# IFMSA-Québec's Policy Document
# Language Barriers in Montreal's Healthcare System

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# Policy Statement

## Introduction

Barriers to quality communication increase the risk for misunderstanding, negatively impact the thoroughness of health investigations, and can lead to delayed diagnoses and increased readmissions [1]. In addition, language barriers disproportionately affect the most vulnerable populations; thus, a lack of appropriate interpretation services promotes health disparities and increases the vulnerability of the underserved minority populations [2]. According to the Act Respecting Health Services and Social Services of Quebec, health organizations need to take into account the distinctive linguistic and sociocultural characteristics of each region and, “foster, to the extent allowed by the resources, access to health services and social services through adapted means of communication for persons with functional limitations” [3]. A language barrier is a form of functional limitation that patients face when accessing healthcare services. Despite a clear policy, the current use of professional interpretation services is limited in our healthcare facilities. Though a variety of services exist at different institutions, not all healthcare workers are aware of the services they have access to. As a result, patients with language barriers are not offered adequate resources for mitigating obstacles in accessing healthcare services.

## Position of the Student Task Force on Language Barriers and IFMSA-Québec

A student task force on language barriers has been created by medical students from the Universities of Montreal and McGill with the goal of investigating the current state of care for non-French and non-English speakers in Montreal. This initiative, put forward by MedComm, has been put in place because of our belief that there is a need to raise awareness of the existence of language barriers, in order to identify possible solutions to bridge the gap in Montreal and in the rest of the province of Quebec. By identifying how language barriers present and by highlighting the tools available, we feel that healthcare workers, including medical students, may be better placed to serve the non-French and non-English speaking community. We also hope to emphasize the need for alternative solutions to the current state of affairs in regard to dealing with language barriers in our city.

## Calls for action

*For these reasons, this Task Force and IFMSA-Quebec, through its mandate of improving health both locally and globally, calls on the following actors:*

Note: The calls to action are numbered for reference purposes, the numbering does not represent a hierarchical order.

Upon the **Provincial Government** to**:**

1. Reinforce the policy regarding the obligation to provide language access to patients at healthcare institutions in Quebec.
2. Dedicate funding to implement universal medical interpretation solutions at all public healthcare institutions in Quebec.

Upon the **Faculties of Medicine** to**:**

3. Educate students on the importance of quality communication and access to interpretation resources.
4. Introduce learning activities into the undergraduate (UGME) and postgraduate (PGME) medical curriculum aimed at educating medical trainees on the prevalence and effects of language barriers in healthcare, as well as training on how to approach and manage patients with whom they face language discordance, such as how to effectively navigate clinical scenarios requiring a medical interpreter.
5. Acknowledge that lack of interpretation services is a form of systemic racism.
6. Continue the diversification of the cohorts of medical students, who may represent underserved communities, and have the linguistic abilities to serve linguistic minorities.

Upon **Healthcare Institutions** to**:**

7. Revise the needs for language interpretation and explore currently available interpretation services.
8. Establish a clear protocol for accessing interpretation services within the institution for inpatient, outpatient and urgent clinical encounters.
9. Facilitate access to and usage of said services by the workers through regular promotional and educational campaigns.

Upon the **Current & Future Healthcare Professionals** to**:**

10. Make an effort to self-educate on prevalence and effects of language barriers on patient care.
11. Explore available interpretation resources and implement them into personal practice
12. Advocate on a personal, local and provincial level, and call on the provincial government and your healthcare institutions to dedicate funding for medical interpretation solutions.

Upon the **Public** to**:**

13. Bring language barriers to the attention of provincial governments and support initiatives that advocate for implementation of medical interpretation services at healthcare institutions.

*This is why IFMSA-Quebec, through its mandate of improving health both locally and globally, is committed to:*

1. Raise awareness among members of the prevalence and effects of language barriers on patient care.
2. Collaborate with partners, such as MedComm, in initiatives on the issue of language barriers in access to care.
3. Advocate with government authorities on this issue and solutions.

