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Research Article

Analyzing Linguistic and Culturally Discordant Care from the Perspectives of Nurses and Nurse Practitioners in Ontario, Canada

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Abstract

Background and Objectives: Despite Canada's Official Languages Act, linguistic concordant care directives are lacking. This study investigates challenges faced by Ontario's nurses and nurse practitioners in caring for patients from minority linguistic and ethno-cultural groups, along with their adopted strategies. **Approach:** Adopting a qualitative descriptive approach, this study engaged nurses and nurse practitioners from diverse practice settings across Ontario through semi-structured interviews. Our bilingual recruitment strategy used convenience and snowball sampling from existing professional networks and through social media. Data were analyzed with Reflexive Thematic Analysis within an intersectionality framework. **Results:** Nurses commonly used professional interpreters and Google Translate. Major challenges included high costs and inconsistent access to interpretation services due to organizational and funding constraints. Nurses needed flexibility to adapt to each patient's needs and commented on the significant time required for care in linguistically and culturally discordant encounters. They emphasized understanding cultural nuances and sensitivity as integral to a holistic care model that encompasses physical, psychological, and social aspects. Nurses often pursued cultural-competency training independently and sought mentorship to improve their care quality for minority populations. Continuous professional development and skill advancement were crucial for managing the complexities of linguistic and cultural discordance in care. **Conclusion:** The study highlights the need for accessible tools to navigate linguistic and cultural barriers, and for continuous education and mentorship to foster culturally competent care. These elements are crucial for nurses to provide equitable, high-quality care to minority groups.

Keywords: Nursing; Language barrier; Cultural diversity; Health communication; Cultural competency; Healthcare equity

Introduction

The effectiveness of healthcare is closely connected to the skill of healthcare professionals in communicating with their patients, particularly in the patient's primary language [1]. When healthcare providers and patients share a common language, it enhances care outcomes, deepens the patient's understanding of their diagnosis, improves treatment adherence, and reduces emergency visits and medical errors [2]. These positive outcomes underscore the vital importance of linguistic concordance in healthcare settings [2].

Linguistic diversity is one of Canada's defining features. The federal Official Languages Act (1969) and subsequent amendments mandates the availability of bilingual services in federal institutions, aiming to bridge linguistic gaps and provide services in both Canada's official languages, English and French [3]. However, within Canada's most populous province of Ontario, the French Language Services Act (1990) includes provisions for French language services in designated cities, but an exemption exists for most hospitals [4]. In addition, this Act does not address the needs of allophones, people whose first language is neither French nor English. In Canada, where more than 9 million people speak a minority language that is not officially recognized in any province or territory [5], failure to offer linguistic concordant care – where the patient and their health care provider speak the same primary language – is a significant concern. Linguistic discordance is linked to disparity in access and quality of healthcare services provided to linguistic minority populations across North America. Previous studies suggest that people experiencing linguistic discordance are less likely to communicate concerns about their health, less adherent to crucial follow-up care, experience more adverse events related to medication management, and generally report less satisfaction with care [6-9]. Negative health outcomes of linguistic discordance have been widely observed in management of asthma, diabetes, cancer, and tuberculosis [10-13]. From a health systems perspective, linguistic discordance leads to decreased safety due to reduced diagnostic confidence and increased use of health care resources through more emergency visits, more diagnostic tests ordered, and longer stays in hospital [4,14-17].

Canada and more specifically Eastern Ontario, have witnessed a notable increase in linguistic diversity over the past four years [5]. As a result, there is a growing demand for healthcare services in languages other than English or French [5]. While some work has been done looking at the experiences of physicians providing language discordant care, there is a lack of understanding how nurses cope with language discordant patient interactions. This is a significant knowledge gap given that there are over 450,000 of nurses practicing across Canada, with 184,000 of these involved in clinical practice in Ontario [17]. Furthermore, the shortage of family physicians across the country has prompted the integration of Nurse Practitioners (NPs) into primary and specialty care, with over 7,000 NPs now playing a pivotal role in the Canadian healthcare system [17]. Despite their increasing role, little attention has been given to the challenges nurses and NPs face in providing care across linguistic and cultural barriers.

