Language Policy as a Barrier between Practitioners and Patients: A Study on Spoken Communication in Saudi Hospitals

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Abstract:

This paper sheds light on the language policy in Saudi hospitals and how it creates barriers between medical practitioners and patients. Based on the researcher's observation and what other researchers found, language barriers hinder communication and result in less meaningful linguistic interaction. Thus, there is a need to explore the language policy in Saudi hospitals. Consequently, the research attempts to reveal the impact of language barriers on spoken communication between medical practitioners and patients. It also examines the influence of gender, age, and education as variables that affect this linguistic interaction. The number of participants in the study includes 30 medical practitioners and 30 Saudi patients. A mixed-method design is applied using a web-based questionnaire and audio-recorded interviews.

Keywords: language policy, Saudi hospitals, language barriers, spoken communication

Highlights

- English was preferred by medical practitioners, whereas Arabic was more favored by patients.
- Medical practitioners faced difficulties when communicating with Saudi patients in English.
- There was no difference in medical practitioners' responses in terms of gender, age, and education.
- There was no difference in patients' responses in terms of gender and age.
- There was a significant difference in patients' responses due to the effect of education.

Introduction

"What many patients miss and resent today is their inability to communicate with physician in a meaningful manner . . . to have a practical effect upon the patient, the clinician must have the facility to communicate with him"(Tumulty, 1970, p.22).

This quotation was taken from an opening lecture to third-year medical students in 1970. Later, Carrasquillo et al. (1999) saw these words were still applicable in 1999 when they studied the impact of language barriers on patients' satisfaction. One may wonder whether these words still apply to today's situations and whether language barriers continue to affect communication.

Recently, Ali and Watson (2018) reminded us that the issue of language barriers affecting the provision of healthcare is not new. However, they were among other researchers who stressed the lack of evidence regarding this issue in non-English-speaking countries. Since this issue has not been given appropriate attention globally (Ali & Watson, 2018) as well as in the Saudi context, this paper examines the impact of language barriers on spoken communication between practitioners and patients. It is highly significant to ensure that Saudi patients are provided with the healthcare that meets their needs and satisfaction.

Moreover, the Kingdom of Saudi Arabia

is a monolingual country and most of its citizens are Arabic monolinguals (Begum & Haque, 2013). English is viewed as a foreign language (Liton, 2013) and it should not take over the mainstream language. It is important to protect Arabic from English hegemony which can be seen in the medical field because medical services are provided for Saudis and the majority of them are not proficient English speakers. During the period from 2008 to 2012, the number of non-Saudi caregivers increased from 57,518 to 68,806 (Health Statistics Annual Book, 2012). The non-Saudi medical staff speak English as a medium of communication because it is the common language used in health facilities (Al-Shahri, 2002). This raises some concerns regarding the effect of English on Arabic as well as the effectiveness and appropriateness of communication between medical staff members and Saudi patients. Consequently, the present study sheds light on the language policy in Saudi hospitals to provide depths and understanding of how such policies of language can affect the healthcare system.

Theory

The theoretical impact of language policies can be found in Tollesfson's (1991, as cited in Johnson, 2013) historical-structural approach. This is one of the approaches towards language planning work and it focuses on the social and political influences that led to the rise of certain language policies. It is assumed that some language policies are made to serve the interests of dominant groups. This approach developed later to be known as Critical Language Policy which defends the linguistic rights of minorities due to the assumption that language policies create and sustain social inequalities. However, language policies are not always created by a higher authoritative body such as the government. According to Foucault's (1991) notion of Governmentality, some policies can be found in the practices of individuals. Thus, the focus here shifts from the government as a "sovereign and singular power" to the "government of oneself" (Johnson, 2013, P. 41). Therefore, the researchers are interested in exploring language policies that are not necessarily written by the Saudi Ministry of Health but practiced by the medical staff members in hospitals.

Literature Review

A number of studies investigated the impact of language barriers on healthcare services in various English-speaking countries, such as: the UK (Ali & Watson, 2018; Sedgwick & Garner, 2017), the USA (Gallagher et al., 2013; Tschurtz et al., 2011), and Canada (De Moissac & Bowen, 2019). Most of the previous works compared between English-native speakers and non-native speakers in terms of healthcare services. The non-native speakers were known to have limited English proficiency (LEP henceforth). Karliner et al. (2007) defined LEP as lacking the ability to "speak, read, write or understand the English language at a level that permits them to interact effectively with healthcare providers."