# Position Paper

## Background information

According to Statistics Canada, 6.8% (2.3 million people) of Canadians speak a language other than English and French [4]. Consequently, many people still face challenges in accessing care due to limited language proficiency (LLP) in English or French [5]. The people that experience these challenges are mainly from migrant upbringing or part of the indigenous population. Despite Canada's Universal health coverage, these people continue to face several barriers when accessing healthcare, exacerbated by language barriers, which amplifies health disparities between LLP and English/French proficient patients [6]. When assessing a patient, communication is crucial to understand their medical problem and address their needs, particularly in a setting like the Emergency Department, where certain conditions need to be identified rapidly. In those instances, communication is essential to ensure the patient's questions, concerns, and treatment preferences are addressed. That is why language barriers can significantly affect the quality of care by increasing the risk of misunderstanding, misdiagnosis, delayed treatment, and increase readmissions [1]. Despite the growing numbers of LLP patients and the significant cost of care resulting from compromised care, the quality of care offered to these vulnerable populations continues to be very limited. This problem persists due to the limited recruitment of professional interpreters (PIs) in primary care settings [7,8] and the lack of recognition of the necessity of universally offered language services at Quebec healthcare institutions [5].

Additionally, many health care professionals continue to use either google translate or a family member to communicate with patients with LLP. Both of these alternatives have been proven to be of modest benefit [2,5]. Many studies have shown clearly that professional interpreters (PIs) improve the quality of care delivered to patients facing language barriers and close the gap between LPP and English/French proficient patients [5]. Even if resorting to a family member or a friend may seem easier, it can be problematic when the patient's confidentiality is compromised. A family member or friend that can act as an interpreter may also not be present or available when the patient needs to be reassessed. Lastly, expecting patients to bring their own interpreters such as a family member, a friend, or an untrained interpreter places responsibility for quality of care on the patient rather than on the health care system [2]. On the other hand, PIs are professionally trained to deliver quality interpretation while preserving patient confidentiality and doing their job in an objective manner [5]. For all the reasons mentioned above, access to adequate interpretation service is a cornerstone of a successful relationship with unilingual patients in a healthcare setting. Therefore, provision of interpretation services for LLP patients should be a standard practice in our healthcare system.

In Canada, the First Nations & Inuit communities, immigrants & refugees, and D/deaf people constitute three important groups of people who have the most crucial needs for interpretation services. Not only are they more susceptible to suffering discrimination within the healthcare setting (which may prevent them from seeking medical attention in the first place), but First Nations, Inuit communities, refugees and Deaf people are more susceptible to both a lower health status and to increased healthcare needs as compared to the rest of the general population of Canada [9, 10, 11]. It is clear that the number of people that need and may benefit from interpretation services is significant. For instance, in Montreal, even if only 1.6% (63,480) of the population reports knowing neither French nor English, about 25% of the population reports having a mother tongue that is neither of the two official languages of Canada [12]. These last percentages, while they may appear optimistic, hide a deeper problem.  In fact, minimal language proficiency is often not

enough for a patient to express their health care needs, to understand the medical jargon used by healthcare professionals and to be understood by them. Therefore, the needs in interpretation services are actually higher than what the percentages would like to reflect. Unfortunately, as discussed above, interpretation services are not readily available, and the guides to navigating the few existing services are not well taught to healthcare professionals. Some of our most vulnerable populations are therefore left with unmet critical healthcare needs, reducing their already poor health status, in a manner that is preventable.

Since 1984, Canada has made *portability*, *public administration*, *access, universality* and *comprehensiveness* the 5 guiding principles of provincial and territorial health insurance programs. The three latter principles are of particular interest in the discussion of language barriers within the Canadian health care system. Unfortunately, it seems like health interpretation services (except for the case of sign language interpretation) are still not considered medically necessary, making it more challenging to have the latter principles applied to them. From a viewpoint of basic rights, the Canadian Charter of Rights and Freedoms stipulates that *''every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical ability.''* There is no question that a significant language barrier in the healthcare setting can lead to reduced security and safety for the patient due to increased risk of medical errors and mutual misunderstanding. In fact, for users of sign languages, failure to provide medical interpretation services has been ruled as a fundamental violation of the Canadian Charter of Right and Freedoms in 1997 (Eldridge vs. British Columbia, [Attorney General], 1997) [13]. Unfortunately, it has yet to become the case for non-official languages. In that matter, the province of Quebec, for instance, has adopted the Act Respecting Health Services and Social Services in which the fundamental idea of the deliverance of safe health services is emphasized in the 5th article of the first chapter: ''Every person is entitled to receive, with continuity and in a personalized and *safe manner*, health services and social services which are scientifically, *humanly and socially appropriate* [14]''. In an even more obvious fashion, one of the numerous aims of the Act Respecting Health Services and Social Services of Quebec (LSSS) is to ''foster, to the extent allowed by the resources, access to health services and social services in *their own languages* for members of the various cultural communities of Québec". However, there is yet to see the important changes that were envisioned in this Act.