This study explored the experiences of nurses and NPs across Ontario who have provided care across linguistic and cultural barriers with the aim of identifying barriers and facilitators to providing high quality care for linguistic and ethno-cultural minority groups. Exploring the complexities inherent in providing linguistic and culturally discordant care using in-depth qualitative analysis is an important next step in understanding the trends connecting linguistic discordance care with adverse health outcomes found using health administrative data in previous studies [2,4,14].

Methods

Building on our study protocol of linguistic and culturally discordant care amongst primary care physicians [18], we explored the perspectives of nurses and how their professional training and work environments have shaped their experiences of patient-provider linguistic and cultural discordant care. This study was led by a student researcher who is also a registered nurse with the support of an academic supervisor and mentor with nursing training. Participants were encouraged to share their lived experiences providing nursing care to linguistic and cultural minority groups and reflect on the facilitators and barriers associated with patient-provider language and cultural discordance that impacted their ability to provide high quality patient care to these often-marginalized groups.

Theoretical Framework

This study was guided by the Intersectionality-Based Policy Analysis (IBPA) Framework, as detailed by Hankivsky et al. [19], focusing on the contextualization of themes and clarifying the complex relationships between social locations, power, and privilege within the prevailing socio-economic context. The IBPA Framework served as our health equity lens, enabling us to capture and respond to the multi-level interacting forces, factors, power statuses, and power structures that shaped and influenced nurses' experiences of linguistic and cultural discordance. This lens informed our understanding of how language between NPs, nurses, and patients might intersect with other equity factors such as sex/gender, race/ethnicity, geographic region, and care service model. Furthermore, applying this lens helped us to consider how

the relative power status of these individuals could interact in complex ways that shaped patients' access to quality care.

Recruitment

Using a combination of purposive and snowball sampling, we recruited nurses and NPs from across Ontario who had experienced linguistic and/or cultural discordance when providing care to their patients. Our goal was to enlist a diverse group of NPs only of varying in sexes/genders, primary languages, races/ethnicities, and practice settings across different geographic regions in the provinces, including urban, suburban, and rural areas. Recruitment began January 2024, using a multifaceted strategy that incorporated bilingual outreach through convenience sampling via email lists, social media, and a recruitment flyer. Between December 2023 and January 2024, we placed targeted Facebook posts on the Ontario Nurse Practitioners' Facebook group seeking NP research participants. Additionally, the research team leveraged their professional networks at the University of Ottawa, and reached out to professional bodies such as the Registered Nurses' Association of Ontario (RNAO), the College of Nurses of Ontario (CNO), and educational institutions like the University of Ottawa to recruit NPs. However, we experienced significant challenges recruiting NP participants – successfully recruiting only two. By the end of February 2024, we broadened the inclusion criteria to include all nurses to recruit a sufficient sample during the timeframe of the study. Our final inclusion criterion for this study encompassed any NP or nurse practicing in a healthcare setting in Ontario who had encountered linguistic discordance during their clinical practice.

Data Collection

Data was collected through semi-structured interviews that were conducted virtually for approximately 1 hour. The interviews were audio-recorded and transcribed by hand or by Trint, a virtual transcription software [20]. Interviews were conducted by a master's in nursing student who is also a Registered Nurse. In the first two interviews, the student shadowed the principal investigator. Interviews were conducted in English or French based on the participant's preference. The master's student, trained and mentored by the principal investigator in qualitative interviewing, followed the interview guide composed of open-ended questions on linguistic discordant care, as well as existing resources or strategies to navigate linguistic discordance challenges. An interview guide, previously used to study linguistic discordance barriers between primary care physicians and patients, was adapted to the current study (Appendix 1).

Semi-structured Interview Guide for Nurse Practitioners and Nurses

Introduction

Hi, my name is [NAME]. I am part of the research team from the University of Ottawa and Bruyere Research Institute doing a study analyzing linguistic concordance in care and barriers and facilitators encountered by health care providers in the Champlain Region. Thank you for again for agreeing to participate in this research and for meeting with me today. This interview format is called semi-structured which means I'll guide it with questions but really, you are in charge. Since we just reviewed the informed consent form, you know that we are here to learn about your experiences as a nurse or nurse practitioner with linguistic and cultural discordant care. I am looking forward to speaking with you. Are you ready to begin? Yes? Okay, I am going to start recording now.

Q1. Would you prefer to conduct this interview in French or English?

Q2. Where do you work? How long have you been in this position?

Q3. What does "linguistic discordant care" mean to you?

