is English. Such a belief may undermine efforts to offer linguistic sensitivity training. Finally, from the perspective of behavioural **control**, physicians may have thought the program would be too time-consuming, a commonly reported reason for not participating in continuing education programs (Gagnon et al., 2007; Guan et al., 2008; Sadenghi-Bazargani et al., 2014), or that the patient surveys would be too disruptive to their practice. In fact, each of these concerns were raised during the workshop and in the post program survey as weaknesses within the education program. Therefore, despite physicians highlighting the lack of continuing education opportunities surrounding Francophone populations as a barrier to serving Francophones (Timony et al., 2016), it is possible that these physicians do not **intend** to participate in such opportunities.

Even with the possibility of earning numerous certified continuing education credits by participating in the present CPD program, relatively few physicians responded to recruitment efforts, suggesting continuing education credits alone are not enough to encourage participation. It is essential that physicians believe that there is a need within their practice for them to invest time in education (Filipe et al., 2016). Research has found that physicians are more likely to participate in education programs that address specific clinical skills when they have more patients with corresponding health needs (Schoen et al., 2009; Wall et al., 2005). For instance, Schoen and colleagues (2009) found that they could predict participation in a post-myocardial infarction (MI) education program by the number of post-MI patients within a practice (Schoen et al., 2009). Thus, until physicians perceive the need to offer linguistically adapted services to their Francophone patients, further education efforts on the active offer of French-language health services may be met with limited success.

Considering physicians tend to overestimate their own communication skills, while underestimating the linguistic needs and preferences of their patients (Back et al., 2019), the objective of the **assessment phase** in the present CPD program was to identify communication strengths and weaknesses and provide feedback from patients to help demonstrate the need for the active offer within each physician's practice. An assessment of this nature was intended to sensitize physicians to their own unperceived needs, thus encouraging them to seek further education in this area. However, this strategy was ineffective at stimulating interest from many physicians. To be persuaded to participate in the present CDP program, physicians had to previously be aware of the importance of linguistically adapted communication and perceive a gap in their own communication skills. Since the present assessment phase identified unperceived needs, to be most effective at encouraging CPD participation, the assessment phase may need to be separated from the education program, particularly assessments surrounding the clinical audit process. Given the government of Ontario's recent French Languages Service Strategy (Ministry of Francophone Affairs, 2022a; Ministry of Francophone Affairs, 2022b) and recent changes to the French Language Services Act (FLSA) (French Language Services Act, 1990; Ministry of Francophone Affairs, 2022b), both of which describe the importance of evaluating the availability and quality of French language services being offered, it would be reasonable for the Ministry of Health or Ontario Health to begin monitoring the state of active offer in medical offices of Ontario using tools such as the *Active Offer of French Language Services in Minority Context Measure* (Savard et al., 2014). Such an evaluation should be expected given the new requirement for Ministers (including the Minister of Health) to report annually on how they have implemented the FLSA and the active offer of French language services (French Language Services Act, 1990; Ministry of Francophone Affairs, 2022b). As a

result, it would not be surprising to see such requirements trickle down to front-line provider (i.e., the Ontario Health Teams) who will likely need to report annually to the Ministry of Health regarding the French language services they provide. Levinson, Lesser and Epstein (2010) encourage such annual evaluations of communication skills, which they add should include peer and patient evaluations. Thus, including a patient satisfaction survey, such as the one used in the present thesis, would provide insight into how communication skills influence the patient experience. Such annual evaluations would also highlight gaps in French language services, which, in turn, would sensitize physicians to their own unperceived needs, thus encouraging participation in communication training.

In addition, evidence from the United States suggests that legislative changes, as well as changes to competency guidelines, can persuade physicians to participate in continuing education training. Given the prevalence of racial and ethnic minorities in the US and the health discrepancies they experience, various national, state and local initiatives have been implemented to improve the provision of culturally competent care (Beamon et al., 2006; Like, 2011). For instance, in 2005 the New Jersey State Board of Medical Examiners enacted relicensing mandates that require physicians to obtain cultural competency training (Like et al., 2008). Recent legislative changes in Ontario, such as Bill 74 (The People's Health Care Act, 2019), the French Languages Service Strategy of 2022 (Ministry of Francophone Affairs, 2022b) and the modernized FLSA (French Language Services Act, 1990) point to a shift in health care delivery to be more responsive to the needs of the Francophone population. If the government of Ontario is serious about implementing true change to the provision of linguistically adapted health care, they would be wise to follow examples from the US and have the College of Family

Physicians of Canada and the Royal College of Physicians and Surgeons of Canada include communication-training requirements as part of the certification process (i.e., in addition to establishing the number of credits that need to be acquired, physicians could also be required to maintain credits in nonclinical skills, such as patient-centred communication, empathy and cultural awareness), as suggested by Levinson, Lesser & Epstein (2010). This in combination with enhanced evaluations of the availability of French language services would sensitize providers to their unperceived communication needs, encourage participation in communication training and provide educators with the data needed to create CPD programs that best meet the needs of the Francophone population.

Finally, limited response rates from physicians provoked additional limitations with the physicians' surveys. For instance, I originally intended to survey receptionists and patients post-intervention, as recommended by Levinson, Lesser and Epstein (2010) (as can still be seen in much of the recruitment material and information letters initially provided to physicians and receptionists in Appendices). However, with so few physicians participating in the workshop, it was decided that only the post-intervention physician surveys would be included to fulfill the reflective evaluation requirements for CFPC accreditation. The receptionist and patient surveys were eliminated as it was decided that the burden of having receptionists fill out a survey and provide survey packages to their patients (which some physicians did find cumbersome) would not yield useful data, as there would be too few of these to allow for meaningful statistical analysis. Thus, since only physicians completed the post-intervention survey, it is impossible to determine whether the improvements reported by physicians were also perceived by receptionists and, more importantly, patients. We also could not compare pre- and post-intervention patient

surveys to determine whether patient satisfaction improved as a result of improved active offer behaviours. Both questions should be explored in future research and should be included in future implementations of this program. Furthermore, the evaluation of the present CPD program consisted of a pre- and post-intervention survey, comparing baseline active offer scores to post-intervention scores. However, a control group who completes the pre- and post-intervention surveys without receiving the educational intervention would have been needed to determine the true impact of the CPD program. It can be difficult to differentiate the relative influence of evaluation from education in the present CPD program. By simply completing the pre-intervention survey, physicians were exposed to several active offer strategies that they can apply to their practice even without participating in the educational intervention. Once again, removing the assessment phase from the education program and having the Ministry of Health or Ontario Health conduct annual evaluations on the state of French language services and the active offer (as is established in the modernized FLSA (French Language Services Act, 1990)), would provide a provincial database which can be used to evaluate continuing education interventions by comparing physicians who participated in training to those who did not.

#### 6.4.2 Limitations with the patient surveys

Despite having achieved an acceptable sample of patients who completed the pre-intervention survey, the patient survey was not without its limitations. First, it is important to note that satisfaction scores as a whole were quite high and, although there were clear and consistent trends in the data, there was limited variability in satisfaction scores across comparison groups, which is commonly observed in research using satisfaction surveys (Jenkinson et al., 2002). Two limitations of the study may help explain these high satisfaction scores. First, the demographic

characteristics of the sample do not correspond to the demographic profile of Francophones in Northeastern Ontario (Ministry of Francophone Affairs, 2019), with the present sample being older (median age of 57 vs. 46 in the region) with far more women (68.2% in this sample vs. 51.3% in the region). These differences are important considering both older patients and women have been found to be more satisfied with health care services (Batbaatar et al., 2017; Boscardin & Gonzales, 2013). Furthermore, certain patient subgroups are commonly under-represented in satisfaction surveys, including those who experience language barriers (Boscardin & Gonzales, 2013; Gayet-Ageron et al., 2011). Thus, it is possible that the present sample does not include those patients who experience the most significant linguistic discordances or other characteristics (i.e., being younger or being men) associated with dissatisfaction. The potential that certain subgroups would be missing from the sample is even more likely given the patient recruitment method used in the present study. Although recruiting patients from physicians' offices and having receptionists distribute survey packages has many advantages (as discussed earlier), it is unlikely that this method will produce a random sample of patients. For instance, patients who are very dissatisfied with their care are less likely to return for follow-up appointments (Naidu, 2009) and are less likely to have visited their family physician's office during the recruitment period.

Furthermore, although receptionists were instructed to distribute survey packages to patients randomly, they could choose to whom they handed surveys. Thus, receptionists could introduce a bias to the recruitment. In the most innocent scenario, they could select to only hand out surveys to patients who they believe would be most likely to participate, thus implementing arbitrary exclusion criteria that were not originally intended. In a more manipulative scenario,

knowing patients were receiving satisfaction surveys, receptionists could have excluded patients who they believe to be more dissatisfied (i.e., those who they know have complained in the past or who are more difficult to please), only handing out surveys to patients they deem highly satisfied. In all three instances, data from the ‘hardest to reach’ patients would have been limited, thus further explaining the high satisfaction scores. However, these data are needed to better understand the influence of communication on satisfaction and to develop and implement communication strategies that address the experiences of these hard to reach patients.

Second, the sample was relatively small. A power analysis based on the findings of Lockyer, Violato, Wright and Fidler (2009) revealed that 480 respondents would be needed to detect statistically significant differences in satisfaction using the PAR patient survey. However, the present sample consisted of only 235 respondents, which was further curtailed in analyses conducted strictly on Francophones (n=103). The fact that significant differences were detected in such a small sample suggests that these differences may be even more prominent in the population at large. A larger, more diverse and more representative sample may exhibit greater variability in satisfaction scores and trends observed in this study may become more pronounced.

Furthermore, many factors, which have been found to influence patient satisfaction, were not considered in the present study. These include provider characteristics, such as accessibility and continuity of care (i.e., receiving timely care from the same providers), and efficacy of care (i.e., improved health outcomes) as well as patient characteristics, such as education level, socio-economic status, personality and expectations (Batbaatar et al., 2017). Future studies should account for such factors and consider the impact of language concordance on satisfaction with other components of care such as physician access or the physical environment. Additionally, a

more nuanced measure of active offer from multiple sources (e.g., patients, providers, and support staff) would be needed to determine how active offer strategies beyond the patient's perception (i.e., at the organizational level) could affect patient satisfaction. Finally, a larger scale recruitment with a more diverse and representative sample would be needed to confirm the present findings.

#### 6.4.3 Limitation with the CPD program

Although many best practice standards and adult learning principles were followed when developing the present CPD program, the program could be improved in several ways. As we saw in the literature review, effective CPD is a cyclical process, with each subsequent iteration of the CPD building on previous learnings and evolving through feedback received during post-program evaluations (Filipe et al., 2014; Filipe et al., 2016; World Federation for Medical Education, 2015). Since the present CPD program was only implemented once, it has not had the opportunity to evolve and mature through this cyclical process. Future iterations of this or similar CPD programs should learn from the limitations described in this thesis.

For instance, physicians who participated in the present CDP program were provided with an opportunity to learn from one another and develop active offer strategies that can be applied in their practice (Filipe et al., 2016; Merriam, 2018). They were also provided with an opportunity to implement the strategies developed during the workshop before being evaluated in the post-intervention survey, representing practice-based and experiential learning strategies (Filipe et al., 2016; Merriam, 2018). However, providers did not have the opportunity to practice these strategies in a controlled environment and receive feedback before applying them in a real-world setting (Ammentorp et al., 2021; Choudhary & Gupta, 2015; Deveugele et al., 2005; Haq et al.,

2004; Suojanen et al., 2018; Venktaramana et al., 2022). Future iterations of this CPD program should provide participants with an opportunity to practice the active offer with colleagues or standardized patients while being observed and receiving constructive feedback from knowledgeable facilitators before applying these strategies in their practice (Alexander et al., 2006; Berkhof et al., 2011; Levinson et al., 2010).

Finally, although the CPD program was evaluated using three of Dixon's (1978) four levels of evaluation, namely: perceptions and satisfaction, a competency assessment of knowledge, skills and attitudes and a professional performance assessment, it was outside the scope of the present thesis to conduct a health-care outcome assessment. As described above, a single implementation of a CDP program rarely provokes measurable changes in patient health outcomes (World Federation for Medical Education, 2015). Once again, it is the cyclical nature of CPD that leads to health improvements at the patient population level. Given recent legislative changes in Ontario, namely mandating the active offer in the FLSA (French Language Services Act, 1990) and including expectations for Ontario Health Teams to comply with the FLSA in Bill 74 (The People's Health Care Act, 2019), and the fact that results from my thesis suggest a general lack of active offer in physicians office of northern Ontario, it would be prudent to develop more CPD surrounding active offer training for practicing health care providers. This, in combination with a prior recommendation for the Ministry of Health to begin evaluating the state of French language services in Ontario (Ministry of Francophone Affairs, 2022b, French Language Services Act, 1990) and its impact on the patient experience (Levinson et al., 2010) would allow for a health-care outcome assessment to be performed in the future. Furthermore, improvements in active offer behaviours measured in this thesis relied strictly on self-assessments from

participating physicians. As described above, an evaluation of the presence of the active offer from various sources, such as receptionists and patients (as was originally intended) or direct observations from an external evaluator would be needed to measure if the improvements reported by physician represent actually changes in the way care is provided.

## 6.5 Recommendations

### 6.5.1 System level recommendations

As we have seen, the main limitation of my thesis was low physician participation, which prevented me from making broad generalizations about the effectiveness of the CPD program or the presence of the active offer in physician's offices across northeastern Ontario. Although the active offer has been suggested as a means of systematically providing French language health services (Office of the French Language Services Commissioner of Ontario, 2016a), physicians must be aware of their patient's linguistic needs and preferences and of limitations in their own communication behaviours to seek out and participate in educational opportunities addressing communication skills and the active offer. Therefore, it may be preferable to evaluate the state of French language services, the presence of active offer and its impact on the patient experience prior to inviting physicians to participate in a CPD program on such topics. Such an evaluation aligns well with Ontario's recent French Languages Services Strategy (Ministry of Francophone Affairs, 2022a; Ministry of Francophone Affairs, 2022b) and the modernization of the French Language Services Act (FLSA). An assessment of the state of French language services and its impact on patient experiences would serve two purposes. First it would sensitise providers to their own unperceived needs (i.e., gaps in their communication behaviours), thus encouraging them to participate in CPD opportunities regarding communication skills and the active offer.

Second, an annual assessment of this nature would allow CPD providers to conduct Health-Care Outcome Assessments (Dixon, 1978) by identifying improvements in patient experiences and health outcomes following the implementation of communication/active offer training initiatives. Furthermore, providers may be more likely to practice the active offer and participate in active offer training opportunities if they are required to report on their active offer strategies and if active offer standards are included in funding agreements. For instance, the Ministry of Health and Ontario Health could mandate OHTs to develop active offer policies.

Beyond provincial level policy and decision makers, the Federal government could also support the widespread implementation of patients-centered primary care services (such as the implementation of the active offer) through funding agreements and by setting national standards (Rubenson, 2006). Since 1996, the Federal government has been assisting the provinces to fund health, education and social services through the Canada Health and Social Transfer (CHST) (Government of Canada, 2014), which was divided into the Canada Health Transfer (CHT) and the Canada Social Transfer (CST) in 2004 (Government of Canada, 2014). Recently, the federal government has made significant contributions to the CHT, for instance, in December 2022 it was announced that total allocated funds provided under the CHT will increase by 9.3% in 2023-24 (Government of Canada, 2022). In addition, the Federal government and the premiers are currently negotiating a 10 year, multibillion-dollar funding agreement that, according to the Intergovernmental Affairs Minister Dominic LeBlanc and the Federal Health Minister Jean-Yves Duclos, could see a significant increase to the CHT as well as additional bilateral financial agreements in target areas such as home and long-term care (Aiello, 2023; Fife, 2023). There is therefore an opportunity and a precedence for the Federal government to designate funding in

priority areas, such as investments in publicly funded patient-centered primary care services, which could include minimum requirements for the provision of care in Canada's two official languages. Such an agreement could encourage the active offer as a means of complying with national standards, which would also align with Ontario's recent French Languages Services Strategy (Ministry of Francophone Affairs, 2022a; Ministry of Francophone Affairs, 2022b).

Therefore, three system level recommendations can be made:

#### System level recommendations

- 1) It is recommended that the Ministry of Health/Ontario Health implement an annual evaluation of the state of French language services and of the active offer provided by Ontario Health Teams and health service providers, including an assessment of patient experiences.
- 2) It is recommended that the Ministry of Health/Ontario Health hold the Ontario Health Teams and health service providers accountable to the FLSA by including active offer standards in funding agreements.
- 3) It is recommended that the Federal government invest in publicly funded patient-centered primary care by allocating a percentage of federal funding to the provinces for such services and by setting national standards for the provision of care in Canada's two official languages.

#### 6.5.2 Organizational level recommendations

The present thesis identified various active offer behaviours, many of which were infrequently reported by physicians. Furthermore, although many active offer behaviours and strategies were improved following participation in the present CPD program, those that showed little to no

improvement often did not address direct patient-physician interaction. These were often organizational level strategies, such as French language telecommunication strategies, informing the patients of the availability of French services (both visually and verbally), providing French documents and entertainment options and encouraging the use of French between staff members. Furthermore, although it was not addressed in the active offer questions from the physician and receptionist surveys, the Ministry of Health suggests including Francophone patients in governance structures and in management positions (Ministry of Health, 2019b). Since the responsibility of the active offer lies not only in front-line providers but also in the leadership of health care organizations, the OHTs and other health care organizations could support providers in implementing the active offer by having leadership participate in active offer training to learn what role they can play in promoting the active offer and by implementing organizational policies which encourage the active offer. Such policies could ensure patients are proactively being greeted in French; address individual behaviours (e.g., wearing an identification when one can speak French or having French-speaking receptionist answer the phone in French followed by English); encourage the use of French within the office environment (e.g., providing French reading and entertainment options, broadcasting French media or holding meetings in French); and incorporate linguistic preferences in existing tools (e.g., in the patient's chart and on referral forms), thus systematically encourage a discussion surrounding linguistic preferences.

Therefore, I suggest the following organizational level recommendation:

Organizational level recommendation

- 1) It is recommended that leadership of the OHTs and health care organizations support the active offer by including Francophone members in their governance structures,

developing policies on active offer, supporting the use of French in their internal culture and ensuring all staff receive active offer training.

### 6.5.3 Provider level recommendations

Results from my thesis suggest that the Francophone patient experience can be improved by increasing concordance between the patient's linguistic preferences and the language in which services are provided. The active offer of French language services provides strategies that both French-speaking and English-speaking physicians can use to raise awareness of their patient's linguistic needs and preferences and adapt their language of service accordingly. The correlation between the active offer and patient satisfaction observed in my thesis suggests that the patient experience can be improved by implementing more frequent active offer behaviours.

Fortunately, an evaluation of the present CPD program suggests active offer behaviours can be learned by participating in training. However, the pre-intervention physician surveys suggest that the active offer is largely absent in physician's offices. Therefore, results from this thesis support the following provider level recommendation:

#### Provider level recommendation

- 1) It is recommended that physicians and health service providers wishing to improve their patient-centred communication skills and improve the patient experience should participate in active offer training when it is available and implement active offer strategies in their practice.

#### 6.5.4 Recommendations for CPD providers and medical schools

The general infrequency of active offer behaviours reported on the pre-intervention physicians and receptionist surveys suggests further education is needed to instruct practicing providers about the importance of linguistic concordant communication and how they can implement the active offer. Although existing active offer training opportunities offer excellent resources for improving knowledge about Francophone health needs and the role of the active offer, these resources rely primarily on passive learning strategies by providing literature, videos, case studies and online modules that are reviewed independently. However, there is little evidence such passive teaching is effective at changing communication behaviours if they are not combined with group discussion, feedback from peers and an opportunity to practice (Berkhof et al., 2011). Furthermore, CPD activities are most effective when they reflect adult learning principles and include experiential and practice-based learning that provide opportunity to practice active offer strategies in a safe environment (e.g., via role-play or standardized patients) and receive constructive feedback, all of which build confidence to implement the active offer in practice (Berkhof et al., 2011; Filipe et al., 2016; Merriam, 2018).

##### Recommendation for CPD providers

- 1) It is recommended that CPD providers incorporate adult learning principles and experiential and practice-based learning strategies when developing future active offer training initiatives.