## Discussion

### Resources Available in Montreal

*Our system for delivering medical interpretation is haphazard and inconsistent.*

The resources available to address language barriers in healthcare are location and institution dependent. Unfortunately, in Montreal, information regarding existing interpretation services is not readily available for consultation. Workers who are in close contact with patients, such as nurses, physicians and social workers, are often not aware of a clear protocol to serve patients with language barriers. In many cases, in order to communicate with patients of linguistic minority with LLP, health care workers either rely on the family members of patients or colleagues in their department with certain language proficiencies.

**Hospital-Based Methods**

In the hospital setting and in urgent care, communication between the health care professional and the patient with a language barrier relies largely on layperson/ad hoc/unprofessional interpretation, requested in certain institutions through the hospital's overhead announcement service. Unfortunately, this service is not as effective as perceived and far from being the gold standard of care, which is face-to-face interpretation with PIs [15]. In fact, according to a recent quality assessment done by MedComm analyzing overheard announcement requests across the McGill University Health Center (MUHC) between January 2018 and November 2020, 1349 overhead requests were made for a volunteer interpreter.It is difficult to determine if the people returning the calls have received any type of training in order to make them qualified interpreters and the likelihood that they are trained is low. In such context, the quality of interpretation is compromised. Studies have shown that the use of untrained individuals as interpreters increases the risk of omission of diagnostically and prognostically relevant information [16]. Furthermore, patient confidentiality and adherence to ethical principles is compromised when untrained individuals are used as interpreters [16]. With this information in mind, healthcare workers may reasonably hesitate to rely on ad hoc interpreters requested through overhead announcement service. As a more reliable method, some institutions, such as the Institute of Cardiology of Montreal (ICM), recruit interpreters from the list of employees with minority language proficiencies. When hired, the employee can declare the languages in which they deem proficient in communication and accept to be added on the hospital's list of potential interpreters. This list of health care worker interpreters is particularly useful if professionals require interpretation services in a more urgent setting. It is meant to be used for emergencies, meaning that it should not be the primary source of interpretation services. This solution is not the ideal or gold standard of care, since employees are not trained interpreters, and they may not be able to fully understand or effectively transmit information to the patients, but can be better than relying on family members where confidentiality issues may arise. This is also not the primary duty of the employees, who are usually very busy and might have conflicting schedules. Further, finding an employee who speaks the right language at the right time might not always be easy. This list is also limited to the languages employees speak and might not be representative of the language needs of the patient population. In any case, both intercom calls and institution-based registries are measures that rely on untrained interpreters and should not be the standard of care for patients with language barriers. These solutions are also not widely available in Montreal hospitals, creating conditions for unequal access to care. This lack of standardization among the different healthcare institutions highlights the lack of guidelines in addressing the care of patients with language barriers.

**Banks of Interpreters**

For some inpatient and outpatient interpretation needs, healthcare institutions have access to professional interpreters on an appointment basis, through the *Banque interrégionale d'interprètes* (BII). With over 200 interpreters at their disposal across the province of Quebec, the BII serves more than 50 languages, commonly Arabic, Spanish, and Chinese. [19,20] This demand has led to an average of approximately 40 000 hours of interpretation annually. In accordance to the region of the request, services may be offered in-person, by phone, or through video conferencing. Guidelines from the Ministry for Health and Social Services (MSSS) [21] prioritize in-person interpretation whenever possible as it facilitates the interpreter's recognition of nonverbal cues, thus enhancing the quality of the interpretation. These interpretation services can usually be booked a few days to a few weeks in advance. The Montreal Children's Hospital is the only hospital in the MUHC network that has an in-house professional interpretation service. This service is administered by the Sociocultural Consultation and Interpretation Services (SCIS). Appointments with

trained interpreters can be booked with at least 48h notice.[16]. Unfortunately, when questioning different professionals working in hospitals, it was discovered that many are not aware of how to access interpretation services and no clear protocol seems to be put in place. Therefore, these services will most likely only be used if no family member can be present to serve as an interpreter and all other options have been exhausted. This goes to show once again that many professionals have little training regarding language barriers and how to deal with such patients.