Q4. Can you explain if/how linguistic discordance impacts your daily work with patients receiving care from a nurse or nurse practitioner?

Q5. Can you describe a situation where linguistic discordance with a patient complicated your ability to provide good care?

Q6. Can you give me an idea of what it means for a patient to deal with linguistic discordant care?

Q7. How do you see linguistic discordance impacting patients' access to care or health outcomes? Can you give me an example?

Q8. What solutions or resources do you or your organization have for resolving issues of linguistic discordance with patients?

Q9. What does "cultural discordant care" mean to you?

Q10. Can you describe if/how cultural discordance impacts your daily work with patients?

Q11. Can you describe a situation where cultural discordance with a patient complicated your ability to provide good care?

Q12. Can you give me an idea of what it means for a patient to be seen by a nurse or nurse practitioner and to deal with cultural discordant care?

Q13. How do you see cultural discordance impacting patients' access to care or health outcomes specifically in relation to nurses or nurse practitioners? Can you give me an example?

Q14. What solutions or resources do you or your organization have to resolve issues of cultural discordance with patients?

Q15.Can you help us understand if/how COVID impacted your ability to provide linguistic and/or cultural concordant care to patients? Have things now returned to pre-COVID ways of working? Explain.

Q16. How does your team and/or manager support you to provide linguistic concordant care? What about cultural concordant care? Do you make use of these resources/strategies? Why or why not?

Q17. Think back to any previous jobs you have had as a nurse – were issues related to the provision of linguistic/cultural concordant care the same? Why? If not, can you explain what was different?

Q18. What kinds of support/resources would you like to see that might help you provide more linguistic and/or cultural concordant care?

Q19. We have previously conducted interviews with physicians who specialize in palliative care and end-of-life care. Have you ever found yourself in a situation where you had to provide end-of-life care while facing a language barrier? If so, could you kindly share how this particular challenge influenced the care you provided?

Q20. Is there anything else you wish to tell me about how linguistic discordant or cultural discordant care impacts your ability to provide good care to patients, or anything else that you feel that we've missed in this interview?

Appendix 1: Interview Guide.

Before the interview, participants completed a 5-minute demographic survey collecting information on gender, primary language, race/ethnicity, country of birth, educational background, geographic region (postal code), practice facility, among others. This demographic data characterizes the sample and helps understand the connections between social location and lived experiences.

Analysis

Data from the interview transcripts, complemented by the master's student reflexive journal entries, were analyzed using Braun and Clarke's approach to reflexive thematic analysis (2022) [21], employing a hybrid approach of inductive and deductive theme development. The inductive analysis focused on pattern recognition involving generating initial codes, searching for themes, and defining themes that represented responses within the dataset. Deductive coding was guided by the IBPA framework to capture key domains of interest including power relations, gender, race/ethnicity, and systemic barriers contributing to or reinforcing social inequalities. Deidentified verbatim quotes, along with an accompanying description of the participants' location, were utilized as evidence of dominant themes.

Results

There were 12 participants recruited to the study. The participants were primarily female, with ages ranging from 25 to 62 years. Participants were from various ethnic backgrounds, including European, Hispanic, African, and Middle Eastern. Participants were all fluent in English, with some participants additionally fluent in other languages including French, Spanish, Portuguese, and Swahili. All participants had a professional background in nursing, with qualifications ranging from Bachelor's degrees to Master's and PhDs in progress, and predominantly certified in Ontario. Their professional experience varied from 3.5 to 14 years, with employment settings including community health centers, primary care with a focus on refugee health, clinical research, hospital sectors, and public health, reflecting a mix of urban, suburban, and remote locations. Employment status varies from full-time, part-time, to casual, with work hours and settings differing significantly among participants. Demographic characteristics of the 12 study participants are summarized in Table 1.

Characteristic	No. of participants n=12
Age, year	
≤ 30	6
31–40	3
> 40	3
Gender	
Female	12
Male	0
Ethnic background	
European	7
Hispanic or Latinx	2
African	1
Middle Eastern	1
First Nations or Indigenous	1
Multilingualism	
Yes	11
No	1

Years of practice as staff	
0–10	9
11–20	3
Geographic location	
Urban	10
Rural	1
Remote	1
Primary practice setting	
Hospital	4
Community clinic	8
Employment status	
Full-time	9
Part-time	2
Casual	1
% time spent in palliative care	
0%	7
5–25%	4
26–50%	1

Table 1: Participant demographic characteristics.

