

Access to Healthcare for Dutch-Speaking Patients in Brussels

A Comprehensive Investigation of Linguistic
Barriers in a Multilingual Context

Laura Moreno Rodríguez

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Supervisor: prof. dr. Elke Brems

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Résumé

Bruxelles est officiellement bilingue en néerlandais et en français, ce qui signifie que les services publics devraient théoriquement être accessibles dans ces deux langues. Cependant, ce n'est pas toujours le cas, et les citoyens néerlandophones rencontrent fréquemment des barrières linguistiques lorsqu'ils accèdent aux soins de santé. L'objectif de ce mémoire est d'identifier l'ampleur de ces barrières du point de vue des patients, en évaluant leur impact sur l'accessibilité et la qualité des soins. Parallèlement, l'étude analyse à la fois les stratégies et les défis auxquels sont confrontés les professionnels de la langue dans le secteur de la santé et le personnel hospitalier. Ceci a pour but de fournir une compréhension globale du problème. Cette recherche adopte une approche méthodologique mixte; les données primaires ont été recueillies à travers une enquête auprès de 215 citoyens néerlandophones et des entretiens semi-directifs avec cinq professionnels clés de la langue dans le secteur de la santé. Ces données ont été complétées par une analyse secondaire d'une enquête menée auprès de 259 membres du personnel soignant francophone travaillant dans plusieurs hôpitaux de Bruxelles. Les résultats montrent que des barrières linguistiques substantielles et persistantes affectent à la fois l'accessibilité et la qualité des soins pour les citoyens néerlandophones. L'enquête auprès des citoyens met en évidence des retards ou des reports dans les soins, ainsi que des erreurs de diagnostic liées à des difficultés de communication. Les entretiens révèlent les efforts déployés par les hôpitaux publics et privés, ainsi que par les institutions de soutien, principalement par le biais d'initiatives de formation en néerlandais, bien que celles-ci soient limitées par les pénuries de personnel et les ressources restreintes. Enfin, l'enquête auprès du personnel hospitalier montre une volonté générale d'apprendre le néerlandais afin d'améliorer la communication avec les patients bien que cette motivation soit freinée par des charges de travail importantes et un manque d'opportunités de pratique. Ces résultats soulignent la nécessité de solutions différenciées. À court terme, il est crucial de proposer des formations accessibles, des incitations financières pour le personnel, des mesures rendant le secteur de la santé bruxellois plus attractif pour les professionnels néerlandophones et un financement externe accru pour les initiatives linguistiques dans les hôpitaux. À long terme, une solution structurelle réside dans l'intégration de l'enseignement des langues dès le plus jeune âge, ce qui permettrait de réduire la pression sur les hôpitaux et de traiter le problème à sa source.

Abstract

Brussels is officially bilingual in Dutch and French, which means public services should theoretically be accessible in these two languages. In practice, however, this is not always the case, and Dutch-speaking citizens frequently encounter linguistic barriers when accessing healthcare. The aim of this thesis is to identify the extent of these barriers from the patients' perspective, assessing their impact on accessibility and quality of care. At the same time, the study examines the strategies and challenges faced by language professionals within the healthcare sector and hospital staff, in order to provide a global understanding of the issue. This research adopts a mixed-methods approach. Primary data were collected through a survey of 215 Dutch-speaking citizens and semi-structured interviews with five key language professionals in the healthcare sector. These data were complemented by secondary analysis of a survey of 259 Francophone healthcare staff working across several hospitals in Brussels. The results show that substantial and persistent language barriers affect both accessibility and quality of care for Dutch-speaking citizens. The citizen survey highlights delays or avoidance of care as well as misdiagnoses linked to communication difficulties. The interviews reveal efforts made by public and private hospitals, as well as support institutions, mainly through Dutch language training initiatives, though these are constrained by staff shortages and limited resources. Finally, the hospital staff survey shows a general willingness to learn Dutch in order to improve patient communication, but this motivation is hindered by heavy workloads and a lack of opportunities to practice. These findings point to the need for differentiated solutions. In the short term, accessible training opportunities, financial incentives for staff, measures to make the Brussels healthcare sector more attractive for Dutch-speaking professionals, and increased external funding for hospital language initiatives are crucial. In the longer term, however, a structural solution lies in integrating language education at an earlier age, which would reduce pressure on hospitals and address the problem at its root.

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Chapter 1: Introduction

Brussels¹ presents a complex sociolinguistic landscape. Characterized by its official bilingual status in Dutch and French, it is also deeply marked by enduring historical tensions and present-day frictions between these linguistic communities. While this bilingual framework means access to public services should theoretically be guaranteed in both languages, the reality of daily life is profoundly shaped by these ongoing interactions, potentially contributing to feelings of misrepresentation among Dutch-speaking citizens in the public sphere. Within this context, access to healthcare becomes a critical area where language policies and linguistic practices directly impact residents' well-being and social equity. The paramount importance of effective communication in this sector means that misunderstandings can seriously impact health outcomes and compromise patient safety (Rings & Rasinger, 2022).

This matter represents a long-standing issue. Concerns regarding the healthcare rights of Dutch speakers in Brussels were formally brought to international attention as early as 2002 via a petition to the Council of Europe. A subsequent 2005 report by the Council's Social, Health and Family Affairs Committee explicitly addressed the vital link between language and care quality, concluding that satisfactory patient-staff understanding is indispensable for effective medical treatment (Cliveti, 2005). The relevance and severity of these barriers are underscored by recent political actions. Early in March 2025, the Flemish government drew media attention to an existing online platform where citizens can report inadequate provision of Dutch-language healthcare services in Brussels. This reporting point signals non-compliance with laws requiring bilingual services in critical settings like emergency departments, consequently leading to considerations of legal action against these institutions (The Brussels Times, 2025). More recently, on August 17th 2025, the Flemish minister for Brussels Cielte Van Achter launched the *ToTaalplan Nederlands for Brussels* ("Masterplan for Dutch in Brussels"), an initiative to strengthen the position of the Dutch language in the capital. The plan includes improved language support in hospitals as well as a pilot project to improve bilingualism among staff in one of them (Schoofs, 2025).

Despite these legal frameworks and complaint mechanisms, significant barriers persist, indicating a need for deeper investigation into why these conventional solutions fall short. To understand the gap between law and practice, a useful analytical approach has been to analyze the Brussels case as a system of "dual monolingualism" (Dalle Mule, 2016, p. 2) or "parallel monolingual networks" (Vogl & Hüning, 2010, p. 232) that functions through the establishment of separate Dutch-language and French-language institutions. This framework helps to explain why, even with legal rights, true linguistic integration is not achieved and why inter-community contact remains limited.

¹ 'Brussels', officially 'Brussels-Capital Region', is one of the three regions in Belgium. This territorial entity comprises 19 municipalities, being one of them the City of Brussels, which is the capital of the country. As O'Donnell & Toebosch (2008) suggest, the whole of these 19 autonomous municipalities are commonly referred to as 'the City of Brussels', which can cause confusion about the correct jurisdictional terms. In this study, as in theirs, 'Brussels' refers to 'Brussels-Capital Region'.

However, while the "dual monolingualism" concept is crucial for understanding the structural issues, the existing literature applying it directly to healthcare is limited and often dated. The most comprehensive investigation into practical healthcare barriers in Brussels remains the 2005 Council of Europe report. What is currently missing is a contemporary investigation that examines the lived experiences of patients and the operational realities of professionals within this system today, in a city that has become even more demographically and linguistically complex over the past two decades. This evolution has been underscored by Brussels' Minister for the Promotion of Multilingualism, Sven Gatz, who notes that more people have moved to Brussels since the year 2000 than currently live there. Today, the city is home to residents from approximately 180 different nationalities, speaking more than 100 languages (Gatz, 2024).

This context therefore demands a clear answer to a fundamental question: What is the extent of language barriers faced by Dutch-speaking citizens when accessing healthcare in Brussels? We hypothesize that these barriers have a detrimental effect on both the accessibility and the quality of care. Specifically, the accessibility hypothesis (H1) asserts that language barriers significantly reduce the accessibility of healthcare for Dutch-speaking patients, making it more difficult for them to seek and receive medical care. The quality hypothesis (H2) further proposes that these barriers negatively affect the quality of healthcare received, potentially leading to delays in treatment and patient safety risks.

This thesis aims to provide an updated, comprehensive investigation by using a mixed-methods approach, gathering primary data through a survey of Dutch-speaking citizens and complementing this with semi-structured interviews with five language professionals working within or in relation to the healthcare sector in Brussels (representing iris network, Europe Hospitals, Huis van het Nederlands, and GIBBIS). Secondary survey data further contextualizes these findings by offering firsthand perspective of hospital staff across multiple sites in the city. The purpose of this study is to generate current, evidence-based insights that can inform future efforts by policymakers, healthcare administrators, and researchers to improve language access and equity in Brussels healthcare.

The study will commence in Chapter 2, the literature review, which provides the necessary context for understanding the findings. Chapter 3 details the research methodology to gather and analyze the primary and secondary data. The core empirical contribution of this thesis is presented in Chapter 4, which reports the findings from the citizen survey, the professionals interviews and the secondary survey data. Finally, Chapter 5 discusses these findings, offers policy recommendations and identifies areas for further research, leading into the final conclusion, provided in Chapter 6.

Chapter 2. Literature Review

This chapter provides the theoretical and contextual foundation for the study by reviewing three key bodies of literature. It begins by establishing the study's significance, examining scholarship that defines language as a critical determinant of health and outlining the documented impacts of linguistic barriers on patient outcomes. It then focuses on the sociolinguistic and demographic landscape of Brussels. Finally, it examines the language requirements and barriers within the healthcare sector in Brussels

Language as a Determinant of Health

Communication is critical in the health domain (Spolsky, 2009). This importance is underscored by estimates that oral communication forms the basis for as much as 80% of medical diagnoses (Watt, 2008, as cited in Cox & Lazaro, 2016). The consequences of linguistic barriers compromise diagnostic accuracy and treatment adherence. Cox and Lazaro (2016) identify the lack of a common language between a patient and a doctor as a major cause of health disparities in healthcare (Divi et al., 2007; Karliner et al., 2012; Schillinger & Chen, 2004, as cited in Cox & Lazaro, 2016). Similarly, the study conducted in Dutch hospitals by van Rosse et al. (2015) found that language barriers threatened patient safety in crucial daily nursing tasks such as medication administration and pain management, as well as in high-stakes physician interactions concerning diagnosis and risk communication.

These challenges are often particularly acute in high-pressure environments like the emergency departments (EDs), where rapid information exchange occurs under stress (Silverman et al., 2016, as cited in Cox & Maryns, 2021), often leading to longer patient stays (Cox & Lazaro, 2016). Language barriers exacerbate these difficulties, causing patients to struggle with understanding vital information such as discharge instructions and test explanations. Consequently, individuals frequently report lower satisfaction and reduced willingness to return for care (Carrasquillo et al., 1999). Moreover, these barriers have been linked to decreased treatment compliance, suboptimal care—including a lower likelihood of receiving anesthesia—and poorer self-reported wellbeing among patients with chronic conditions when language concordance is lacking (Carrasquillo et al., 1999, citing Manson, 1988; Lee et al., 1998; Perez-Stable et al., 1997).

The importance of addressing these barriers is increasingly recognized, with quality assurance bodies emphasizing the need to meet patients' language needs, since they consider this aspect to be “just as important as other components of quality” (Carrasquillo et al., 1999, p. 86). The literature strongly recommends the use of professional interpreters (Ramirez et al., 2008 as cited in Cox & Lazaro, 2016), a practice that is “hardly used” (van Rosse et al., 2015, p. 5), alongside improved governmental management of multilingual support resources (Roels et al., 2015 as cited in Cox & Maryns, 2021). Moreover, targeted training is identified as essential: clinicians need heightened awareness of communication challenges in multilingual settings and the importance of interpreter use, while interpreters require familiarity with specific healthcare contexts like the EDs (Scheeres et al., 2008, as cited in Cox & Lazaro, 2016). While ad-hoc solutions like using family members, untrained

staff, or translation software are common (van Rosse et al., 2015), studies show these methods can create a "false fluency", lack necessary nuance, increase communication errors, and potentially compromise diagnoses (Karliner et al., 2007; Flores et al., 2003, 2012, as cited in Cox & Lazaro, 2016; Cox & Maryns, 2021).

Moving beyond the immediate language barrier, Schouten et al. (2020) highlight the critical importance of also addressing cultural differences to ensure effective intercultural communication in healthcare. This dimension is crucial, as it can shape the perception of core medical concepts like 'pain' (Goddard & Ye, 2016, as cited in Rings & Rasinger, 2022). Care provision itself is culturally embedded, requiring healthcare professionals to develop intercultural competence to effectively align their practices with diverse patient needs (Almutari et al., 2015, as cited in Rings & Rasinger, 2022). This competence, involving sensitivity to differing belief systems, awareness of stereotypes, and navigating potential power imbalances, is crucial but "needs to be learned or acquired" (Lin et al., 2019, as cited in Rings & Rasinger, 2022, pp. 204, 207). Furthermore, attitudes toward seeking medical help can vary significantly across linguistic and cultural groups (Watson et al., 2012, as cited in Rings & Rasinger, 2022). Effective interventions often require integrated approaches combining language support with culturally sensitive patient education (Schouten et al., 2020).

Sociolinguistic Context of Brussels

Current Situation

The contemporary linguistic landscape of Brussels is defined by its status as a bilingual region (Dutch-French) within the complex federal structure of Belgium (Van der Jeught, 2017; Dalle Mulle, 2016). The city adheres to the 'personality principle'² (Vogl & Hüning, 2010; Dalle Mulle, 2016), which legally guarantees residents the right to choose either Dutch or French when interacting with public authorities and accessing public services, including healthcare, within the capital's 19 municipalities (Van der Jeught, 2017; Dalle Mulle, 2016; Cliveti, 2005). This contrasts with the monolingual regions of Flanders and Wallonia, which operate under the 'principle of territoriality'³, where the regional language dictates official interactions.

However, the implementation of this official bilingualism diverges significantly from a model promoting widespread individual bilingualism. Indeed, historical analyses have shown that "individual bilingualism has not become a model goal" in the reformation of the Belgian state (Witte & Baetens Beardsmore, 1987, as cited in Treffers-Daller, 2002). Instead, research indicates that the system functions largely through "dual monolingualism" (Dalle Mulle, 2016, p. 2) or "parallel monolingual

² "The principle of personality means that the rules will depend on the linguistic status of the person or persons concerned" (McRae, 1975, p. 33). This concept is described using different terminology across the literature. Dalle Mulle (2016) refers to it as the 'non-territoriality principle', emphasizing its contrast with territorial-based rights. In a more legalistic framing, van der Jeught (2017) uses the term 'freedom of language', aligning with the phrasing of the Belgian Constitution.