Additionally, medical schools could play an important role in training future patient-centered communicators. First, the active offer could be taught in medical schools as a patient-centered communication strategy that can be used with all patients who may potentially experience communication barriers (including linguistic minority groups, children, the elderly or the hearing impaired). Second, medical schools could strategically recruit French-speaking learners from underserved areas, provide learning opportunities in French and surrounding the needs of minority language populations, and provide experiential learning opportunities by offering placements in underserved Francophone communities (Timony et al., 2022). Such strategies have been employed by the NOSM University to improve the availability of physicians in underserved rural and northern communities (Hogenbirk, 2016; Straser, 2013); a similar approach could be utilized to improve the supply and distribution of French-speaking physicians.

#### Recommendation for medical schools

- 1) It is recommended that medical schools include active offer training as part of the curriculum.
- 2) It is recommended that medical schools recruit French-speaking learners, offer some education in French and offer experiential learning opportunities in underserved Francophone communities

## Chapter 7

### 7 Conclusion

As part of the present thesis, a CPD program was developed that used a three-phase approach to teach patient-centred communication to practicing physicians of Northeastern Ontario. First, an **assessment phase** measured the presence of the active offer in participating physician's offices through a series of physician, receptionist and patient surveys. Next, in an **education phase**, physicians received personalized reports that identified gaps in their active offer behaviours and offered resources for implementing active offer strategies to overcome these gaps. Physicians were also given the opportunity to participate in a workshop in which strategies to implement the active offer in their practice were collaboratively developed. Finally, a **reflective phase** provided physicians with a post-intervention survey followed by a final progress report that highlighted improvements made to their active offer behaviours. This CPD program served two purposes, first it used experiential and practice based learning strategies as well as adult learning principles to teach practicing physicians how to implement the active offer in their practice. Second, data collected during the CPD program allowed me to answer the research questions posed in the present thesis.

#### 7.1 Take away message

Results from my thesis suggest patient satisfaction is influenced by language concordance between patients and physicians. However, it is not enough to simply have French-speaking physicians serve Francophone patients, as this level of concordance had less impact on satisfaction. Rather it seems preferable to ensure that the practice language is adapted to the

patient's needs, values and preferences. This can be achieved through the active offer, which was positively correlated with Francophone patient satisfaction. This is important as it is much more feasible to train practicing physicians on how to implement the active offer, than it would be to train new French-speaking physicians or to convince physicians who can practice in French to relocate their practice to Francophone communities. It bears repeating that physicians do not need to be fluent in French to ensure French language services are received. Any provider practicing patient-centred care/communication should naturally remain aware of their patient's needs, values and preferences, including communication needs, and adapt the care they provide accordingly (Hashim, 2017).

The active offer is an example of patient-centred communication and many of the responsibilities for the active offer described in the Joint Position Statement on the Active Offer by the French Language Health Planning Entities and French Language Health Networks of Ontario (2015) closely resemble patient-centred care (Hashim, 2017). For instance: *proactively welcome Francophone patients in French* is simply an acknowledgment of the patient's cultural values and identity; *understand the needs of Francophone patients* is the starting point of any patient-centred approach; and *ensure quality of care and patient safety* is the responsibility of all physicians, regardless of the patient's linguistic background. Furthermore, active offer strategies can also be used to improve patient-centred communication with all patients, particularly when they are limited in their communication capacities (e.g., linguistic minority groups, children, the elderly, the hearing impaired). Conveniently, the active offer seems to align well with the health system integration that is currently occurring in Ontario, as both are patient-centred principles that aim to improve the patient experience with the health care system. Furthermore,

implementing the active offer would ensure OHTs and health service providers are complying with the requirements of the French Language Services Act, as mandated by Bill 74. Finally, the Ministry of Health, Ontario Health and the OHTs should consider annual assessments of the status of French language services in the health care system and implement active offer strategies at the system, organizational, and provider level.

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## Appendix A

### Large recruitment poster

(Posted during physician attended conferences/events)

(Double click on the icon below to open the poster as a PDF)



Larger Poster — Ici  
on Parle.pdf



## How to Actively Engage Francophone Patients

Tools for French and English-Speaking Physicians

## Comment activement engager vos patients francophones

Outils pour les médecins francophones et anglophones

The Centre for Rural and Northern Health Research (CRaNHR) in collaboration with the Northern Ontario School of Medicine invite you to participate in a unique continuing education and professional development (CEPD) opportunity which aims to help improve the Francophone patient experience within your office.

Le Centre de recherche en santé dans les milieux ruraux et du nord (CReSRN) en collaboration avec l'École de médecine du Nord de l'Ontario vous invite à participer à un programme d'éducation continue et de perfectionnement professionnel unique qui a pour but d'améliorer l'expérience des patients francophones qui fréquentent votre bureau.

### BENEFITS

- FREE CEPD program
- Opportunity to earn a number of Mainpro M1, M2 and up to 6 Mainpro C credits
- Participate at your own rate
- Participate in as much or as little of the program as you chose
- Education tailored to your needs
- Contribute to research on health care in Northern Ontario

### OBJECTIVES

- This program aims to:
- Better understand services rendered by family physicians practising in Northern Ontario.
  - Identify gaps in the 'active offer' of French language services and understand the impact of language concordance on patient satisfaction.
  - Encourage patient centered care through the 'active offer' of French language services while evaluating its impact on practice.

### WHO SHOULD ATTEND

All family physicians and general practitioners practicing in Northern Ontario. Given the link between patients' health and provider communication, it is essential that physicians who have chosen to practice in Northern Ontario, both those who can and who cannot speak French, are equipped with strategies to offering patient-centered care to their Francophone patients.

### ACCREDITATION

This program meets the accreditation criteria of The College of Family Physicians of Canada and has been approved by the Continuing Education and Professional Development Office at the Northern Ontario School of Medicine.

Activity / Activité	Possible credits earned / Crédits possibles						
	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5	Scenario 6	Scenario 7
<b>PHASE 1</b> Assessment / Évaluation	Complete Physician, Receptionist and Patient survey Remplir questionnaire de médecin, de la réceptionniste et du patient	1 M2 credit (1 hour/heure)	1 M2 credit (1 hour/heure)	1 M2 credit (1 hour/heure)	1 M2 credit (1 hour/heure)	1 M2 credit (1 hour/heure)	1 M2 credit (1 hour/heure)
<b>PHASE 2</b> Education / Éducation	Review survey results and send feedback Revoir les résultats et les feedbacks	1+ M2*	1+ M2*	1+ M2*	1+ M2*	1+ M2*	1+ M2*
	Do Linking Learning to Practice activity Faire l'activité « Relier l'apprentissage à la pratique »			2 C credits = 2 M1 Bonus/Bois			
<b>PHASE 3</b> Post-Evaluation / Post-évaluation et activité de réflexion	Participate in Workshop 3: complete reflective exercises Participer dans l'atelier et faire l'exercice de réflexion			2 C credits = 2 M1 Bonus/Bois			
	Complete Physician, Receptionist and Patient survey Remplir questionnaire de médecin, de la réceptionniste et du patient				1 M2 credit (1 hour/heure)	1 M2 credit (1 hour/heure)	1 M2 credit (1 hour/heure)
	Review final report Revoir le rapport final					1+ M2*	1+ M2*
	Do Linking Learning to Practice activity Faire l'activité « Relier l'apprentissage à la pratique »						2 C credits = 2 M1 Bonus/Bois
<b>Total Mainpro credits earned / Total des crédits Mainpro accordés</b>	1 M2*	2+ M2*	2 C = 2 M1*	4 C = 4 M1*	4 C = 4 M1*	4 C = 4 M1*	6 C = 6 M1*

1. M2 credits are earned on an hourly rate. 1 M2 credit can be claimed for every hour of work. Les crédits M2 sont obtenus sur un taux horaire. 1 crédit M2 peut être réclamé pour chaque heure de participation.  
 2. For every C credit earned, the CEPC automatically awards 1 bonus M1 credit (physicians are not required to claim these). Pour chaque crédit C obtenu, le CEPC accorde automatiquement 1 crédit M1 bonus (les médecins n'ont pas à réclamer ces-les).  
 3. This workshop meets the accreditation criteria of the College of Family Physicians of Canada and has been accredited for up to 2 Mainpro C credits. Get atelier répond aux critères d'accréditation du Collège des médecins de famille du Canada et a été accrédité pour 2 crédits Mainpro-C.

### AVANTAGES

- Programme éducatif GRATUIT
- Occasion d'obtenir de nombreux crédits Mainpro M1, M2 et jusqu'à 6 crédits Mainpro C
- Participer à votre rythme
- Participer dans autant d'éléments du programme que vous désirez
- Éducation adaptée à vos besoins
- Contribuer à la recherche sur les soins de santé offerts dans le nord de l'Ontario

### OBJECTIFS

- Le programme a pour but de :
- Mieux comprendre les services offerts par les médecins de famille pratiquant dans le nord de l'Ontario.
  - Identifier les lacunes dans l'offre active des services de santé en français et comprendre l'impact de la concordance linguistique sur le niveau de satisfaction du patient.
  - Encourager les soins axés sur le patient par l'entremise de l'offre active tout en évaluant son impact sur la pratique.

### QUI DEVRAIT PARTICIPER

Tout médecin de famille et généraliste qui pratique dans le nord de l'Ontario. Étant donné le lien entre la communication médecin-patient et la santé, il est essentiel que tous les médecins qui se sont établis dans le nord de l'Ontario soient outillés de stratégies pour offrir des soins axés sur les patients francophones, peu importe leur capacité de parler en français.

### ACCREDITATION

Ce programme répond aux critères d'accréditation du Collège des médecins de famille du Canada et a été approuvé par le Bureau d'éducation continue et de perfectionnement professionnel à l'École de médecine du Nord de l'Ontario.

### FOR MORE INFORMATION / POUR PLUS DE RENSEIGNEMENTS

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## FREE CEPD program / Programme éducatif GRATUIT



## Appendix B

### Small recruitment poster

(Available at conferences, and shared by community partners)

# Ici on parle!

**How to Actively Engage Francophone Patients**  
Tools for French and English-Speaking Physicians

The Center for Rural and Northern Health Research (CRaNHR) in collaboration with the Northern Ontario School of Medicine invite you to participate in a unique continuing education and professional development (CEPD) opportunity which aims to help improve the Francophone patient experience within your office.

## OBJECTIVES

This program aims to:

- Better understand services rendered by family physicians practising in Northern Ontario.
- Identify gaps in the "active offer" of French language services and understand the impact of language concordance on patient satisfaction.
- Encourage patient centered care through the 'active offer' of French language services while evaluating its impact on practice.

## BENEFITS

- FREE CEPD program
- Opportunity to earn a number of Mainpro M1, M2 and up to 6 Mainpro C credits
- Participate at your own rate
- Participate in as much or as little of the program as you chose
- Education tailored to your needs
- Contribute to research on health care in Northern Ontario

## ACCREDITATION

This program meets the accreditation criteria of The College of Family Physicians of Canada and has been approved by the Continuing Education and Professional Development Office at the Northern Ontario School of Medicine.

## FOR MORE INFORMATION, CONTACT:

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COMING THIS SPRING

# Ici on parle!

Comment activement engager vos patients francophones  
Outils pour les médecins francophones et anglophones

Le Centre de recherche en santé dans les milieux ruraux et du nord (CReSRN) en collaboration avec l'École de médecine du nord de l'Ontario vous invite à participer à un programme de formation professionnelle continue et de perfectionnement unique qui a pour but d'améliorer l'expérience des patients francophones qui fréquentent votre bureau.

## OBJECTIFS

Le programme a pour but de:

- Mieux comprendre les services offerts par les médecins de famille pratiquant dans le nord de l'Ontario.
- Identifier les lacunes dans l'offre active des services de santé en français et comprendre l'impact de la concordance linguistique sur le niveau de satisfaction du patient.
- Encourager les soins axés sur le patient par l'entremise de l'offre active tout en évaluant son impact sur la pratique.

## AVANTAGES

- Programme éducationnel GRATUIT
- Occasion d'obtenir de nombreux crédits Mainpro M1, M2 et jusqu'à 6 crédits Mainpro C
- Participer à votre rythme
- Participer dans autant du programme que vous le voulez
- Éducation adaptée à vos besoins
- Contribuer à la recherche sur les soins de santé offerts dans le nord de l'Ontario

## ACCREDITATION

Ce programme répond aux critères d'accréditation du Collège des médecins de famille du Canada et a été approuvé par le Bureau d'éducation continue et de perfectionnement professionnel à l'École de médecine du nord de l'Ontario.

## POUR PLUS DE RENSEIGNEMENTS, VEUILLEZ COMMUNIQUER AVEC:

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À VENIR CE PRINTEMPS

## Appendix C

### Fax recruitment letter

(Sent to all family physicians with an active practice in a strong French community of  
northeastern Ontario)

FAX: FREE CPD

You are invited to participate in a unique continuing education and professional development (CEPD) opportunity which aims to help improve the Francophone patient experience within your office.

#### BENEFITS

- FREE CEPD program
- Opportunity to earn up to 22 certified Mainpro+ credits
- Program meets the certification criteria of The College of Family Physicians of Canada
- Participate without leaving your office
- Contribute to research on health care in Northern Ontario

#### FOR MORE INFORMATION, CONTACT:

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 ☎ : 1-800-461-4030 ext. 4298  
 ✉ : [pe\\_timony@laurentian.ca](mailto:pe_timony@laurentian.ca)



FAX: DPC Gratuite

Vous êtes invité à participer à un programme de formation professionnelle continue et de perfectionnement unique qui a pour but d'améliorer l'expérience des patients francophones qui fréquentent votre bureau.

#### AVANTAGES

- Programme éducationnel GRATUIT
- Occasion d'obtenir jusqu'à 22 crédits certifiés Mainpro+
- Programme répond aux critères de certification du Collège des médecins de famille du Canada
- Participer sans quitter votre bureau
- Contribuer à la recherche sur les soins de santé offerts dans le nord de l'Ontario

#### POUR PLUS DE RENSEIGNEMENTS, VEUILLEZ COMMUNIQUER AVEC:

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## Appendix D

### Fax recruitment poster

(Sent to all family physicians with an active practice in a strong French community of  
northeastern Ontario)

# Ici on parle!

**How to Actively Engage Francophone Patients**  
Tools for French and English-Speaking Physicians

The Centre for Rural and Northern Health Research (CRaNRH) in collaboration with the Northern Ontario School of Medicine invite you to participate in a unique continuing education and professional development (CEPD) opportunity which aims to help improve the Francophone patient experience within your office.

## OBJECTIVES

This program aims to:

- Better understand services rendered by family physicians practising in Northern Ontario.
- Identify gaps in the "active offer" of French language services and understand the impact of language concordance on patient satisfaction.
- Encourage patient centered care through the 'active offer' of French language services while evaluating its impact on practice.

## BENEFITS

- FREE CEPD program
- Opportunity to earn up to 22 certified Mainpro+ credits
- Participate at your own rate
- Participate in as much or as little of the program as you chose
- Education tailored to your needs
- Contribute to research on health care in Northern Ontario

## CERTIFICATION

This program meets the certification criteria of The College of Family Physicians of Canada and has been approved by the Continuing Education and Professional Development Office at the Northern Ontario School of Medicine.

## FOR MORE INFORMATION, CONTACT:

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Northern Ontario  
School of Medicine  
École de médecine  
du Nord de l'Ontario  
الكلية الطبية  
للشمال



EARN FREE MAINPRO + CREDITS

# Ici on parle!

How to Actively Engage Francophone Patients  
Tools for French and English-Speaking Physicians

## POSSIBLE MAINPRO+ CREDITS EARNED

Activity		Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5	Scenario 6	Scenario 7
Assessment Phase	Complete Physician Survey & coordinate Receptionist and Patient surveys	1 Non-certified credit (1 hour)	1 Non-certified credit (1 hour)	1 Non-certified credit (1 hour)	2 Certified credits <sup>1</sup> (1 hour)	2 Certified credits <sup>1</sup> (1 hour)	2 Certified credits <sup>1</sup> (1 hour)	2 Certified credits <sup>1</sup> (1 hour)
	Review survey results and read literature		1 Non-certified credit per hour <sup>2</sup>	1 Non-certified credit per hour <sup>2</sup>	2 Certified credits per hour <sup>2</sup>			
Education Phase	Do Linking Learning to Assessment activity			5 Certified credits	5 Certified credits	5 Certified credits	5 Certified credits	5 Certified credits
	Participate in Workshop <sup>3</sup> & complete Reflective exercise				4 Certified credits	4 Certified credits	4 Certified credits	4 Certified credits
Post-education & Reflective Phase	Complete Physician Survey & coordinate Receptionist and Patient surveys					2 Certified credits (1 hour)	2 Certified credits (1 hour)	2 Certified credits (1 hour)
	Review final report						2 Certified credits per hour <sup>2</sup>	2 Certified credits per hour <sup>2</sup>
	Do Linking Learning to Practice activity							5 Certified credits
<b>Total Mainpro+ credits earned</b>		<b>1 Non-certified</b>	<b>2+ Non-certified</b>	<b>2+ Non-certified 5 Certified</b>	<b>13+ Certified</b>	<b>15+ Certified</b>	<b>17+ Certified</b>	<b>22+ Certified</b>

1. All Non-certified self learning credits earned will be eligible for Certified group learning credits upon attending the workshop, otherwise they will remain Non-certified.

2. These credits are earned on an hourly rate, 1 non-certified credit can be claimed for every hour of work.

3. This workshop meets the certification criteria of the College of Family Physicians of Canada and has been approved for 4 Mainpro + certified group learning credits.

EARN FREE MAINPRO + CREDITS

# Ici on parle!

Comment activement engager vos patients francophones  
Outils pour les médecins francophones et anglophones

Le Centre de recherche en santé dans les milieux ruraux et du nord (CReSRN) en collaboration avec l'École de médecine du nord de l'Ontario vous invite à participer à un programme de formation professionnelle continue et de perfectionnement unique qui a pour but d'améliorer l'expérience des patients francophones qui fréquentent votre bureau.

## OBJECTIFS

Le programme a pour but de:

- Mieux comprendre les services offerts par les médecins de famille pratiquant dans le nord de l'Ontario.
- Identifier les lacunes dans l'offre active des services de santé en français et comprendre l'impact de la concordance linguistique sur le niveau de satisfaction du patient.
- Encourager les soins axés sur le patient par l'entremise de l'offre active tout en évaluant son impact sur la pratique.

## AVANTAGES

- Programme éducationnel GRATUIT
- Occasion d'obtenir jusqu'à 22 crédits certifiés Mainpro+
- Participer à votre rythme
- Participer dans autant du programme que vous le voulez
- Éducation adaptée à vos besoins
- Contribuer à la recherche sur les soins de santé offerts dans le nord de l'Ontario

## CERTIFICATION

Ce programme répond aux critères de certification du Collège des médecins de famille du Canada et a été approuvé par le Bureau d'éducation continue et de perfectionnement professionnel à l'École de médecine du nord de l'Ontario.

## POUR PLUS DE RENSEIGNEMENTS, VEUILLEZ COMMUNIQUER AVEC:

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OBTENIR DES CRÉDITS MAINPRO+ GRATUIT

# Ici on parle!

Comment activement engager vos patients francophones  
Outils pour les médecins francophones et anglophones

## CRÉDITS MAINPRO+ POSSIBLES

Activité		Scénario 1	Scénario 2	Scénario 3	Scénario 4	Scénario 5	Scénario 6	Scénario 7
Phase d'évaluation	Remplir le questionnaire du médecin et coordonner les questionnaires de la réceptionniste et du patient	1 crédit non-certifié (1 heure)	1 crédit non-certifié (1 heure)	1 crédit non-certifié (1 heure)	2 crédits certifiés <sup>1</sup> (1 heure)			
	Revoir les résultats et lire la littérature		1 crédit non-certifié par heure <sup>2</sup>	1 crédit non-certifié par heure <sup>2</sup>	2 crédits certifiés <sup>1</sup> par heure <sup>2</sup>			
Phase de formation	Faire l'activité « Relier l'apprentissage à l'évaluation »			5 crédits certifiés	5 crédits certifiés	5 crédits certifiés	5 crédits certifiés	5 crédits certifiés
	Participer à l'atelier <sup>3</sup> et faire l'exercice de réflexion				4 crédits certifiés	4 crédits certifiés	4 crédits certifiés	4 crédits certifiés
Phase Post-formation et réflexion	Remplir le questionnaire du médecin et coordonner les questionnaires de la réceptionniste et du patient					2 crédits certifiés <sup>1</sup> (1 heure)	2 crédits certifiés <sup>1</sup> (1 heure)	2 crédits certifiés <sup>1</sup> (1 heure)
	Revoir le rapport final						2 crédits certifiés <sup>1</sup> par heure <sup>2</sup>	2 crédits certifiés <sup>1</sup> par heure <sup>2</sup>
	Faire l'activité « Relier l'apprentissage à la pratique »							5 crédits certifiés
<b>Total des crédits Mainpro+ accordés</b>		<b>1 non-certifié</b>	<b>2+ non-certifiés</b>	<b>2+ non-certifiés 5 certifiés</b>	<b>13+ certifiés</b>	<b>15+ certifiés</b>	<b>17+ certifiés</b>	<b>22+ certifiés</b>

1. Tous les crédits non-certifiés d'autoapprentissage acquis seront admissibles comme crédits certifiés d'apprentissage de groupe si vous assistez à l'atelier, autrement, ils demeureront non-certifiés.

