Aim/Purpose  
The purpose of this study was to explore the healthcare experiences of Black anglophone Montrealers who use our public healthcare system.

Background  
There are many information gaps when it comes to Quebec’s English-speaking Black Community (ESBC) particularly in the area of health and since this type of data is not regularly collected there is a need to find ways to understand what is going on in this community.

Methodology  
A qualitative approach, consisting of in-depth interviews and a focus group, was applied in order to solicit the personal experiences of the participants and thematic analysis was used to identify themes in the data set.

Findings  
Community support is extremely important and valuable in the ESBC and participants believe that the quality of care has eroded in the local health system over time and it is not like it used to be. The in-depth interviews also raised issues of people being dismissed for pain and attempts to be overmedicated for mental health issues.

Impact on Society  
Black people frequently face poor outcomes on many scales. Understanding the challenges they are facing as they navigate the health system can help us come up with solutions to help them get the quality care that they need.

Keywords  
Black persons; language; health; healthcare; social support; empathy

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### Paper Category
- [x] Original Research
- [ ] Case Study
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### Type of Study
- [ ] Radical
- [ ] Incremental/Enhancing
- [ ] Disruptive
- [x] Breakthrough
- [ ] Basic Research
- [ ] Sustaining
- [ ] Architectural
- [x] Component/Modular
- [ ] Discriminatory Bias

### Industry
- [x] Media
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- [x] Business Technology
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- [ ] History
- [ ] Philosophy
- [ ] Religion/Theology
- [ ] Mathematics
- [ ] Physics
- [ ] Digital Media
- [ ] Astrology
- [ ] Social Sciences
- [ ] Art and Culture
- [ ] Psychology/Consciousness
- [x] Astronomy
- [ ] Economics

### Human Elements Addressed
- [ ] Personality Traits
- [x] Behavior
- [x] Equality and Equity
- [ ] Development
- [ ] Environmental
- [x] Social
- [ ] Mental Wellbeing
- [ ] Consciousness
- [x] Physical Wellbeing
**INTRODUCTION**

In 2021 BCRC published *Quebec’s English-Speaking Black Community (ESBC): An analysis of the outcomes and information gaps* (Black Community Resource Centre, 2021). Among the findings listed in that report were the challenges of finding disaggregated data specifically about the health of the ESBC. Data existed for visible minorities as a whole but not Black’s specifically. The information gap in knowledge related to the health of Black Canadians has been acknowledged and various groups are working on addressing it. There is currently a group of researchers who have published a protocol related to the scoping review they are doing on Black health in Canada (Olanlesi-Aliu et al., 2023). Canada does not routinely collect health data based on race however in recent years the call to do so has increased. Provinces such as Nova Scotia (Government of Nova Scotia, 2021) and Manitoba (Dow, 2023) have begun collecting race-based data but to date Quebec has not expressed a plan to do so. British Columbia’s premier commissioned the Office of the Human Rights Commissioner to put forth recommendations (British Columbia’s Office of the Human Rights Commissioner, 2020) on how to collect this data. The Black Health Equity group in Ontario has also created a data governance framework for health data collected in their province (Black Health Equity Working Group, 2021).

According to a report published in 2020, “14.2% of Black Canadians age 18 years and older reported their health to be fair or poor, compared to 11.3% of White Canadians. The prevalence of fair or poor health for Black women reached 15.0%” (Public Health Agency of Canada, 2020). In a Canadian population-based study related to chronic disease, of the races assessed, Blacks reported more experiences of discrimination, poorer service and being treated with less courtesy (Siddiqi et al., 2017). A recent study focused on mental health showed that Black anglophones in Quebec experienced more discrimination, lower mental health and reported more barriers to mental healthcare than Black francophones (Nweze et al., 2023). In their 2021 commentary, Dryden and Nnorom assert that examples of anti-Black racism in the Canadian health system are plentiful and that the situation is exacerbated by the fact that the proportion of Black physicians in the system is much lower than the proportion of Blacks in the general population (Dryden & Nnorom, 2021). Statistics Canada data accessed via the Dashboard on the Vitality of the Black English-Speaking and Bilingual Communities in Quebec, shows that in Quebec, in the lower income brackets there is a higher proportion of Black anglophones compared to Black francophones and the Quebec population as whole. For example, in
2021, 20.7% of Black anglophones made between $20,000-$29,000 as compared to 16.5% of Black francophones, 15.9% Black bilingual people and 16.6% of the entire Quebec population. In 2021 46.9% of the Black English-speaking population in Quebec aged 15 and older did not have a postsecondary certificate, degree or diploma. 9.9% of the population studied in health or related fields (Statistics Canada, 2016). This is relevant because we know that income and education are social determinants of health (Public Health Agency of Canada, 2020). In light of the need to learn more about the health status of the ESBC in Montreal, particularly due to the group’s status as a minority, linguistically and racially, this exploratory research was crafted to lay the groundwork for future analysis. The purpose of this research was to explore the experiences of Black English-speaking users (people who are either patients or caregivers) of the public healthcare system (e.g. family doctor, walk-in clinic, hospital) in Montreal so that we can better understand the needs of our community and identify issues that can be the focus for future research.