³ "The principle of territoriality means that the rules of language to be applied in a given situation will depend solely on the territory in question" (McRae, 1975, p. 33).

networks" with the establishment of separate Dutch-language and French-language institutions (Treffers-Daller, 2002, p. 53; Vogl & Hüning, 2010, p. 232).

The Belgian model of territoriality, which links a specific language to a territory, could not only be viewed as a solution to its current linguistic situation but as part of the conflict itself, as it institutionalizes separation (Vogl & Hüning, 2010). A key example is the education system, where the separate monolingual schools mean that "both linguistic communities in Brussels live side by side, having hardly any contact with each other and each other's language" (Dalle Mulle, 2016, p. 33). The most recent data from the BRIO Language Barometer⁴ 5 (LB5), conducted in 2024, illustrates this educational divide: among young adults (18-30) educated in Brussels' Dutch-speaking schools, 82.9% are proficient in French, whereas only 6.5% of those educated in Brussels' French-speaking schools are proficient in Dutch (Saeys, 2024). While allowing individuals the freedom to choose, this structure inherently fosters linguistic separation and may limit inter-community contact within official spheres (Dalle Mulle, 2016; Vogl & Hüning, 2010).

This institutional divide is further compounded by sociolinguistic behaviours and attitudes. Studies have highlighted a mutual reluctance between Dutch and French speakers in Brussels to use the other national language (O'Donnell & Toebosch, 2008; Treffers-Daller, 2002). Additionally, O'Donnell & Toebosch confirmed the preference for English as a "neutral third party" for communication, finding that 40% of Francophones preferred English to Dutch, while 90% of Dutch speakers preferred English to French (p. 166). Data from the LB1 (presented in 2001) and the LB2 (presented in 2007) confirm these trends, showing a decrease in high-level proficiency in Dutch (from 33.3% to 28.2%) and a corresponding increase in English (from 33.3% to 35.4%) (Janssens, 2008). The most recent data from the LB5 (presented in 2024) confirms the culmination of this shift, showing that proficiency in English among Brussels residents (46.9%) has now officially surpassed that of Dutch (22.3%), solidifying its role as the second most-known language in the city (Saeys, 2024).

These sociolinguistic trends are driven by powerful demographic realities. The city's population is in a state of constant flux, characterized by two opposing migratory trends: a strong positive international migration balance that brings new languages and cultures to the city, and a significant negative internal migration balance, with residents moving to Flanders and Wallonia (Hermia & Tennstedt, 2024). The scale of this internationalization is significant, as shown in the 2024 Hermia & Tennstedt report, indicating that over a third of the population is of foreign nationality. They also indicate that approximately 12% of the current Brussels population grew up in a household with Dutch. While this represents a decline over the past two decades, the profile of this group is shifting toward a younger demographic that is increasingly composed of individuals who have moved to Brussels from Flanders, and who use Dutch more frequently than before (Saeys, 2025; Hermia & Tennstedt, 2024).

⁴ The Language Barometer is a large-scale study conducted by the Brussels Information, Documentation and Research Centre (BRIO). Since 2001, it has surveyed approximately 2,500 respondents every five to six years to provide a representative overview of the linguistic landscape of the city.

Historical Overview

While a complete account of Brussels's linguistic history is beyond the scope of this thesis, the following overview will highlight the most relevant developments to understand the city's contemporary situation. The current sociolinguistic landscape is deeply rooted in centuries of shifting power dynamics and political compromises that have directly shaped the institutional framework of healthcare and other public services.

Brussels' linguistic origins lie in a predominantly Dutch-speaking environment. When the city was part of the Duchy of Brabant (between XI and XIV centuries), the use of Dutch was general, with rulers reportedly opposed to French influence (Van der Essen, 1916, as cited in Van der Jeught, 2017). However, beginning in the fifteenth century under Burgundian rule and solidifying through subsequent Spanish period (centuries XVI and XVII), French gained considerable prestige as the language of the nobility and administration. As a consequence, the Dutch language became increasingly associated with the lower classes, laying the groundwork for a future social stratification based on language (Treffers-Daller, 2002; Van der Jeught, 2017). The brief French revolutionary rule (1792–1815) significantly reinforced the position of French through stringent language policies, and a subsequent attempt by the United Kingdom of the Netherlands (1815–1830) to establish Dutch as the sole administrative language was met with strong resistance and ultimately failed (Witte et al., 2009, as cited in Van der Jeught, 2017).

The establishment of the Belgian state in 1830 marked a critical turning point. While the new Constitution guaranteed "freedom of language" (Art. 30), in practice, this principle favoured the already prestigious French, which became the sole *de facto* language of the new state, its administration, and judiciary (Van der Jeught, 2017). This immediately established a structural disadvantage for Dutch speakers, where social and professional advancement became almost entirely dependent on proficiency in French, reinforcing the perception of Dutch as an inferior language (Treffers-Daller, 2002). The recognition of Dutch was a slow and arduous process, beginning with early language laws like the Act of 17 August 1873, which regulated language use in criminal proceedings, and the 1898 Law on Linguistic Equality, which granted theoretical legal status but failed to achieve practical equality for decades.

The most significant policy shift in shaping today's landscape occurred in 1932, when legislation was fully founded on the territoriality principle, establishing the rule that "the regional language is the administrative language" and making Dutch the official language in Flanders (Vermeire, 2010). This legislation was driven by the Flemish movement—a nationalist movement aimed at the "cultivation of the Dutch language and the empowerment of its speakers" (Vogl & Hüning, 2010, p. 237)—in response to the ongoing "Frenchification" of Brussels, a historical language shift driven by the structural dominance of French (Treffers-Daller, 2002). This process culminated in the laws of 1962–63, which formally subdivided Belgium into four language areas: the Dutch-language area, the French-language area, the German-language area, and the bilingual Dutch-French area of Brussels (Vermeire, 2010). These foundational rules were then consolidated and converted in 1966 into the comprehensive Language Act on Administrative Affairs, which continues to apply throughout Belgium today (Vermeire, 2010).

This subdivision was incorporated into the Constitution in 1970, enshrining the territoriality principle and paving the way for Belgium's transformation into a federal state. This reform created a dual structure of Regions (based on territory) and Communities (based on language). Crucially, responsibility for "personal matters"—a category that explicitly includes public health—was assigned to the Language Communities (Cliveti, 2005). This is the direct legal and political origin of the "dual monolingualism" or "parallel monolingual networks" that define public service provision in Brussels today (Dalle Mulle, 2016; Vogl & Hüning, 2010). This historical trajectory, from a state dominated by a single language to one organised around strict linguistic separation, has created the complex contemporary system where legal guarantees of bilingualism coexist with deeply embedded institutional and social divisions, setting the stage for the practical language barriers that are the focus of this study.

Healthcare Sector in Brussels

Language Requirements

The healthcare system in Brussels is composed of a mix of public, private and university hospitals, each type operating under different linguistic regulations. Public hospitals in Brussels are fully subject to the Language Act on Administrative Affairs from 1966 (Vermeire, 2010), which means they must offer bilingual care in all their departments, giving patients the right to be treated in either Dutch or French. In contrast, private and university hospitals have more autonomy. They are not, in principle, subject to language regulations for their general services and are typically affiliated with a specific Community, making them primarily Dutch- or French-speaking (Flemish government n.d.).

Despite these differences, a fundamental legal exception applies to the recognized EDs (including mobile emergency groups, or MUGs) of all hospitals, regardless of their status. These services are considered a public task that exceeds the boundaries of a private enterprise, particularly as patients in need are taken to the nearest hospital and have no free choice. As such, all EDs in Brussels are legally required to offer a bilingual service in Dutch or French, both during an intervention and in subsequent administrative processing (Flemish government, n.d.).

The governance of this complex linguistic system is rooted in Belgium's federal structure, formalized in the 1970 constitutional reform where personal matters such as public health and social assistance were assigned to the Language Communities (Cliveti, 2005). To exercise these powers in Brussels, the Joint Community Commission—known as the GGC (Gemeenschappelijke Gemeenschapscommissie) in Dutch and COCOM (Commission Communautaire Commune) in French—was established. This body monitors and supervises the majority of the capital's healthcare services, particularly those that have not opted to belong exclusively to either the Flemish or the French-speaking community, often referred to as "dual-community health-care institutions" (Cliveti, 2005). Furthermore, compliance with language laws is overseen by specific bodies, including the Permanent Committee for Linguistic Control and, for the 19 Brussels municipalities, the Vice-Governor of the Brussels-Capital district (Flemish government, n.d.).

Underpinning the entire healthcare system is the Belgian Law on Patients' Rights of 2002, most recently updated in 2024 (*Loi relative aux droits du patient*, 2002). This legislation establishes the fundamental principles of patient-provider communication, mandating that healthcare professionals must respect the "dignity and autonomy of the patient" (Art. 5). More critically for this study, Article 7 stipulates that the patient has the right to "all information concerning him/her which may be necessary to understand his/her state of health and its probable evolution". Furthermore, it requires professionals to provide this information in a "quality-oriented and patient-friendly manner", allowing sufficient time and explicitly inviting the patient to ask questions. While this law does not name specific languages, its emphasis on ensuring patients can truly understand their health situation implicitly requires that communication be adapted to the patient's linguistic needs, making the overcoming of language barriers a *de facto* legal necessity for providing quality care.

Language Barriers and Use

The potential for practical barriers within Brussels' healthcare was explicitly recognized in a 2005 Council of Europe report, which serves as a key historical benchmark for understanding the issue. Originating partly from petitions by Dutch speakers, the report concluded that the core issue lies not in an absence of legal rights, but in the inconsistent application and enforcement of bilingualism rules in practice (Cliveti, 2005). Specific barriers identified included insufficient Dutch-speaking healthcare staff, administrative hurdles like receiving documents only in French, and a resulting perception among Dutch-speaking patients of being treated as "second-class citizens" (Cliveti, 2005).

However, the literature also suggests the situation is complex and not entirely static. Research from a similar period by Janssens (2008) indicated a potential positive shift in practice, observing that "Dutch speakers are increasingly attended to in Dutch, in the sense that it is less a French-only-matter and both official languages are increasingly being used" (p. 7). This finding points to a dynamic environment where acknowledged, systemic failings could coexist with gradual, on-the-ground improvements.

Language use within the Dutch-speaking community itself is not uniform, with home language background appearing to strongly influence linguistic practices in healthcare settings. Data from the LB5 (2024) reveals a significant divergence in language use within hospitals based on a Dutch speaker's home language background. Specifically, a large majority of residents from monolingual Dutch-speaking families (72.3%) report using Dutch 'often to always' in hospitals. In contrast, only 25% of residents from traditionally bilingual (Dutch-French) families report using Dutch with the same frequency (Saeys, 2025). This finding underscores how home language background shapes actual language practices, suggesting that bilingual upbringing may reduce the likelihood of consistently using Dutch in healthcare settings.

Chapter 3: Research Methodology

Research Design

This study employs a mixed-methods research design, an approach supported by a growing consensus in social research that combining quantitative and qualitative data can offer a more complete and purposeful understanding of a phenomenon (Young, 2016). Specifically, a convergent parallel approach was utilized, which allowed for the concurrent collection and separate analysis of distinct data sets. The design combines primary data, gathered from a citizen survey and five professional semi-structured interviews, with secondary survey data from hospital staff, allowing for a multi-perspective analysis of the research problem.

The purpose for this mixed-methods design is complementarity, a strategy described by Hammersley (1996, as cited in Young, 2016) in which different research methods are used so that various aspects of an investigation can “speak to each other” (p. 177). Its selection is supported by precedents in similar research contexts. For instance, Garone et al. (2020) combined surveys and interviews in their study on multilingualism in nursing education in Brussels. Similarly, van Rosse et al. (2015) used a mixed-methods design to investigate the link between language barriers and patient safety risks in Dutch hospitals, combining quantitative record reviews with in-depth interviews.

Sample Selection

The data of this research involved three distinct groups of participants: citizens who completed the survey, professionals who participated in semi-structured interviews, and hospital staff who completed a secondary survey. The purpose of the study was communicated transparently through clear introductory information for the survey and a verbal explanation before each interview.

Survey Participants

The target population for the survey included two criteria: being a Dutch speaker (either as a sole native language or in combination with others) and residing in Brussels. Participant recruitment occurred between March 6 and 31, 2025. The initial data collection process yielded 220 submissions. Upon review, one duplicate entry was identified and removed, resulting in 219 responses. From this pool, participants were excluded based on two further criteria. First, two individuals who indicated German as their only native language as they fell outside the target population. Second, two participants aged 71 and over, since a subgroup of this size ($n=2$) would produce expected counts well below the minimum of five needed for a reliable Chi-square test (Van Voorhis & Morgan, 2007), the statistical method used to examine the relationship between categorical variables in this study. Therefore, the final analytical sample size is $n=215$, whose demographic characteristics (e.g. linguistic background and age) are presented in detail in the Results chapter.

Interview Participants

The primary inclusion criterion for interview selection was relevant professional expertise in language services within the healthcare sector in Brussels. In total, five professionals were interviewed to provide a comprehensive institutional perspective:

- Participant 1 - Languages team coordinator, iris network⁵ (representing public hospitals), interviewed on April 22, 2025.
- Participant 2 - Language coach, Europe Hospitals (representing private hospitals), interviewed on January 23, 2025.
- Participant 3 - Language policy advisor specialized in the healthcare sector, Huis van het Nederlands⁶ (HvN), interviewed on April 14, 2025.
- Participant 4 - Coordinator for elderly and innovative care, GIBBIS⁷.
- Participant 5 - Legal expert specializing in language legislation, GIBBIS.

Participants 4 and 5 were interviewed jointly on July 30, 2025. The professional roles of the five participants are detailed in the Results chapter.

Secondary Survey Data Participants

The original survey targeted healthcare staff across multiple Brussels hospitals (e.g., Chirec, Europe Hospitals, Silva Medical, Saint-Jean, Valisana) and encompassed a wide range of professional roles, including nurses, doctors, administrative staff, and human resources personnel. It was administered in both French and Dutch between May 13 and June 26, 2024 and yielded a total of 290 responses.

For the purpose of this layer of the analysis, which aimed to understand the perspective of the French-speaking healthcare workforce regarding the use of Dutch at hospitals, two language-based exclusion criteria were applied. First, only responses submitted in French were included (respondents could choose to fill the survey in French or in Dutch). Second, two respondents who identified as bilingual despite answering in French were also excluded. After applying this criteria, the final analyzable sample from the secondary survey consisted of 259 respondents. This dataset offers a view from on-the-ground staff, highlighting both the motivations and challenges that influence hospital staff engagement in Dutch learning, as well as the obstacles they face in the process.