Our data revealed three major themes in how nurses experience and navigate patient-provider linguistic and culturally discordant care. First, we found that nurses encounter systemic barriers to providing equitable care to linguistic and ethno-cultural minority groups. Second, there are common tools nurses use to provide care in linguistic and culturally discordant interactions with patients. Third, nurses overcame barriers to linguistic and culturally discordant care by providing holistic care, seeking out culturally competent education and prioritizing patient advocacy.

Theme 1: Barriers to Providing Linguistic and Ethno-Cultural Concordant Care

Nurses encountered multiple challenges rooted in systemic issues such as service unavailability and inadequate funding for interpretation and cultural services, and strict time constraints for patient encounters. One participant (P5) noted "It's difficult for [patients], especially when there are care issues or things that aren't going well. It's hard to explain to the patients what's happening. And these are quite traumatic and difficult situations that we have experienced there, in addition to limited access."

In particular, the inconsistent availability of interpretation services and religious services, a result of organizational and budgetary limitations, restricted nurses' ability to offer comprehensive care to linguistically diverse patient populations. Participant 11 stressed "We don't have resources like spiritual support for end-of-life patients. Recently, just yesterday, a staff member brought in a friend who works in the religious field. This person was able to administer the last rites to the patient, an immigrant, because we had no available religious services". Moreover, healthcare providers encountered substantial obstacles in obtaining patient consent and accessing international health records in patients' native languages due to stringent translator selection policies and the difficulty of hiring linguistically diverse staff. As one participant (P3) noted "There should be a healthcare team or something there to translate (medical) documents and integrate them into the provincial systems. Just because, for us, we can't specialize in every language either." This was exacerbated by the lack of sufficient cultural and linguistic training for healthcare professionals, which led to a significant misalignment between service provider capabilities and patient needs. Healthcare professionals are unable to meet the demands of all linguistic diversity as emphasized by one participant (P8) "We are expecting patients to make decisions, with very limited information, and it's because of the language discordance. As you know, they are perfectly capable of making this decision. But because I am limited in the language, I'm not able to give them the necessary information".

Furthermore, many described the dynamics of power within healthcare interactions created additional barriers, with patients often hesitant to express their lack of understanding to nurses, who were perceived as authority figures. One participant (P6) notes that it can be "embarrassing [for patients] to admit that they do not understand instructions". Nurses underscored the necessity for a paradigm shift towards empowering patients, fostering an environment where they feel comfortable expressing their needs.

Theme 2: Tools to Overcome Linguistic Barriers

Nurses reported a common practice of utilizing professional interpreters via phone for linguistic support. However, they also frequently resorted to using Google Translate and their own creativity to overcome language barriers. For instance, one participant (P2) shared, "We use a lot of pictures. I bring out anatomy models. Just the other day, I explained an IUD to a woman who didn't really understand it, by showing her a speculum and an actual IUD. Those visual aids significantly helped her comprehension. She realized, 'Oh, that's all it is.' I affirm, 'Yes.' Similarly, when discussing medications or over-the-counter products, I often Google them and show the images so patients can take pictures. They can then visit the pharmacy and request that specific product." This creative approach underscores the resourcefulness nurses employ in their communication strategies.

Exploring collaborative efforts by nurses in navigating the complexities of healthcare delivery reveals a critical theme in

healthcare practices, particularly in culturally and linguistically diverse environments. Nurses demonstrated a commitment to overcoming language barriers to ensure clear communication and accurate medication management. For instance, one participant (P1) detailed the lengths they go to facilitate understanding, "Amoxicillin is a big word if English isn't your first language and it's not your first alphabet. So, then I'm going to call the pharmacy because the pharmacist speaks English. " Such actions underscore the initiative nurses take to collaborate with health care professionals, ensuring patients receive appropriate care.

The significance of team support is further demonstrated by the role's individuals play within healthcare teams. One participant (P6) notes that "we often made calls on all the intercoms [in the hospital] to find a hospital staff for a patient who speaks Russian or Arabic, we are able to find solutions like right now and that don't cost much, that don't cost anything." The narrative emphasizes the importance of creating a supportive environment where diverse skills and cultural competencies are actively engaged to meet patient needs, often extending beyond standard protocols.