**Clinic and GMF Practice**

Outside of hospital environments, a significant portion of requests to the BII are made by CLSCs (Centre Local de Services Communautaires). In contrast to urgent care settings and hospitals, clinics offer a more favorable environment for the recruitment of interpretation services, as appointments requiring interpreters could be planned beforehand. Jérôme+, an online platform created by the MSSS and managed by the CIUSSS Centre-Sud, is often the first choice for most clinics and Groupe de médecine de famille (GMFs) in Montreal, specifically those serving communities with less demand for interpretation services. The Jérôme+ platform allows healthcare practitioners to access interpreters from the BII more efficiently. As depicted in Figure 1 [23], patients seeking an appointment at a clinic or GMF will be asked by an administrative agent regarding their need for an interpretation service. If one is needed, the administrative agent will proceed to book an in-person or at a distance interpreter through Jérôme+ at least 48 hours prior to the scheduled appointment time. For in-person interpretation, the interpreter is responsible for being present in the clinic at the scheduled appointment time. On the other hand, for telephone (at a distance) interpretation, the administrative agent notes the interpreter's telephone number on the patient's file for the health professional to call at the scheduled appointment time. Jérôme+ is a paid service, charging $90 for a minimum of 2 hours of in-person interpretation and $11.25 per 15 minutes of telephone (at a distance) interpretation. Unfortunately, one of the primary issues with this service is that interpreters refuse to interpret for more than one patient during the minimum 2 hours period. In other words, if the first appointment only lasts for a few minutes, interpreters will refuse to interpret for a second appointment unless they are booked for another 2 hours, which becomes very costly for clinics. To remedy the high costs of interpretation services, the CLSC Parc Extension hired in 2012 an on-the-spot interpreter for their two most spoken languages: ourdu and punjabi. By having a salaried employee and not needing to go through the BII every time, the CLSC spent 50% less on their interpretation budget.

Some clinics use Jérôme+ in conjunction with other services. Such is the case at CLSC Côtes-des-Neiges, which has adopted two distinct interpretations systems. At their regular clinic, healthcare professionals may request an interpreter from the BII. For CDAR (Clinique des demandeurs d'asile et des réfugiés) visits, CLSC Côte-des-Neiges maintains a list of physicians who speak the most-needed languages, who they can call upon for their refugee and asylum seeking patients. For languages and time slots that are unavailable on Jérôme+, clinics and GMFs may resort to other telephone-based interpretation services such as RIO (Remote Interpretation Ontario). During an appointment, a physician contacts the service and asks for an interpreter in the desired language, without the need for a prior booking. Following a waiting period of 30 seconds to 5 minutes, the physician will be connected to an interpreter of the desired language by telephone. RIO is a paid service charging $1.50 per minute of telephone interpretation. Nevertheless, the nearly instantaneous access to this interpretation service permits its employment in a variety of clinical settings, including walk-in clinics and emergencies. In fact, with the rise of telemedicine during the pandemic, interpretation services at a distance like RIO became very popular with a significant number of clinics and GMFs in Montreal.

**Partners in the Community**

The *Service d'interprète, d'aide et de référence aux immigrants* (SIARI) is a community group in Montreal that provides interpretation services for immigrants with language barriers in different contexts, including appointments with health care professionals. They offer services in 20 languages for all immigrants throughout Quebec, most of them localized on the island of Montreal. Professionals can access these services by calling their main number, which can easily be found on their website [18]. They will then be redirected to one of their interpreters to make an appointment. Their services are fast and simple to use, costing an affordable fee. However, these interpreters are not trained specifically for medical purposes which can become problematic and limit their ability in effective medical interpretation. Nevertheless, they offer a number of other services that can help patients, such as assistance with the translation of documents and help with filling forms. During the COVID pandemic, they contributed to translating many information posters explaining the measures that were put in place by the health authorities and the government. They also distributed multilingual resources to inform the residents of Côtes-des-neige and Notre-dame-de-Grâce neighborhoods of the sanitary measures put in place. Community groups such as SIARI can offer a wide range of complementary services which can be very useful for patients with language barriers and should be partners in the development of better access to health care for all.