Data Collection Instruments

Survey

The citizen survey was administered online via Google Forms (see Appendix A). It consisted of 15 questions combining closed-ended formats (e.g., multiple-choice for demographics, Likert scales

⁵ iris network is the umbrella organization that consolidates the public hospitals in Brussels. Established by ordinance in 1996, the network now comprises 11 different sites across five hospital groups: Brugmann University Hospital, Saint-Pierre University Hospital, Iris South Hospitals, the Queen Fabiola Children's University Hospital, and the Jules Bordet Institute.

⁶ Huis van het Nederlands is an institution that promotes the use of Dutch in Brussels and provides guidance to multiple organizations in shaping their language policies.

⁷ GIBBIS is the federation of health institutions in Brussels, representing them before administrative and governmental bodies.

for perceptions) with three open-ended questions designed to gather qualitative insights into personal experiences. The survey covered several key themes:

- Demographics: Age and native language(s).
- Personal healthcare practices: Frequency of seeking care, postponement or avoidance of care due to language barriers, and prior awareness of hospital language policies.
- Linguistic obstacles: Perceived frequency of communication difficulties and the specific settings where they occurred.
- Perceptions: Overall sentiment regarding the adequacy of care and language support for Dutch speakers.
- Qualitative insights: Specific problems encountered, methods for addressing issues, and recommendations for improvement.

The survey was administered in English due to the researcher's linguistic capabilities. This methodological choice limits the sample to Dutch speakers who possess sufficient English proficiency. The potential implications of this sampling limitation are addressed in the Discussion chapter.

Interviews

A semi-structured interview protocol was used to guide conversations with the professionals (see Appendix B). This instrument was not a rigid questionnaire but rather a flexible guide with predetermined open-ended questions that were adapted for each institution. The flexibility of this semi-structured format, often defined as a 'conversation with a purpose' (Burgess, 1984, as cited in Taylor, 2005), was crucial for exploring the unique context of each professional's institution.

For the first three interviews (with representatives from the iris network, Europe Hospitals, and HvN), a consistent set of core topics was explored to ensure comparability. These key topics included:

- Strategies for training and incentivizing bilingual staff.
- Organization and funding of language support initiatives.
- Challenges and barriers to providing bilingual care from an operational standpoint.

While this protocol offered a consistent framework, the interviews remained flexible, and the conversation was allowed to evolve based on the specific expertise and responses of each interviewee. In contrast, the fourth interview, conducted jointly with the two professionals from GIBBIS, followed a more distinct, targeted structure. It was conceived primarily to clarify legal and systemic questions that arose during the research, resulting in a shorter and more focused discussion on the legal obligations of different hospital types and sector-wide challenges.

Secondary Survey Dataset

Access to the anonymized, individual-level responses of this survey was provided by Participant 3, who originally administered the instrument via Microsoft Forms. The instrument was designed with conditional branching logic; depending on their answers to two specific questions (e.g. "Have you done anything to improve your Dutch in the last 12 months?", "Would you like to improve your Dutch in the next 12 months?"), respondents were directed to different question paths.

For the purpose of this thesis, a subset of questions was analyzed to examine motivations, challenges, obstacles and desired support systems for language learning among hospital personnel. Most of these items used a multiple-choice format allowing for multiple responses.

Data Collection Methods

Survey

A combination of non-probability sampling techniques was utilized to maximize reach. Initially, the online survey link was disseminated through snowball sampling, distributed via WhatsApp to the researcher's contacts who were encouraged to forward it within their networks ('friends of friends'). Young (2016) notes this method is "particularly useful [...] because the researcher only knows or has good access to a very few members of the target population" (p. 170), which is applicable to the demographic of Dutch speakers residing in Brussels. The link to the survey was also posted in targeted Facebook community groups for Dutch speakers living in the city.

To supplement online recruitment, convenience sampling was employed by choosing participants based on "ease of access [...] or the willingness of people to participate" (Young, 2016, p. 169). A street intercept method was utilized in streets and terraces within the Sainte Catherine and Dansaert neighbourhoods, areas specifically chosen due to their reputation as locales frequented by Dutch speakers in Brussels. Potential participants were preliminarily identified by the researcher overhearing conversations in Dutch or English. They were then approached directly and screened via inquiry to confirm their status as Dutch speakers residing in the city. Following this, participants were provided with a flyer containing a QR code to the survey, allowing them to complete it at their convenience. It is acknowledged that the use of non-probability sampling methods limits the generalizability of the findings; therefore, the sample is not considered statistically representative of the entire Dutch-speaking population of Brussels.

Interviews

For the qualitative component of the study, purposive sampling was employed to recruit five professional informants. This non-probability sampling strategy was selected to ensure that participants were deliberately selected for their relevance to the research aims, with the intention of including those "most likely to yield appropriate and useful information" on language policy implementation (Campbell et al., 2020, p. 654).

Interviews were conducted using modalities that accommodated participant availability and preference. Those with representatives from Europe Hospitals and HvN took place on-site at their respective institutions, while those with professionals from the iris network and GIBBIS were conducted online via video conference (Teams). The first three interviews lasted between 45 and 60 minutes, whereas the fourth was shorter, at approximately 22 minutes.

All interviews were audio-recorded with prior consent and transcribed using a combination of tools: the iris network interview was transcribed directly with the Teams platform, while the other three interviews (Europe Hospitals, HvN, and GIBBIS) were transcribed using Otter.ai. All transcripts were then manually reviewed and cleaned by the researcher to ensure accuracy.

Secondary Survey Dataset

The survey was designed by HvN to gain a general understanding of how Brussels healthcare workers view Dutch language learning and how they wish to pursue it, without strict adherence to scientific survey design criteria. Participants could respond in Dutch or French. In the Excel provided, closed-question responses appeared in Dutch regardless of the respondent's chosen language, while open-ended responses appeared in Dutch if answered in Dutch and in French if answered in French. All Dutch open-ended responses were translated into English using Google Docs to ensure consistency in the analysis.

As this instrument was developed and administered by an external organization for its own research purposes, detailed information regarding the original data collection protocol was not available and is outside the scope of this thesis.

Data Analysis Methods

The data collected from both surveys and the semi-structured interviews were examined using distinct quantitative and qualitative methods, respectively.

Survey

Quantitative and qualitative data from the 215 valid survey responses were analyzed manually using Microsoft Excel. To explore potential differences based on linguistic background, participants were categorized into two groups based on their self-reported native language(s). The validity of this grouping was further informed by responses to a Likert scale question assessing comfort with non-Dutch healthcare. However, during data collection, it was determined that the scale's direction could be counterintuitive for participants. To address this, a clarification ("1=very comfortable and 5=very uncomfortable") was added to the live survey after 86 responses had been collected. Due to this mid-collection modification, statistical analyses involving this specific question were conducted only on the subset of data from respondent 87 onwards to ensure all included participants responded to the clarified question.

To summarize participant demographics and responses to closed-ended questions, descriptive statistics, including frequencies, percentages, and means, were calculated. Pivot tables were employed to filter and examine these responses across the two primary linguistic groups and the three defined age cohorts. To explore associations between key categorical variables, such as linguistic group and the reported frequency of language barriers, the Chi-square test for independence was conducted. For all inferential tests, a p-value of less than 0.05 was considered the threshold for statistical significance.

Answers to the open-ended survey questions were analyzed using a qualitative content analysis (QCA) approach (Mayring, 2000), a systematic, rule-guided method that adapts quantitative content analysis techniques for qualitative data. Responses were coded to categorize recurring ideas and patterns. During this process, three participants identified themselves as medical doctors and provided detailed answers from a professional standpoint. To distinguish this expert feedback from the broader patient perspective, their qualitative responses were coded and analyzed as a separate

subgroup. These findings are presented in the Results chapter under the heading *Doctors' Opinions*, providing a complementary professional viewpoint to the general sample. Minor spelling and typographical errors in survey responses were corrected for readability when presenting direct quotations, while wording and meaning remained unchanged.

Interviews

The four semi-structured interviews were analyzed using a thematic analysis (TA) methodology. As Ahmed et al. (2025) note, TA provides a "theoretically flexible and accessible approach, ideal for researchers aiming to identify patterns of meaning without being constrained by specific epistemological commitments" (p. 1). This flexibility is particularly well-suited for identifying key themes across the diverse institutional perspectives captured in the interviews. The process was guided by the six-phase framework developed by Braun and Clarke (2006), which Ahmed et al. (2025) confirm "remains the cornerstone for conducting robust thematic analysis" (p. 1). The six phases followed were: (1) familiarization with the data; (2) generating initial codes; (3) searching for themes; (4) reviewing themes; (5) defining and naming themes; and (6) producing the final report.

The coding process was conducted manually and followed an inductive or "bottom-up" approach, where the identified themes were derived directly from the content of the interview transcripts rather than from a preconceived theoretical framework (Braun & Clarke, 2006). Consistent with the exploratory nature of this study, themes were identified based on their relevance to the research question and the richness of the insights they provided, rather than on their frequency alone. As argued by Braun & Clarke (2006), the importance of a theme is not necessarily dependent on its prevalence but on "whether it captures something important in relation to the overall research question" (p. 82). The major themes identified through the analysis were common across interviews, providing a cohesive framework for the Results chapter. However, specific codes and subthemes sometimes varied between participants, reflecting individual perspectives.

Secondary Survey Data

The analysis of the secondary survey data from HvN was primarily descriptive and selective. Rather than analyzing the full survey, we examined only the aggregated results of a subset of questions that were directly pertinent to the objectives of this thesis. Frequencies and percentages from these specific questions were reviewed to identify broad patterns and tendencies among healthcare staff regarding their motivations, challenges and obstacles they encounter.

It is important to acknowledge the limitations of using this secondary data. As the full methodological details of the original HvN survey were not part of this thesis's design, no inferential statistical tests were performed on this dataset. The interpretation of these findings is therefore handled with caution.

Ethical Considerations

This research was conducted in strict adherence to ethical principles to ensure the dignity and well-being of all participants, with key considerations including informed consent and anonymity. Informed consent was a mandatory prerequisite for all participation, with procedures tailored to each data collection method. For the survey, consent was obtained on an implied basis; before accessing the questions, participants were presented with an introductory information piece detailing the study's purpose and anonymity procedure. For the semi-structured interviews, explicit verbal consent was obtained at the beginning of each recorded session, after the researcher explained the study's purpose. Confidentiality was ensured through anonymization: all identifying details, such as names, were removed during transcription and replaced with pseudonyms (e.g., Participant 1, Participant 2) in the final transcripts and reporting of findings.

Use of Generative AI Tools

In the interest of methodological transparency, it is noted that generative artificial intelligence (AI) tools were utilized in a supportive capacity during various stages of this research project. The primary tools employed were OpenAI's ChatGPT and Google's AI Studio. ChatGPT was consulted for specific technical and methodological queries. This included seeking guidance on appropriate Microsoft Excel formulas for conducting quantitative statistical calculations, such as the Chi-square test, and exploring the suitability of different qualitative research methodologies, which helped to confirm, for instance, the selection of thematic analysis as the most appropriate framework for this study's objectives. Additionally, Google's AI Studio was employed for proofreading and text refinement, which involved improving sentence structure, ensuring grammatical correctness, and enhancing the overall clarity and flow of the written thesis.

Chapter 4. Results

Citizens' Perspective

This section presents the findings from the survey administered to Dutch-speaking citizens living in Brussels. Following the application of exclusion criteria (see Research Methodology), the final analyzable sample consists of 215 participants. The following subsections start by outlining the demographic profile of the sample, their personal practices in seeking healthcare, and linguistic obstacles encountered. This is followed by an explanation of their coping mechanisms to navigate language barriers on-site, their personal opinions regarding linguistic obstacles in Brussels healthcare, and recommendations to improve Dutch-language accessibility. The section concludes with the distinct perspectives provided by three medical doctors who participated in the survey.

Demographic Profiles

To facilitate a nuanced analysis, participants were first categorized into two distinct linguistic groups.

- Group A (n=199): participants whose native language was Dutch, either solely (n=194) or in combination with another language other than French (n=5), specifically Portuguese, English, Arabic, Armenian, and Spanish.
- Group B (n=16): participants who declared themselves as natively bilingual in both Dutch and French.

This categorization was informed by a preliminary comparison of participants' comfort levels when receiving healthcare in a language other than Dutch (rated on a scale from 1=very comfortable to 5=very uncomfortable). A clear difference in average comfort was observed: participants from Group A reported significantly lower comfort ($M = 3.33$), compared to those from Group B ($M = 1.83$). To determine if this observed difference was statistically significant, a Chi-square test for independence was performed, which confirmed that the overall pattern of responses was highly statistically significant ($\chi^2(4, N = 131) = 19.44, p < .005$) and justified the division of the sample.

The demographic characteristics, divided by linguistic group and age cohort, are presented in Table 1. Overall, the largest age cohort in the study is the 31-50 year-old group (47%), followed by the 18-30 year-old group (37.7%) and 51-70 (15.3%). As shown in the table, the age distribution differs between the two linguistic groups; Group B is proportionally younger, with a majority of its participants (62.5%) belonging to the 18-30 age cohort, whereas Group A's largest segment is the 31-50 age group (48.2%). The predominance of participants from the younger and middle age groups may reflect the survey distribution methods (which included street approaches and dissemination via Facebook groups), potentially limiting participation from older individuals—a skew consistent with national data on digital engagement⁸.

⁸ According to Statbel, the Belgian statistical office, older age cohorts in Belgium generally demonstrate lower levels of overall digital skills and less frequent participation in online social networks compared to younger populations (Statbel, 2023). Such trends suggest that reliance on online platforms for survey distribution may inherently lead to lower participation rates among older demographics.

Table 1*Age Cohorts Divided by Linguistic Groups*

Age Cohorts	Group A n=199 (92.6%)	Group B n=16 (7.4%)	Total Sample N=215
18-30 years	71 (35.7%)	10 (62.5%)	81 (37.7%)
31-50 years	96 (48.2%)	5 (31.3%)	101 (47%)
51-70 years	32 (16.1%)	1 (6.3%)	33 (15.3%)

Personal Practices

This subsection examines the personal practices and awareness of participants concerning healthcare in Brussels, based on responses to questions regarding frequency of healthcare use, avoidance of care due to language barriers, and prior knowledge of hospital language policies.

Frequency of Healthcare Use. The survey first examined how often participants seek healthcare in Brussels. A large majority in both groups reported accessing healthcare at least once annually (92.5% in Group A and 93.8% in Group B). Specifically, Group A demonstrated a more varied pattern of use, including a notable segment engaging in "regular" or "frequent" care, particularly among older participants. In contrast, Group B's usage was more concentrated around "occasional" visits.