**Methodology**

This was a qualitative study. “Qualitative research can help researchers to access the thoughts and feelings of research participants, which can enable development of an understanding of the meaning that people ascribe to their experiences” (Sutton & Austin, 2015). This research method was therefore ideal for the exploratory nature of the work. The data collection phase of this research was conducted between January and May 2023. Participants were recruited through various community organizations. One focus group and four individual in-depth interviews were conducted. All participants were female and ranged in age from mid-thirties to senior citizens. All interviews were recorded and transcribed. The transcriptions were then read, and the thematic analysis method was employed to identify themes in the data set. Informed consent was obtained from all participants. Oral informed consent was performed in most cases. The researcher read the informed consent aloud at the beginning of the call and the participant gave consent before proceeding with the interviews. Three of the four individual interview participants were Canadian born. Data was protected, and treated confidentially, responses were securely stored and all personal data deleted after the analysis phase of the research. It is important to note that all names used in this paper are aliases.

**Results and Discussion**

**Focus Group**

The focus group consisted of nine senior citizens. There was a general feeling among the group that “some improvements are necessary.”
When asked to give examples, they commented about the long wait times especially in the emergency room, that technicians seem to be rushed and stressed and that nurses are leaving without being replaced. As a young researcher and non-Montreal native I was quite struck by how all participants harkened back to a sense of nostalgia that “things today are not how they used to be”. Nevertheless, they are very grateful that they do not have to pay for care like people in the United States.

**LANGUAGE**

Quite a few cited language issues. Participant A mentioned that one time a nurse called to give her some information via telephone and although she understood French she preferred to receive important information in English, the nurse said she would have someone call her back to explain in English and no one ever called back. At the time of the focus group, three months had passed since that phone call. Another participant, Participant B, shared an example of the *Centres Locaux de Services Communautaires* (CLSC) assigning a unilingual French home care worker to her unilingual Anglophone aunt. The homecare worker reportedly never tried to understand what her aunt was saying. Eventually the woman’s child called and reported it and someone else was sent. Participant B voiced that “this is an issue for elderly Black folks living in their own homes who need help.” Someone else shared that “those special organizations that service particular health issues, like HearQuebec are difficult to navigate if you do not speak French. In a place where those services are rendered if you can’t speak French and help yourself, it’s likely they don’t even bother.”

**RELATIONSHIP AND COMMUNITY**

Many of the women who spoke up in the focus group mentioned that they had good long-standing relationships with their family doctors whom they have had for years. For trusted health information they turned to family and friends. The importance of being in community also came up often as participants shared that they learned about health by attending workshops and events and then sharing the information with their peers. Some participants also mentioned that having someone accompany them to appointments was very important and valuable as that person would take notes and ask questions. None of the seniors felt like they had ever received inadequate treatment because of their race but they mentioned that they have seen or heard of such instances on TV.

**INDIVIDUAL INTERVIEWS**

**Interview 1** was with a 70-year-old woman, Bernice, who went to hospital A three times because she was in pain and each time she was sent back home. The
fourth time she decided to try hospital B and was also dismissed, and she said the doctor lied and told her she could not get a particular test. The fifth time she went she was told that she needed urgent surgery to remove her gallbladder. After the surgery they tried to send her home the next day and she refused. She filed a report with the help of the ombudsman. The report mentioned lack of follow up, wrong therapeutic approach and lack of respect. This interviewee felt that she was denied care and had to deal with a lot of back and forth. She believes that the doctor who did her surgery has been avoiding her and learned that the doctor who did the surgery did not belong to the hospital where the surgery took place. When asked who has been managing her care since she was discharged, she responded:

“I’ve been managing myself. And that’s, that’s the way it is gonna be. Cuz I don’t want nothing to do with that doctor because he doesn’t care.”

She wants accountability and measures put in place to prevent something like this from happening again. She said “the system is not like what it used to be”.