Shah et al. (2015) provided a valid counterargument to the previous assumption that many medical conditions and clinical decisions could be made on the basis of physical examination results. It was thought that these results were purely objective because they were taken from reliable sources including laboratory testing and diagnostic imaging. Therefore, patients' language was not given appropriate attention because the provision of care was provided according to their medical results not their language. Patients' spoken communication was overlooked as it was not seen reliable and objective compared to their lab tests. However, this old assumption was challenged when Shah et al. (2015) found that making a decision for patients with language barriers in the Stroke Care was based on communication between caregivers and patients. In other words, patients' diagnosis was affected by their communication with medical staff members. For example, the doctor might need to ask the patient some subjective questions like asking about the symptoms. The researchers examined the causal relationship between language barriers and the poor-quality care at 12 stroke centers in Canada. They found patients with language barriers stayed longer and received assessment from different healthcare professionals. Patients were also discharged with a neurological deficit which ranged in some cases from moderate to severe due to language barriers.

In another study, obtaining an informed consent was more complex due to language

barriers (Schenker et al., 2007). Two groups were examined; English speakers, and LEP Spanish and Chinese speakers. The findings showed that only 41% of LEP patients had a consent form in their first language. However, race as a factor might have played an important role in the process of examination and affected the results. As mentioned by the authors themselves they could not include the race factor in their multivariate analysis because there would be an overlap between race and language. Therefore, it would not be feasible to analyze their independent contribution.

Carrasquillo et al. (1999) were concerned with patients' low satisfaction and willingness to return to an emergency department (ED) they once visited. Even though, this study overcame the race factor by focusing only on English and Spanish speakers, the results were still similar to Schenker's et al. (2007). Latino patients who were not proficient speakers of English were less satisfied with the care they received in ED. Hence, they were less willing to come back if they faced a medical problem. That was because LEP patients did not understand discussions of causes of medical conditions, discharge instructions, and explanation of reasons for some diagnosis and results (Carrasquillo et al., 1999).

Furthermore, De Moissac and Bowen (2019) examined the impact of language barriers on the quality of care and patient's safety for official minority language (OML) speakers in Canada. English and French were both regarded as official languages with equal status in the Canadian Constitution (Hudon, 2009). However, most participants of OML (French speakers) experienced poorer quality of care due to language barriers. The researchers further explained how these language barriers affected the quality of care including inadequate assessment, misdiagnosis, and delayed treatment. For example, many patients reported that they had to repeat their concerns or the provider repeated questions which in either case resulted in prolonging the assessment process. Other patients reported difficulty in finding the correct terms. Stress increased due to the inability of describing symptoms precisely or understanding treatment. Based on the findings, the authors claimed that stress caused by language barriers was not temporary, it may have long-term effects. Even

some bilingual patients who could speak English were found unable to communicate in English when they were under stress or in painful situations (De Moissac & Bowen, 2019).

Similarly, Arabic was recognized as an official language alongside Hebrew in Israel. On March 13, 2018, the status of Arabic shifted from an "official language" to "a language of special status" (Knesset, 2018, as cited in Keshet & Popper-Giveon, 2019). Keshet and Popper-Giveon (2019) examined language practices and policy at public hospitals in Israel from a sociopolitical stance. They believed that these practices and policies were affected by social and political power relations. Consequently, the choice of the language spoken among Jews and Arabs could raise tensions as a reflection of social and political conflicts. The researchers examined two contexts of language use; the language used in the presence of the patient, and the language used among the practitioners in the absence of patients. They found clear guidelines regarding the use of language with the patient, and the choice of whether speaking Hebrew or Arabic was based on the patient's language. On the other hand, there were no clear policies regarding the language used among practitioners. The lack of such policies showed how the macro-level of political life influenced the micro-level of everyday interactions between Arab and Jewish colleagues. The researchers called for a policy to regulate language practices in order to reduce tension among practitioners. They also suggested that a meso-level policy was needed. This type of policy was more related to an organizational level (Mahili & Angouri, 2015) like the policies given by the Ministry of Health. The meso-level is the state-level of language policies which can vary across states and districts. It is well represented in Johnson's (2013) example of bilingual education programs in the United States. In Arizona, it is challenging to preserve bilingual education programs, whereas the state-level language policy in Washington promotes bilingualism.