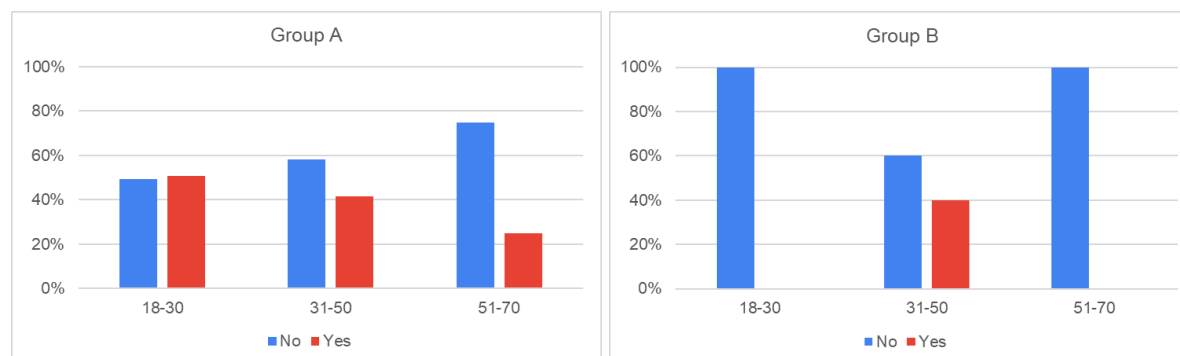
The Chi-square test indicated that these differences were not statistically significant, $\chi^2(4, N = 215) = 3.42$, $p \approx 0.49$. Thus, despite minor descriptive variations, Dutch speakers and Dutch-French bilinguals accessed healthcare with comparable frequency. This supports treating both groups as active users of the Brussels healthcare system, validating the relevance of their subsequent feedback on language barriers.

Avoidance of Care due to Language Barriers. Beyond the frequency of healthcare use, the survey investigated whether participants had ever postponed or avoided seeking medical care specifically due to potential language barriers. The responses indicated a clear difference between the two linguistic groups, as shown in Figure 1. A considerable proportion of Group A, 42.2% overall, affirmed that they had postponed or avoided seeking medical care because of potential language difficulties, compared to only 12.5% of Group B.

The Chi-square test revealed a statistically significant association between language background and the reported postponement or avoidance of medical care due to language barriers ($\chi^2([df]) = 5.45$, $p \approx 0.02$). This p-value, being less than the conventional alpha level of 0.05, suggests that the differing rates of care avoidance are unlikely due to random chance and indicates that language background is indeed associated with these behaviors.

Figure 1

Postponement or Avoidance of Medical Care Due to Language Barriers, by Linguistic Group and Age



Within Group A, age-related trends were also observed. This behavior of postponing or avoiding care was most prevalent among the youngest cohort (18-30 years), with 50% reporting such avoidance. This figure was somewhat lower for the 31-50 age group (41.7%) and decreased further for the 51-70 age group (25%). This pattern suggests that younger, primarily Dutch-speaking individuals may be more inclined to let language concerns deter them from seeking care. In contrast, within Group B, the behavior of postponing or avoiding care was reported exclusively by 2 individuals in the 31-50 age bracket, with no participants in the other age categories reporting this. Table 2 shows the absolute numbers and percentages of care avoidance by linguistic and age group.

Table 2

Medical Care Postponed or Avoided Due to Language Barriers, by Linguistic Group and Age

Linguistic Groups and Age Cohorts	Postponed / avoided n (%)	Did not postpone / avoid n (%)
Group A		
18-30 years	36 (50.7%)	35 (49.3%)
31-50 years	40 (41.7%)	56 (58.3%)
51-70 years	8 (25%)	24 (75%)
Total Group A	84 (42.2%)	115 (57.8%)
Group B		
18-30 years	0 (0%)	10 (100%)
31-50 years	2 (40%)	3 (60%)
51-70 years	0 (0%)	1 (100%)
Total Group B	2 (12.5%)	14 (87.5%)

These findings, supported by statistical analysis, indicate that the anticipation or experience of language barriers acts as a significant deterrent to seeking medical care for a substantial portion of Group A, particularly for younger adults. Conversely, Group B appears substantially less affected by this specific barrier.

Comments from the open-ended responses provide further insight into these healthcare-seeking decisions. Many participants linked their active avoidance of most Brussels facilities to the perceived scarcity of Dutch-speaking providers. Anticipation of these challenges lead to delayed or foregone care, with some admitting they might "tough it out" when sick rather than face the hassle of finding a setting where they could communicate effectively. One respondent explained avoiding consulting doctors in Brussels because they consider receiving healthcare in Dutch essential, while another reported not having a general practitioner (GP) for three years after relocating to the city.

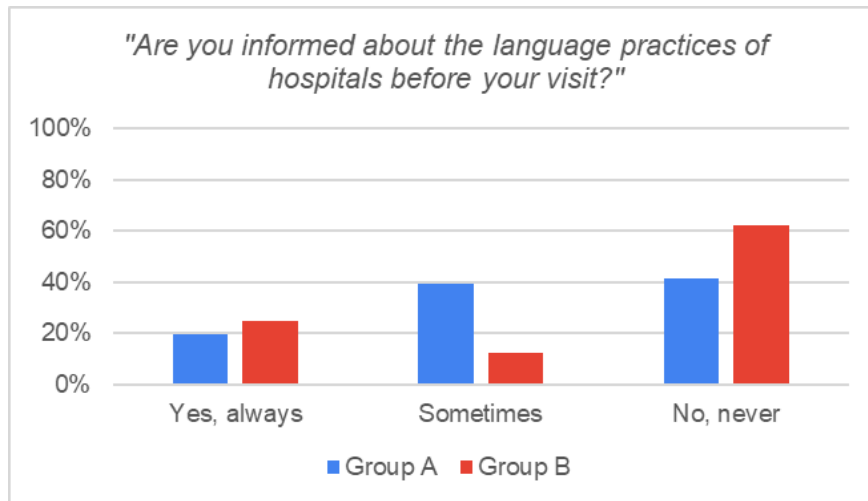
A common strategy to address this issue involved traveling to Flanders for care. Several individuals reported regularly traveling for GP visits, dental care, or specialist consultations such as with obstetrician-gynecologists. As one participant stated, "I have a hospital nearby, but I ride 12 kilometers to a hospital where they all speak two or three languages... because they speak perfect Dutch". Others described similar practices, including traveling to Leuven for maternity care or continuing to see a Flemish doctor in their former village 15 kilometers away.

Among Brussels hospitals, the notable exception consistently mentioned was UZ Brussel in Jette, widely recognized within the Dutch-speaking community as a hospital where patients generally feel understood in their language. Commitment to this institution was strong, even when it required additional travel. One respondent described bypassing a nearby hospital to drive at least 30 minutes to UZ Brussel, despite living "around the corner of a [different] hospital".

Prior Knowledge of Hospital Language Policies. The study then explored participants' awareness of hospital language practices before seeking care. Their responses revealed varied levels of prior information, with some differences observed between the linguistic groups, though these overall group distinctions were not found to be statistically significant ($\chi^2(df) = 4.62, p > .05$). As shown in Figure 2, responses within Group A were fairly even: 19.6% declared being "always" informed, 39.2% "sometimes", and 41.2% stated they were "never" informed prior to a visit. In contrast, for Group B, while 25% reported being "always" informed and 12.5% "sometimes", a clear majority of 62.5% indicated they were "never" informed.

Figure 2

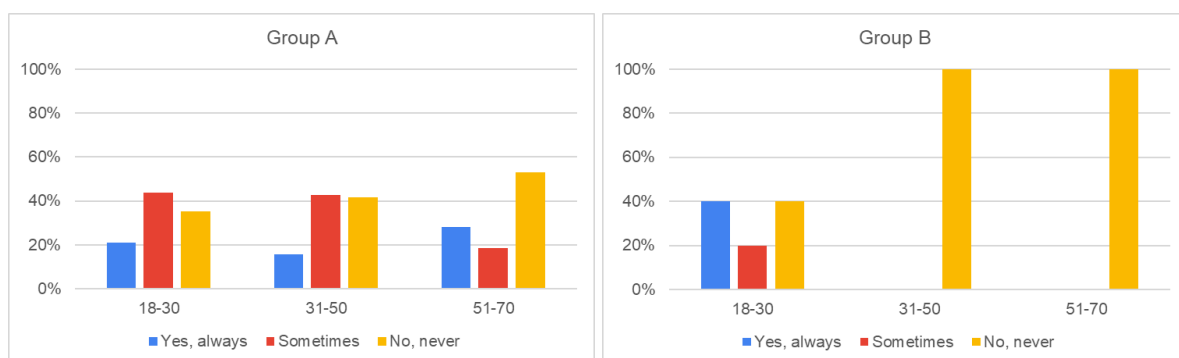
Prior Awareness of Hospital Language Practices



Further analysis within these groups revealed distinct age-related patterns (Figure 3). Within Group A, the oldest cohort (51-70 years) presented the most polarized experience: while they were the most likely to report being "never" informed (53.1%), they also contained the highest proportion who felt "always" informed (28.1%). In contrast, younger (18-30) and middle-aged (31-50) participants in this group predominantly reported being either "sometimes" or "never" informed. For Group B, the trend among older cohorts was particularly uniform: all participants aged 31-50 and 51-70 reported never being informed prior to their visits. The youngest bilinguals (18-30), however, presented a different picture, with an equal 40% split between those "never" informed and those "always" informed.

Figure 3

Prior Awareness of Hospital Language Practices, by Linguistic Group and Age



Overall, these findings suggest that proactive awareness of hospital language policies before a visit is not a widespread practice for many participants. While a segment of some older primarily Dutch-speaking individuals and younger bilinguals report consistent prior knowledge, a substantial number—particularly among primarily Dutch speakers across all ages and bilingual individuals in older age groups—approach hospital visits without prior information on language services.

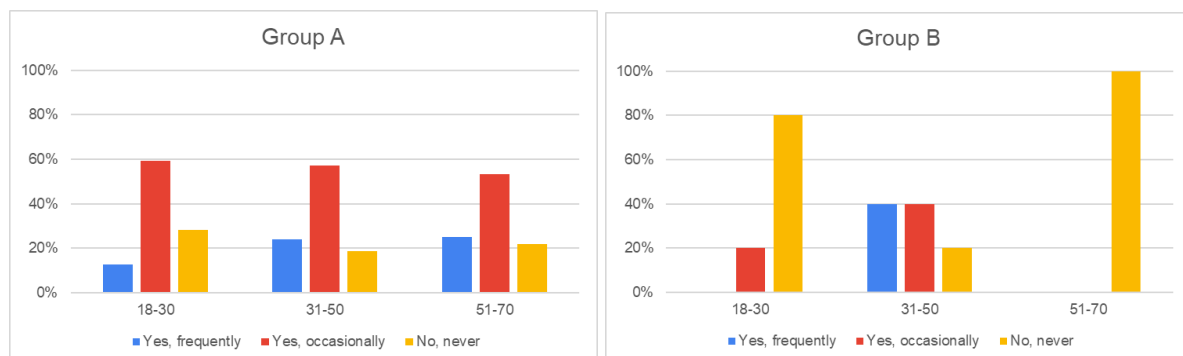
Linguistic Obstacles

Perceived Frequency. Regarding the perceived frequency of language obstacles in interactions with healthcare professionals, significant differences emerged between Group A and Group B. Among respondents in Group A, 20.1% indicated they "frequently" faced communication difficulties due to language, 57.3% encountered them "occasionally", and 22.6% stated they had "never" experienced such issues. In contrast, participants in Group B reported these problems less often: 12.5% had "frequently" experienced difficulties, 25% "occasionally", while a majority of 62.5% reported "never" facing such barriers.

A Chi-square test for independence was performed to examine the relationship between linguistic groups and the reported frequency of communication difficulties. The results indicated a statistically significant association between these variables, $\chi^2(2, N = 215) = 12.46, p < 0.05$. This finding suggests that an individual's language background is significantly related to their likelihood of encountering communication difficulties in Brussels healthcare settings, with those in Group B reporting fewer such encounters. Figure 4 shows these frequencies, divided by linguistic and age group.

Figure 4

Perceived Frequency of Language Barriers in Interactions with Healthcare Staff, by Linguistic Group and Age.



Within Group A, age also appeared to influence the experience of these barriers. Older participants (51-70 years) reported the highest incidence of "frequent" communication difficulties, closely followed by the middle age group (31-50 years). Younger adults (18-30 years) in this group, while still frequently reporting "occasional" issues, indicated "frequent" problems less often than their older counterparts. Across all age segments in Group A, however, experiencing at least occasional communication challenges was a common theme.

These findings reveal a statistically significant disparity in perceived communication barriers based on linguistic background. Furthermore, age plays a modulating role in the frequency of these challenges, particularly within Group A. A detailed breakdown of the absolute numbers and percentages is presented in Table 3.

Table 3

Perceived Frequency of Language Barriers in Interactions with Healthcare Professionals, by Linguistic Group and Age

Linguistic Groups and Age Cohorts	Frequently n (%)	Occasionally n (%)	Never n (%)
Group A			
18-30 years	9 (12.7%)	42 (59.1%)	20 (28.2%)
31-50 years	23 (24%)	55 (57.3%)	18 (18.7%)
51-70 years	8 (25%)	17 (53.1%)	7 (21.9%)
Total Group A	40 (20.1%)	114 (57.3%)	45 (22.61%)
Group B			
18-30 years	0 (0%)	2 (20%)	8 (80%)
31-50 years	2 (40%)	2 (40%)	1 (20%)
51-70 years	0 (0%)	0 (0%)	1 (100%)
Total Group B	2 (12.5%)	4 (25%)	10 (62.5%)

Healthcare Settings. Participants were also asked about the specific settings where they encountered language difficulties, and they could select multiple answers. As shown in Table 4, Group A reported a substantially higher number of mentions (374 mentions among 199 participants) compared with Group B (16 mentions among 16 participants).

Table 4

Healthcare Settings Where Participants Encountered Language Difficulties, by Linguistic Group

Healthcare Settings	Group A	Group B	Row total
Pharmacy	102	3	105
Hospital (non-emergency care)	96	3	99
Hospital (emergency department)	87	4	91
Dentist	46	3	49
General practitioner (GP)	43	3	46
Column total	374	16	390

Pharmacies were the primary setting where challenges were reported, with almost half of all respondents (105 out of 215) indicating problems in this environment. Following this, non-emergency hospital services were the second most cited (n=99), followed by emergency services (n=91).

Difficulties in dental practices (n=49) and with GP (n=46) were also notable. Other healthcare settings were mentioned less frequently, including ophthalmologists (n=4), physiotherapists (n=3 mentions), dermatologists (n=3) and dietitians (n=1).

Specific Problems Encountered. A closer examination of participant testimonies reveals the specific problems faced when accessing medical care in Brussels. Respondents reported issues across various stages of the healthcare journey, starting with the act of making appointments and extending to the phase of understanding and implementing post-treatment care instructions. These challenges encompassed issues accessing Dutch-speaking providers, the inability to accurately express symptoms, and even negative interpersonal encounters with staff.