2. Ces crédits sont obtenus sur un taux horaire, 1 crédit non-certifié peut être réclamer pour chaque heure de participation.

3. Cet atelier répond aux critères de certification du Collège des médecins de famille du Canada et a été approuvé pour 4 crédits certifiés d'apprentissage en group Mainpro +.

OBTENIR DES CRÉDITS MAINPRO+ GRATUIT

## Appendix E

### Instruction letter for participating physicians

(This document was also available in French)



## Assessment Phase Instructions

Dear Dr. X,

We welcome you to the assessment phase of the education program “Ici on parle”. The present document offers an outline of the material enclosed within this survey package along with a few short instructions. Enclosed you will find:

	Material	Instructions
1.	1 physician survey package	Complete the questionnaire and place it in the provided business reply envelope.
2.	1 receptionist survey package	If you have multiple receptionists, please provide the survey to the receptionist who is most responsible for your patients or who has been working with you the longest.
3.	40 patient survey packages	Please ask your receptionist to distribute these randomly to 20 Francophone patients and 20 non-Francophone patients – to the extent that is possible. Patient packages contain bilingual material.
4.	2 patient information posters (in English and in French)	These can be posted in your waiting room. Your receptionist can refer patients to this information when providing them with a survey.
5.	1 large business reply envelope	In which all completed surveys can be placed and returned to CRaNHR at the end of this phase  You can also return completed surveys as you receive them by simply placing the sealed business reply envelope in your outgoing mail.

If you have any further questions, please do not hesitate to contact us.



Patrick Timony

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## Appendix F

### Patient information poster

(Could be posted in waiting rooms)

(This document was also available in French)

# Ici on parle!

**How to Actively Engage Francophone Patients**  
Tools for French and English-Speaking Physicians

Your family doctor is participating in a continuing education and professional development program to help improve the patient experience in his/her office. Part of this education program includes an evaluation of the doctor's communication skills by his/her patients.

## WHAT AM I BEING ASKED TO DO?

- Complete a short questionnaire concerning your experience with your family doctor.
- The questionnaire should only take 15 minutes to fill out and can be completed while you are waiting to be seen.
- Place the completed questionnaire in the provided envelope.
- Return the envelope to the receptionist or place it in any outgoing mailbox.

## WHY AM I BEING ASKED TO FILL OUT A QUESTIONNAIRE?

- The information you provide will be used to adapt the education program to your doctor's needs.
- Your questionnaire will also be used to better understand:
  1. The current state of health services in Northern Ontario.
  2. The importance of language and communication on the patient experience.

## IF YOU ARE INTERESTED

3 ways to participate:

1. Ask the receptionist for a survey package. Questionnaires are available in both French and English.
2. Enter the following link in any web browser:

[www.cranhr.ca/icionparlept](http://www.cranhr.ca/icionparlept)

OR

Scan the following QR code with any mobile device



Enter the following ID code when prompted

**ID code: Z8NTSC**

3. Contact:

**Patrick E. Timony, Ph.D.** (Candidate)  
Research Associate,  
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Laurentian University  
☎ : 705-675-1151 ext. 4298  
☎ : 1-800-461-4030 ext. 4298  
✉ : [pe\\_timony@laurentian.ca](mailto:pe_timony@laurentian.ca)

## Appendix G

### Physician information letter

(This document was also available in French)

# Ici on parle!

How to Actively Engage Francophone Patients  
Tools for French and English-Speaking Physicians

## Family Physician Information letter

### Background information

The Centre for Rural and Northern Health Research (CRaNHR) in collaboration with the Northern Ontario School of Medicine are pleased to offer a unique continuing education and professional development (CEPD) opportunity. This CEPD program aims to help improve the Francophone patient experience within your office. A review of literature revealed certain gaps in French-language health services in Northern Ontario. For instance, though Northern Ontario Francophones are an aging population with higher rates of numerous chronic conditions and complex care needs, there exists a maldistribution of physicians who are competent enough to conduct their practice in French in the province, with rural and northern communities finding themselves particularly underserved. This maldistribution is concerning given the high Francophone population in the north. Given the link between patients' health and provider communication, it is essential that physicians who have chosen to practice in Northern Ontario, both those who **can** and who **cannot** speak French, are equipped with strategies to offering patient-centered care; which includes offering services in the patient's language of preference.

Recent discussions with family physicians working in Northern Ontario revealed several unique challenges faced when serving French-speaking patients. In particular, the lack of education and opportunities for continued professional development regarding Francophone needs were frequently discussed. In addition, physicians identified that those opportunities that do exist are expensive and often require a leave from work and travel to attend, which many found inconvenient and often impossible. The present CEPD program was developed to address these needs. As a result, we are offering you an education program that addresses the communication needs of Francophones in Northern Ontario; we are providing this program free of charge, virtually eliminating the need to travel, and providing you with an opportunity to earn numerous Mainpro+ credits.

### The education program

This CEPD program is composed of three phases:

#### PHASE 1: Assessment

You will receive a survey package that uses a multisource feedback approach to assess the offer of French language services in your office.

- You will begin by completing a short questionnaire that measures your current offer of French language health services.

- You will also provide your receptionist with the survey package, who will again distribute surveys to patients.
- You will receive a final report summarising results from the education program, including your post-education results in comparison to your pre-education results.

## Possible Credits Earned

By participating in this education program, you will have the opportunity to earn a number of *certified* and/or *non-certified* Mainpro+ credits. The number and class (*certified* or *non-certified*) of credits earned will depend on the extent to which you participate in each component of the program. For instance, *non-certified* Mainpro+ credits can be claimed for self-directed learning such as completing and coordinating the survey, reading the literature and reviewing the final reports. For each hour you spend on these self-directed activities, you can claim *non-certified* Mainpro+ credits. You will also be invited to complete a Linking Learning to Assessment and a Linking Learning to Practise exercise following your readings (in the Education phase and Post-education & Reflective phase) which are eligible for 5 *certified* Mainpro+ credits each. Finally, the 2 hour workshop in the Education phase has been certified by the College of Family Physicians of Canada for 4 *certified* group learning Mainpro+ credits. In addition, upon participating in the workshop, all activities in the assessment and education phase will qualify for *certified* group learning credits. Note that you cannot claim both *certified* and *non-certified* credits for the same activity. You do not need to complete all parts of the program and you can choose to only participate in certain parts (for instance, you can fill out the pre and post-education questionnaires without having to do the Linking Learning to Assessment/Practice exercises or the Workshop). Any credits you have earned over the course of the program will be awarded to you regardless of the percentage of the program completed. The following table summarises how multiple credits could be earned:

Activity		Possible Mainpro+ credits earned						
		Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5	Scenario 6	Scenario 7
Assessment Phase	Complete Physician Survey & coordinate Receptionist and Patient surveys	1 Non-certified credit (1 hour)	1 Non-certified credit (1 hour)	1 Non-certified credit (1 hour)	2 Certified credits <sup>1</sup> (1 hour)			
	Review survey results and read literature		1 Non-certified credit per hour <sup>2</sup>	1 Non-certified credit per hour <sup>2</sup>	2 Certified <sup>1</sup> credits per hour <sup>2</sup>			
Education Phase	Do Linking Learning to Assessment activity			5 Certified credits	5 Certified credits	5 Certified credits	5 Certified credits	5 Certified credits
	Participate in Workshop <sup>3</sup> & complete Reflective exercise				4 Certified credits	4 Certified credits	4 Certified credits	4 Certified credits
Post-education & Reflective Phase	Complete Physician Survey & coordinate Receptionist and Patient surveys					2 Certified <sup>1</sup> credits (1 hour)	2 Certified <sup>1</sup> credits (1 hour)	2 Certified <sup>1</sup> credits (1 hour)
	Review final report						2 Certified <sup>1</sup> credits per hour <sup>2</sup>	2 Certified <sup>1</sup> credits per hour <sup>2</sup>
	Do Linking Learning to Practice activity							5 Certified credits
<b>Total Mainpro+ credits earned</b>		<b>1 Non-certified</b>	<b>2+ Non-certified</b>	<b>2+ Non-certified 5 Certified</b>	<b>13+ Certified</b>	<b>15+ Certified</b>	<b>17+ Certified</b>	<b>22+ Certified</b>

1. All *Non-certified* self learning credits earned will be eligible for *Certified* group learning credits upon attending the workshop, otherwise they will remain *Non-certified*.

2. These credits are earned on an hourly rate, 1 *non-certified* credit can be claimed for every hour of work.

3. This workshop meets the certification criteria of the College of Family Physicians of Canada and has been approved for 4 Mainpro+ *certified* group learning credits.

## The research component

In addition to receiving Mainpro+ credits, by participating in this CEPD program you will also be participating in a unique research study that is seamlessly imbedded within the education program. The surveys in phase 1 will serve as both a needs assessment, used to tailor your education experience, while also being analysed to gain a better understanding of the current state of French-language health services in Northern Ontario and the importance of language on the patient experience. The barriers to offering French-language health services and the action plan developed in the workshop will be qualitatively analysed to inform future educational activities. Finally, results from the post-education phase will both inform you about your progress and be analysed to evaluate the impact of the education program.

You have the right to withdraw from the education program (and in turn the research component) without penalty or consequence. You can also refuse to answer any question on the survey or to refuse participation in any part of the program. As this is a continuing education program, you will only be awarded Mainpro+ credits for the sections completed (as described above), however refusing to answer questions on a survey will not prevent you from earning credits and the credits you have earned will not be compromised should you choose to withdraw from any subsequent part of the program. You can also withdraw from the study while still remaining in the education program simply by making a request to Patrick Timony ([PE\\_Timony@laurentian.ca](mailto:PE_Timony@laurentian.ca)) to have your data destroyed. Your receptionist and patients will also be informed that they are participating in a research study. Note that the receptionist and patients will have the right to refuse participation, which will not negatively impact your ability to participate in the program or earn credits.

Beyond earning Mainpro+ credits, there are a number of benefits to participating in the program for yourself, your coworkers and your patients. By learning about the importance of offering linguistically appropriate health services; you will be better able to offer patient-centered care to your Francophone patients. The built-in needs assessment in phase 1 will allow the education to be tailored specifically to your needs, which will allow you to gain skills and develop strategies that are directly applicable to your practice. You will also be encouraged to share these skills and strategies with coworkers who will indirectly benefit from your involvement. Finally, your patients will ultimately benefit the most, by receiving quality service in their language of preference.

Though there are no physical or psychological risks to participating in the program, there may be social risks. Some physicians could feel uncomfortable having their patients rate their communication skills for fear that a bad rating could harm their professional image. To reduce this risk, your name will not appear on any research material (e.g. surveys, consent forms); rather a unique ID number will solely identify you. As a result, there is no way for anyone other than the research team to link a particular survey to a physician. Furthermore, the surveys are comprised mainly of close-ended multiple choice questions and give very little opportunities for respondents to elaborate on issues they may have with their physician. Thus, no professionally damaging information will be collected.

Any and all data you provide will be stored in the strictest of confidence. All paper questionnaires will be stored in a locked filing cabinet, within a locked office of an access-controlled building at Laurentian University. All electronic data, including web-based versions of the questionnaires, will be stored on CRaNHR's secure server that is protected by the security protocols of Laurentian University Computer Services. Only researchers who are working on the study and have signed non-disclosure agreements will have access to the data. Your data will

also be stored anonymously without any identifiable information. Your data will be identified by a unique ID code and only the lead researchers will be able to link your data back to you. Given that the information learned from this study will be used to inform future educational initiatives, your data will remain securely stored on CRaNHR's server indefinitely and could be used for future research purposes.

If you have any further questions about the education program or the built-in research components, please contact:

<p><b>Patrick E. Timony, Ph.D. (Candidate)</b> Research Associate, Centre for Rural and Northern Health Research, Laurentian University</p> <p>☎: 705-675-1151 ext. 4298 ☎: 1-800-461-4030 ext. 4298 ✉: <a href="mailto:pe_timony@laurentian.ca">pe_timony@laurentian.ca</a></p>	<p><b>Danielle Barbeau-Rodrigue M.A. (Candidate)</b> Director, Francophone Affairs, Northern Ontario School of Medicine</p> <p>☎: 705-662-7291 ☎: 1-800-461-8777 ext. 7291 ✉: <a href="mailto:dbarbeurodrigue@nosm.ca">dbarbeurodrigue@nosm.ca</a></p>	<p><b>Alain P. Gauthier, Ph.D. (Supervisor)</b> Associate Professor, School of Human Kinetics, Laurentian University</p> <p>☎: 705-675-1151 ext. 1071 ☎: 1-800-461-4030 ext. 1071 ✉: <a href="mailto:agauthier@laurentian.ca">agauthier@laurentian.ca</a></p>	<p><b>Deborah Smith, MD CCFP FCFP</b> Medical Director of Continuing Medical Education, Northern Ontario School of Medicine</p> <p>✉: <a href="mailto:debsmith@nosm.ca">debsmith@nosm.ca</a></p>
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You can also contact the **Research Ethics Officer** at Laurentian University regarding possible ethical issues or complaints about the research itself at 705-675-1151 ext. 3213 or 2436 or toll free at 1-800-461-4030 or email [ethics@laurentian.ca](mailto:ethics@laurentian.ca).



## Appendix H

### Physician consent form

(This document was also available in French)



## Family Physician Consent form

By agreeing to participate in this study I acknowledge that I have read the attached information letter and understand that:

### Purpose

- I will be participating in a multiphase education program aimed at improving the Francophone patient experience within my office.
- A research study is seamlessly built into the education program and information I provide will be used for research purposes.

### Tasks

- This program employs a multisource feedback approach to measure French-language health services offered in my office, which includes a needs assessment consisting of questionnaires to be completed, by myself, a receptionist, and 40 patients.
- I will receive a report which will provide me with my survey results along with literature aimed at improving my skills in offering French language health services and treating French-speaking patients.
- I will be invited to participate in a workshop in which barriers to the offer of French-language health services will be discussed and an action plan to implement strategies within my practice will be created.
- I will receive post-workshop questionnaires (for myself, my receptionist and my patients) to measure changes to the offer of French-language health services in my office.
- I have the right to withdraw from the education program (and the research study) at any time without penalty or consequence.
- I can refuse to answer any question on the surveys or to refuse participation in any part of the program.

### Benefits

- For participating in the program, I can receive a number of *certified* and *non-certified* Mainpro+ credits (which will be earned by completing various phases of the program).
- I will learn strategies to offering patient-centered care to my Francophone patients by learning about the importance of offering linguistically appropriate health services.
- The built-in needs assessment will allow the education to be tailored specifically to my needs, which will allow me to gain skills and strategies which are directly applicable to my practice.



## Appendix I

### Physician pre-intervention survey booklet

(This document was also available in French)

# Ici on parle!

How to Actively Engage Francophone Patients  
Tools for French and English-Speaking Physicians

## Survey of Active Offer of French Language Services

### Family Physician Questionnaire

Expected completion time: 15 minutes



**ici on parle!**How to Actively Engage Francophone Patients  
How to Actively Engage Francophone Patients  
How to Actively Engage Francophone Patients

## Instructions for the online survey:

1. Enter the following link in any web browser: [www.cranhr.ca/icionparlemd](http://www.cranhr.ca/icionparlemd)

OR

Scan the following QR code with any mobile device:



2. Enter the following ID code when prompted

ID code: \_\_\_\_\_

3. For **Mac** users, it is suggested that Safari be avoided as the “cache” sometimes prevents the survey from opening. This can be avoided by using an alternative web browser such as Internet Explorer, Google Chrome or FireFox.


**ici on parle!**

How to Actively Engage Francophone Patients  
 Tools for Patient and Anger-Related Professionals

## Linguistic abilities

- Can you speak English or French well enough to conduct a conversation?
 

<input type="checkbox"/> English only	<input type="checkbox"/> French only
<input type="checkbox"/> Both English and French	<input type="checkbox"/> Neither English nor French
  
- What language do you speak **most often** at home?
 

<input type="checkbox"/> English	
<input type="checkbox"/> French	
<input type="checkbox"/> Other	<i>Please specify:</i> _____
  
- Do you speak any other languages on a regular basis at home?
 

<input type="checkbox"/> No	
<input type="checkbox"/> Yes, English	
<input type="checkbox"/> Yes, French	
<input type="checkbox"/> Yes, Other	<i>Please specify:</i> _____
  
- What is the language that you **first learned** at home **in childhood** and **still understand**?  
*If you no longer understand the first language learned, indicate the second language learned.*

<input type="checkbox"/> English	
<input type="checkbox"/> French	
<input type="checkbox"/> Other	<i>Please specify:</i> _____
  
- Do you consider yourself competent enough to communicate with patients in French?
 

<input type="checkbox"/> Yes	
<input type="checkbox"/> No	

## Interactions with Francophone patients

- In the **past week**, please estimate the percentage of patients you saw who belong to each of the following primary language groups. (*Total percentage must add up to 100%*)
 

_____ %	Anglophone
_____ %	Francophone
_____ %	Other (neither Anglophone nor Francophone)
  
- In the **past week**, please estimate the percentage of patient interactions which you conducted in each of the following languages. (*Total percentage must add up to 100%*)
 

_____ %	English
_____ %	French
_____ %	Other (neither English nor French)

## ICI on parle!

How to Actively Engage Francophone Patients  
 with French and English-speaking Healthcare

Answer the following questions as honestly as possible.  
 It is normal that all the behaviors listed in this questionnaire are not fulfilled.  
 Answer the questionnaire so as to reflect your real practice.

### Active Offer Behaviour

What actions do I personally take to make it known that I can offer services in French?

	Never	Rarely	Often	Always	Not Applicable
8. In my workplace, I wear some sort of identification which indicates that I can offer services in French (e.g. badge/pin)	<input type="checkbox"/>				
9. I ask my patient in which language, French or English, they wish to communicate.	<input type="checkbox"/>				
10. When I welcome a patient whose language I don't know, I first greet him/her in French, followed by a greeting in English.	<input type="checkbox"/>				
11. In my workplace, there are visual indicators demonstrating that I offer services in French or in both official languages. (e.g. a sign on my door, in my office)	<input type="checkbox"/>				
12. When he/she doesn't do it, I sensitize my employer to the importance of promoting the French language services which are available at my workplace (e.g. posters, advertisements, Web site)	<input type="checkbox"/>				
13. When I answer the phone, I first answer in French followed by English, when necessary.	<input type="checkbox"/>				
14. The message on my phone voicemail includes a greeting in French, as well as one in English.	<input type="checkbox"/>				
15. The message on my phone voicemail <b>begins</b> with a greeting in French, followed by one in English.	<input type="checkbox"/>				
16. The signature on my email appears both in French and in English.	<input type="checkbox"/>				
17. The signature on my email <b>first</b> appears in French.	<input type="checkbox"/>				
18. I make sure informative documents and entertainment options (e.g. pamphlets, magazines, newspaper, radio, television, games) are available in French in the common areas (waiting room or other).	<input type="checkbox"/>				
19. I use certain expressions and a vocabulary used by the patient so that (s)he feels comfortable speaking with me in French.	<input type="checkbox"/>				

## Ici on parle!

How to Actively Engage Francophone Patients  
 How to French and English-Speaking Patients

### Support and Referrals

When I refer Francophone patients to another service provider (e.g. referrals to a specialist), whenever possible I...