Organizations within the community have also been particularly helpful to mitigate language interpretation issues for Indigenous patients. In fact, despite the aforementioned interpretation resources in Montreal, one area of major concern is the interpretation in Indigenous languages, since the BII does not cover these languages in its mandate. For instance, as recently as 2019, no interpreters for the Inuktitut language were available at the BII. Even the MSSS has acknowledged the lack of interpretation services for Indigenous patients, and has committed to monitoring this issue: "*In regards to the First Nations people, the use of interpretation services to assist them is poorly documented. Aware of this situation, the MSSS will seek to implement, in the following years, an extensive literature review in terms of this community's need in interpretation services in order to offer appropriate resources accordingly*" [21]. As a result, some hospital networks have partnered with local organizations to serve their communities better. The CHUM (Centre hospitalier universitaire de Montréal) has been working with the Centre d'amitié autochtone de Montréal. Similarly, the MUHC (McGill University Health Network) benefits from services by Ullivik, which houses Inuit patients on temporary stays. However, there is still much room for improvement in terms of the accessibility and the scale of interpretation services for Indigenous patients, and the burden of finding solutions cannot be placed on community groups.

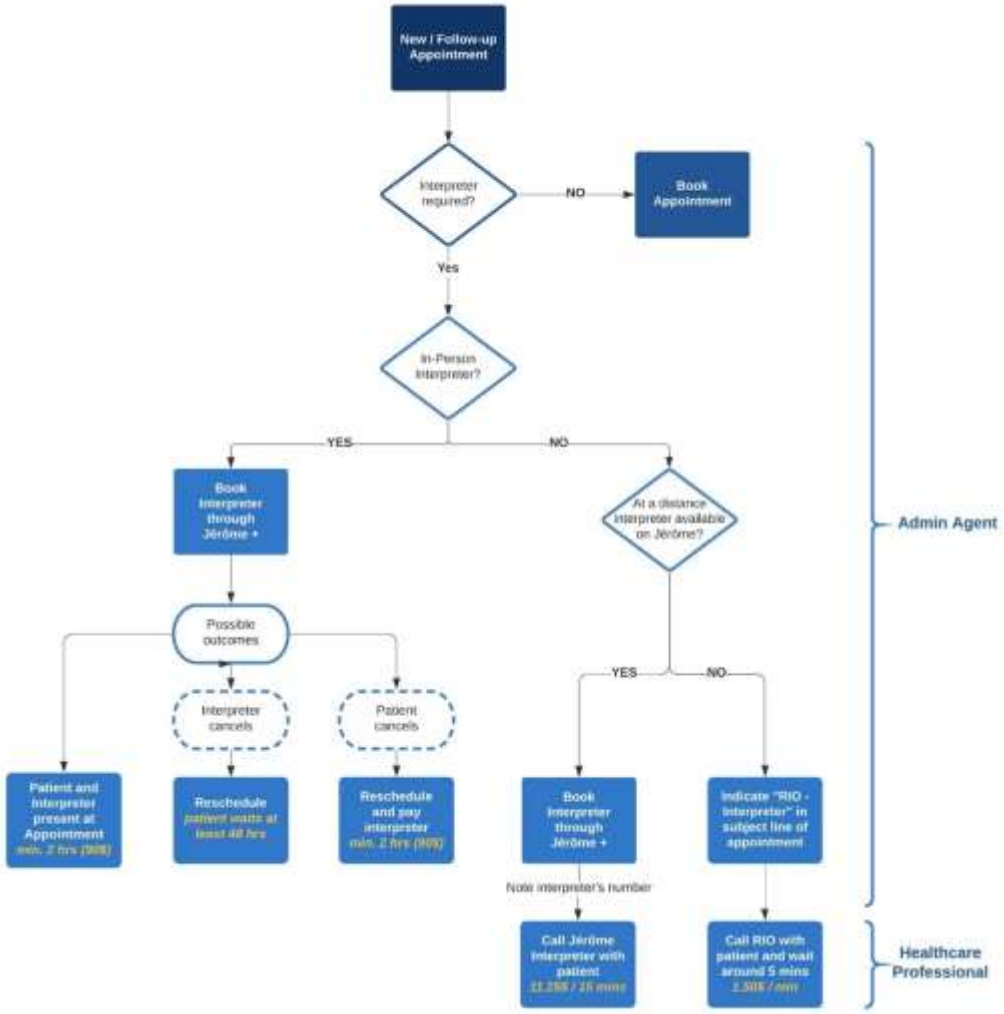


**Figure 1. Decision tree for the employment of interpretation services in GMF-U Village Santé CCOMTL**

## Tools Available in the Rest of Canada & Elsewhere

By exploring the way in which neighboring regions have dealt with language access, we can appreciate that there are a number of methods that healthcare administrative bodies may choose to tackle the issue of language barriers. The following section will highlight some of the services adapted in various other healthcare systems, and technological innovations that can possibly be adapted across various settings.