A primary difficulty lies in basic communication and achieving mutual understanding. Respondents frequently reported encountering medical and administrative staff, such as doctors, nurses and receptionists, who were not able to speak Dutch. Consequently, several relied on English as a means of communication, given the staff fluency in this language reported by some of the respondents. Nevertheless, English was not always a viable alternative, as some respondents also highlighted instances where professionals lacked proficiency in both English and Dutch.

While several patients indicated a partial understanding of staff explanations, they reported considerable difficulty in accurately conveying their own needs and symptoms when communicating in a language other than their mother tongue. A common concern, as one individual expressed, was the worry that "little nuances got lost" when attempting to describe subtle or specific sensations, such as a particularly heavy stomach feeling. This challenge was echoed by another respondent who noted that providing details in French inhibited their ability to explain very specific problems adequately.

This potential for miscommunication extends the avoidance of posing follow-up or clarification questions. For instance, one participant recalled, "I didn't dare to ask extra questions, because I didn't feel comfortable asking them in French", in the context of discussing childbirth. This suggests that linguistic challenges can lead patients to communicate what one participant termed merely "close to the feeling", falling short of precise explanations of their condition. Even participants who described themselves as having "decent French" emphasized that conversational ability differs from medical French, preferring Dutch for important health discussions.

As highlighted in the previous section, these communication challenges appear particularly acute in emergency settings, where multiple participants signaled a significant lack of Dutch-speaking staff. One illustrative case involved an individual who suffered a concussion in an e-scooter accident. Because the staff could not understand the patient, the incident was misclassified as a motorcycle accident, and the patient had to communicate in French throughout the situation. Another respondent explained the distressing impossibility of receiving assistance in Dutch during an urgent appendicitis emergency. The emotional toll of such barriers is significant. For instance, a patient hospitalized after a suicide attempt felt unable to communicate because the sole Dutch-speaking doctor "was gone pretty quick". This difficulty was echoed by another needing urgent care for self-harm injuries, who described the experience of discussing such issues in a non-native language as "very uncomfortable".

Beyond emergencies, recurring issues were noted in neonatal care, with several respondents citing the inability of nurses to speak Dutch during the critical period of childbirth. Furthermore, language barriers were linked to tangible medical errors, including incorrect medication prescriptions and mistaken consultations, as exemplified by one individual who stated, “go in for an echo of my thigh but the receptionist did not understand me and got me an abdominal echo”.

Accessing Dutch-language healthcare providers presents a major impediment. Participants described finding Dutch-speaking GPs, dentists, or specialists in Brussels as “very hard”, a challenge exacerbated by misleading provider information. One noted some “claim on their website that they speak Dutch, while in reality they don’t”, while another lamented the inability to verify if listed Dutch proficiency was adequate “to help medically”. The pressure to forgo Dutch can be direct; one individual was advised to register as a French speaker in a hospital or risk being “ignored by the nurses”. This dominance of French-language services was further exemplified by a patient who was told they would only “find out during the appointment if [the orthopedist] speaks Dutch or not”.

Additionally, some participants reported negative experiences with healthcare staff when language issues arose. Testimonies included receiving “hostile reactions” or even “getting insulted” when they asked for Dutch speaking providers, as well as a perceived “lack of patience when trying to explain something and French is not perfect”. Conversely, other participants’ experiences recounted more positive interactions. For example, one individual found staff “very friendly” and accommodating when the patient sought to understand “specific jargon” in French. Another acknowledged that healthcare staff often “try their best”, frequently using English as a practical workaround when direct communication in Dutch or French proved challenging.

Methods of Navigating Language Barriers On-Site

The survey also inquired about the methods employed on-site when facing communication difficulties in healthcare settings. The most frequently reported strategy across both linguistic groups was to switch to a different language. However, the breadth of coping mechanisms varied significantly between the two groups, as shown in Table 5.

Table 5

Methods of Navigating Language Barriers On-Site, by Linguistic Group

Methods	Group A	Group B	Row total
Switch to a different language	127	6	133
Request a Dutch-speaking provider	74	0	72
Use online translation tools or apps	37	0	37
Ask a family member/friend to translate	15	0	15
Column total	253	16	259

For Group A, while switching languages was the predominant approach (n=127), participants used a diverse range of other strategies. A significant number reported actively requesting a Dutch-speaking health provider (n=72). Others turned to technological aids, such as online translation tools or apps (n=37), or sought interpersonal assistance by asking a family member or friend to translate (n=15). Among Group A participants who switched languages, French was the most common choice (53.2%), followed by English (42.4%). Additionally, one respondent mentioned using Tamazight or Spanish, and two of them Arabic. In contrast, Group B demonstrated a more singular approach; switching to a different language was the only method reported, with 6 out of the 16 individuals in this group indicating this strategy—all to French.

The act of switching to French, the most common fallback, manifested in two distinct approaches. The first was an active management strategy, where patients attempted to control the pace and clarity of the conversation to ensure understanding. This involved prompting the healthcare provider to adapt their French, with participants noting they would "just ask to repeat themselves and/or speak more slowly". Another described a similar method of asking the professional to "use a synonym" for unfamiliar words or to "slow down and repeat". This approach, while still operating in French, represents an effort by the patient to assert their communication needs and mitigate potential misunderstandings.

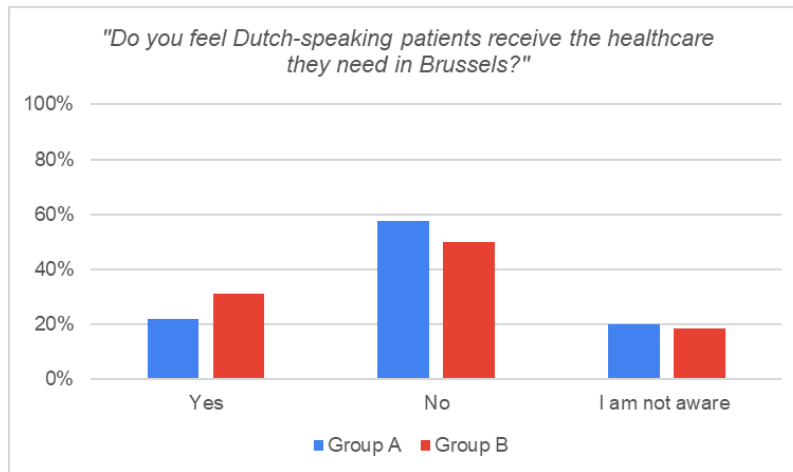
Conversely, the second strategy reflects a sense of resignation to the linguistic challenge. Rather than attempting to manage the provider's communication, these responses conveyed a feeling of concession to the necessity of using French. This sentiment was captured in phrases like the decision to "Give up and speak French" or the feeling of "Being obliged to speak French". This highlights a more passive acceptance of the situation, where the burden of adaptation falls entirely on the patient without an attempt to request accommodation from the provider.

Citizens' Opinions

To assess overall sentiment regarding the adequacy of care for the Dutch-speaking community, participants were asked if they felt Dutch-speaking patients receive the healthcare they need in Brussels. As shown in Figure 5, responses were fairly similar between Group A and Group B. A majority of Group A, 57.8% overall, indicated a belief that Dutch-speaking patients do not consistently receive the healthcare they require in Brussels. Conversely, only 20.1% of this group answered "Yes", while 22.1% selected "I am not aware". In contrast, Group B presented a somewhat different, though still concerned, perspective. While half of the bilingual participants (50%) also answered "No" to this question, a larger proportion compared to Group A, 31.3%, answered "Yes", believing Dutch speakers do receive the care they need. The remaining 18.75% of Group B responded "I am not aware".

Figure 5

Perceptions of Adequacy of Healthcare for Dutch-Speaking Patients in Brussels, by Linguistic Group

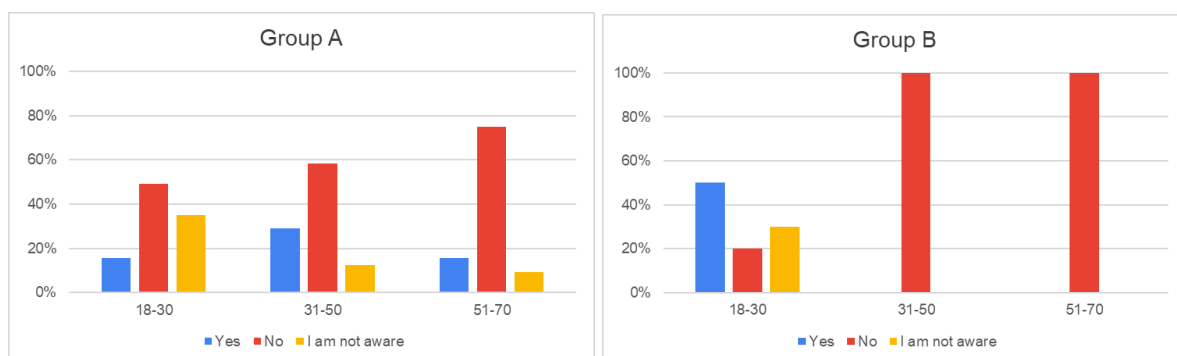


As shown in Figure 6, age-related analysis within Group A found that this perception of inadequate care was most pronounced among the oldest cohort (51-70 years), where 75% answered "No". In the 31-50 age group, 58.3% also responded "No", while for the 18-30 age group, this figure was 49.3%. Group B showed a distinct pattern: all participants in both the 31-50 and 51-70 age categories responded "No", indicating a strong perception of inadequate care among these older bilingual individuals. However, the youngest bilingual cohort (18-30) expressed more optimism, with 50% affirming that Dutch speakers receive the necessary care.

The results from the Chi-square test indicated that these differences were not statistically significant, $\chi^2(2, N = 215) = 0.71$, $p = 0.7$, which means that there is not strong statistical evidence from this test to conclude a genuine association between an individual's linguistic group and their overall perception of care adequacy for Dutch speakers in this specific categorization.

Figure 6

Perceptions of Adequacy of Healthcare for Dutch-Speaking Patients in Brussels, by Linguistic Group and Age



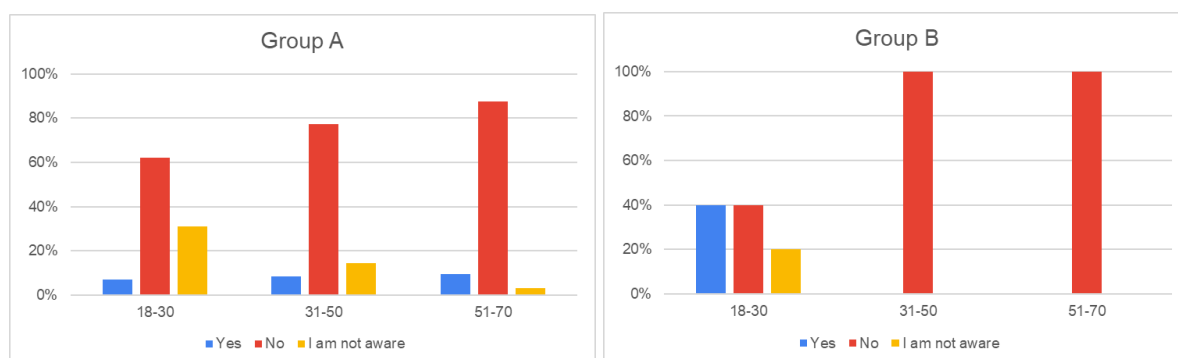
When participants were specifically questioned if they felt hospitals provide enough language support for Dutch-speaking patients, a predominant view within Group A was that such support is insufficient, with nearly three-quarters (73.4%) responding "No". This perspective appeared to

strengthen with age, as Figure 7 shows; while a majority of younger participants (18-30 years) already felt this way (61.9% "No"), the proportion rose among middle-aged (31-50 years, 77.1% "No") and older respondents (51-70 years, 87.5% "No"). Only a small minority across all age cohorts in Group A considered support to be adequate. Interestingly, fewer respondents reported being unaware of the issue as age increased.

Participants in Group B also predominantly perceived language support from hospitals as insufficient, with 62.5% overall responding "No". However, a comparatively larger segment in this bilingual group believed support was adequate (25%) compared to Group A. Age-related analysis within Group B revealed a particularly consistent view among older individuals; all participants aged 31-50 and 51-70 who offered an opinion stated that support was lacking. In contrast, younger bilinguals (18-30) were evenly divided on this issue, with equal proportions answering "Yes" and "No".

Figure 7

Perceptions of Adequacy of Language Support from Hospitals, by Linguistic Group and Age



The descriptive data consistently point toward a prevalent sentiment, particularly strong among Group A across all ages and among older individuals in Group B, that the language support provided for Dutch-speaking patients in Brussels hospitals often falls short of what is perceived as necessary. However, the Chi-square test ($\chi^2(2, N = 215) = 5.12, p = 0.077$) indicated that the observed differences in the distribution of responses did not reach statistical significance at the conventional alpha level of 0.05.

Recommendations to Improve Dutch-language Accessibility in Healthcare

Respondents offered a broad spectrum of suggestions to enhance Dutch-language accessibility in Brussels healthcare, encompassing measures that target both hospitals and the government. While the inherent complexities of finding healthcare staff were acknowledged—with one participant noting, "having a health care professional that speaks no Dutch is still better than having no health care professional at all"—the proposals collectively aim to address the identified linguistic challenges and promote more equitable access to care.

Measures for Hospitals and Healthcare Institutions. A dominant theme among participant suggestions was the need for hospitals to directly address staffing and language proficiency. The

most frequent call was to simply "enroll more Dutch speaking staff" across all roles. Many elaborated on this, emphasizing the importance of personal bilingualism by advocating for making proficiency in both Dutch and French a formal prerequisite for employment. To ensure this, some stressed the need for rigorous language proficiency testing during the hiring process to prevent misrepresentation of abilities.

Beyond individual hiring, participants highlighted the necessity of ensuring bilingualism at the service level, so that "for every service at least one Dutch speaking person is available". The goal, as one person articulated, is to "make sure there are also native Dutch speaking doctors present in all parts of Brussels", ensuring a Dutch-speaking point of contact is always accessible, particularly in critical departments.

Complementary to hiring practices, numerous proposals focused on upskilling existing personnel through training and support. Many respondents advocated for hospitals to encourage or even "oblige language courses and tests" for current staff, with some adding that these should be offered "during work hours" to ensure feasibility. Furthermore, financial incentives, such as a "language bonus", were seen as a viable way to encourage language acquisition and attract bilingual personnel, with some suggesting this would "make it (financially) more attractive for Dutch speakers to work in Brussels healthcare". For situations where language concordance is not possible, providing professional translators was mentioned as a key support, with participants suggesting dedicated "interpreters on staff, especially for difficult conversations".

Finally, participants underscored the need for greater transparency and improved patient-facing communication. This involves hospitals clearly publicizing the languages spoken by each practitioner so that patients can "visualize clearly on websites [...] when booking appointments what language doctors speak". In addition, a fundamental yet often overlooked step is for staff to proactively inquire about a patient's preferred language during interactions, which was noted as a basic measure to facilitate more effective communication from the outset.