**Interview 2** was with a young woman, in her 30’s, Simone. She described extremes in the therapeutic approach. When it came to her mental health, she felt that doctors wanted to overmedicate her but for her physical health and pain she was dismissed. She had an issue with her leg and the official diagnosis took years because her family doctor kept dismissing her. Her parents and siblings also have the same doctor and it was not until her father raised the issue on her behalf when he visited the doctor that the doctor began to take it seriously. One day when her leg pain flared up she called the paramedics because she could not move. When the Emergency Medical Technician (EMT) questioned her, he felt strongly that this was a severe issue that needed to be addressed. In a wonderful show of allyship and advocacy, upon arriving at the hospital he said he would stay with her to ensure that she saw the right doctor and he was true to his word. He said, “I don’t even wanna leave you here until I know for sure that you’re gonna see somebody”. The doctor she saw was initially flippant but once he finally took the time to truly listen to her, his findings were sent to her family doctor which eventually led to a diagnosis. She does not trust the system particularly, the mental health system because she thinks her autonomy will be taken away. She puts on “a little bit of armor” when interacting with healthcare
professionals. She thinks that medical advice is delivered with no care and that testing could be done when patients express concerns instead of just dismissing them. Bernice also shared similar sentiments. Like Bernice, Simone also required emergency surgery to remove her gall bladder after having her pain and symptoms dismissed on prior visits to medical providers.

**Interview 3** was with a woman in her 50’s, Agatha. Her family doctor was a septuagenarian who decided to retire during the COVID pandemic. She is a savvy lady who asks questions and feels at ease finding the information she needs and in helping others to do so. She has had to accompany family members in the system and also had her gallbladder removed within the last few years. She filed a complaint with the ombudsman on behalf of a family member when she did not receive necessary information in a timely manner. She feels the system tries to shuffle people through with no room to ask questions. When interacting with healthcare providers she enunciates and set expectations upfront of what she needs from them. She is leery about providing her health data because she does not trust that the system keeps things confidential. This is due to a prior experience where information about a situation that occurred at a hospital got into the community. This participant also had concerns about the way her mental health concerns were addressed. She said, “they kept wanting to give me drugs”, her preference was to see a psychologist. Both she and Simone referenced a 72-hour hold (referring to when a person is involuntarily held in hospital for an emergency assessment) that they know other people were put on when they sought help for mental health concerns. Similar to Simone, she uses social media, like Facebook, to say what she needs and is looking for. She stated that she is extremely worried about the French government.

*The province is in charge of health and if they could erode our language rights what other rights can they erode next? They are talking about overhauling the system again and that has never gone well for our community.*

She is tired of fighting and feels we should not need to be assertive to get the care we need. When it comes to race her concern also relates to language.

*Our English hospitals are no longer English. And why that touches race, why that touches race? Because the English hospitals were where the large concentration of Black professionals were, and so for the most part some of them were managers and stereotypes were broken but now there are very few.*

The also expressed concern that “the lions in the health care are dying out and not being replaced, people who could give tips on how to handle the system”.

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Family medicine needs to be a lot more family medicine
Interview 4 was with another woman also in her 50s, Donna. She was not born in Canada but has been here most of her life.

She does not have a family doctor but based on where she works she has access to doctors if she needs them. She has never had a negative experience in the health system or felt like she received inadequate care. She seeks out providers based on referrals. She believes that she has a right to be taken care of and get the answers that she needs and she approaches her appointments with that belief. To help have positive interactions she uses laughter. As someone who “takes matters into her own hands” and does not let people deter her from what she wants or needs she shared an example of going to one ER and recognizing that the wait would be too long and so she left and went to another so that she could get the answers she needed in a shorter time frame (5 hours as opposed to likely 12+ hours).

I cannot in any reasonable term, think of a moment or try in my, in the 40 odd years that I’ve been going to the hospital here in Montreal that I felt that I did not matter.

Additional Reflection

It was interesting that the youngest interviewee considered that her race impacted the quality of care that she received, and the older participants did not. It was interesting as well that the older participants had strong and satisfying relationships with their family doctors in a way that the younger participant did not. When asked about if she thinks her race impacts her care, Simone said:

I do. Um, I do with my (family) doctor a hundred percent. And then in the hospitals, it’s hard to tell, but it almost, it’s hard to tell if it’s my race, my gender, my age, if it’s all of it, if it’s one of it, if it’s half of it, if it’s a quarter of that. Um, but I think, as a Black woman, that’s always something that I ask.