Theme 3: Strategies to Providing Holistic Care

Nurses felt they were particularly well suited to provide comprehensive healthcare to patients in language discordant encounters. They discussed integrating their medical expertise with an understanding of the various social factors that influence patient health, including the social determinants of health. The nurses explained how they subscribed to a nursing model of care which employed a holistic approach aimed at addressing both the immediate health concerns and the underlying causes and contributing elements that affect a patient's overall well-being. One example shared by an NP highlighted how patients were often surprised when learning about the extensive support available, including a wide range of community services. This reflects nurses' commitment to delivering care that encompasses not just physical health, but also emotional, social, and environmental well-being. One participant (P5) shared that "Nurses adapt culturally, especially for Indigenous individuals who perform Smudging ceremonies. We shut off the ventilation in the (hospital) room when the baby is born, allowing the family and friends who brought their materials to perform the ritual".

Central to the roles of nurses was their advocacy for patients, ensuring comprehensive access to healthcare services. Acting as intermediaries, they facilitated understanding and navigation through the complex healthcare system, supporting informed decision-making. This commitment to deeper patient connections is illustrated by one participant (P1) initiative: "My solution has been I've been learning Arabic to speak to them. And so now I speak medical Arabic and there's a couple of assessments I can do when I'm not Arabic." Such dedication to overcoming linguistic barriers and providing culturally competent care highlighted the efforts to ensure accessibility and sensitivity to the cultural context of the patients, thereby fostering a strong therapeutic relationship. As an example, one participant (P5) shared "I had been looking at some information in Swahili that I could find to translate. I remember writing down medical information on the whiteboard in the patient's room with the translations I had found on Google Translate. This way, if she had any questions, she could refer to it-even at 3 a.m. There were instructions in Swahili." By creating resources in the patients' primary languages, nurses further tailored their care to enhance comfort and understanding, practicing a patient-centered and holistic approach to care.

Discussion

Findings from the study highlight significant challenges to delivering care across linguistically diverse populations including the lack of services, funding, and time constraints. Furthermore, the investigation revealed innovative communication and collaboration strategies among NPs and nurses, revealing their resourcefulness in overcoming linguistic barriers through professional interpreters, Google Translate, and visual aids to ensure clear patient understanding and accurate medication management. The study underscores the importance of teamwork, flexibility, and cultural competency within healthcare settings, as illustrated by diverse staff supporting linguistic and cultural needs. Lastly, the study reveals the significance of holistic care and advocacy by NPs and nurses, emphasizing their role in helping patients navigate the healthcare system, addressing social determinants of health, and providing patient-centered care that goes beyond physical health.

This examination reinforces that nurses are uniquely positioned to provide linguistic concordant care, seamlessly aligning with the core competencies of the nursing profession [22]. Cultural sensitivity and communication adaptability demonstrated by nurses are critical components in bridging linguistic gaps, making their role indispensable in culturally diverse healthcare environments. The intimate, frontline interactions nurses have with patients afford them a profound understanding of individual needs and cultural nuances, essential for effective linguistic concordant care. This role is inherently tied to nursing values, which prioritize patient advocacy, empathetic communication, and holistic well-being [23].

The results of this study aligned with existing findings evaluating linguistic concordant care amongst other healthcare professionals [24]. The barriers identified in this study, such as limited resources and the challenges of delivering linguistic concordant care, are well established [25]. The challenges related to obtaining consent and suitable translators, along with the lack of sufficient cultural

and linguistic training, were also highlighted in an evaluation of barriers to linguistic concordant care amongst medical students and physicians [24,26]. Systemic changes and improved training for healthcare professionals is needed, including advocacy for more inclusive healthcare systems capable of effectively serving diverse patient populations.

Several existing strategies are currently being employed by healthcare providers, including professional interpreters and online translation services [27]. Collaborative efforts and adaptability are also emphasized in the literature and underscore the importance of teamwork and cultural competency within healthcare settings [28]. Similar themes in delivering holistic care and in advocacy are identified as important to delivering linguistic concordant care [29], reflecting the healthcare system's shift towards more comprehensive healthcare models. The parallels between the study's findings and existing literature underscore the ongoing challenges and innovative strategies in overcoming linguistic barriers in healthcare, calling for the urgent need for systemic improvements and enhanced cultural competency in the healthcare sector [30].