Measures for Government and Educational Institutions. On a broader, systemic level, participants highlighted the need for educational reform, a responsibility implicating governmental and educational institutions. This included calls for implementing "compulsory course[s] in the second language, focusing on medical conversations" for all Belgian medical students. Many also pointed to the need for earlier intervention within the general education system, advocating for "raising the level of Dutch in French-speaking schools" from a young age.

Calls for stricter governmental enforcement of existing language laws were also prominent. Suggestions included moves to "enforce the laws that mandate bilingualism in certain hospitals" and, more forcefully, to "apply the law and lower their subsidies" for non-compliant institutions. Some proposed directly linking hospital funding to their performance in providing bilingual services or imposing specific sanctions "when they refuse to speak Dutch". One individual framed this as a

rights-based issue, stating the need to “give Brussels citizens the right to be taken to a Dutch speaking hospital, like people in the *Vlaamse Rand*⁹ have”.

Lastly, some participants touched upon the underlying need for a shift in attitude and awareness. This included fostering a greater willingness to engage with Dutch, addressing perceptions that “the mindset of French speaking citizens need to change, they don’t show much effort to try to learn Dutch” and the need to “start having real attention for the problem in the first place”.

Doctors’ Opinions

The survey also captured valuable perspectives from three participating healthcare professionals, referred to as Individual 1, 2, and 3. Their accounts corroborate many of the issues raised by patients and illustrate the complexities of the linguistic environment from within the Brussels medical system. Furthermore, their testimonies highlight systemic challenges related to institutional practices and staff dynamics while also pointing toward potential solutions.

The Nature and Scope of Language Barriers. The professionals expressed that challenges caused by language barriers extend from internal administrative processes to direct patient interaction. Individual 1 highlighted a systemic language imbalance within the hospital's own operations, noting that “even during meetings with hospital management everything was in French (even though the written contract is in Dutch)”. This suggests the preference for French can be an institutional default that extends beyond patient-facing roles.

The consequences of this environment are then felt in clinical practice. Individual 2, while confirming the absence of language barriers within the specialized context of the Dutch-speaking UZ Brussel, contrasted this with a different reality elsewhere based on experience from clinical rotations: “In other hospitals though... I have seen it frequently that patients can’t fully articulate their problem in another language because the health care professionals don’t speak Dutch.”

These challenges manifest in specific operational dynamics, particularly in high-pressure environments. Individual 3 described a situation where French-speaking emergency doctors “tend to be more reluctant to see a Dutch-speaking patient if there is a Dutch-speaking colleague on guard”, a practice that can increase waiting times. This behavior appears linked to a broader societal norm that “Dutch-speaking Belgians are generally expected to master French well enough to manage”. This underlying assumption seems to influence the institutional response to language needs, leading to what Individual 3 described as an “illogical and unproductive phenomenon” where a translator is rarely sought for a Dutch-speaking patient, while for other languages, “calling a translator seems to be a faster reflex”.

Proposed Solutions. In response to these challenges, the professionals proposed a range of solutions targeting different levels of the healthcare system. As some citizens expressed, Individual 1

⁹ The *Vlaamse Rand* (Flemish Periphery) is the collective term for the 19 municipalities belonging to the region of Flanders that form a ring around Brussels. As part of Flanders, the sole official language in this area is Dutch.

suggested to “promote Dutch-speaking doctors to work (and live) in Brussels, make it financially more interesting”. Individual 2 pointed to a need for systemic educational reform, highlighting a perceived disparity in language training between medical universities: “During my medical school studies in Dutch, we also received a few French practice courses... I believe the French speaking universities don’t have the same for Dutch”. Finally, Individual 3 described an organizational solution where “the shift system is organized in such a way that a Dutch-speaking professional from every job category (nurse, physio, doctor ...) is available at any time”, a goal achievable through either “stricter requirements for hiring or by organizing accessible language courses”.

While acknowledging the need for these systemic solutions, Individual 1 also reflected on the impact of personal habits. This doctor shared a reflection on how the habit of speaking French automatically might have masked patients' linguistic preferences. After changing the approach to now always start with a bilingual greeting, “*Goeiedag, Bonjour*”, this person was “surprised by the amount of Dutch-speaking patients (who would otherwise probably start the consultation in French)”. This observation directly suggests that patient language choice can be influenced by the practitioner's initial approach and that proactive bilingual engagement can reveal a greater need for Dutch-language care than is immediately apparent.

Language Professionals' Perspective

To gain an understanding of how language policies are implemented in practice, the survey findings were complemented with semi-structured interviews with five key professionals who manage and shape language initiatives within the Brussels healthcare sector. They include insights from the languages team coordinator at the iris network; a human resources professional responsible for language training at Europe Hospitals; a language policy advisor specialized in the healthcare sector at Huis van het Nederlands (HvN), and the coordinator for elderly and innovative care as well as a legal expert on language legislation, both from GIBBIS. The following sections present the findings from these expert testimonies, organized thematically to illustrate the perspectives from distinct yet interconnected institutional settings.

Public hospitals: iris network

The perspective on the implementation of language policy within the public hospital system was provided by Participant 1, the languages team coordinator for the iris network. The network, which encompasses 11 sites across five major public hospital groups in Brussels (Brugmann, University Hospital of Queen Fabiola, Iris South Hospitals, Jules Bordet Institute, and Saint-Pierre), began its language support initiatives in 2006, initially offering private courses only for the emergency department. Since then, it has expanded to a point where now, “everybody who is working in the hospital can register to follow a course”. With 17 years of experience within the network, initially as a languages teacher and now as the coordinator of a dedicated team of six people teaching across all 11 sites, Participant 1 offered an in-depth view of the linguistic obligations and approach in the Brussels public hospitals.

Linguistic Situation. Participant 1 explained the distinct context of Brussels' public hospitals, which operate under a legal obligation to be bilingual. However, they clarified that while the hospitals are legally bound, individual staff members are not obliged to attend the language courses. This distinction shapes the mission of the iris language team as one of motivation and facilitation rather than enforcement.

Departments address the legal requirement for bilingualism differently, depending on staffing pressures. Participant 1 explained that for roles such as receptionists, hospitals "are really trying to make it more bilingual". In contrast, for positions with shortages, like nursing, language proficiency cannot be a primary hiring criterion; as they explained, hospitals "can't really make choices in terms of language. They're just happy to have new nurses."

Language Trainings and Other Initiatives. The core of the iris network language program consists of group courses offered for one hour each week, a model that was deliberately chosen to facilitate staff attendance. According to Participant 1, the fact that the session is only one hour facilitates supervisor approval, and crucially, "it counts as a working hour", which is a key factor in securing participation. To accommodate different operational needs, the network also provides half an hour private courses for staff in the emergency services who cannot leave their posts to attend a group session as well as interactive one-hour online courses that facilitate attendance for certain positions. According to Participant 1, motivation for course attendance stems from both professional and personal sources, ranging from the need to communicate with Dutch-speaking patients at work to personal reasons, such as having a child enrolled in a Dutch school.

The entire program follows an academic calendar, running from October to June. In the current school year (2024-2025), the program enrolled 765 students out of approximately 9,000 total employees across the network's 11 hospital sites. The demand for training is predominantly for Dutch, which accounted for 570 students, compared to 168 for English and 27 for French. Of these 765 students, the majority (556) follow courses in classrooms within the hospitals, while 209 participate online. Participant 1 noted, however, that there is an increasing preference for online courses, as the greater flexibility they offer is very convenient for some staff.

A central feature of the training is its practical focus. The languages team develops all its own materials to ensure direct relevance. Participant 1 stated that the content is "always in the context of the hospital", covering topics from human resources vocabulary to medical terminology like body parts, and communication skills such as making a phone call. For logistical reasons, groups often include a mix of professional profiles; Participant 1 noted that while they try to create homogenous groups, they often have to put medical and administrative staff together.

The program employs a multi-stage assessment process. Upon registration, each participant undergoes an initial oral test to place them in an appropriate group. Progress is then formally monitored through two more oral exams, in January and June, which serve both to assess their progress and to motivate them. Participant 1 emphasized that progression through the proficiency levels is gradual and realistic, explaining that advancement is non-linear and slows significantly at higher levels. For example, while a beginner might progress to the next level within a year, students at the B1 level could take up to three school years to advance to the more demanding B2 level. To

manage this, the team often creates mixed-level groups, such as A2/B1, or uses designations like A1+ to reflect incremental progress. The highest proficiency level offered is C2; however, Participant 1 noted that participants typically do not continue with group training after they have reached the B2 level.

Although participants receive no direct reward for attendance, the language courses are designed to help them improve their proficiency to the B2 level required to pass the official Selor bilingualism exam. To support staff in this goal, the languages team provides a practice bundle of questions and organizes oral coaching sessions. Upon successfully passing this exam, employees who work full-time receive a monthly language bonus of 150 euros. Participant 1 explained that this is a recurring benefit, stating that "they get this bonus for the rest of their careers if they continue to work in the public hospitals".

The languages team actively collaborates with other organizations to enhance its offerings. They partnered with HvN to develop an electronic learning platform called *Hopitaal*, which provides staff with exercises, language games, grammar games and vocabulary to supplement their weekly classes. These online resources, similar to the Duolingo application, are designed to be practical and engaging, with modules on topics like welcoming patients or making appointments.

Funding and Accountability. The language program is co-funded by the GGC/COCOM¹⁰ and the iris hospitals themselves. The GGC/COCOM provides subsidies for 225,000€ per year, which according to Participant 1, "pay only half [...] of the salaries of the team", while the iris hospitals cover the remaining salaries as well as other operational expenses for the courses. Government funding has remained stable but "hasn't increased much", which limits the team's capacity to expand.

Securing this support requires submitting a progress report twice a year detailing all program activities as well as information on the groups and teams they worked with, course attendance numbers, and participants' test scores. However, Participant 1 noted that the requirement for such detailed reporting indicates the program's importance and the value of the support provided.

Challenges and Proposed Solutions. The implementation of the language policy is hindered by a two-fold challenge rooted in the scarcity of healthcare staff in Brussels. The first is the external recruitment reality, which creates a persistent linguistic imbalance. Participant 1 reported a fundamental "lack of Dutch speaking staff", a situation directly shaped by the recruitment of a very multicultural workforce. They explained that while many new hires, particularly from North Africa, can be integrated operationally because they "already speak French", this international workforce typically has no prior knowledge of Dutch. This results in the language program having to manage a lot of beginners each year who must start from the most basic level.

The second challenge is internal work pressure, which directly impacts course attendance and was identified as the primary reason for student attrition. This reality affects roles unequally; Participant 1 observed that for doctors, "it's a bit easier to leave, but the nurse can't just say, 'I'm going

¹⁰ As explained in the Literature Review, the Joint Community Commission—known as the GGC (Gemeenschappelijke Gemeenschapscommissie) in Dutch and COCOM (Commission Communautaire Commune) in French—is the body that monitors and supervises Brussels' healthcare services that have not opted to belong exclusively to either the Flemish or the French-speaking community.

to the course". The direct consequence is inconsistent attendance, which is particularly detrimental for beginners. As Participant 1 articulated, "if they're on a lower level, like beginners, and they miss like three courses, it becomes more difficult for them to catch up and to keep coming". Ultimately, despite the team's efforts, she acknowledged that the operational needs of the hospital mean "it's always the work that comes first". Other contributing factors to attrition include staff sickness, pregnancy, personal problems, and scheduling conflicts.

Given these practical constraints, Participant 1 suggested a more pragmatic approach to the hospital's language policy. They stated that the goal of making "all the staff [...] bilingual is not realistic and it will never happen". A more achievable objective would be to ensure that in "every department [has] somebody that can speak Dutch at any time", thereby guaranteeing access to a Dutch-speaking professional when needed.

Private Hospitals: Europe Hospitals

To complement the perspective from a public hospital, an interview was conducted with Participant 2, the human resources professional responsible for organizing language and well-being training at Europe Hospitals, a private hospital in Brussels.

Linguistic Situation. Participant 2 described Europe Hospitals' objective as being a fully bilingual institution where "everyone could take care [of a patient] in both languages", a goal that extends beyond the legal requirement, which mandates bilingualism only for emergency services in private hospitals. However, they contrasted this ambition with the hospital's current linguistic reality, which is "mainly French speaking, both staff and patients". While there is generally "someone who can speak Dutch" in all departments, she acknowledged that their proficiency is not always optimal, leading to a situation where the hospital can "claim themselves as bilingual, but in practice it is difficult". Nevertheless, Participant 2 stated that due to its known provision of Dutch-language support, Europe Hospitals is often chosen by patients specifically seeking care in that language.

The hiring process constitutes the first step to achieve its bilingual goal: all new hires must be proficient in either French or Dutch upon starting. To foster bilingualism, their contract includes a commitment to reach a specified level in their non-proficient language within five years, a policy meant to demonstrate "their engagement toward the second language". Beyond this formal bilingual policy, Participant 2 explained that the hospital also leverages the existing multilingualism of its staff by keeping a record of other languages they speak.

Language Fostering Initiatives. Once employed, all staff with a qualifying contract (*Contrat à Durée Indéterminée* or CDI—a permanent contract) are offered two voluntary language initiatives. The core of the hospital's program is comprehensive language training. To ensure participants can attend without work interruptions, the courses are structured as "five full days, during working hours", spread over five consecutive weeks, always on the same day. This model, which contrasts with the one-hour sessions in public hospitals, was chosen because, as Participant 2 explains, a full-day absence is easier for teams to manage than a partial day, where staff can report easier they have to

stay longer because “there is always extra work or more than [...] anticipated”. Unlike the year-long academic calendar followed in public hospitals, these courses are offered during three fixed periods each year—January-February, May-June, and November-December—allowing staff to register for the session that best suits their schedule, though they must first secure approval from their team lead.

Participant 2 stated that the courses are tailored to the healthcare context with exercises that “relate to the work they do so that people feel that it’s really useful”. While end-of-course evaluations are generally positive and staff “are really motivated and happy about it”, a recurring critique arises when there is a mix of professional profiles, with an administrative employee, for example, noting a course “wasn’t really relevant all the time [...] because there were more nurses than admins”. This concern was also reported in public hospitals.

In addition to formal training, Participant 2 explained that all new recruits with a CDI are invited to take a voluntary bilingualism test. This test allows staff to demonstrate their proficiency and, if successful, receive an incentive such as a phone subscription. The test is structured around two proficiency levels tied to an employee’s role and a required timeline. For example, “a nurse should have a B1 in the first five years and a B2 afterwards”. If that nurse achieves the B1 level, they receive the incentive for five years, after which the hospital will contact them again to test for the B2 level. In 2024, 50 out of approximately 160 new recruits took this test. For individuals who do not achieve the required level, the hospital recommends they participate in the available language training, though this is not obligatory.