	Never	Rarely	Often	Always	Not Applicable
20. consult an updated list of providers and organisations who offer services in French.	<input type="checkbox"/>				
21. offer the patients the option to be directed towards a French speaking provider or Francophone organisation.	<input type="checkbox"/>				
22. specify the patients language of preference on the referral or transfer letter.	<input type="checkbox"/>				
23. verbally inform the provider or organisation of the patients language of preference, or have someone to do it for me.	<input type="checkbox"/>				

### Perception of Organizational Support

In my workplace, it is normal to...

	Never	Rarely	Often	Always	Not Applicable
24. display posters in French or in both official languages of Canada.	<input type="checkbox"/>				
25. supply badges/pins or plaques indicating that services are available in both official languages of Canada.	<input type="checkbox"/>				
26. advertise in a clear and visible manner, the availability of the services in French.	<input type="checkbox"/>				
27. offer information in French or in both official languages of Canada on the Web site.	<input type="checkbox"/>				
28. place at the patient's disposal magazines, booklets or other media which presents information in both official languages of Canada.	<input type="checkbox"/>				
29. broadcast information in newspapers and on the radio in French.	<input type="checkbox"/>				
30. recruit staff capable of offering services in French at all levels of service.	<input type="checkbox"/>				
31. hold meetings in French or both official languages of Canada.	<input type="checkbox"/>				
32. facilitate the use of French between employees.	<input type="checkbox"/>				
33. inform the patient of the establishment's commitment to offer services of equal quality in both official languages of Canada.	<input type="checkbox"/>				
34. converse in French between French-speaking employees.	<input type="checkbox"/>				
35. print letterhead and business cards in French or in both official languages of Canada.	<input type="checkbox"/>				

## Active Offer Perceptions

36. What are the biggest challenges to offering French language health services in your office?

37. How would you define the **Active offer** of French language health services?

a. Were you familiar with this concept prior to filling out this questionnaire?

- Yes  
 No

**Ici on parle!**

How to Actively Engage Francophone Patients  
Tool for French and English-Speaking Healthcare

## Continuing Medical Education

38. Would you like to attend an accredited CME workshop in a community near you to improve the offer of French language health services in your workplace?

Yes

No

### IF YES

Please provide an email address where we can send you further information

Email: \_\_\_\_\_

### IF NO

a. What barriers would limit your ability to attend such a workshop?

b. What would facilitate your participation?

**Thank you for your time!**

## Ici on parle!

How to Access French-Speaking Patients  
 Accès à l'français et English Speaking Patients

<p><b>Patrick E. Timony, Ph.D. (Candidate)</b>            Research Associate,            Centre for Rural and Northern Health            Research,            Laurentian University</p> <p>☎: 705-675-1151 ext. 4298            ☎: 1-800-461-4030 ext. 4298            ✉: <a href="mailto:pe_timony@laurentian.ca">pe_timony@laurentian.ca</a></p>	<p><b>Danielle Barbeau-Rodrigue M.A. (Candidate)</b>            Director, Francophone Affairs,            Northern Ontario School of            Medicine</p> <p>☎: 705-662-7291            ☎: 1-800-461-8777 ext. 7291            ✉: <a href="mailto:dbarbeurodrigue@nosm.ca">dbarbeurodrigue@nosm.ca</a></p>	<p><b>Alain P. Gauthier, Ph.D. (Supervisor)</b>            Associate Professor,            School of Human Kinetics,            Laurentian University</p> <p>☎: 705-675-1151 ext. 1071            ☎: 1-800-461-4030 ext. 1071            ✉: <a href="mailto:agauthier@laurentian.ca">agauthier@laurentian.ca</a></p>	<p><b>Deborah Smith, MD CCFP FCFP</b>            Medical Director of Continuing            Medical Education,            Northern Ontario School of            Medicine</p> <p>✉: <a href="mailto:debsmith@nosm.ca">debsmith@nosm.ca</a></p>
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## Appendix J

### Receptionist information letter

(This document was also available in French)

# Ici on parle!

**How to Actively Engage Francophone Patients**  
Tools for French and English-Speaking Physicians

## Receptionist Information letter

### Background information

The Centre for Rural and Northern Health Research (CRaNHR) in collaboration with the Northern Ontario School of Medicine are offering a unique continuing education and professional development (CEPD) opportunity in which a physician you work with is participating (see physician's name on the envelope in which this information was enclosed). This CEPD program aims to help improve the Francophone patient experience within your office. A review of literature revealed certain gaps in French-language health services in Northern Ontario. Given the link between patients' health and provider communication, it is essential that physicians, who have chosen to practise in Northern Ontario, both those who can and who cannot speak French, are equipped with strategies to offer patient-centered care; which includes offering services in the patient's language of preference.

### The education program

This CEPD program uses a multisource feedback approach, in which the physician(s), a receptionist and 40 patients complete a series of surveys that measure the physician's current offer of French-language health services. The physicians will then receive literature regarding the importance of language in health care delivery and participate in a workshop that will identify barriers to the offer of French-language health services in the North and create an action plan to implement strategies within their practice. A series of follow-up surveys will then measure changes the physician has made within their practice.

As a result, you have been asked to assist with the completion of the survey component of the education program. Your participation will require you to fill out two receptionist surveys, one now and a second one when the education program has come to an end. These surveys simply asked you to rate the frequency of certain behaviours in your work environment. As we are interested in frequency in which French-language health services are being offered by the physicians and in the office in general, the questionnaire will ask you to rate yourself, the physician, and the general office environment. These questionnaires are available in both French and English and you can either fill out the enclosed hard copy version or participate in the online version. To access the online survey:

- Enter the following link into your browser: [www.cranhr.ca/icionparlerc](http://www.cranhr.ca/icionparlerc)  
OR
- Scan the QR code on the first page of the questionnaire with a portable device
- Enter the following password to begin: \_\_\_\_\_

unique ID code and only the lead researchers will be able to link your data back to you. Given that the information learned from this study will be used to inform future educational initiatives, your data will remain securely stored on CRaNHR's server indefinitely and could be used for future research purposes.

If you have any further questions about the education program or the built in research components, please communicate with:

<p>Patrick E. Timony, Ph.D. (Candidate) Research Associate, Centre for Rural and Northern Health Research, Laurentian University</p> <p>☎: 705-675-1151 ext. 4298 ☎: 1-800-461-4030 ext. 4298 ✉: <a href="mailto:pe_timony@laurentian.ca">pe_timony@laurentian.ca</a></p>	<p>Danielle Barbeau-Rodrigue M.A. (Candidate) Director, Francophone Affairs, Northern Ontario School of Medicine</p> <p>☎: 705-662-7291 ☎: 1-800-461-8777 ext. 7291 ✉: <a href="mailto:dbarbeurodrigue@nosm.ca">dbarbeurodrigue@nosm.ca</a></p>	<p>Alain P. Gauthier, Ph.D. (Supervisor) Associate Professor, School of Human Kinetics, Laurentian University</p> <p>☎: 705-675-1151 ext. 1071 ☎: 1-800-461-4030 ext. 1071 ✉: <a href="mailto:agauthier@laurentian.ca">agauthier@laurentian.ca</a></p>	<p>Deborah Smith, MD CCFP FCFP Medical Director of Continuing Medical Education, Northern Ontario School of Medicine</p> <p>✉: <a href="mailto:debsmith@nosm.ca">debsmith@nosm.ca</a></p>
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You can also contact the Research Ethics Officer at Laurentian University regarding possible ethical issues or complaints about the research itself at 705-675-1151 ext. 3213 or 2436 or toll free at 1-800-461-4030 or email [ethics@laurentian.ca](mailto:ethics@laurentian.ca).



## Appendix K

### Receptionist consent form

(This document was also available in French)



## Receptionist Consent form

By agreeing to participate in this study, I acknowledge that I have read the attached information letter and understand that:

### Purpose

- A physician I work with is participating in a multiphase education program aimed at improving the Francophone patient experience within my office.
- The physician in question has asked me to participate to help fulfill the educational program requirements surrounding physician assessment (i.e. completing and distributing surveys)
- A research study is seamlessly built into the education program and the information I provide will be used for research purposes.

### Tasks

- This program employs a multisource feedback approach to measure French-language services offered in my office which includes a needs assessment consisting of questionnaires to be completed by the physician, myself (a receptionist), and 40 patients.
- I have been asked to distribute 40 patient surveys, 20 to Francophone patients and 20 to Anglophone patients.
- I have also been asked to collect patient surveys and return all completed materials to the program leads by **September 1<sup>st</sup>, 2017**.
- I have the right to withdraw from the education program (and the research study) at any time and I can refuse to answer any question on the surveys without penalty or consequence.

### Benefits

- The physician in question will learn strategies to offering linguistically appropriate patient-centered care to Francophone patients and will be encouraged to share these with myself and other coworkers.

### Risks

- Though there are no physical or psychological risks to participating in the program, there may be social risks in rating the physician's communication skills, particularly if a rating is unflattering.
- To reduce this risk, my name will not appear on any research material (I will be identified by a unique ID number) and there will be no way for anyone other than the research team to link a particular survey to me.



## Appendix L

### Receptionist survey booklet

(This document was also available in French)

# Ici on parle!

How to Actively Engage Francophone Patients  
Tools for French and English-Speaking Physicians

## Survey of Active Offer of French Language Services

### Receptionist Questionnaire

Expected completion time: 15 minutes

**Ici on parle!**

How to Actively Engage Postoperative Patients  
Tools for Research and Quality-Improvement Professionals

## Instructions for the online survey:

1. Enter the following link in any web browser: [www.cranhr.ca/icionparlerc](http://www.cranhr.ca/icionparlerc)

OR

Scan the following QR code with any mobile device:



2. Enter the following ID code when prompted

ID code: \_\_\_\_\_

3. For **Mac** users, it is suggested that Safari be avoided as the “cache” sometimes prevents the survey from opening. This can be avoided by using an alternative web browser such as Internet Explorer, Google Chrome or FireFox.


**Lci on parle!**

How to Actively Engage Francophone Patients  
 Improve French and English speaking skills

## Linguistic abilities

1. Can you speak English or French well enough to conduct a conversation?
  - English only
  - French only
  - Both English and French
  - Neither English nor French
  
2. What language do you speak most often at home?
  - English
  - French
  - Other *Please specify:* \_\_\_\_\_
  
3. Do you speak any other languages on a regular basis at home?
  - No
  - Yes, English
  - Yes, French
  - Yes, Other *Please specify:* \_\_\_\_\_
  
4. What is the language that you first learned at home in childhood and still understand?  
*If you no longer understand the first language learned, indicate the second language learned.*
  - English
  - French
  - Other *Please specify:* \_\_\_\_\_
  
5. Do you consider yourself competent enough to communicate with patients in French?
  - Yes
  - No
  
6. Would you consider the physician in question competent enough to communicate with patients in French?
  - Yes
  - No

**Ici on parle!**How to Actively Engage Francophone Patients  
Talk to French and English-Speaking Patients**Interactions with Francophone patients**

7. In the **past week**, please estimate the percentage of patients you saw who belong to each of the following primary language groups. (*Total percentage must add up to 100%*)

\_\_\_\_\_ % Anglophone  
\_\_\_\_\_ % Francophone  
\_\_\_\_\_ % Other (neither Anglophone nor Francophone)

8. In the **past week**, please estimate the percentage of patient interactions which you conducted in each of the following languages. (*Total percentage must add up to 100%*)

\_\_\_\_\_ % English  
\_\_\_\_\_ % French  
\_\_\_\_\_ % Other (neither English nor French)

## ICI ON PARLE!

How to Actively Engage Francophone Patients  
Tools for French and English-Speaking Physicians

Answer the following questions as honestly as possible.  
It is normal that all the behaviors listed in this questionnaire are not fulfilled.  
Answer the questionnaire so as to reflect your real experience.

### Your Active Offer Behaviour

What actions do I personally take to make it known that I can offer services in French?

	Never	Rarely	Often	Always	Not Applicable
9. In my workplace, I wear some sort of identification which indicates that I can offer services in French (e.g. badge/pin).	<input type="checkbox"/>				
10. I ask the patient in which language, French or English, they wish to communicate.	<input type="checkbox"/>				
11. When I welcome a patient whose language I don't know, I first greet him/her in French, followed by a greeting in English.	<input type="checkbox"/>				
12. In my workplace, there are visual indicators demonstrating that I offer services in French or in both official languages. (e.g. a sign on my door, in my office).	<input type="checkbox"/>				
13. When he/she doesn't do it, I sensitize my employer to the importance of promoting the French language services which are available at my workplace (e.g. posters, advertisements, Web site).	<input type="checkbox"/>				
14. When I answer the phone, I first answer in French followed by English, when necessary.	<input type="checkbox"/>				
15. The message on my phone voicemail includes a greeting in French, as well as one in English, when necessary.	<input type="checkbox"/>				
16. The message on my phone voicemail begins with a greeting in French, followed by one in English.	<input type="checkbox"/>				
17. The signature on my email appears in French and English.	<input type="checkbox"/>				
18. The signature on my email first appears in French.	<input type="checkbox"/>				
19. I make sure informative documents and entertainment options (e.g. pamphlets, magazines, newspaper, radio, television, games) are available in French in the common areas (waiting room or other).	<input type="checkbox"/>				
20. I use certain expressions and a vocabulary used by the patient so that (s)he feels comfortable speaking with me in French.	<input type="checkbox"/>				


**Ici on parle!**
How to Actively Engage Francophone Patients  
How to French and English Speaking Patients

## The Physician's Active Offer Behaviour

To the best of your knowledge, what actions does the physician in question take to make it known that he/she can offer services in French?

	Never	Rarely	Often	Always	Not Applicable
21. In the workplace, the physician in question wears some sort of identification which indicates that (s)he can offer services in French (e.g. badge/pins).	<input type="checkbox"/>				
22. The physician in question asks his/her patient in which language, French or English, they wish to communicate.	<input type="checkbox"/>				
23. When the physician in question welcomes a patient whose language they don't know, (s)he first greets him in French, followed by a greeting in English.	<input type="checkbox"/>				
24. In the workplace, there are visual indicators demonstrating that the physician in question offers services in French or in both official languages. (e.g. a sign on his/her door, in his/her office).	<input type="checkbox"/>				
25. When (s)he doesn't do it, the physician in question sensitizes their employer to the importance of promoting the French language services which are available at the workplace (e.g. posters, advertisements, web site).	<input type="checkbox"/>				
26. When the physician in question answers the phone, (s)he first answers in French followed by English, when necessary.	<input type="checkbox"/>				
27. The message on the physician's phone voicemail includes a greeting in French and in English, when necessary.	<input type="checkbox"/>				
28. The message on the physician's phone voicemail <b>begins</b> with a greeting in French, followed by one in English.	<input type="checkbox"/>				
29. The signature on the physician's email appears in French and English.	<input type="checkbox"/>				
30. The signature on the physician's email <b>first</b> appears in French.	<input type="checkbox"/>				
31. The physician in question makes sure informative documents and entertainment options (e.g. pamphlets, magazines, newspaper, radio, television, games) are available in French in the common areas (waiting room or other).	<input type="checkbox"/>				
32. The physician in question uses certain expressions and a vocabulary used by the patient so that (s)he feels comfortable speaking in French.	<input type="checkbox"/>				



How to Attract, Engage Francophone Patients  
Comment attirer et engager les patients francophones

## Perception of organizational support

In my workplace it is normal to...

	Never	Rarely	Often	Always	Not Applicable
33. display posters in French or in both official languages of Canada.	<input type="checkbox"/>				
34. supply badges/pins or plaques indicating that services are available in both official languages of Canada.	<input type="checkbox"/>				
35. advertise in a clear and visible manner, the availability of the services in French.	<input type="checkbox"/>				
36. offer information in French or in both official languages of Canada on the Website.	<input type="checkbox"/>				
37. place at the patient's disposal magazines, booklets or other media which presents information in both official languages of Canada.	<input type="checkbox"/>				
38. broadcast information in newspapers and on the radio in French.	<input type="checkbox"/>				
39. recruit staff capable of offering services in French at all levels of service.	<input type="checkbox"/>				
40. hold meetings in French or both official languages of Canada.	<input type="checkbox"/>				
41. facilitate the use of French between employees.	<input type="checkbox"/>				
42. inform the patient of the establishment's commitment to offer services of equal quality in both official languages of Canada.	<input type="checkbox"/>				
43. converse in French between French-speaking employees.	<input type="checkbox"/>				
44. print letterhead and business cards in French or in both official languages of Canada.	<input type="checkbox"/>				

Thank you for your time!

## Ici on parle!

How to Actively Engage Francophone Patients  
 Tools for French and English-Speaking Physicians

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## Appendix M

Instructions included with patient surveys

# Ici on parle!

How to Actively Engage Francophone Patients  
Tools for French and English-Speaking Physicians

## Instructions

**STEP 1**



Read consent form



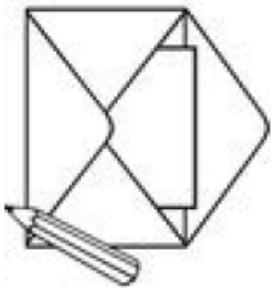
**STEP 2**



Fill out survey



**STEP 3**



Seal in envelope



**STEP 4**



Return to receptionist

OR



Place in mailbox



## Instructions

**ÉTAPE 1**



Lire le formulaire de  
consentement



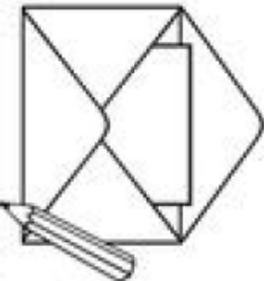
**ÉTAPE 2**



Remplir le  
questionnaire



**ÉTAPE 3**



Le sceller dans  
l'enveloppe



**ÉTAPE 4**



Le remettre à la  
réceptionniste  
OU




Le faire suivre par la  
poste

## Appendix N

### Patient consent form

(This document was also available in French)



## Patient Consent Form

Your family doctor (see doctor's name on the envelope in which this information was enclosed) is participating in a continuing education program to help improve the patient experience in his/her office, which is being offered by the Centre for Rural and Northern Health Research (CRaNHR) in collaboration with the Northern Ontario School of Medicine. Part of this education program includes an evaluation of the doctor's communication skills by his/her patients. Therefore, you are being asked to complete a short questionnaire concerning your experience with your family doctor. The information you provide will then be used to adapt the education program to your doctor's specific needs.

Please complete the enclosed short questionnaire, which is available in both French and English. This questionnaire should only take 15 minutes to fill out and can be completed while you are waiting to be seen. Once you are done, please place the questionnaire in the enclosed postage-paid envelope. You can either return your sealed envelope to the receptionist OR place it in any outgoing mailbox. You can also complete the questionnaire online by following these steps:

- Enter the following link into your browser: [www.cranhr.ca/icionparlept](http://www.cranhr.ca/icionparlept)  
OR
- Scan the QR code on the first page of the questionnaire with a portable device
- Enter the following password to begin: \_\_\_\_\_

By filling out this questionnaire, you will not only be helping your family doctor, you will also be participating in a unique research study. Researchers at CRaNHR will use your questionnaire to better understand 1) the current state of health services in Northern Ontario and 2) the importance of language and communication on the patient experience.

You have the right to refuse to fill out the questionnaire or to refuse to answer any question without any negative consequence. Your choice to refuse to participate will not impact the services you are receiving from your family doctor. In fact, your doctor will not know who has agreed to participate and who has not and your choice to refuse to participate will not negatively impact your doctor's ability to participate in the education program.

By filling out the survey, you will be helping to adapt the education program to your doctor's specific needs. This will ultimately benefit you and other patients, as your doctor will be learning skills to better serve his/her patients. You may however feel uncomfortable rating your doctor. To reduce these feelings, you will never be asked to provide your name; only an ID number will identify your questionnaire. As a result, there is no way for anyone other than the research team to link a particular survey to a physician and not even the research team will know who complete the questionnaires. Also, your individual questionnaire will NEVER be shared with your doctor. Once you seal your questionnaire in the envelope, no one but the researcher will ever see it again.