### Ontario

In contrast to the medical interpretation environment in Montreal, some of Toronto hospitals have adopted a more standardized approach to serving their allophone speakers. In 2012, one of the local government-run bodies (Local Health Integration Network, LHIN), which coordinates access to professional healthcare services in an area of Toronto, implemented a centralized service called Language Services Toronto (LST). This program is an instant, over-the-phone phone interpretation service available to the 19 hospitals and 14 community centers under the LHIN's purview [25]. By pulling the funding, as well as the usage, of each

of these institutions together, they were able to make the LST program available at a lower cost, since the high usage volume reduced the cost of the service. Day and night, interpreters for 170 languages are accessible. Healthcare workers simply have to dial a number and select their language, for them to be transferred to RIO, the provincial interpretation services collaborative. In the eventuality that a RIO interpreter is unavailable, the caller is transferred to a backup agency. Surveys following the implementation of LST indicated overall satisfaction levels of up to 90% and 95% among patients and providers, respectively. In fact, 69% of providers made requests to LST any time a patient warranted interpretation services. Despite the satisfaction, some drawbacks were also highlighted, including the easier accessibility to ad hoc interpreters, the lack of technical equipment in some centers, the delay in reaching an interpreter, and patients preferring someone from their social circle. However, not all the other LHINs in Toronto have opted for a centralized service, and some hospitals within a local body operate independently of other institutions within the same region. For example, Mount Sinai Hospital in Toronto (of Sinai Health System) operates its own internal Interpretation service [26]. They have access to more than 65 languages, and their interpreters join in-person or through telemedicine if on short notice [27]. Another example would be the Toronto Western Hospital, which has a department of translational services that employs 6 translators and allows access to 140 freelance contractors. In addition, the LHIN that includes Toronto Western also provides access to supplemental RIO services at a promotional price by centralizing the resources of their institutions and combining their usage. In short, many institutions in Toronto have put in place structures to ensure professional interpretation services in both emergency and planned consultations, and sometimes even at an optimized cost.

When services are easily accessible, more often than not, physicians do not hesitate to incorporate the use of translational services. In fact the head of translational services at the Toronto Western Hospital explains the importance of promoting the use of translational services to provide equitable access, receive informed consent, and ultimately create a safe environment for the provision of healthcare. In most cases, not excluding Toronto, the limiting factor appears to be due to budgetary constraints, much like the reality in most government-funded healthcare systems. Nonetheless, most local bodies/LHIN have policies in place that strongly discourage the unplanned involvement of employees in providing impromptu translational services. Likewise, they discourage using children, and untrained volunteers and family members as translators. This is to ensure that a standard of reliable and professional translational service is maintained [28].

**British Columbia**

All providers in British Columbia, whether in hospital or in private clinics, have access to medical interpreters through the Provincial Language Service (PLS), created by the Provincial Health Services Authority (PHSA). The PLS serves over 150 languages at any time of the day, using remote or onsite interpretation. [29] In addition, British Columbia pays particular care to members of the deaf and hard-of-hearing community. The Wavefront Centre provides American Sign Language (ASL) interpretation at no cost for services covered by provincial insurance. [30] This attention to sign language accessibility extends to emergency services. In fact, paramedics can access ASL interpreters on the spot through video, using an app on their iPhones issued by the BC Emergency Health Services.[31]. For many, this centralized system serves as a model to emulate. The availability of their service reflects the importance they place on adequate communication.

**United States**

The Cambridge Health Alliance (CHA), an integrated public health system consisting of hospitals and primary health clinics in Massachusetts, also uses a mixed methods approach including both in person interpreters and telecommunications. In an article published in 2011, it was mentioned that the CHA provided “13,000 monthly multilingual interpreter sessions, in more than 60 languages". The organization actually employed 40 staff interpreters and 120 per-diem employees; overall providing translational services in 75 languages. These interpretive sessions were conducted face-to-face, over the phone, and in videoconferences [32].