The impact of our study on patients, providers, and systems is multifaceted. For healthcare professionals, particularly nurses and NPs working in linguistic minority settings, our study highlights the need for more support from healthcare institutions and policymakers [31,32]. Further, our findings underscore the necessity for more research and policy development focused on reducing the additional workload and providing adequate resources and tools to support bilingual healthcare provision. For patients, this research advocates for delivery of care in their preferred language, emphasizing the importance of linguistic concordance for effective and personalized healthcare.

Strengths and Limitations

In this study, a notable strength lies in the ability to capture nurses' perspectives from various backgrounds. This diversification allowed for a broader comparison of experiences, particularly beneficial when comparing these findings with similar research conducted among physicians and staff working in community health centers. By including nurses of different ethnicities, language proficiencies, educational backgrounds, and work settings, this analysis offered a multifaceted view of linguistic challenges in healthcare environments.

Despite these strengths, the study faced limitations, primarily due to its limited sample size, which may not represent the Canadian nursing population, especially linguistic minority groups and nurses and NPs working in different healthcare systems or cultural contexts across provinces. This study did not encompass patient, caregiver, or other healthcare professional perspectives, which are critical for a comprehensive understanding of the impact of linguistic discordance care. Future research should aim to include these diverse viewpoints to provide a more complete picture and facilitate effective strategies to overcome linguistic barriers in healthcare settings.

Future Directions

To ensure a comprehensive understand of healthcare dynamics pertaining to linguistic concordance, it is equally important to broaden the scope to encompass patient and caregiver perspectives. Expanding our research to include these areas will deepen our insights and foster a more holistic approach to healthcare solutions.

Furthermore, our findings suggest a pressing need for healthcare systems to adapt and implement policies that acknowledge and facilitate the work of nurses and NPs. This includes developing clear guidelines on multilingual service provision, increasing visibility of patient and healthcare professional rights regarding language, and ensuring management and institutional support for multilingual healthcare providers. Implementing such measures would not only improve the working conditions of nurses and NPs but also enhance the quality of care for linguistic minority populations, contributing to a more equitable and accessible healthcare system.

Conclusion

Several barriers including lack of funding, time constraints and gaps in training significantly hindered delivery of linguistic concordant care. Despite this, nurses employed several creative tools including new technologies to optimize delivery to minority patient groups. Advocacy for additional funding and training can help bridge these gaps and deliver optimal linguistic concordant care.

Ethical Considerations

This study received approval from the Bruyère Research Institute and the University of Ottawa Ethics Boards (M16-23-015). All participants provided written informed consent before participating in the study.

Other Information

Funding and Conflict of Interest

There are no funding sources or conflict of interest to declare for this study.

References

1. Nouri SS, Rudd RE (2015) Health literacy in the "oral exchange": An important element of patient–provider communication. Patient Education and Counseling. 98: 565-571.

2. Seale E, Reaume M, Batista R, Eddeen AB, Roberts R, et al. (2022) Patient–physician language concordance and quality and safety outcomes among frail home care recipient admitted to hospital in Ontario, Canada. Canadian Medical Association Journal. 194: E899-E908.

3. Government of Canada (2023) Consolidated federal laws of Canada. Official Languages Act. Official Languages Act.

4. Reaume M, Batista R, Talarico R, Guerin E, Rhodes E, et al. (2022) In-Hospital Patient Harm Across Linguistic Groups: A Retrospective Cohort Study of Home Care Recipients. Journal of Patient Safety. 18: e196-e204.

5. Statistics Canada (2022) While English and French are still the main languages spoken in Canada, the country's linguistic diversity continues to grow. The Daily.

6. Green A, Jerzmanowska N, Green M, Lobb EA (2018) "Death is difficult in any language": A qualitative study of palliative care professionals' experiences when providing end-of-life care to patients from culturally and linguistically diverse backgrounds. Palliative Medicine. 32: 1419-1427.

7. Rivadeneyra R, Elderkin-Thompson V, Silver RC, Waitzkin H (2000) Patient centeredness in medical encounters requiring an interpreter. The American Journal of Medicine. 108: 470-474.

8. Timmins CL (2002) The impact of language barriers on the health care of Latinos in the United States: a review of the literature and guidelines for practice. Journal of Midwifery & Women's Health. 47: 80-96.