Your completed questionnaire will be stored in the strictest confidence. All paper questionnaires will be stored in a locked filing cabinet, in a locked building at Laurentian University. All electronic data, including web-based versions of the questionnaires, will be stored on a secure server that is protected by Laurentian University. Only researchers who are working on the study will have access to your questionnaire. All data collected in this study will forever remain stored on the secure server and could be used for future research purposes.

If you have any further question about the education program or the built in research components, please communicate with:

<p>Patrick E. Timony, Ph.D. (Candidate) Research Associate, Centre for Rural and Northern Health Research, Laurentian University</p> <p>☎: 705-675-1151 ext. 4298 ☎: 1-800-461-4030 ext. 4298 ✉: pe_timony@laurentian.ca</p>	<p>Danielle Barbeau-Rodrigue M.A. (Candidate) Director, Francophone Affairs, Northern Ontario School of Medicine</p> <p>☎: 705-662-7291 ☎: 1-800-461-8777 ext. 7291 ✉: dbarbeaurodrigue@nosm.ca</p>	<p>Alain P. Gauthier, Ph.D. (Supervisor) Associate Professor, School of Human Kinetics, Laurentian University</p> <p>☎: 705-675-1151 ext. 1071 ☎: 1-800-461-4030 ext. 1071 ✉: agauthier@laurentian.ca</p>	<p>Deborah Smith, MD CCFP FCFP Medical Director of Continuing Medical Education, Northern Ontario School of Medicine</p> <p>✉: debsmith@nosm.ca</p>
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You can also contact the **Research Ethics Officer** at Laurentian University regarding possible ethical issues or complaints about the research itself at 705-675-1151 ext. 3213 or 2436 or toll free at 1-800-461-4030 or email [ethics@laurentian.ca](mailto:ethics@laurentian.ca).

**Please keep this copy for your records**

## Appendix O

### Patient survey booklet

(This document was also available in French)

# Ici on parle!

How to Actively Engage Francophone Patients  
Tools for French and English-Speaking Physicians

## Patient experiences with Northern Ontario Doctors

Expected completion time: 15 minutes



**Ici on parle!**How to Actively Engage Francophone Patients  
Toward Health and Long-Term Living Objectives**Instructions for the online survey:**

1. Enter the following link in any web browser: [www.cranhr.ca/icionparlept](http://www.cranhr.ca/icionparlept)

OR

Scan the following QR code with any mobile device:



2. Enter the following ID code when prompted

ID code: \_\_\_\_\_

3. For **Mac users**, it is suggested that Safari be avoided as the “cache” sometimes prevents the survey from opening. This can be avoided by using an alternative web browser such as Internet Explorer, Google Chrome or FireFox.



**Ici on parle!**

How to Actively Engage Francophone Patients  
With an English-Speaking Healthcare Provider

## Patient Consent Form

Your family doctor (see doctor's name on the envelope in which this information was enclosed) is participating in a continuing education program to help improve the patient experience in his/her office, which is being offered by the Centre for Rural and Northern Health Research (CRaNHR) in collaboration with the Northern Ontario School of Medicine. Part of this education program includes an evaluation of the doctor's communication skills by his/her patients. Therefore, you are being asked to complete a short questionnaire concerning your experience with your family doctor. The information you provide will then be used to adapt the education program to your doctor's specific needs.

Please complete the enclosed short questionnaire, which is available in both French and English. This questionnaire should only take 15 minutes to fill out and can be completed while you are waiting to be seen. Once you are done, please place the questionnaire in the enclosed postage-paid envelope. You can either return your sealed envelope to the receptionist OR place it in any outgoing mailbox. You can also complete the questionnaire online by following these steps:

- Enter the following link into your browser: [www.cranhr.ca/icionparlept](http://www.cranhr.ca/icionparlept)  
OR
- Scan the QR code on the first page of the questionnaire with a portable device
- Enter the password that appears on the previous page to begin

By filling out this questionnaire, you will not only be helping your family doctor, you will also be participating in a unique research study. Researchers at CRaNHR will use your questionnaire to better understand 1) the current state of health services in Northern Ontario and 2) the importance of language and communication on the patient experience.

You have the right to refuse to fill out the questionnaire or to refuse to answer any question without any negative consequence. Your choice to refuse to participate will not impact the services you are receiving from your family doctor. In fact, your doctor will not know who has agreed to participate and who has not and your choice to refuse to participate will not negatively impact your doctor's ability to participate in the education program.

By filling out the survey, you will be helping to adapt the education program to your doctor's specific needs. This will ultimately benefit you and other patients, as your doctor will be learning skills to better serve his/her patients. You may however feel uncomfortable rating your doctor. To reduce these feelings, you will never be asked to provide your name; only an ID number will identify your questionnaire. As a result, there is no way for anyone other

## ICI ON PARLE!

How to Actively Engage Francophone Patients  
in Research and Quality-Improvement Programs

than the research team to link a particular survey to a physician and not even the research team will know who complete the questionnaires. Also, your individual questionnaire will NEVER be shared with your doctor. Once you seal your questionnaire in the envelope, no one but the researcher will ever see it again.

Your completed questionnaire will be stored in the strictest confidence. All paper questionnaires will be stored in a locked filing cabinet, in a locked building at Laurentian University. All electronic data, including web-based versions of the questionnaires, will be stored on a secure server that is protected by Laurentian University. Only researchers who are working on the study will have access to your questionnaire. All data collected in this study will forever remain stored on the secure server and could be used for future research purposes.

If you have any further question about the education program or the built in research components, please communicate with:

<p>Patrick E. Timony, Ph.D. (Candidate) Research Associate, Centre for Rural and Northern Health Research, Laurentian University</p> <p>☎: 705-675-1151 ext. 4298 ☎: 1-800-461-4030 ext. 4298 ✉: pe_timony@laurentian.ca</p>	<p>Danielle Barbeau-Rodrigue M.A. (Candidate) Director, Francophone Affairs, Northern Ontario School of Medicine</p> <p>☎: 705-662-7291 ☎: 1-800-461-8777 ext. 7291 ✉: dbarbeaurodrigue@nosm.ca</p>	<p>Alain P. Gauthier, Ph.D. (Supervisor) Associate Professor, School of Human Kinetics, Laurentian University</p> <p>☎: 705-675-1151 ext. 1071 ☎: 1-800-461-4030 ext. 1071 ✉: agauthier@laurentian.ca</p>	<p>Deborah Smith, MD CCFP FCFP Medical Director of Continuing Medical Education, Northern Ontario School of Medicine</p> <p>✉: debsmith@nosm.ca</p>
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### Patient Consent

I have read the above consent form and freely agree to complete this questionnaire.

Yes

No

Today's date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

## Demographic Information

1. What is your sex?
  - I prefer not to answer
  - Male
  - Female
  - Please specify: \_\_\_\_\_
  
2. What is your age? \_\_\_\_\_
  
3. What is your postal code? \_\_\_\_\_
  
4. Can you speak English or French well enough to conduct a conversation?
  - English only
  - French only
  - Both English and French
  - Neither English nor French
  
5. What language do you speak **most often** at home?
  - English
  - French
  - Other *Please specify:* \_\_\_\_\_
  
6. Do you speak any other languages on a **regular basis** at home?
  - No
  - Yes, English
  - Yes, French
  - Yes, Other *Please specify:* \_\_\_\_\_
  
7. What is the language that you **first learned** at home **in childhood** and **still understand**?
 

*If you no longer understand the first language learned, indicate the second language learned.*

  - English
  - French
  - Other *Please specify:* \_\_\_\_\_

## About your Health

8. In general, would you say your health is...?

- Excellent
- Very good
- Good
- Fair
- Poor

## About your Family Doctor

9. Before today, when did you last communicate with your Family Doctor (for example: in-person appointment, speak on the phone)?

- In the past 3 months
- More than 3 months and less than 6 months ago
- More than 6 months and less than 12 months ago
- More than 12 months ago

10. How often do you speak French with your Family Doctor?

- Always (*100% of the time*)
- Often (*50% or more of the time*)
- Sometimes (*less than 50% of the time*)
- Never (*0% of the time*)

11. How long have you had this Family Doctor?

- Less than 1 year
- More than 1 and less than 5 years
- More than 5 and less than 10 years
- More than 10 years

## Ici on parle!

How to Actively Engage Francophone Patients  
 (How to Pro-actively Engage Francophone Patients)

Indicate how much you agree with the statements on the left side of the page using the following scale.

	Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5	Unable to Assess UA
<b>Based on the MOST RECENT VISIT to your doctor:</b>						
12. Your Family Doctor explained your illness or injury to you thoroughly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Your Family Doctor adequately explained your treatment choices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Your Family Doctor clearly explained your problem and how to avoid it in the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Your Family Doctor explained when to return for follow-up care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>If your Family Doctor gave you a prescription for medicine:</b>						
16. Your Family Doctor clearly explained how and when to take your medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Your Family Doctor told you of any side effects of the medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>


**Ici on parle!**
How to Actively Engage Francophone Patients  
to Improve Health and Quality of Life

**Based on ALL OF YOUR VISITS to your Family Doctor's office, how do you feel about your doctor's attitude and behavior towards you?**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Unable to Assess
<b>My Family Doctor:</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>UA</b>
18. Spends enough time with me	<input type="checkbox"/>					
19. Shows interest in my problems	<input type="checkbox"/>					
20. Asks details about my personal life, when appropriate	<input type="checkbox"/>					
21. Answers my questions well	<input type="checkbox"/>					
22. Examines me appropriately for my problems	<input type="checkbox"/>					
23. Treats me with respect	<input type="checkbox"/>					
24. Helps me with my fears and worries	<input type="checkbox"/>					
25. Talks with me about treatment plans	<input type="checkbox"/>					


**Ici on parle!**
How to Actively Engage Francophone Patients  
 2018 | French and English Speaking | 104-105

	Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5	Unable to Assess UA
<b>How do you feel that your Family Doctor runs his or her office practice?</b>						
26. When asked, my Family Doctor provides reports, files, or copies of letters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. I am advised of results of tests or x-rays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. My Family Doctor arranges appointments with specialists when necessary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Someone from my Family Doctor's office follows-up on any serious problems I may have	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. I am told what to do if my problems do not get better	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>General:</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>UA</b>
31. My Family Doctor talks to me about preventative care (e.g. quitting smoking, weight control, sleeping, alcohol, exercise, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. My Family Doctor asks regularly about prescription and non-prescription medicine I may be taking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. My Family Doctor has printed health information available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. I would go back to this Family Doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. I would send a friend to this Family Doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## ICI ON PARLE!

How to Actively Engage Francophone Patients  
Tool to French and English-Speaking Healthcare

### Importance of language

36. In what language do you prefer to receive health care services?

English

French

Other *Please specify:* \_\_\_\_\_

	Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5	Unable to Assess UA
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#### In general, how important is language when receiving health care?

37. It is important to me to receive health care services in my preferred language	<input type="checkbox"/>					
38. My Family Doctor communicates with me in my preferred language	<input type="checkbox"/>					
39. Staff (e.g. nurses, receptionists) at my Family Doctor's office communicate with me in my preferred language	<input type="checkbox"/>					
40. I would consider leaving my Family Doctor for one who can speak my preferred language	<input type="checkbox"/>					
41. My satisfaction with my Family Doctor depends mainly on his/her ability to communicate in my preferred language	<input type="checkbox"/>					
42. My satisfaction with my Family Doctor depends on other qualities which are <b>MORE</b> important to me than communicating in my preferred language	<input type="checkbox"/>					

43. If you agree or strongly agree with the last statement, please give a few examples of qualities which impact your satisfaction with your doctor.


**Ici on parle!**
How to Actively Engage Francophone Patients  
Tools to Enhance and Engage Learning, This time

## Your Family Doctor's Active Offer Behavior

**What actions does your Family Doctor take to make it known that (s)he can offer services in French?**

	Never	Rarely	Often	Always	Not Applicable
44. My Family Doctor wears some sort of identification which indicates that (s)he can offer services in French (e.g. badge/pin)	<input type="checkbox"/>				
45. My Family Doctor asks me in which language, French or English, I wish to communicate.	<input type="checkbox"/>				
46. My Family Doctor greets me in French OR in both French and English.	<input type="checkbox"/>				
47. There are visual indicators in my Family Doctor's office demonstrating that they offer services in French or in both official languages. (e.g. a sign on their door, in their office)	<input type="checkbox"/>				
48. Informative documents and entertainment options (e.g. pamphlets, magazines, newspaper, radio, television, games) are available in French in the common areas (e.g. waiting room).	<input type="checkbox"/>				
49. My Family Doctor uses certain expressions and a vocabulary which makes me feel comfortable speaking in French.	<input type="checkbox"/>				

**Thank you for your time!**

## Ici on parle!

How to Actively Engage Francophone Patients  
Tools for Health and Health-Care Workers

<p>Patrick E. Timony, Ph.D. (Candidate) Research Associate, Centre for Rural and Northern Health Research, Laurentian University</p> <p>☎: 705-675-1151 ext. 4298 ☎: 1-800-461-4030 ext. 4298 ✉: <a href="mailto:pe_timony@laurentian.ca">pe_timony@laurentian.ca</a></p>	<p>Danielle Barbeau-Rodrigue M.A. (Candidate) Director, Francophone Affairs, Northern Ontario School of Medicine</p> <p>☎: 705-662-7291 ☎: 1-800-461-8777 ext. 7291 ✉: <a href="mailto:dbarbeaurodrigue@nosm.ca">dbarbeaurodrigue@nosm.ca</a></p>	<p>Alain P. Gauthier, Ph.D. (Supervisor) Associate Professor, School of Human Kinetics, Laurentian University</p> <p>☎: 705-675-1151 ext. 1071 ☎: 1-800-461-4030 ext. 1071 ✉: <a href="mailto:agauthier@laurentian.ca">agauthier@laurentian.ca</a></p>	<p>Deborah Smith, MD CCFP FCFP Medical Director of Continuing Medical Education, Northern Ontario School of Medicine</p> <p>✉: <a href="mailto:debsmith@nosm.ca">debsmith@nosm.ca</a></p>
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## Appendix P

### Example of pre-intervention physician report

(This document was also available in French)



November 22, 2022

Dear Dr. X,

Thank you for your participation in the “Ici on parle!” education program. The current report will outline the importance of active offer while providing you with some feedback on the assessment surveys that both you and your patients completed. According to your assessment survey, you indicated that you can offer services in French. Studies have shown that even physicians who can speak French often do not actively do so. See your personalized report below to learn more about your strengths and areas to work on when communicating with Francophone patients. A number of links to resources (supported by the Northeast LHIN) are offered in the left-hand column of the report. We encourage you to review these resources when areas to work on are identified.

#### What is the Active Offer of French Language Services?

According to the Office of the Commissioner of Official Languages, an [‘active offer’](#) of service is: *“an open invitation to the public to use one of our two official languages—English or French—when communicating with or receiving a service ... active offer includes a bilingual greeting, such as “Hello! Bonjour!”, and visual cues, such as signs, that support this invitation.”*

In the context of health services, according to the [Joint Position Statement on the Active Offer of French Language Health Services in Ontario](#), by the Regroupement des Entités de planification des services de santé en français de l’Ontario and the Alliance des Réseaux ontariens de santé en français, *“active offer of health services in French is the regular and permanent offer of services to the Francophone population. [...] It is the result of a rigorous and innovative process for planning and delivering services in French across the entire health care continuum. It depends on accountability at several levels and requires partners to exercise appropriate leadership with respect to health services in French. In concrete terms, it takes the form of a range of health services available in French and offered proactively, that is, services are clearly announced, visible and easily accessible at all times.”*

To learn more about the importance of the active offer of French language services, refer to the following links:

- [French Language Services Toolkit](#): North East Local Health Integration Network
- [Toolbox for the Active Offer](#): Consortium national de formation en santé
- [Reference Framework Training For Active Offer Of French-Language Health Services](#): Consortium national de formation en santé

For more information on the barriers experienced by Ontario physicians when serving Francophone patients, as well as strategies used when offering French language health services, see: [Barriers and Strategies to Offering Health Services to French-speaking Patients: Perspectives from Family Physicians in Northeastern Ontario](#).





## Personalized report

Below you will find your scores from the Physician Survey and, where applicable, your Patients' survey scores (as well as the average patient and physician scores). Five areas of competence have been identified: Patient Interactions, Visual Cues, Telecommunications, Workplace Culture, and Support & Referrals. Note that some areas of competence are scored low by many physicians and you may feel some areas are not applicable to you. To address these areas, we have included resources to improve the Active Offer of French Language Services at your medical practice. We encourage you to share these resources and tool kits with your frontline and support staff.

Legend	Green	Orange	Red
Rating (1-4)	4.0 – 3.0	2.9 – 2.0	1.9 – 1.0
	Doing Great! <i>You often or always do these</i>	Keep At it! <i>You sometimes do these but there is room for improvement</i>	Let's Work On It! <i>You rarely if ever do these and could add such components</i>

### AREA A: PATIENT INTERACTIONS

Related Items	Score
<ul style="list-style-type: none"> <li>Asking the patient in which language, French or English, they wish to communicate</li> <li>Greeting new patients in French</li> <li>Using French expressions</li> </ul>	<p><b>Physician Ratings</b></p> <p><b>Patient Ratings</b></p>
<p>Additional Resources</p> <ul style="list-style-type: none"> <li><a href="#">How to Engage Francophones...When You Don't Speak French</a></li> <li><a href="#">French Language Training Reimbursement Program Information</a></li> <li><a href="#">French Language Electronic Reference Resources</a></li> <li><a href="#">Tool Box for Physicians for learning medical French to improve your language and culture skills</a></li> <li><a href="#">Med-Interpret App: Interpretation Guide for Health Care Professionals</a></li> </ul>	

### AREA B: VISUAL CUES

Related Items	Score
<ul style="list-style-type: none"> <li>Wearing a badge/lanyard indicating "I offer services in French"</li> <li>Visual indicators (sign on door) demonstrating "I offer services in French"</li> <li>Pamphlets, magazines, newspapers, etc. available in French in common areas</li> </ul>	<p><b>Physician Ratings</b></p> <p><b>Patient Ratings</b></p>
<p>Additional Resources</p> <ul style="list-style-type: none"> <li><a href="#">'Je parle français' Pin</a></li> <li><a href="#">Examples of French Signage</a></li> <li><a href="#">A variety of tools to help professionals in French</a></li> <li>Bilingual promotional tools and translation services - <a href="#">Bonjours/Welcom</a> -</li> </ul>	<p>    <b>MASTER LIST of translated documents</b>  <i>(Double-click the icon above to view content.)</i> </p>

AREA C: TELECOMMUNICATIONS					
Related Items	Score				
<ul style="list-style-type: none"> <li>– Answering the phone in French</li> <li>– Voicemail including greeting in French</li> <li>– Email Signature, both in French, and English</li> </ul>	<p><b>Physician Ratings</b></p> <table border="1"> <tr><td>AVG MD</td><td>2.11</td></tr> <tr><td>You</td><td>3.67</td></tr> </table>	AVG MD	2.11	You	3.67
AVG MD		2.11			
You	3.67				
<p>Additional Resources</p> <ul style="list-style-type: none"> <li>– <a href="#">Over the Counter Tips - Phonetics Card 1</a></li> <li>– <a href="#">Telephone Tips – Card #3</a></li> <li>– <a href="#">Useful Telephone Expressions</a></li> </ul>					