Partnerships and Supplementary Resources. To deliver these language programs, the hospital partners with two private schools, Lerian and Bxl Academy, and uses specific learning tools, like *Medisch Nederlands*, a platform developed by the Instituut voor Levende Talen. In addition to these private training providers, the hospital receives crucial support from HvN, whose role is double: providing ongoing advice on all aspects of the hospital’s language policy—from applying for grants to exchanging ideas with other hospitals—and organizing specific, on-demand trainings on topics such as self-study techniques or how team leaders can motivate their staff to speak more Dutch.

To supplement the courses, the hospital also offers online conversation tables, facilitated by Bxl Academy. These sessions are structured as a series of ten weekly one-hour meetings and its content is dynamically tailored to participants’ proficiency levels and interests, with the primary objective of maximizing active speaking practice.

Funding. The language initiatives at Europe Hospitals are supported by two primary external funds. The first is GGC/COCOM which covers the expenses of Participant 2’s position: “the fact that I’m here is good enough for them to subsidize us”. As in iris network, Participant 2 must submit a detailed report, including proof of their salary and a plan of intended activities at the beginning of the year to secure this structural funding.

The second source of funding is FeBi, a social fund that specifically finances training projects and other well-being initiatives within hospitals. Participant 2 noted that Europe Hospitals has historically utilized these funds “to the fullest” by submitting detailed project plans and anonymous attendance data to secure reimbursement for language courses. However, a limit established in 2024

called authorized maximum budget placed a ceiling on the total annual funding a hospital can receive for all FeBi-supported projects, which is calculated based on its number of full-time equivalent staff. As a result, the hospital must now "calculate a bit and just limit the number of demands", knowing not every initiative will be reimbursed. The hospital currently receives 40,000 euros per year. This directly impacts language training, as the curriculum is designed to align with FeBi's criteria; for instance, language courses are only offered up to Level B1+ because the fund "has a maximum level of B1", and training for higher levels would not be reimbursed. This differs from the public hospitals mentioned above, where courses extend to C2 level.

Challenges for Learning Dutch. Participant 2 identified several persistent challenges in implementing the hospital's language policy. As similarly highlighted by Participant 1, the most significant is the sector-wide shortage of healthcare staff, which makes it difficult to prioritize language requirements during recruitment and to release staff for training. They acknowledged the main tension: "it's really difficult to find nurses and it's just a challenge to have the staff that we need... And then if we also have to say, 'oh, but you also have to be bilingual'. That's just difficult".

A second challenge is ensuring consistent, high-quality Dutch language support. While there may be a Dutch speaker in every department, Participant 2 questioned if their proficiency is always sufficient: "what is the level that they speak then in Dutch? I don't know... not really the best level... and can they really help a patient in Dutch the way that they should ideally?" They concluded that while language should be a priority, the immediate need to care for patients in a context of staff shortages means "it can't be the first thing that they focus on".

Huis van het Nederlands

To gain a broader institutional perspective, an interview was conducted with Participant 3, a language policy advisor specialized in the healthcare sector at Huis van het Nederlands (HvN). As an institution dedicated to promoting the use and learning of Dutch in Brussels, HvN provides crucial insight into the systemic efforts and challenges to improve Dutch-language accessibility in hospitals.

Participant 3 clarified that HvN does not function as a language school itself but rather as a central hub with a multi-faceted mission. A core function is to conduct language screenings to assess individuals' proficiency and direct them to appropriate Dutch courses. In addition to this orientation role, HvN actively works to "create opportunities for people living in Brussels to practice Dutch", for instance, through conversation tables and events, since it can be very difficult to find spaces to use the language in the city. A third key area of HvN's work is to help organizations develop and implement internal language policies.

While the language policy team works with a wide range of organizations, Participant 3 specialises in the healthcare sector. Her role is to actively accompany two hospitals, Europe Hospitals and Saint-Jean, by supporting their on-site language coaches with strategic advice. However, she noted that it is "difficult to get the attention of other hospitals" to engage in similar voluntary policy

development, describing their proactive but challenging efforts to expand their reach within the healthcare sector.

Language Fostering Activities. A significant aspect of HvN's advisory role involves guiding the organization of language courses for hospital staff. Participant 3 described the model implemented at Europe Hospitals, where employees attend a full-day course once a week for five weeks. They emphasized its effectiveness: with a full-day commitment, "everybody knows" the employee is unavailable, making it easier for teams to plan. In contrast, shorter, more frequent sessions are considered less practical, as it is "very hard to pull them out of their work position" for just a couple of hours on a busy day.

The location of these courses is determined by the hospital's capacity; for example, at Europe Hospitals, the course is held at the external academy, while at Saint-Jean, it takes place in a room within the hospital itself. Additionally, HvN organizes and moderates conversation tables, offered online or in the hospital during lunch, although they are trying to find someone who can take over for a longer time.

Participant 3 explained that hospitals partner with different language schools, with a key distinction being the level of content customization. While private academies like Lerian and Bxl Academy, currently engaged by Europe Hospitals, offer the program "medical Dutch", Participant 3 noted that this curriculum has not been changed for several years. In contrast, Saint-Jean has shifted to collaborating with Centers for Adult Education —known as the CVOs (*Centrum voor Volwassenenonderwijs*) in Dutch— which, according to Participant 3, offer more tailored courses.

Funding. Regarding course providers and their funding, Participant 3 described a strategic shift driven by financial constraints. Initially, both of the private hospitals they worked with partnered with private language schools, such as Lerian and Bxl Academy, with costs covered by FeBi. However, as FeBi's funding became insufficient to cover all training, HvN now advises hospitals to collaborate with CVOs, which are funded by the Flemish government and are more cost-effective. Participant 3 noted that this transition is ongoing; for example, Saint-Jean has already shifted to the CVO model, while Europe Hospitals chose not to transition this year "because they wanted stability". In addition to FeBi, as Participant 2 explained, private hospitals can become eligible for funding from GGC/COCOM if they voluntarily choose to provide comprehensive bilingual care beyond the legal minimum required for emergency services.

Despite these external funding sources, Participant 3 also deemed institutional support for Dutch learning as insufficient, "making it difficult to secure funding". Consequently, as already mentioned by Participant 1, hospitals must also invest their own resources to cover the full costs of their language programs, particularly the significant logistical expenses associated with staff attending courses during work hours.

Staff Motivations and Challenges in Language Learning. According to Participant 3, the motivations for healthcare staff to learn Dutch are varied. Professional reasons include working in a Dutch-speaking team or a service with many Dutch-speaking patients. While many staff contracts

include a clause stating a commitment to learn the second language, Participant 3 clarified that this is "not really an obligation" as there are never any sanctions. Therefore, personal motivations are also significant drivers, such as wanting to enroll children in a Dutch-language school—which can require parents to demonstrate their own Dutch proficiency—or moving to a Flemish community.

On the other hand, the most frequently cited challenge for staff remains undertaking language learning alongside a demanding job. This workload constitutes a significant barrier, since learning a language is a time-consuming process involving not just coursework but also active practice. Logistical challenges also abound; for many hospital employees who are not desk-based, finding a suitable time and place for training is difficult. Participant 3 explained that after-hours courses are hard for many to attend, and online learning can be a challenge as staff "often don't have a laptop or a room they can sit in to do the course". Some staff also face a hurdle that Participant 3 described as a "vicious circle": staff report not meeting Dutch-speaking people during their job, which in turn means Dutch-speaking patients are less likely to approach them.

The Broader Context: Education and Evolving Trends. The interview also touched upon the systemic question of where the responsibility for language training should lie. Participant 3 reported a common sentiment from hospital management: "Why is it our task to give our staff language courses? We are a hospital". This points to a desire for language proficiency to be addressed before employment. The current educational landscape in Brussels does not offer fully bilingual public Dutch-French schools. Instead, the closest available model is immersion education, where some courses (e.g. Geography, History) are taught in another language than the primary one.

Despite these educational and systemic challenges, Participant 3 confirmed a positive trend in the demand for Dutch courses, which is "building up" and has surpassed pre-COVID levels. This may be influenced by a shift in the perceived value of Dutch, gaining prominence as one of several important languages in the city—alongside French and English—, potentially increasing its utility for career advancement. Participant 3 characterized this evolution as a move away from the former "big hegemony of French" to a new reality where the city is "more multilingual than ever".

GIBBIS

To provide an overview of the legal and systemic context, an interview was conducted with two professionals from GIBBIS, the federation representing the full spectrum of health institutions in Brussels, including hospitals, nursing homes, and rehabilitation facilities. Participant 4, a coordinator for elderly and innovative care, described GIBBIS's role as linking "what happens in real life and what should be done on the level of administration or politics", mainly through participation in governmental commissions. Together with Participant 5, a legal expert on language legislation, they outlined the legal obligations for different hospital types and the challenges facing the entire sector.

Legal Obligations. In Brussels, public hospitals are subject to the 1966 Language Act on Administrative Affairs, which dictates that "the service has to be bilingual". However, Participant 5 highlighted a crucial area of legal ambiguity regarding the practical implementation of this rule:

whether this means every individual must be bilingual or if having another Dutch-speaking professional available in the same department is sufficient. What is legally unambiguous, they noted, is the requirement for patient paperwork and hospital notifications to be provided in both Dutch and French, with health records needing to be written in the patient's language.

Participant 5 framed this situation as a fundamental conflict between "an old legislation that is very strict" and "the reality that is going on on the terrain". They explained that if the law were enforced across all of Brussels' public administrations, not just in hospitals, many would fail to comply. The primary work of GIBBIS, therefore, is to mediate this gap between the legal requirements and the practical constraints faced by healthcare institutions, with the aim of finding "a middle ground" between hospitals and the government and working "to find solutions and not problems".

The Impact of Staff Shortages and Demographic Shifts. As Participant 1 and 2 emphasized, both GIBBIS professionals identified healthcare staff shortage as the primary barrier to implementing these language laws. Consequently, since hospitals must "recruit within the possibilities that [they] have", clinical skill often becomes the determining factor in hiring, and language knowledge is not the selection criteria applied at the moment.

This challenge is exacerbated by ongoing demographic shifts within the recruitment pool. Participant 4 explained that a decline in French proficiency among new hires makes it "increasingly more difficult to recruit people that are bilingual". They attributed this to an increase in doctors from foreign countries for whom English is a first language and French is a second or third, alongside the growing influence of other languages like Spanish and Arabic in Brussels.

Funding and Education as Systemic Issues. The GIBBIS representatives also highlighted funding and education as critical systemic challenges that lie beyond the control of individual hospitals. Participant 4 noted that the external funding for promoting Dutch—distributed to language coaches employed within hospitals—are "very limited" and insufficient to meet the sector's needs. As a result, public hospitals collectively invest just under two million euros annually to support Dutch language initiatives.

Both professionals agreed that the responsibility for language learning should not fall solely on healthcare institutions. Participant 4 argued that it is "not the job of the hospitals to make their staff bilingual", noting that adult learners cannot realistically learn a new language from scratch while working under high-pressure conditions. They framed the issue as a broader societal challenge, present also in public services like police and fire departments. Therefore, challenges seen in the healthcare sector are a symptom of a broader societal deficit in bilingualism, not a result of "bad will from the hospitals". To address the issue at its root, Participant 4 stated that the "education system needs to step up and provide better language courses from a young age".

Hospital Staff's Perspective

This section presents descriptive findings from a survey of hospital staff conducted by HvN. As detailed in the methodology, the analysis focuses on a sample of 259 French-speaking

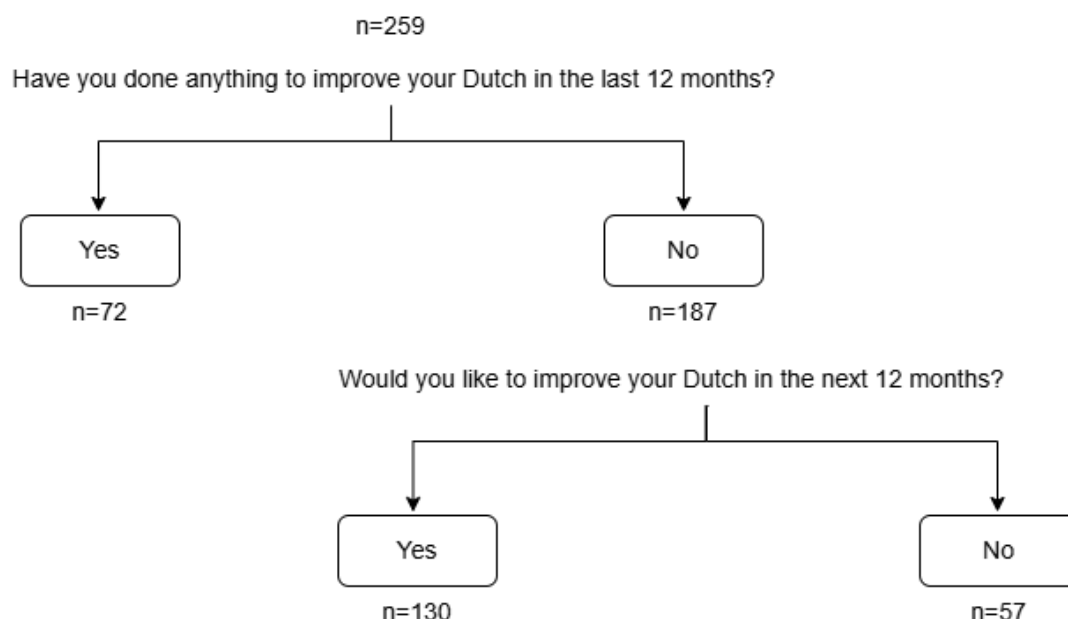
respondents from various roles and hospitals across Brussels. The following analysis is based on a selection of questions that provide an on-the-ground perspective on the motivations, barriers, and potential solutions related to improving Dutch language accessibility in healthcare.

Reasons to Improve Their Dutch. The survey first explored staff engagement with learning Dutch, as illustrated in Figure 8. Of the 259 respondents, 27.8% (n=72) indicated they had taken active steps to improve their Dutch in the past 12 months. The remaining 187 respondents who had not recently engaged in Dutch learning were then asked if they would like to improve the language in the next 12 months. Of this group, a strong majority of 69.5% (n=130) expressed a desire to do so.

These 130 motivated individuals were asked about their reasons for wanting to learn Dutch, with multiple answers possible. The most frequently cited motivation was speaking Dutch with patients (n=75), closely followed by a desire to speak the language in Brussels generally (n=65) and to speak it with colleagues (n=47). Other reasons included speaking with family (n=23), enrolling children in a Dutch-speaking school (n=14), and wanting to live in Flanders (n=7). As Participants 1 and 3 noted, these motivations stem from both professional and personal factors.