Similar to Bernice who felt that providers were uncaring, Simone when discussing the removal of her gallbladder said:

Could you like, maybe act like you care, you know, a little bit more to what’s happening or maybe you’re doing that so I don’t panic or freak out, but.

She felt that there was no care or concern on the part of the providers that she was about to lose an organ and that no discussion was had about what her life would be like after and if she would need to change anything about her lifestyle. A theme in the individual interviews and the focus group was community. Bernice had a friend who supported her and let her stay a few nights at her home when she was afraid to be alone due to all the back and forth at the hospital with no relief. For Simone community and social media were very important to her. Through social media she was able to find people with a similar
condition. Agatha also had a community that she could call on for help and that she was able to help. In fact, she commented that, “we are supplementing the healthcare system with needs of a lot of elderly people (who were alone) by teaching them how to use their cellphone properly and WhatsApp”. This comment was mirrored in the focus group when the seniors shared how valuable it was having others share their experiences and accompany them as needed. Agatha posited that “family medicine needs to be a lot more family medicine” referring to the fact that not everyone may have support and that providers can be more caring and offer resources too. She gave an example of how a nurse, knowing that she had just received challenging news asked her if there’s someone she wanted to call. This was not an idea she had come up with on her own but was so helpful. She referred to this as “the old care system”, again another example I saw in this data gathering process of people feeling like the system has changed and not for the better. She then went on to give an example of today’s system where a family was given news that a relative has cancer but they were provided with no pamphlets, brochures or anything to refer to.

All the individual interviewees except Donna commented about dismissal in some way, but they all asserted themselves in whatever ways they could. When emergency surgery became the necessary outcome none of their providers acknowledged that this could have been avoided if they were not dismissed prior. For Simone, when she went to the hospital with the paperwork for her surgery one of the things indicated was that she had jaundice and the admitting nurse was saying she did not. She told me this is exactly why she felt it necessary to be sure she had all the paperwork from her provider because she knew she was likely to encounter resistance at the ER. Later that day a Black nurse took one look at her and said she had jaundice. The sense that most interviewees were exhausted by the constant advocacy they had to do was palpable but they all acknowledge that not all providers are bad. In each case follow up was conducted by each interviewee for things they needed because the providers said they would do things and never did. e.g. booking/scheduling a required test, forwarding medication information etcetera. Simone has a recommendation on what we can do. She said:

We need to create a collective, an organization where we can put on events or have talks or offer some sort of counseling. Things like that, I think is like what’s gonna help, because I think it’s gonna take a while to break down the institutional biases and ideologies that are in place that a lot of the doctors, I don’t even think my doctor recognizes what she is doing.
The recommendation from the focus group was to have more doctors in the system, especially in the emergency room, and to provide more incentives to doctors and nurses: better training programs, shorter hours, better benefits.

Some mentioned that the government is pushing privatization and that making the public system better is not a priority for the government, “they don’t care about the public, if they cared about the public system they would have a system that is perfect for everyone”.

**CONCLUSION AND REMARKS**

This research was exploratory in nature and the reflections from the focus group and individual interviews have provided a good starting point for issues which need to be addressed within the Black English-Speaking Community in Montreal and areas where we can intervene to support our community. Recurring themes were the value of community and support in each person’s life as they navigated their health care experiences, the fact that the healthcare system has changed for the worse and it is not like it used to be and the feeling that providers tend to be dismissive, and several tries are needed to get issues resolved. Given that three of four individual interview participants had their gallbladder removed it could be worthwhile looking to see how many members of our community have had this operation and what if anything can be done to avoid it. The quality of the doctor patient relationship for those who have family doctors could also be worth exploring further to see if age makes an impact in the strength of the relationship and how both parties interact with each other. More than one participant also brought up the concern about providers trying to overmedicate them for mental health issues which is quite concerning. The point of departure has been the lack of knowledge about Black Health in Canada and this research gives us directions to look further into the healthcare experiences of our community. Overall, the collection of these experiences and reflections from the ESBC helps to make the community visible and maintain its vitality.

**REFERENCES**


Statistics Canada. (2016). Dashboard on the Vitality of the Black English-Speaking and Bilingual Communities in Quebec [dataset]. Adapted from Statistics Canada. Target Group Profile (TGP 2A-L): Population in private households who indicated “Black” as visible minority and who are part of a linguistic minority, Census 2016. This does not constitute an endorsement by Statistics Canada of this product. Adapted from Statistics Canada. Target Group Profile by gender, first official language spoken and visible minority group, Census 2021. This does not constitute an endorsement by Statistics Canada of this product.


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