AREA D: WORKPLACE CULTURE / “HR POLICIES”					
Related Items	Score				
<p><b>Written</b></p> <ul style="list-style-type: none"> <li>– Providing bilingual letterhead and/or business cards</li> <li>– Advertising clearly the availability of services in French</li> <li>– Offering information in French or both official languages on your Website</li> <li>– Broadcasting information in newspapers and on the radio in French</li> </ul> <p><b>Verbal</b></p> <ul style="list-style-type: none"> <li>– Recruiting staff capable of offering services in French</li> <li>– French-speaking employees converse in French</li> <li>– Informing patients of the establishment’s commitment to offer services of equal quality in both official languages</li> </ul>	<p><b>Written Culture</b></p> <p><b>Physician Ratings</b></p> <table border="1"> <tr><td>AVG MD</td><td>1.91</td></tr> <tr><td>You</td><td>1.63</td></tr> </table>	AVG MD	1.91	You	1.63
AVG MD		1.91			
You	1.63				
<p>Additional Resources</p> <ul style="list-style-type: none"> <li>– <a href="#">Francophone Media Sources in Ontario</a></li> <li>– <a href="#">Human Resources Support Kit</a></li> <li>– <a href="#">Active Offer of French Language Services in Health Management and Employee Fact Sheets</a></li> <li>– <a href="#">Recruiting &amp; Retaining Bilingual Staff</a></li> <li>– <a href="#">Creating a Bilingual Organizational Culture</a></li> <li>– <a href="#">‘Making your Organization Bilingual’</a></li> <li>– <a href="#">Framework for Recruitment &amp; Retention of Bilingual Human Resources</a></li> <li>– <a href="#">Informal Evaluation of French Competency Levels</a></li> </ul>	<p><b>Patient Ratings</b></p> <table border="1"> <tr><td>AVG Pt</td><td>3.10</td></tr> <tr><td>Your Pt</td><td>3.57</td></tr> </table>	AVG Pt	3.10	Your Pt	3.57
AVG Pt	3.10				
Your Pt	3.57				
	<p><b>Verbal Culture</b></p> <p><b>Physician Ratings</b></p> <table border="1"> <tr><td>AVG MD</td><td>2.51</td></tr> <tr><td>You</td><td>3.20</td></tr> </table>	AVG MD	2.51	You	3.20
AVG MD	2.51				
You	3.20				

AREA E: SUPPORT & REFERRALS					
Related Items	Score				
<ul style="list-style-type: none"> <li>– Consulting an updated list of providers and organizations who offer services in French when making referrals.</li> <li>– Offering patients the option to be directed to a French-speaking provider or Francophone organization</li> <li>– Specifying the patients’ language of preference on referral letters</li> <li>– Informing providers/organizations of the patient’s language of preference</li> </ul>	<p><b>Physician Ratings</b></p> <table border="1"> <tr><td>AVG MD</td><td>2.51</td></tr> <tr><td>You</td><td>2.80</td></tr> </table>	AVG MD	2.51	You	2.80
AVG MD		2.51			
You	2.80				
<p>Additional Resources</p> <ul style="list-style-type: none"> <li>– List of <a href="#">identified providers</a> and <a href="#">designated providers</a> for FLS in the North East LHIN</li> <li>– List of <a href="#">identified providers</a> for FLS in the North West LHIN</li> </ul>					

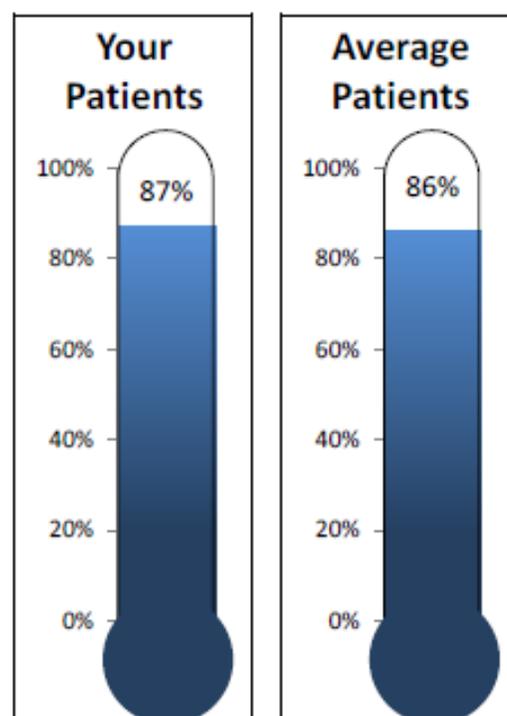
THE FOLLOWING TABLE PRESENTS YOUR PATIENTS' LEVEL OF SATISFACTION WITH YOUR COMMUNICATION BEHAVIOURS IN COMPARISON TO THE AVERAGE PATIENT SATISFACTION SCORE.

#### PATIENT SURVEY – SATISFACTION WITH PHYSICIAN COMMUNICATION

Patients rated their level of satisfaction with their physician's communication techniques. These range from satisfaction with their physician's ability to explain their illness, answer their questions and talk about a treatment plan.

The thermometer charts represent patients' level of satisfaction with the communication they have been receiving. The higher the score, the more patients are satisfied.

The first thermometer represents the level of satisfaction from your own patients, whereas the second thermometer represents the average level of satisfaction of all patients who completed a survey as part of this education program.

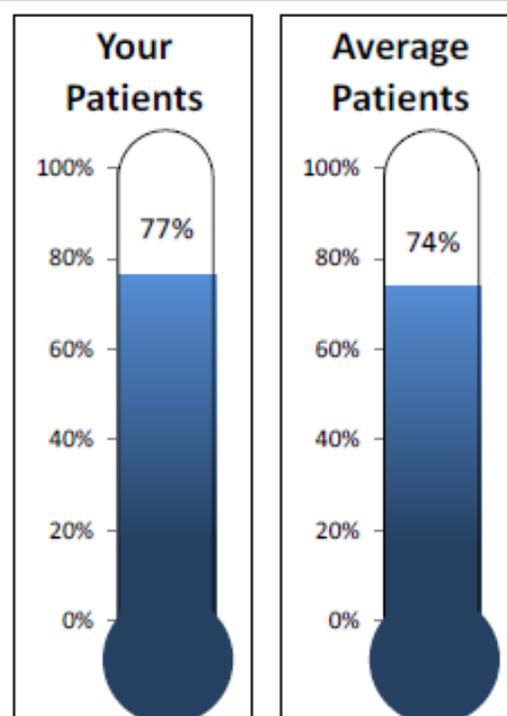


#### PATIENT SURVEY – IMPORTANCE OF RECEIVING SERVICES IN THE LANGUAGE OF PREFERENCE

Patients were asked to rate the importance of receiving services in their language of preference.

The thermometer charts represent the level of importance patients place on language when receiving health care services. The higher the score, the more patients consider language being an important component of care.

The first thermometer represents the level of importance your own patients place on language, whereas the second thermometer represents the average level of importance of all patients who completed a survey as part of this education program.



## Appendix Q

### Workshop consent form

(This document was also available in French)

# Ici on parle!

How to Actively Engage Francophone Patients  
Tools for French and English-Speaking Physicians

## Workshop consent from

Thank you for your interest in the Ici on parle! continuing education and professional development program. Following your participation in the assessment phase, you have been invited to participate in a 2 hour workshop. There are 4 goals for the workshop:

1. Understand the concept of the Active Offer of French Language Services.
2. Review your survey results, highlighting strengths and areas to work on.
3. Discuss the barriers to Active Offer in your practice.
4. Establish practical strategies for the implementation of the Active Offer.

### Credits Earned

As was originally outlined in the program information letter, this 2 hour workshop has been certified by the College of Family Physicians of Canada for 4 *certified* group learning Mainpro+ credits. In addition, upon participating in the workshop, credits earned to date as well as any future credits you earn as part of this education program will qualify for *certified* group learning credits.

### Research tasks

In order to better understand the barriers to offering French Language Health Services and to learn from patient-centered care strategies discussed here today, we are requesting your permission to have the workshop audio/video recorded for future analysis. Your participation in this qualitative study simply require that you participate in the workshop as planned. This is an observational study with no researcher intervention. The results from the workshop will help inform future continuing education strategies and may be shared with the scientific community through conference presentations, peer-reviewed publications and newsletters.

### Benefits

Beyond earning Mainpro+ credits, through the workshop, you will develop strategies to offering patient-centered care to your Francophone patients by learning about the importance of offering linguistically appropriate health services. You are encouraged to share these skills and strategies with coworkers.

### Risks

The risks to participating in this qualitative study are no greater than those experienced by participating in the workshop. Though you may initially feel frustrated with the thought of offering French Language Services, the workshop is developed specifically to offer you the skills needed to do so.

## Confidentiality

As with any group discussion, the opinions expressed during the workshop will be shared with all participating physicians. We ask you only share comments which you are comfortable revealing to the group. Though we ask that all participants respect the confidentiality of others, we cannot guarantee your anonymity nor the confidentiality of your comments. You do not need to share anything you are uncomfortable with and you can withdraw from the workshop at any time without penalty or consequence.

All data you provide will be stored in the strictest of confidence. Your consent form and any research notes will be stored in a locked filing cabinet, within a locked office of an access-controlled building at Laurentian University. All recoding and transcripts will be stored on CRaNHR's secure server. Only researchers who are working on the study and have signed non-disclosure agreements will have access to the data. Your data will also be stored anonymously without any identifiable information. Given that the information learned from this study will be used to inform future educational initiatives, your data will remain securely stored on CRaNHR's server indefinitely and could be used for future research purposes.

If you have any further questions about the education program or the built-in research components, please contact:

<p>Patrick E. Timony, Ph.D. (Candidate) Research Associate, Centre for Rural and Northern Health Research, Laurentian University</p> <p>☎: 705-675-1151 ext. 4298 ☎: 1-800-461-4030 ext. 4298 ✉: <a href="mailto:pe_timony@laurentian.ca">pe_timony@laurentian.ca</a></p>	<p>Danielle Barbeau-Rodrigue M.A. (Candidate) Director, Francophone Affairs, Northern Ontario School of Medicine</p> <p>☎: 705-662-7291 ☎: 1-800-461-8777 ext. 7291 ✉: <a href="mailto:dbarbeau@nosm.ca">dbarbeau@nosm.ca</a></p>	<p>Alain P. Gauthier, Ph.D. (Supervisor) Associate Professor, School of Human Kinetics, Laurentian University</p> <p>☎: 705-675-1151 ext. 1071 ☎: 1-800-461-4030 ext. 1071 ✉: <a href="mailto:agauthier@laurentian.ca">agauthier@laurentian.ca</a></p>	<p>Deborah Smith, MD CCFP FCFP Medical Director of Continuing Medical Education, Northern Ontario School of Medicine</p> <p>✉: <a href="mailto:debsmith@nosm.ca">debsmith@nosm.ca</a></p>
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You can also contact the Research Ethics Officer at Laurentian University regarding possible ethical issues or complaints about the research itself at 705-675-1151 ext. 3213 or 2436 or toll free at 1-800-461-4030 or email [ethics@laurentian.ca](mailto:ethics@laurentian.ca).

	Yes	No
I freely agree to participate in this study.	<input type="checkbox"/>	<input type="checkbox"/>
I agree to have the workshop recorded.	<input type="checkbox"/>	<input type="checkbox"/>
I agree to publishing the results from the workshop in presentations, papers and newsletters	<input type="checkbox"/>	<input type="checkbox"/>

Today's date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Signature: \_\_\_\_\_

## Appendix R

### Workshop agenda and workbook



## **Workshop / Atelier**

**Agenda / Ordre du jour**

**&**

**Workbook / Cahier de travail**

**March 5<sup>th</sup> 2018 / le 5 mars 2018**

1. Opening remarks -----5 min  
*Remarques d'ouverture* -----5 min
2. The Active Offer of French-Language Health Services -----15-20 min  
*L'offre active des services de santé en français* -----15-20 min
  - Le Réseau du mieux-être francophone du nord de l'Ontario
3. Review survey results ----- 5-10 min  
*Revue des résultats du questionnaire* ----- 5-10 min
  - Feedback on report/program/process  
*Rétroaction sur le rapport/programme/processus*
4. Discussion of barriers & strategies-----80-90 min  
*Discussion des barrières et des stratégies*-----80-90 min
  - Review each areas of competence from the report  
*Revue des domaines de compétences identifiés dans le rapport*
  - Identify barriers to implementing each areas of competence  
*Identifier les barrières à l'exécution de chaque domaine de compétence*
  - Develop practical strategies to include the active offer in your practices  
*Développer des stratégies pratiques afin d'inclure l'offre active dans votre pratique*
  - Areas of competence  
*Domaines de compétences*
    - i. Area / *Domaine* A: Patient Interactions / *Interaction avec les patients*
    - ii. Area / *Domaine* B: Visual Cues / *Repères visuels*
    - iii. Area / *Domaine* C: Telecommunications / *Télécommunications*
    - iv. Area / *Domaine* D: Workplace Culture / *Culture organisationnelle*  
Written / *Écrit*  
Verbal / *Verbal*
    - v. Area / *Domaine* E: Support & Referrals / *Soutien et aiguillage*















## Appendix S

### Examples of bilingual signage

# EXAMPLES OF BILINGUAL SIGNAGE



LE RÉSEAU DU MIEUX-ÊTRE  
FRANCOPHONE  
DU NORD DE L'ONTARIO

## Letting Your Clients Know You Offer Services in French

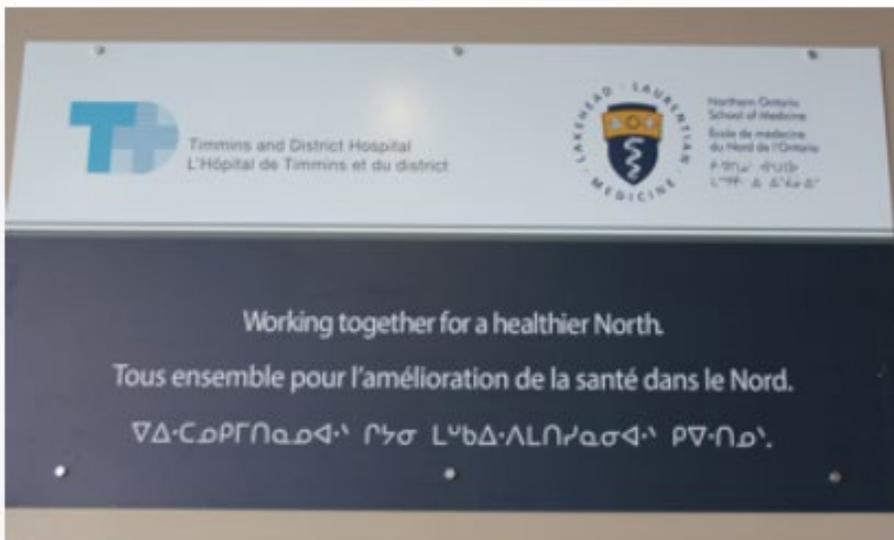
### Welcome/Bienvenue

In this location, services are offered  
in both English and French.

Ici, nos services sont offerts en  
français et en anglais.



# Exterior & Interior Signage



## Name of Rooms or Areas



## Memos & Other Messages



## Staff Identification



## Business Cards



**LE RÉSEAU DU MIEUX-ÊTRE  
FRANCOPHONE  
DU NORD DE L'ONTARIO**

1 866-489-7484 | www.rmefno.ca

**Frédérique Dallaire-Blais**  
 Agente de planification et  
 d'engagement communautaire  
 Région de Sudbury /  
 Manitoulin / Parry Sound

Tel. : 1 866-489-7484 poste 231  
 Cell. : 249 878-1418  
 fdallaireblais@rmefno.ca

469, rue Boeuchard, bureaux 270  
 Sudbury (Ontario) P3E 2K8



**LE RÉSEAU DU MIEUX-ÊTRE  
FRANCOPHONE  
DU NORD DE L'ONTARIO**

1 866-489-7484 | www.rmefno.ca

**Frédérique Dallaire-Blais**  
 Planning and Community  
 Engagement Officer  
 Sudbury / Manitoulin /  
 Parry Sound region

Tel. : 1 866-489-7484 x 231  
 Cell. : 249 878-1418  
 fdallaireblais@rmefno.ca

469 Boeuchard Street, Suite 270  
 Sudbury, Ontario P3E 2K8

## Event Promotion

L'atelier s'adresse aux professionnels de la santé qui parlent français et qui sont appelés à faire de l'**interprétation** de manière informelle.



This workshop is geared toward bilingual health care professionals who may be called upon to provide informal **interpretation** services.





### L'interprétation et toi

Un atelier de formation en français sur l'interprétation et l'offre active

**Objectifs visés**

- \* Reconnaître les avantages de réduire les barrières linguistiques
- \* Approfondir les connaissances par rapport à l'offre active
- \* Se sentir à l'aise d'offrir des services d'interprétation de base

**Hôpital de District de Geraldton**  
 9 novembre 2017  
 14 h à 16 h

Pour plus de renseignements, veuillez communiquer avec :



**Chantal Bohémier**  
 1 866 489-7484, poste 402  
 cbohemier@rmefno.ca



### Interpretation and You

A French Workshop on Interpretation and Active Offer

**Goals**

- \* Recognize the benefits of reducing language barriers
- \* Increase knowledge and awareness regarding active offer
- \* Feel more comfortable in providing basic interpretation services

**Geraldton District Hospital**  
 November 9, 2017  
 2:00 pm to 4:00 pm

For more information, please contact :



**Chantal Bohémier**  
 1 866-489-7484, ext. 402  
 cbohemier@rmefno.ca

Formation conçue par l'Accueil francophone de Thunder Bay et subventionnée par :



Workshop developed by l'Accueil francophone de Thunder Bay and funded by:



## Appendix T

### Workshop presentation






# Ici on parle!

How to Actively Engage Francophone Patients  
Tools for French and English-Speaking Physicians

Dr. Meghan Cusack  
Patrick E. Timony  
Dr. Deborah Smith

Danielle Barbeau-Rodrigue  
Dr. Alain P. Gauthier

Accredited by

THE COLLEGE OF  
FAMILY PHYSICIANS  
OF CANADA



LE COLLÈGE DES  
MÉDECINS DE FAMILLE  
DU CANADA










## Agenda / *Ordre du jour*

- |    |                                    |       |
|----|------------------------------------|-------|
| 1. | Opening remarks -----              | 5 min |
|    | <i>Remarques d'ouverture</i> ----- | 5 min |
- |    |   |           |
|----|---|-----------|
| 2. | The Active Offer of French-Language Health Services -----     | 15-20 min |
|    | <i>L'offre active des services de santé en français</i> ----- | 15-20 min |



**LE RÉSEAU DU MIEUX-ÊTRE  
FRANCOPHONE  
DU NORD DE L'ONTARIO**

- |    |   |          |
|----|---|----------|
| 3. | Review survey results -----                       | 5-10 min |
|    | <i>Revue des résultats du questionnaire</i> ----- | 5-10 min |
- |    |   |           |
|----|---|-----------|
| 4. | Discussion of barriers & strategies -----               | 80-90 min |
|    | <i>Discussion des barrières et des stratégies</i> ----- | 80-90 min |





## In your package



Document	Physical	Electronic
Personalised report	✓	✓
Agenda & Workbook	✓	✓
Réseau du Mieux être – presentation slides		✓
Examples of Bilingual Signage		✓
CNFS Reference Framework	✓	✓
FOCUS - Barriers and Strategies to Offering Health Services to French-speaking Patients	✓	✓
How to claim your Mainpro+ credits	✓	✓
Je Pale Français - Pin	✓	
Stethoscope badge	✓	
USB key (with electric documents)	✓	





## REFERENCE FRAMEWORK

TRAINING FOR ACTIVE OFFER  
OF FRENCH-LANGUAGE HEALTH SERVICES



Learning Framework for the Future Health Professional

To improve the active offer of quality French-language services, future health professionals must be properly equipped to develop their personal confidence, their professional commitment and their motivation to be leaders in their work environments in minority situations

The future professional must

**Acquire Knowledge**

1. The patient-centred approach
2. Active offer to improve the quality of health services
3. Health determinants, particularly language and culture, which make French-language services an issue of safety, quality, legitimacy and ethics
4. The realities, challenges and rights of Francophone minority communities
5. The characteristics of working in healthcare in a Francophone minority context

**Acquire Skills**

1. Ability to reflect on one's identity as a Francophone (personal and social identity) and as a professional (professional identity) in order to support the evolution of one's identity and self-affirmation
2. Ability to improve and tailor one's language skills to the socio-cultural environment
3. Cultural skills and openness to pluralism
4. Social and inter-personal skills, indicators of emotional intelligence

**Adopt Attitudes**

1. Become a practitioner who is able to adapt to ongoing evaluation of offered services in a minority context
2. Become a professional who demonstrates critical thinking on the active offer of French-language health services
3. Become a person who affirms his or her feelings of belonging, of pride and of being a Francophone citizen of Canada
4. Become an ethical professional who is prepared to guarantee an ongoing active offer of health services in the preferred official language of a patient or beneficiary
5. Become a catalyst for change and innovation in the workplace

Consortium national de formation en santé



**CR**<sup>re</sup>**NHR** **Gap in Beliefs** **CR**<sup>re</sup>**SRN**

« Je suis beaucoup plus à l'aise si je peux m'exprimer en français, même si je parle un assez bon anglais. »

"People are so bilingual that it makes no sense for me to be speaking French."