Figure 8

Flowchart of Hospital Staff engagement and Willingness to Learn Dutch



Conversely, for the 57 staff members who expressed no interest in improving their Dutch, the primary reasons cited—again with multiple answers possible—were a perceived lack of need (n=28) and a lack of time (n=19). Other reasons mentioned included disliking Dutch (n=10), finding it too difficult (n=9), or wishing to learn Dutch but not finding anybody to speak it with (n=6). These constitute not only practical but also attitudinal barriers, contrasting with the motivations of the 130 staff members willing to engage in Dutch learning.

Desired Skills and Perceived Difficulties. Participants who had done something to improve their Dutch in the last 12 months (n=72) or willing to learn Dutch in the next 12 months (n=130) were asked to specify which skills they wished to improve. The responses prioritized oral communication skills relevant to direct patient care. The most frequently cited skill was "Chatting with patients, their families and visitors" (n=142), followed by "Providing explanations to patients and their families" (n=129) and "Understanding what patients say" (n=123). Written communication was mentioned less frequently but remained significant, including understanding reports (n=108), writing emails (n=99), and writing reports (n=71). Workplace interaction was also important, with 91 participants selecting "Chatting with colleagues".

When asked what makes it difficult to improve their Dutch, staff identified three main categories of barriers: a lack of practice opportunities, institutional and workplace constraints, and personal or logistical challenges. The most significant barrier reported was the lack of practice opportunities. This was cited by 84 respondents, a sentiment echoed by 76 others who noted a specific social dynamic where "Dutch speakers always switch to French or English," actively preventing them from being able to practice.

Workplace and institutional barriers were also prominent. 62 respondents felt that learning Dutch was "not a priority in [their] department". Workload and time constraints were another major factor, frequently cited under labels such as "Too much workload", "Too much work pressure", and a general lack of "Time". This was compounded by a perceived lack of institutional support, with some participants noting that no courses were available at their workplace or that the hospital was unwilling to finance training.

Finally, personal and logistical challenges were also mentioned. A recurring issue was scheduling, with many finding that training hours offered during the workday were incompatible with their service's needs. Other personal factors included feeling too tired after work, inherent learning difficulties with the language, and the challenge of maintaining motivation and perseverance.

Perceived Advantages of Knowing Dutch in the Workplace. All 259 survey respondents, regardless of their engagement and willingness to learn Dutch, were asked about the advantages of knowing Dutch for their work. A large majority identified several key benefits, with only 26 individuals stating there were none. The most dominant theme was the direct improvement of patient communication, with many citing the ability to "Talk with patients" in their own language as a key factor in providing better overall quality of care. This was often framed as a way to ensure more equitable and respectful treatment, giving staff the ability to "be able to converse with different actors without obliging them to switch to French or English".

A second theme was enhanced professional collaboration and efficiency within the hospital itself. Internally, participants noted the benefit of improved "Communication with Dutch colleagues" and the ability to better understand administrative and medical documents. The advantages also extended to interactions with the broader healthcare network and other external institutions, with several participants mentioning the importance of being able to "improve collaboration with the Dutch-speaking care network in Brussels and in Flanders". A specific aspect of external collaboration

was the perceived advantage of communicating with psychiatric services in Flanders, which they considered to be more advanced in this field.

Proposed Solutions From the Staff Perspective. When asked what their hospital could do to increase Dutch language knowledge, the most common suggestion, offered by 121 respondents, was the provision of Dutch language training. Financial incentives, such as a prime or compensation, were the second most popular proposal (n=35), with an additional 23 suggesting a combination of both courses and a prime. Other proposed activities included conversation tables and collaborations with Dutch-speaking hospitals. One notable suggestion was the creation of a badge stating “I am learning Dutch”, an accessory that would signal to patients and colleagues that an effort is being made and encourage patience during interactions.

Chapter 5. Discussion

This study set out to provide an updated and comprehensive investigation into the language barriers faced by Dutch-speaking citizens when accessing healthcare in Brussels. By combining a citizen survey with expert interviews from across the public, private, and institutional support sectors, as well as with a survey administered to hospital staff, the research captured not only the challenges faced by patients seeking care in Dutch but also the perspectives of two other key stakeholder groups navigating this complex situation. This chapter will interpret the key findings in relation to the initial research question and the literature reviewed in Chapter 2, propose policy recommendations based on the evidence, and reflect on the study's limitations and avenues for future research.

Interpretation of Key Findings

The overarching research question—"What is the extent of language barriers faced by Dutch-speaking citizens when accessing healthcare in Brussels?"—can be answered unequivocally: the extent is substantial and persistent. The findings from this research confirm that a significant gap remains between the *de jure* right to bilingual services guaranteed by the 'personality principle' and the *de facto* experiences of many Dutch speakers. The results strongly support both of the initial hypotheses: that language barriers reduce the accessibility of healthcare (H1) and negatively affect its perceived quality (H2).

The survey results, which provide an overview of the healthcare system as a whole, paint a clear picture from the patient's perspective: a significant majority of primarily Dutch speakers (Group A) have experienced communication difficulties, compared to a much smaller proportion of Dutch-French bilinguals (Group B). This reality directly corroborates the concerns raised in the 2005 Council of Europe report (Cliveti, 2005) and suggests that almost two decades later, the core problems of inconsistent enforcement and Dutch-speaking staff remain. The most direct evidence supporting the accessibility hypothesis (H1) is the statistically significant finding that 42.2% of primarily Dutch speakers have postponed or avoided seeking medical care due to anticipated language barriers. Moreover, many respondents reported considerable difficulty in finding reliable information about Dutch-language hospitals availability. This demonstrates that the problem extends beyond mere inconvenience to become a tangible deterrent to accessing care—evidenced by patients reporting that they seek treatment only at UZ Brussels, widely recognized as the only Dutch-speaking hospital in the city, or even travel to Flanders altogether.

In support of the quality hypothesis (H2), the qualitative data from the survey revealed that even when care is accessed, its quality is perceived as compromised. Participants' concerns that "little nuances got lost" and their tendency to express something merely "close to the feeling", to avoid posing follow-up or clarification questions align with the literature on the clinical risks of language discordance (Cox & Lazaro, 2016). The reported instances of medical errors, such as a mistaken diagnosis for an echo, incorrect medication prescriptions and mistaken consultations directly connect these communication challenges to patient safety risks, a link also established in the literature (van Rosse et al., 2015).

The interviews with the five language professionals provide a crucial explanatory layer, offering insight into why these barriers persist. Their testimonies—more closely focused on the hospital context—unanimously confirm the systemic challenges rooted in the "lack of Dutch speaking staff" and the sector-wide scarcity of healthcare professionals. This creates a fundamental tension, acknowledged by representatives from both public and private hospitals, between the legal or institutional goal of bilingualism and the daily operational priority of providing care with the staff available. The suggestion by the iris network languages team coordinator to shift focus from individual staff bilingualism to guaranteeing "somebody that can speak Dutch at any time" in every department is a pragmatic admission that the ideal of universal bilingualism is, as the GIBBIS representatives noted, in conflict with "the reality that is going on on the terrain".

The secondary survey of hospital staff offers the on-the-ground perspective that helps paint the whole picture of the situation: the workforce is not unwilling but heavily constrained, with a strong majority of French-speaking staff expressing a desire to improve their Dutch. However, these same respondents identified several obstacles to developing their skills, including limited practice opportunities and the heavy workload within their professional environment.

A more nuanced finding is the internal complexity of the "Dutch-speaking" community. The data showing that monolingual Dutch speakers (from Saeys, 2025) and those in this study's Group A are far more likely to assert their language preference in hospitals than their bilingual counterparts suggests that bilinguals may act as linguistic mediators, switching to French in a predominantly French-speaking environment. This behavior, while a practical coping mechanism, may inadvertently mask the extent of the language barrier for the system as a whole, as it reduces the visible demand for Dutch services. This is confirmed by the healthcare staff surveyed, recognizing that "Dutch speakers always switch to French or English", creating a vicious circle where the adaptive strategies of some patients contribute to the underrepresentation of Dutch in the public sphere.

Policy Recommendations

The findings from both surveys and the professional interviews point toward a need for a comprehensive approach to address these persistent language barriers. The recommendations proposed by participants and professionals can be logically grouped into two main categories: measures for hospitals and healthcare institutions, and broader system-wide measures for government and educational bodies.

For Hospitals and Healthcare Institutions

1. Adopt a pragmatic service-level bilingualism model. The interviews with professionals from both public and private hospitals revealed a consensus that making every staff member bilingual is "not realistic" given the sector-wide staff shortages. Therefore, it is recommended that hospitals shift from an aspirational goal of individual bilingualism to a more pragmatic and achievable model of service-level bilingualism. This involves a strategic effort to guarantee a minimum level of Dutch-language capacity at all critical points of the patient journey. Hospitals should identify key points

of contact—such as reception desks and emergency services—and ensure that there is someone who can speak Dutch in every department at any time. This approach guarantees access to a Dutch-speaking professional when needed, directly addressing the core issue of accessibility without placing an impossible burden on recruitment for every single position.

2. Continue investing in language training. The findings show the will for language training among a majority of non-Dutch speaking staff, with the primary motivation being improving communication with patients. It is crucial that hospitals continue to invest in and offer language training for their existing personnel. While workload constitutes a difficulty for staff to combine their demanding job with language learning, their motivation represents an opportunity: flexible, targeted programs—integrated into working hours—would help staff build practical skills without adding excessive burden.

3. Strengthen financial incentives for bilingualism. Motivation is a key factor in language acquisition, and financial incentives were identified as a powerful tool by both patients and professionals. Hospitals should actively promote and potentially enhance the existing financial incentive pathways. By clearly communicating and facilitating access to competitive incentives, hospitals can more effectively motivate staff to invest the significant time and effort required to achieve and maintain a high level of bilingual proficiency.

4. Improve transparency and proactive patient welcome. Hospitals must improve the transparency of their language capabilities, which involves accurately indicating the languages spoken by practitioners on their websites and empowering reception staff to provide this information during appointment booking. Furthermore, a fundamental yet often overlooked step is to proactively inquire about a patient's preferred language upon registration, as suggested by survey respondents. This simple measure would not only facilitate more effective communication from the outset but also signal to Dutch-speaking patients that their linguistic rights are recognized and respected.

For Government and Educational Institutions

1. Address the educational root cause of the language deficit. As argued forcefully by citizens and hospital staff surveyed, as well as by professionals interviewed, the language barrier in healthcare is a symptom of a broader societal and educational issue. A sustainable, long-term solution requires fundamental educational reform. This must be a dual strategy. First, as illustrated by the stark asymmetry in language proficiency from the BRIO Language Barometer (where only 6.5% of graduates from French-speaking schools are proficient in Dutch), Dutch language education in the French-speaking school system in Brussels must be strengthened to aim for functional proficiency, not just basic familiarity. To facilitate mobility across regions and prevent future challenges, this measure should be extended to all French-speaking areas of Belgium. Second, as an easier to apply measure, mandatory, practical Dutch language training focused on clinical communication should be integrated into the curricula of all healthcare programs (e.g., Medicine, Nursing) in Brussels and Francophone

Belgium. This would create a sustainable pipeline of bilingual professionals, addressing the problem at its source rather than placing the entire burden of remediation on hospitals.

2. Increase and restructure funding for language support. The current funding model is insufficient to meet the scale of the challenge. As revealed in the interviews, the government subsidies are "very limited" and often only cover structural costs like the salaries of language coaches, leaving hospitals to fund the direct and indirect costs of training from their own budgets. It is recommended that the government establishes a scalable fund for language training in the healthcare sector. This fund should not only cover course fees but also the critical operational costs of replacing staff on the floor while they attend training. The goal should be to remove the financial and logistical constraint that currently acts as a significant disincentive for hospitals to organize the large-scale training initiatives that are needed.

3. Support a centralized and verified information platform. The survey findings show that patients find it "very difficult to find" Dutch-speaking providers and often resort to informal methods like social media inquiries or traveling to Flanders, which demonstrates a critical information gap. It is recommended that a governmental body, or a mandated collaboration between organizations like GIBBIS and iris network, supports the creation and promotion of a centralized, reliable platform for patients. This platform should not be a simple directory; it must provide verified information on the language proficiency of healthcare providers (going beyond self-declaration) and indicate whether they are accepting new patients. Such a tool would transform the legal right to choose a provider into a practical ability to do so, directly empowering patients, reducing the hassle that leads to care avoidance, and making the 'personality principle' a functional reality.

Limitations of the Study and Areas for Further Research

While this study provides a comprehensive view of the situation, it is important to acknowledge its limitations, which in turn suggest avenues for future research. The primary limitation is the use of non-probability sampling for the citizen survey, which means the findings cannot be generalized to the entire Dutch-speaking population of Brussels. Secondly, the survey was administered in English, which inherently excludes Dutch speakers who are not proficient in English and may have introduced a bias toward a more internationally-oriented or highly-educated subset of the population. Finally, the qualitative data, while rich, is based on self-reported experiences rather than direct observation of clinical interactions. Self-reports can be shaped by memory and perception, which means they may not fully capture the nuances of real-time communication in medical encounters.

Future research should aim to build upon these findings with a larger, representative survey administered in Dutch to capture a more complete picture of the Dutch-speaking community. Observational studies of patient-provider interactions in different Brussels hospitals would provide invaluable data on how language barriers manifest in real-time. Finally, a comparative study investigating the experiences of French-speaking patients who require care in the Flemish periphery would offer a complementary perspective on the challenges of Belgium's complex linguistic healthcare landscape.

Chapter 6. Conclusion

This study highlights a persistent gap between *de jure* and *de facto* language policies in Brussels healthcare, impacting both accessibility and quality of care for Dutch-speaking patients. These individuals report frequent communication difficulties, with many postponing or avoiding medical care and some experiencing misdiagnoses due to linguistic barriers. Systemic challenges, such as the shortage of Dutch-speaking staff, constitute drivers that perpetuate this cycle of inadequate care.

While Dutch-speaking citizens have the constitutional right to receive care in their language, practical solutions must consider the realities on the ground. Providing accessible training and financial incentives for staff, making employment in Brussels healthcare more attractive to Dutch-speaking professionals, and increasing external funding for language fostering initiatives at hospitals can help address the problem in the short term. A long-term solution, however, is to implement language education at a younger age, a key solution emphasized by both citizens and professionals. This would reduce pressure on hospitals and tackle the issue at its root.

The primary contribution of this thesis is its updated and comprehensive analysis of a long-standing issue. By employing a mixed-methods approach that synthesizes the perspectives of patients, language professionals within the healthcare sector, and hospital staff, this research moves the conversation from the known historical problem to the current, practical reality. The citizen survey directly addresses the central research question, while the professionals' interviews and survey provide a broader understanding of the systemic challenges, helping to identify actionable solutions. Overall, this study provides policymakers, administrators, and researchers with concrete evidence to improve Dutch-language accessibility and equity in Brussels healthcare.

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