**Technological Innovation**

MedComm’s recent literature review showed that mobile applications that offer direct translation tools are becoming popular in the field of healthcare [33]. These applications include both general translation (i.e. Google Translate) and healthcare-specific applications (i.e. X-prompt, CALD Assist, S-MINDS, iTranslate). Healthcare-specific applications offer pre-set sentences and diagrams most often used in emergency assessments and basic history taking. One of such applications is called Care to Translate [34], and it is an app to facilitate interpretation created by a group of medical students from the Karolinska Institute in 2017. The objective was very much to improve patient safety and accuracy in care by translating 40 common phrases into 5 different languages, so that healthcare providers can better communicate with their patients. The app can be used by patients, healthcare providers and even organizations. At this time, there are common phrases that are used by either patients or clinicians that have been translated into 37 different languages. However, it is important to acknowledge that mobile applications can only be used as complimentary solutions and cannot fully replace professional interpreters.

## Possible Improvements

A great deal can be done in order to overcome the challenges associated with language barriers in Quebec, and in Montreal in particular. First and foremost, a clear policy on language access should be implemented on a provincial, municipal and institutional levels. Interpreter services need to be provided, free of charge and at all key points of contact with patients with language barriers. Indeed, patients should be informed of their rights to interpretation assistance. In addition, for the healthcare workers, a specific protocol should be put in place, describing how to determine the need for an interpreter, as well as how to access the interpretation services. The establishment of a clear procedure for contacting interpretation services will reduce the reliance on ad-hoc interpreters, who have no formal training. As a matter of fact, it is recommended that only trained interpreters be used in order to minimize the risk associated with using inexperienced interpreters who are not as familiar explaining medical procedures, diagnoses and treatments compared to professionals. Also, training includes discussion on the confidentiality and the privacy of the information shared with them. All of these potential changes could be put in place under the supervision of a head of translation services within each institution and CIUSSS. Having such a position in each healthcare institution will make any transition smoother. Having an individual dedicated to the better assessment of the needs of the population they serve is critical.

The use of professional medical interpreters is the gold standard to overcome language barriers and the negative implications it has on both the provider and the patient. However, for an optimal experience, it is important for healthcare workers to be trained on how to use these interpreters appropriately. In fact, there is evidence that proves that in order to ensure the best possible patient-centered care, healthcare providers

need to be informed as to how to adequately interact with the medical interpreters [35]. Training would contribute to health professionals being more comfortable with the use of interpreters and therefore being more likely to request them as needed. In fact, a study has shown that previous training in interpreter use is associated with increased use of professional interpreters and increased sense of satisfaction from the health provider in regards to the medical care they provide [36].

Once all these changes are put in place, it is wise to ensure proper collection of data regarding which language is most utilized, how often are the services requested, any issue during or while organizing the interpretation, etc. That way, we are ensured to continuously be able to monitor progress and understand how to improve the delivery of services. The healthcare professionals and the patients are both encouraged to evaluate their interactions while using interpreters, which would most likely highlight how the needs are being met & how more efficient this allows the workers to be [37]. Another way to improve the delivery of service would be to properly identify and document patients with language barriers as they enter the healthcare system. Being able to analyze how these individuals receive services will facilitate research on the challenges faced by this population and allow for targeted solutions.

## Conclusion

Through research and personal experiences, it is clear that the services that are currently available for our non-English and non-French speaking community do not meet the need, especially in large multicultural centers like Montreal. There is a lack of awareness as to the impact of language barriers on the quality of care provided within the healthcare systems. As supported by the provincial and national laws and regulations, all should be done in order to avoid any risk of misunderstanding which could lead to delayed diagnoses and increased readmissions of our most vulnerable populations. This inevitably leads to high costs for needless medical investigations, when a fraction of the price could be invested in resources to avoid such situations. Hence, a reevaluation of the services currently available and their practical use is warranted. Reforms can be inspired by looking at the services used in other centers in North America. Having a clear and easily available protocol for accessing the interpretation services currently available could go a great way towards improving care. If a facility decides to adopt a registry of the employees that are multilingual, it would be wise to provide training to everyone as to how to facilitate and utilize interpretation services. However, the fact remains that the tools at our disposal are not ideal. Investigations and investments into alternative options that make use of professional and timely interpretation services, like the RIO in Toronto, is the ultimate goal in the context of being liable for the quality of the assistance provided.

It is however of note that the implementation of proper interpretation services does not replace affordable language courses to help allophone communities learn French & English and integrate more easily in the country. In fact, while interpreter services are a basic resource for good medical practice, the importance remains to encourage patient's self-empowerment through concurrently accessing language courses.

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