**Communication**



Laurentian University  
Université Laurentienne

**CR**<sup>re</sup>**NHR** **CR**<sup>re</sup>**SRN**



**LE RÉSEAU DU MIEUX-ÊTRE  
FRANCOPHONE  
DU NORD DE L'ONTARIO**

Laurentian University  
Université Laurentienne




## Review survey results

- Early adopters of the program
- Next step
  - Automating surveys /report
- Your thoughts:
  - The program
  - The surveys
  - The report



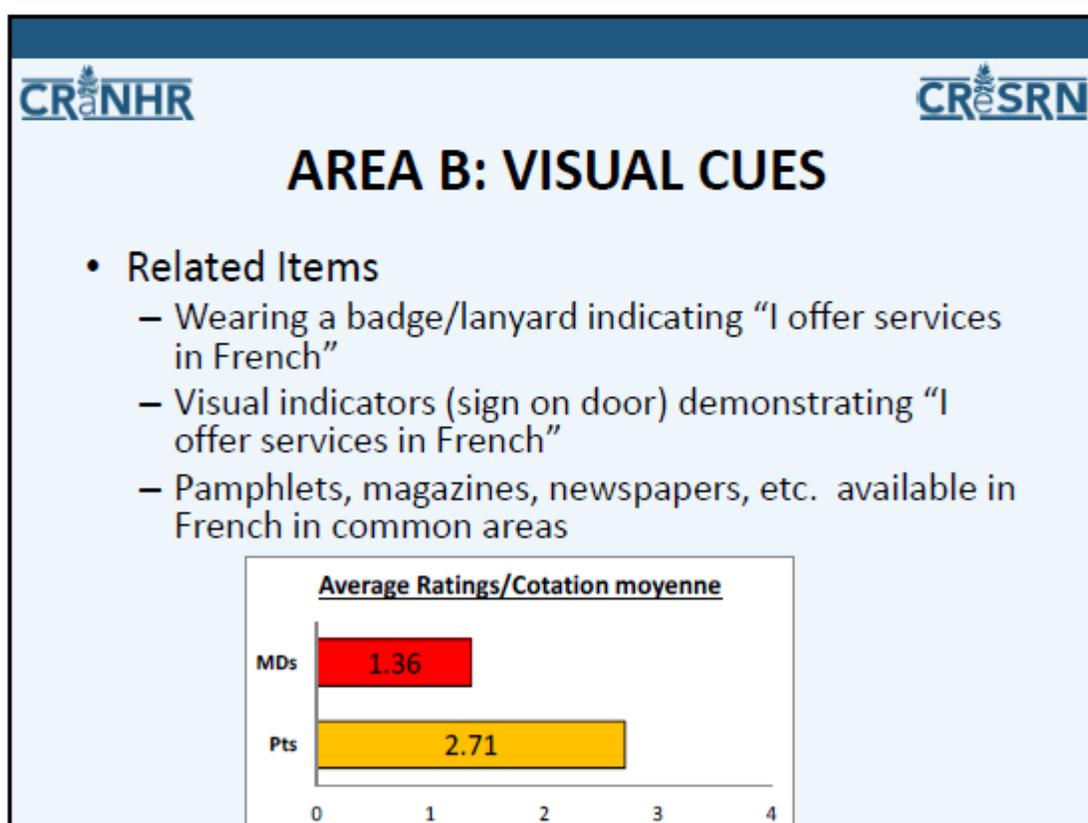
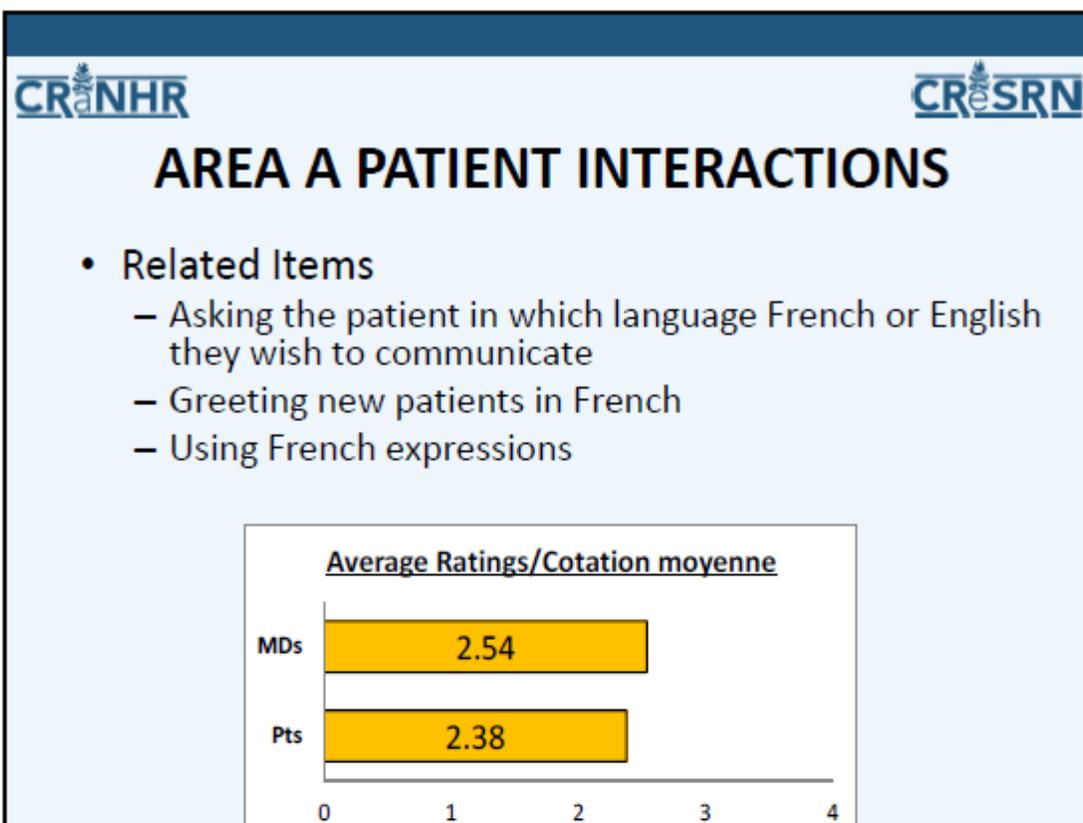



## Areas of competence

- Area A: Patient Interactions
- Area B: Visual Cues
- Area C: Telecommunications
- Area D: Workplace Culture
  - Written
  - Verbal
- Area E: Support & Referrals

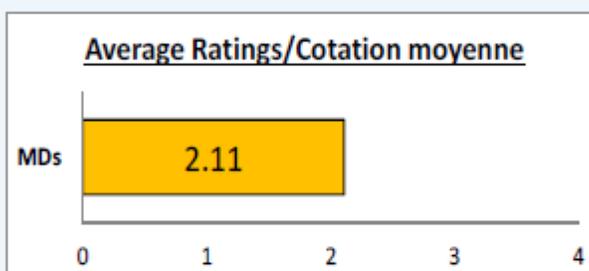
Legend	Green	Orange	Red
Rating (1-4)	4.0 – 3.0	2.9 – 2.0	1.9 – 1.0
	Doing Great! <i>You often or always do these</i>	Keep At it! <i>You sometimes do these but there is room for improvement</i>	Let's Work On It! <i>You rarely if ever do these and could add such components</i>





## AREA C: TELECOMMUNICATIONS

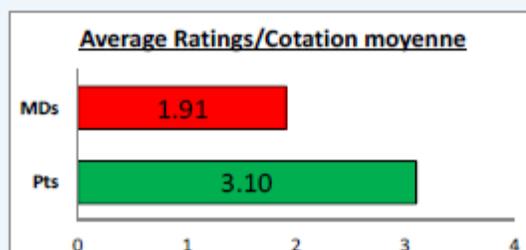
- Related Items
  - Answering the phone in French
  - Voicemail including greeting in French
  - Email Signature, both in French, and English

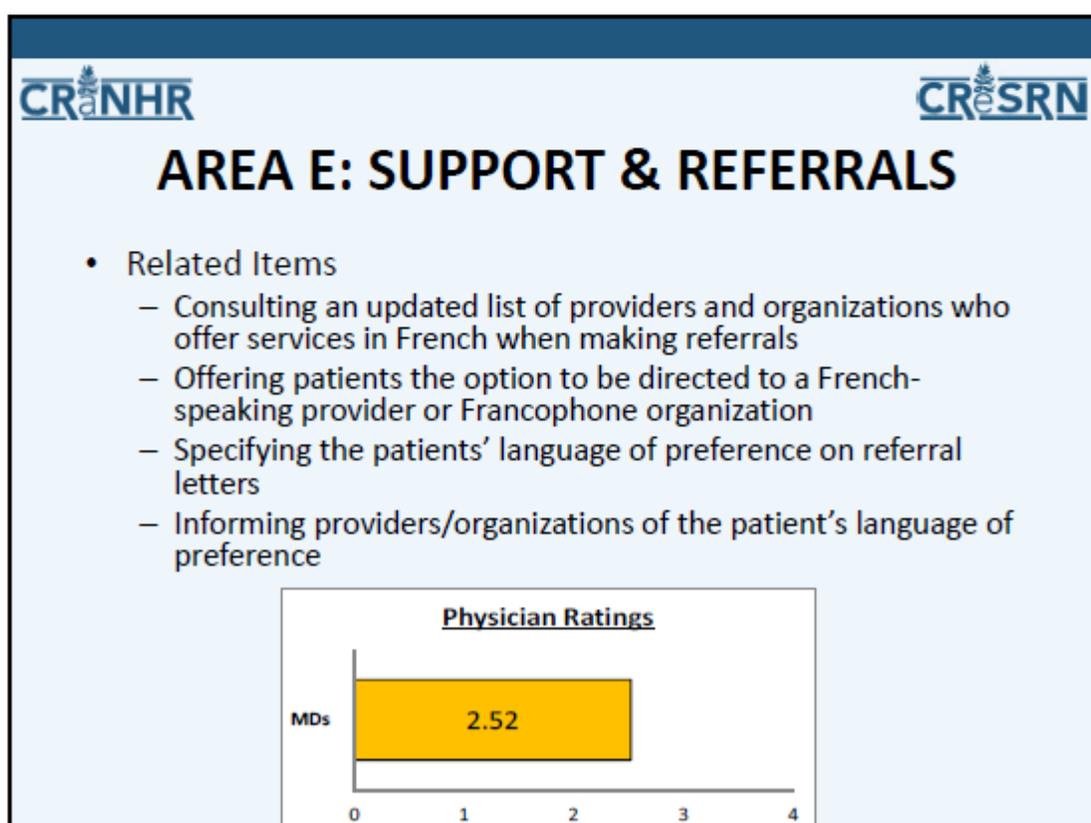
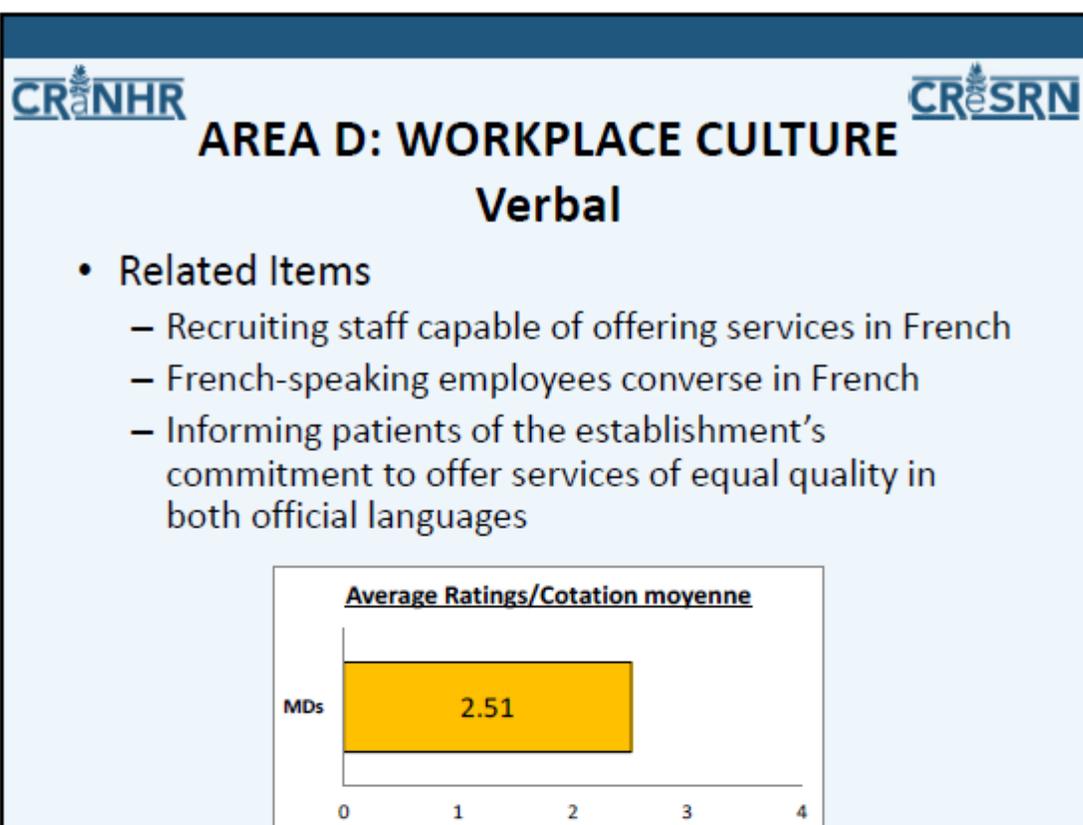


## AREA D: WORKPLACE CULTURE

### Written

- Related Items
  - Providing bilingual letterhead and/or business cards
  - Advertising clearly the availability of services in French
  - Offering information in French or both official languages on your Website





## Appendix U

### Physician post-intervention survey booklet

(This document was also available in French)

# Ici on parle!

How to Actively Engage Francophone Patients  
Tools for French and English-Speaking Physicians

## Survey of Active Offer of French Language Services

### Post program Questionnaire

Expected completion time: 15 minutes



## lci on parle!

How to Actively Engage Francophone Patients  
How to Activer et Engager les Patients Francophones

### Completed activities

Please indicate the components of the program which you have completed and the number of hours spent on each (this information is needed to calculate the number of credits you have earned):

ACTIVITY	Completed		# of hours
	Yes	No	
Initial physician, receptionist and patient surveys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Review survey results and provided resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Participate in workshop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Post-education physician surveys & reflective exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Review final report (please estimate the number of hours you will spend reviewing the report)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

## Ici on parle!

How to Actively Engage Francophone Patients  
 Tools for French and English speaking Physicians

The following questions refer to your behaviour since participating in the workshop.  
 It is normal that some the behaviours listed have not changed.  
 Answer the questionnaire so as to reflect your real practice since participating in the workshop.

### Active Offer Behaviour

Since participating in the workshop, what actions do I personally take to make it known that I can offer services in French?

	Never	Rarely	Often	Always	Not Applicable
1. In my workplace, I wear some sort of identification which indicates that I can offer services in French (e.g. badge/pin)	<input type="checkbox"/>				
2. I ask my patient in which language, French or English, they wish to communicate.	<input type="checkbox"/>				
3. When I welcome a patient whose language I don't know, I first greet him/her in French, followed by a greeting in English.	<input type="checkbox"/>				
4. In my workplace, there are visual indicators demonstrating that I offer services in French or in both official languages. (e.g. a sign on my door, in my office)	<input type="checkbox"/>				
5. When he/she doesn't do it, I sensitize my employer to the importance of promoting the French language services which are available at my workplace (e.g. posters, advertisements, Web site)	<input type="checkbox"/>				
6. When I answer the phone, I first answer in French followed by English, when necessary.	<input type="checkbox"/>				
7. The message on my phone voicemail includes a greeting in French, as well as one in English.	<input type="checkbox"/>				
8. The message on my phone voicemail <b>begins</b> with a greeting in French, followed by one in English.	<input type="checkbox"/>				
9. The signature on my email appears both in French and in English.	<input type="checkbox"/>				
10. The signature on my email <b>first</b> appears in French.	<input type="checkbox"/>				
11. I make sure informative documents and entertainment options (e.g. pamphlets, magazines, newspaper, radio, television, games) are available in French in the common areas (waiting room or other).	<input type="checkbox"/>				
12. I use certain expressions and a vocabulary used by the patient so that (s)he feels comfortable speaking with me in French.	<input type="checkbox"/>				


**Ici on parle!**

How to Attract, Engage Francophone Patients  
and to Educate and Empower them

## Support and Referrals

Since participating in the workshop, when I refer Francophone patients to another service provider (e.g. referrals to a specialist), whenever possible I...

	Never	Rarely	Often	Always	Not Applicable
13. consult an updated list of providers and organisations who offer services in French.	<input type="checkbox"/>				
14. offer the patients the option to be directed towards a French speaking provider or Francophone organisation.	<input type="checkbox"/>				
15. specify the patients language of preference on the referral or transfer letter.	<input type="checkbox"/>				
16. verbally inform the provider or organisation of the patients language of preference, or have someone to do it for me.	<input type="checkbox"/>				

## Perception of Organizational Support

Since participating in the workshop, in my workplace, it is normal to...

	Never	Rarely	Often	Always	Not Applicable
17. display posters in French or in both official languages of Canada.	<input type="checkbox"/>				
18. supply badges/pins or plaques indicating that services are available in both official languages of Canada.	<input type="checkbox"/>				
19. advertise in a clear and visible manner, the availability of the services in French.	<input type="checkbox"/>				
20. offer information in French or in both official languages of Canada on the Web site.	<input type="checkbox"/>				
21. place at the patient's disposal magazines, booklets or other media which presents information in both official languages of Canada.	<input type="checkbox"/>				
22. broadcast information in newspapers and on the radio in French.	<input type="checkbox"/>				
23. recruit staff capable of offering services in French at all levels of service.	<input type="checkbox"/>				
24. hold meetings in French or both official languages of Canada.	<input type="checkbox"/>				
25. facilitate the use of French between employees.	<input type="checkbox"/>				
26. inform the patient of the establishment's commitment to offer services of equal quality in both official languages of Canada.	<input type="checkbox"/>				
27. converse in French between French-speaking employees.	<input type="checkbox"/>				
28. print letterhead and business cards in French or in both official languages of Canada.	<input type="checkbox"/>				

## Interactions with Francophone patients

29. In the past week, please estimate the percentage of patients you saw who belong to each of the following primary language groups. (*Total percentage must add up to 100%*)

<input type="text"/>	%	Anglophone
<input type="text"/>	%	Francophone
<input type="text"/>	%	Other (neither Anglophone nor Francophone)

30. In the past week, please estimate the percentage of patient interactions which you conducted in each of the following languages. (*Total percentage must add up to 100%*)

<input type="text"/>	%	English
<input type="text"/>	%	French
<input type="text"/>	%	Other (neither English nor French)

## Active Offer Perceptions

31. How would you define the Active offer of French language health services after participating in the workshop?

a. Has your definition changed?

- Yes  
 No

## Impact of the program

32. Have you implemented any changes in your practice as a result of this education program?

a. What specific changes did you implement?

b. What effect, if any, has the program had on your confidence in dealing with Francophone patients?

33. Have you shared any lessons/strategies from the program with coworkers/staff?

- Yes  
 No

a. If yes, what changes have coworkers/staff implemented?

## Ici on parle!

How to Actively Engage Francophone Patients  
to Improve French and English Speaking Health Care

34. If you have not changed your practice as a result of this programme:

a. Did you find the program to be irrelevant to your practice? If yes, please explain.

b. Have you encountered barriers to implementing change? If yes, please explain.

c. How might the program have been modified to make it more useful?