9. Timony P, Gauthier A, Wenghofer E, Hien A (2022) The Impact of Linguistic Concordance and the Active Offer of French Language Services on Patient Satisfaction. Diversity of Research in Health Journal. 5: 29-46.

10. Gardam M, Verma G, Campbell A, Wang J, Khan K (2009) Impact of the patient-provider relationship on the survival of foreign-born outpatients with tuberculosis. Journal of Immigrant and Minority Health. 11: 437-445.

11. Manson A (1988) Language concordance as a determinant of patient compliance and emergency room use in patients with asthma. Medical Care. 26: 1119-1128.

12. Parker MM, Fernández A, Moffet HH, Grant RW, Torreblanca A, et al. (2017) Association of Patient-Physician Language Concordance and Glycemic Control for Limited-English Proficiency Latinos With Type 2 Diabetes. JAMA Internal Medicine. 177: 380-387.

13. Silva MD, Genoff M, Zaballa A, Jewell S, Stabler S, et al. (2016) Interpreting at the End of Life: A Systematic Review of the Impact of Interpreters on the Delivery of Palliative Care Services to Cancer Patients with Limited English Proficiency. Journal of Pain and Symptom Management. 51: 569-580.

14. John-Baptiste A, Naglie G, Tomlinson G, Alibhai SMH, Etchells E, et al. (2004) The effect of English language proficiency on length of stay and in-hospital mortality. Journal of General Internal Medicine. 19: 221-228.

15. Ngai KM, Grudzen CR, Lee R, Tong VY, Richardson LD, et al. (2016) The Association Between Limited English Proficiency and Unplanned Emergency Department Revisit Within 72 Hours. Annals of Emergency Medicine. 68: 213-221.

16. Olsson L-E, Hansson E, Ekman I, Karlsson J (2009) A cost-effectiveness study of a patient-centred integrated care pathway. Journal of Advanced Nursing. 65: 1626-1635.

17. Canadian Nurses Association (2021) Nursing statistics and supply.

18. Lee SH, Gibb M, Macleod KK, Cody M, Collin S, et al. (2023) Exploring primary care physicians' experiences of language and cultural discordant care for linguistic minority patients at the end-of-life: A study protocol. Int J Qual Res 22.

19. Hankivsky O, Grace D, Hunting G, Giesbrecht M, Fridkin A, et al. (2014) An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity. International Journal for Equity in Health. 13: 119.

20. Trint (2022) London: Trint Limited.

21. Braun V, Clarke V (2022) Thematic analysis: A practical guide. Sage.

22. Fahrenwald NL, Bassett SD, Tschetter L, Carson PP, White L, et al. (2005) Teaching Core Nursing Values. Journal of Professional Nursing. 21: 46-51.

23. Schmidt BJ, McArthur EC (2018) Professional nursing values: A concept analysis. Nursing Forum (Hillsdale). 53: 69-75.

24. Garcia ME, Williams M, Mutha S, Diamond LC, Jih J, et al. (2023) Language-Concordant Care: a Qualitative Study Examining Implementation of Physician Non-English Language Proficiency Assessment. Journal of General Internal Medicine: JGIM. 38: 3099-3106.

25. Health Canada (2001) Language barriers.

26. Molina RL, Kasper J (2019) The power of language-concordant care: A call to action for medical schools. BMC Medical Education. 19: 378-378.

27. Al Shamsi H, Al Mashrafi S, Al Kalbani T, Almutairi AG (2020) Implications of Language Barriers for Healthcare: A Systematic Review. Oman Medical Journal. 35: 1-7.

28. Wynia MK, Von Kohorn I, Mitchell PH (2012) Challenges at the Intersection of Team-Based and Patient-Centered Health Care: Insights from an IOM Working Group. JAMA: The Journal of the American Medical Association. 308: 1327-1328.

29. Braveman P, Gottlieb L (2014) The Social Determinants of Health: It's Time to Consider the Causes of the Causes. Public Health Reports 129: 19-31.

30. Fereday J, Muir-Cochrane E (2006) Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. International Journal of Qualitative Methods. 5: 80-92.

31. Forbes M (2021) Thematic analysis: A practical guide. Evaluation Journal of Australasia. 22: 132-135.

32. Lincoln YS, Guba EG (1986) But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. New Directions for Program Evaluation. 1986: 73-84.