**Thank you for your time!**

<p>Patrick E. Timony, Ph.D. (Candidate) Research Associate, Centre for Rural and Northern Health Research, Laurentian University</p> <p>☎: 705-675-1151 ext. 4298 ☎: 1-800-461-4030 ext. 4298 ✉: pe_timony@laurentian.ca</p>	<p>Danielle Barbeau-Rodrigue M.A. (Candidate) Director, Francophone Affairs, Northern Ontario School of Medicine</p> <p>☎: 705-662-7291 ☎: 1-800-461-8777 ext. 7291 ✉: dbarbeurodrigue@nosm.ca</p>	<p>Alain P. Gauthier, Ph.D. (Supervisor) Associate Professor, School of Human Kinetics, Laurentian University</p> <p>☎: 705-675-1151 ext. 1071 ☎: 1-800-461-4030 ext. 1071 ✉: agauthier@laurentian.ca</p>	<p>Deborah Smith, MD CCFP FCFP Medical Director of Continuing Medical Education, Northern Ontario School of Medicine</p> <p>✉: debsmith@nosm.ca</p>
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## Appendix V

### Instructions on how to claim Mainpro+ credits

(This document was also available in French)



## How to Claim Your Mainpro+® Credits

As a participant in the “Ici on Parle!” education program, you have been/will be provided with a number of opportunities to earn Mainpro+ credits. The number and type (certified vs. non-certified) of credits earned depends on the activities you complete. This document will serve as a guide to identifying the credits you are eligible for and to describe the means of claiming your credits. The document is divided by the type of educational activities you have (or will) participate in. Take note that for some activities, the number and type of credits will differ depending on whether or not you participate in the workshop.

ACTIVITY: COMPLETE INITIAL PHYSICIAN, RECEPTIONIST AND PATIENT SURVEYS		
	Without the Workshop	With the Workshop
Credits Earned	1 Non-certified credit/hour	2 Certified credits/hour
Description	These are considered <u>self-learning</u> credits. These credits can be claimed for completing the physicians survey and coordinating the receptionist and patient surveys	These certified <u>group learning</u> credits are eligible only for those who participate in the workshop. Participating in this activity is considered preparation for and an extension of the workshop certified group learning credits.
How to Claim	Log in to the CFPC website and “Enter a CPD Activity”. For a short instructional video click: <a href="https://youtu.be/RFzHE8BGJ4w">https://youtu.be/RFzHE8BGJ4w</a>	You will want to wait to record these credits until after your final step in this program is complete at which time you can follow the instructions under “REVIEW FINAL REPORT”

ACTIVITY: REVIEW SURVEY RESULTS AND PROVIDED RESOURCES		
	Without the Workshop	With the Workshop
Credits Earned	1 Non-certified credit/hour	2 Certified credits/hour
Description	These are considered <u>assessment</u> credits, 1 non-certified credit can be claimed for every hour of work. Credits can be claimed for reviewing the physician report and reading the resources provided therein.	These certified <u>group learning</u> credits are eligible only for those who participate in the workshop. Participating in this activity is considered preparation for and an extension of the workshop certified group learning credits.
How to Claim	Log in to the CFPC website and “Enter a CPD Activity”. For a short instructional video click: <a href="https://youtu.be/RFzHE8BGJ4w">https://youtu.be/RFzHE8BGJ4w</a>	You will want to wait to record these credits until after your final step in this program is complete at which time you can follow the instructions under “REVIEW FINAL REPORT”

ACTIVITY: COMPLETING "LINKING LEARNING TO ASSESSMENT" ACTIVITY	
Credits Earned	5 Certified Credits per Activity
Description	These certified <u>self-learning</u> credits are eligible for all physicians, regardless of participation in the workshop. This activity challenges you to appraise the physician report and the resources provided and integrate them into practise.
How to Claim	See <a href="#">detailed description</a> below. The same steps can be taken to claim credits by completing the "Linking Learning to Practice" activity after reviewing the final report at the very end of the education program. There is no limit to the number of Linking Learning activities a physician can claim.

ACTIVITY: PARTICIPATE IN WORKSHOP & COMPLETE REFLECTIVE EXERCISE	
Credits Earned	4 Certified Credits
Description	This workshop meets the certification criteria of the College of Family Physicians of Canada and has been approved for 4 Mainpro + certified <u>group learning</u> credits. You will be issued a certificate once you complete the reflective exercise (4-6 weeks after the workshop).
How to Claim	You may choose to log in to the CFPC website now or after having reviewed the final report and claim 2 credits/hour for the total number of hours you spent on this program (including the workshop). You are permitted to claim <u>up to 18 certified group learning credits</u> for the whole program. For a short instructional video click: <a href="https://youtu.be/RFzHE8BGJ4w">https://youtu.be/RFzHE8BGJ4w</a> .

ACTIVITY: COMPLETE POST-EDUCATION PHYSICIAN, RECEPTIONIST AND PATIENT SURVEYS	
Credits Earned	2 Certified credits/hour
Description	These certified <u>group learning</u> credits are eligible only for those who participate in the workshop. Participating in this activity is considered an extension of the workshop certified <u>group learning</u> credits.
How to Claim	You can claim these credits now or you can wait to record these credits after having reviewed the final report at which time you can follow the instructions under "REVIEW FINAL REPORT"

ACTIVITY: REVIEW FINAL REPORT	
Credits Earned	2 Certified credits/hour
Description	These certified <u>group learning</u> credits are eligible only for those who participate in the workshop. Participating in this activity is considered an extension of the workshop certified <u>group learning</u> credits.
How to Claim	Once you have completed this step you can log in to the CFPC website and claim 2 credits/hour for the total number of hours you have spent on this program (including the workshop). You are permitted to claim <u>up to 18 certified group learning credits</u> for the whole program. For a short instructional video click: <a href="https://youtu.be/RFzHE8BGJ4w">https://youtu.be/RFzHE8BGJ4w</a> .

**Note:** A certificate is only issued for the certified credits. You are responsible for tracking and claiming your own non-certified credits.

## How to Complete a Linking Learning to Assessment

You can complete a 'Linking Learning to Assessment' activity and receive 5 Certified Mainpro+ credits. Completing the online questionnaire will take about 20 minutes but it does require some reflection and can only be completed after some time has elapsed after receiving the educational material (usually 6-8 weeks).

Attached you will find a step by step description of how to complete the Linking Learning activity with some helpful screenshots. At any point during the submission process you can save your form to complete at a later time by scrolling to the bottom of the page and clicking on 'SEND TO HOLDING AREA'.

### Step 1: Log In to the CFPC website using your user name and password and go to 'My Account'

The screenshot shows the CFPC website homepage. At the top, there is a navigation menu with links for ABOUT US, EDUCATION, CPD, MEMBERSHIP, HEALTH POLICY, RESOURCES, PUBLICATIONS, RESEARCH, and DIRECTORIES. Below the navigation is a large red banner with the text "Stay up to date on our government relations work with *Reaching Out!*". To the right of the banner is a "NEWS AND EVENTS" section with several news items. Below the banner is a "Subscribe to our informative newsletter." section. The main content area is divided into four columns: "FOR PHYSICIANS", "FOR RESIDENTS & STUDENTS", "FOR TEACHERS & RESEARCHERS", and "FOR PATIENTS". The "MEMBERS AREA" button is circled in red and contains the following text: "MEMBERS AREA", "• Update profile information", "• Check Mainpro+® credits", "• Access Self Learning™", and "LOGIN NOW". Below the members area is a "CFP CURRENT ISSUE" section for January 2018.

### Step 2: Click on the Mainpro+ icon in the middle of the page on the right hand side.

The screenshot shows the "MY MAINPRO+®" page. At the top, there is a blue header with the text "MY MAINPRO+®". Below the header is a large orange and blue logo for "Mainpro+". Below the logo is the text "Access your Mainpro+ Account and CPD Summary »".

### Step 3: Click on 'ENTER CPD ACTIVITY' in the top left corner



## Step 4: Select Assessment/Certified/Linking Learning and press 'continue'

To enter an activity, choose from the options below.

[Need Help?](#)

\*Indicates Required Field/Question

Category: \*

Certification Type: \*  Certified  Non-Certified

Activity Type: \*  [To view a full list of activities please click here](#)

## Step 5: Complete the questions

Program/Activity ID **177391**

Here is an example of the description of the program

\*Indicates Required Field/Question

**Linking Learning to Assessment**

Category: \*

Certification Type: \*  Certified  Non-Certified

Activity Type \*

Once you have completed the form in its entirety, click "SUBMIT". You can save the information you have entered on this form at any time by scrolling to the bottom of the page and clicking on "SEND TO HOLDING AREA". The editable, saved form will be accessible from your Holding Area and will require further action.

Linking Learning to Assessment is a self-administered, semi-structured reflection exercise, which provides you the opportunity to earn 5 Certified Mainpro+™ credits. Fill out the following form to reflect on issues or questions that arise in your practice. You may complete as many Linking Learning exercises as you like in a 5-year cycle.

Indicate your role for this activity. \*  Assessment of Self  Assessment of Practice  Assessment of Other(s)  Assessment of Material(s)

Identify the type of assessment activity. \*

If other, please explain.

Briefly describe the assessment activity in which you participated: include references to any tools or resources you employed, as well as any other persons/parties involved in the process (please do not include identifiers). \*

Program/Activity ID

Briefly describe the assessment activity in which you participated; include references to any tools or resources you employed, as well as any other persons/parties involved in the process (please do not include identifiers). \*

I participated in the Ici on parle! How to Actively Engage Your Francophone Patients - Tools for French- and English-Speaking Physicians, developed by the Centre for Rural and Northern Health Research and by NOSM and certified by the CFPC. Along with up to 40 of my patients, I completed the surveys provided. I was provided with a report of the survey results and resources to improve identified gaps. Specifically I have reviewed the following: \_\_\_\_\_

### Step 6: Answer the remaining questions

Describe the outcome of the assessment activity. \*

Do you anticipate this experience benefiting your practice? \*

Yes

No

If no, why not.

What would you do differently next time-- if anything (For example, data collection methodology, qualitative measures, use of materials/articles/tools, other [please describe]). \*

How will you incorporate the knowledge you gained from the described assessment activity in your work? \*

Activity Start Date \*

Activity Completion Date \*

Date of Reflection \*

Approximate Number of Hours Involved? \*

Credits Requested \*

Credit Approval Documentation Optional

Your activity needs to be approved before credits are issued. Supporting documentation is OPTIONAL, you may use the option below to upload your documentation before submitting for approval.

**Step 7: Upload any files and click 'Submit'**

UPLOADED FILES			
Filename	Source	Date Uploaded	Delete
No files found.			

[UPLOAD FILES](#)

Please enter any additional information below:

[CANCEL](#) [SEND TO HOLDING AREA](#) [SUBMIT](#)

[Need Help?](#)

## Appendix W

### Final post-intervention report

(This document was also available in French)



November 22, 2022

Dear Dr. X,

Thank you for completing the “Ici on parle!” education program. The current report will provide you with some feedback on the changes you have made to your practice since joining the program. This report is based on the self-assessment of your own communication behaviors as reported on the pre and post program surveys.

According to your pre-program survey, you indicated that you consider yourself competent enough to communicate with patients in French. Studies have shown that even physicians who can speak French do not always actively do so, as was evident in many of your pre-program survey scores. As you will see in your personalized report below, many French language communication behaviours have been improved since joining the program. This report will outline areas where improvement were made as well as areas to continue working on when communicating with Francophone patients. The same links to resources (supported by the Northeast LHIN) are once again offered in the left-hand column of the report. We encourage you to review these resources as needed when areas to work on are identified.

### Personalized report

Below you will find a comparison of your scores from the pre and post Physician Surveys. After participating in the program, noticeable improvements have been made in the areas of PATIENT INTERACTIONS, VISUAL CUES and written and verbal WORKPLACE CULTURE. The area of SUPPORT & REFERRALS remained unchanged; however you were already doing great in this area. Of note, one area, TELECOMMUNICATIONS, appears to have declined. However this is due to the fact that questions pertain to signatures on emails were scored as “not applicable” on the pre-program survey, which statistically inflated the average score for this area. In reality, the questions that were answered both at pre and post remained unchanged.

Though improvements have been made to your communication behaviours, a successful active offer of French Language services requires constant self-evaluation and conscious efforts to serve patients in both official languages. The resources included in this report will aid in maintaining the improvements you have made and we encourage you to share these with your frontline and support staff.

Legend	Green	Orange	Red
Rating (1-4)	4.0 – 3.0	2.9 – 2.0	1.9 – 1.0
	Doing Great!	Keep At it!	Let's Work On It!
	<i>You often or always do these</i>	<i>You sometimes do these but there is room for improvement</i>	<i>You rarely if ever do these and could add such components</i>





### AREA A: PATIENT INTERACTIONS

Related Items	Score						
<ul style="list-style-type: none"> <li>Asking the patient in which language, French or English, they wish to communicate</li> <li>Greeting new patients in French</li> <li>Using French expressions</li> </ul>	<p><b>Your Ratings</b></p> <table border="1"> <caption>Your Ratings</caption> <thead> <tr> <th>Time</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>Pre</td> <td>2.67</td> </tr> <tr> <td>Post</td> <td>3.33</td> </tr> </tbody> </table>	Time	Score	Pre	2.67	Post	3.33
Time		Score					
Pre	2.67						
Post	3.33						
<p>Additional Resources</p> <ul style="list-style-type: none"> <li><a href="#">How to Engage Francophones...When You Don't Speak French</a></li> <li><a href="#">French Language Training Reimbursement Program Information</a></li> <li><a href="#">French Language Electronic Reference Resources</a></li> <li><a href="#">Tool Box for Physicians for learning medical French to improve your language and culture skills</a></li> <li><a href="#">Med-Interpret App: Interpretation Guide for Health Care Professionals</a></li> </ul>							

### AREA B: VISUAL CUES

Related Items	Score						
<ul style="list-style-type: none"> <li>Wearing a badge/lanyard indicating "I offer services in French"</li> <li>Visual indicators (sign on door) demonstrating "I offer services in French"</li> <li>Pamphlets, magazines, newspapers, etc. available in French in common areas</li> </ul>	<p><b>Your Ratings</b></p> <table border="1"> <caption>Your Ratings</caption> <thead> <tr> <th>Time</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>Pre</td> <td>1.00</td> </tr> <tr> <td>Post</td> <td>2.50</td> </tr> </tbody> </table>	Time	Score	Pre	1.00	Post	2.50
Time		Score					
Pre	1.00						
Post	2.50						
<p>Additional Resources</p> <ul style="list-style-type: none"> <li><a href="#">'Je parle français' Pin</a></li> <li><a href="#">Examples of French Signage</a></li> <li><a href="#">A variety of tools to help professionals in French</a></li> <li>Bilingual promotional tools and translation services - <a href="#">Bonjour/Welcome</a></li> </ul> <div style="text-align: center;">   <b>MASTER LIST of translated documents</b>  <i>(Double-click the icon above to view content.)</i> </div>							

### AREA C: TELECOMMUNICATIONS

Related Items	Score						
<ul style="list-style-type: none"> <li>Answering the phone in French</li> <li>Voicemail including greeting in French</li> <li>Email Signature, both in French, and English</li> </ul>	<p><b>Your Ratings</b></p> <table border="1"> <caption>Your Ratings</caption> <thead> <tr> <th>Time</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>Pre</td> <td>3.67</td> </tr> <tr> <td>Post</td> <td>2.60</td> </tr> </tbody> </table>	Time	Score	Pre	3.67	Post	2.60
Time		Score					
Pre	3.67						
Post	2.60						
<p>Additional Resources</p> <ul style="list-style-type: none"> <li><a href="#">Over the Counter Tips - Phonetics Card 1</a></li> <li><a href="#">Telephone Tips - Card #3</a></li> <li><a href="#">Useful Telephone Expressions</a></li> </ul>							



AREA D: WORKPLACE CULTURE / "HR POLICIES"					
Related Items	Score				
<p><b>Written</b></p> <ul style="list-style-type: none"> <li>– Providing bilingual letterhead and/or business cards</li> <li>– Advertising clearly the availability of services in French</li> <li>– Offering information in French or both official languages on your Website</li> <li>– Broadcasting information in newspapers and on the radio in French</li> </ul> <p><b>Verbal</b></p> <ul style="list-style-type: none"> <li>– Recruiting staff capable of offering services in French</li> <li>– French-speaking employees converse in French</li> <li>– Informing patients of the establishment's commitment to offer services of equal quality in both official languages</li> </ul>	<p><b>Written Culture</b></p> <p><b>Your Ratings</b></p> <table border="1"> <tr><td>Pre</td><td>1.63</td></tr> <tr><td>Post</td><td>2.29</td></tr> </table>	Pre	1.63	Post	2.29
Pre	1.63				
Post	2.29				
<p><b>Additional Resources</b></p> <ul style="list-style-type: none"> <li>– <a href="#">Francophone Media Sources in Ontario</a></li> <li>– <a href="#">Human Resources Support Kit</a></li> <li>– Active Offer of French Language Services in Health <a href="#">Management</a> and <a href="#">Employee</a> Fact Sheets</li> <li>– <a href="#">Recruiting &amp; Retaining Bilingual Staff</a></li> <li>– <a href="#">Creating a Bilingual Organizational Culture</a></li> <li>– <a href="#">'Making your Organization Bilingual'</a></li> <li>– <a href="#">Framework for Recruitment &amp; Retention of Bilingual Human Resources</a></li> <li>– <a href="#">Informal Evaluation of French Competency Levels</a></li> </ul>	<p><b>Verbal Culture</b></p> <p><b>Your Ratings</b></p> <table border="1"> <tr><td>Pre</td><td>2.80</td></tr> <tr><td>Post</td><td>3.40</td></tr> </table>	Pre	2.80	Post	3.40
Pre	2.80				
Post	3.40				

AREA E: SUPPORT & REFERRALS					
Related Items	Score				
<ul style="list-style-type: none"> <li>– Consulting an updated list of providers and organizations who offer services in French when making referrals.</li> <li>– Offering patients the option to be directed to a French-speaking provider or Francophone organization</li> <li>– Specifying the patients' language of preference on referral letters</li> <li>– Informing providers/organizations of the patient's language of preference</li> </ul>	<p><b>Your Ratings</b></p> <table border="1"> <tr><td>Pre</td><td>3.25</td></tr> <tr><td>Post</td><td>3.25</td></tr> </table>	Pre	3.25	Post	3.25
Pre	3.25				
Post	3.25				
<p><b>Additional Resources</b></p> <ul style="list-style-type: none"> <li>– List of <a href="#">identified providers</a> and <a href="#">designated providers</a> for FLS in the North East LHIN</li> <li>– List of <a href="#">identified providers</a> for FLS in the North West LHIN</li> </ul>					

To learn more about the importance of the active offer of French language services, refer to the following links:

- [French Language Services Toolkit](#): North East Local Health Integration Network
- [Toolbox for the Active Offer](#): Consortium national de formation en santé
- [Reference Framework Training For Active Offer Of French-Language Health Services](#): Consortium national de formation en santé

For any further questions or comments, please contact Patrick Timony at 705-675-1151 Ext. 4298 or by email at [pe\\_timony@laurentian.ca](mailto:pe_timony@laurentian.ca).



## Appendix X

Ethics approval letter



**APPROVAL FOR CONDUCTING RESEARCH INVOLVING HUMAN SUBJECTS**  
Research Ethics Board – Laurentian University

This letter confirms that the research project identified below has successfully passed the ethics review by the Laurentian University Research Ethics Board (REB). Your ethics approval date, other milestone dates, and any special conditions for your project are indicated below.

TYPE OF APPROVAL / New <input checked="" type="checkbox"/> / Modifications to project / Time extension	
<b>Name of Principal Investigator and school/department</b>	Patrick Timony, CRaNHR, supervisor, Alain Gauthier, Human Kinetics
<b>Title of Project</b>	Ici on parle! How to Actively Engage Francophone Patients - Tools for French- and English-Speaking Physicians
<b>REB file number</b>	2016-04-01
<b>Date of original approval of project</b>	April 25, 2016
<b>Date of approval of project modifications or extension (if applicable)</b>	
<b>Final/Interim report due on:</b> <i>(You may request an extension)</i>	April, 2017
<b>Conditions placed on project</b>	

During the course of your research, no deviations from, or changes to, the protocol, recruitment or consent forms may be initiated without prior written approval from the REB. If you wish to modify your research project, please refer to the Research Ethics website to complete the appropriate REB form.

All projects must submit a report to REB at least once per year. If involvement with human participants continues for longer than one year (e.g. you have not completed the objectives of the study and have not yet terminated contact with the participants, except for feedback of final results to participants), you must request an extension using the appropriate LU REB form. In all cases, please ensure that your research complies with Tri-Council Policy Statement (TCPS). Also please quote your REB file number on all future correspondence with the REB office.

Congratulations and best wishes in conducting your research.

Rosanna Langer, PHD, Chair, *Laurentian University Research Ethics Board*