The issue of language barriers had gained some considerable investigation in the United States, but little is known about the Saudi context. In a study conducted by Alsubaiai (2019), the dominance of the English language was investigated to examine whether English affects healthcare

provision at Bisha King Abdullah Hospital in Saudi Arabia. Alsubaiai(2019) also explored the attitudes of medical staff and patients towards the dominance of English. The findings revealed that 60% of patients found it difficult to understand medical practitioners when they used English. Al-Harasis (2013) investigated the impact of language barriers on the quality of Nursing Care at three Armed Forces Hospitals in Taif, Saudi Arabia. The findings showed that a large number of nurses found it difficult to deal with patients because of the language barriers. This issue had an impact on many areas; general nursing care, communication with patients, understanding patients' needs, and healthcare errors. Owaidh et al. (2018) evaluated the level of patients' satisfaction in the Southern region of Saudi Arabia, Al-Baha. They found that participants were satisfied with the care they received. The study was not designed to examine the effect of language barriers, but the findings revealed that the least satisfactory factor was related to the communication skills of healthcare providers. The patients needed more explanation of the medical conditions by nurses and less by doctors. This could be due to language barriers as admitted by the researchers themselves. Therefore, the current study contributes to the field of language policy and examines the impact of language on spoken communication in Saudi hospitals in the capital city, Riyadh.

Research Questions

The researchers will answer the following questions:

- 1- What is the impact of language barriers on spoken communication between medical practitioners and patients?
- 2- Does gender influence the impact of language barriers on spoken communication between medical practitioners and patients?
- 3- Does age influence the impact of language barriers on spoken communication between medical practitioners and patients?
- 4- Does education influence the impact of language barriers on spoken communication between medical practitioners and patients?

Methodology

Instruments

Most previous research used questionnaires to explore attitudes of practitioners and patients, whether regarding their satisfaction (Carrasquillo et al., 1999) or language preference (Hacker et al., 2012). The present study applied a mixed-method data-collection in order to triangulate the results of interviews with those of the questionnaire. The questionnaire was adapted from Alsubaiai (2019) with minor modification to fit the purpose of this study. There were two different sets of the questionnaire; one for medical practitioners and the other for patients. The medical practitioners' questionnaire was written in English, whereas the one for patients was written in Arabic. All medical practitioners studied medicine in English and some of them did not speak Arabic because they were foreigners. As for patients, they were all Saudis, and Arabic was their first language. Each form of the questionnaire had 12 questions for demographic information, perceptions, and Likert-scale statements. These statements targeted 4 axes; understanding, satisfaction, policy and rights, and language of communication. The interview questions were developed by the researchers to explore the issue in depth.

Participants

The study included 60 participants as the total number of both medical practitioners (30) and Saudi patients (30). Participants were not chosen randomly as they should meet the criteria of inclusion and exclusion. The medical practitioners were Saudi and non-Saudi who were working in Saudi public hospitals at the time data was collected. The selection of current workers helped to ensure more accurate results when participants reflect on their experience. To meet the criteria, only current Saudi patients were included as the primary aim of this study is to help improve the linguistic communication in the Saudi medical context. However, children and patients with mental disabilities were eliminated from the study to ensure more accurate and representative results. The reason for excluding Saudi patients with mental disabilities was due to the fact that barriers could be attributed to their medical condition instead of

their linguistic communication. A coding system was applied on interview transcriptions to ensure quoting what is most relevant to language barriers.

Procedures

Data was personally collected from participants after signing a consent form (see Appendix) at a well-known public hospital in the Kingdom of Saudi Arabia, Riyadh. They were asked to fill in a web-based survey which was created on Microsoft Forms. This allowed the participants to answer anonymously and to feel confident about the confidentiality of their responses. Data were analysed quantitatively with SPSS to test the reliability of instruments and normality of data. Means were statistically calculated for each item and for each axis. Means were calculated for the four axes (i.e. understanding, satisfaction, policy and rights, and the language of communication) to measure the impact of language barriers on the spoken communication between medical practitioners and Saudi patients. To find whether gender affected participants' responses, an independent samples t-test was applied. The Analysis of Variance (ANOVA) was also applied to find the effect of factors such as age and education on participants' answers.

Participants (N=20) who agreed to take part in the interview were contacted by the researcher over the phone. It was not possible to meet them in person due to the current coronavirus pandemic. These interviews were audio-recorded, transcribed, and analysed qualitatively.

Results

Analysis of Medical Practitioners' Responses

A Quantitative Analysis

The demographic information showed that the majority of medical practitioners (96%, N=29) were educated and young as their age ranged between 20 to 40 (93%, N=28). They were also representative of both gender; 60% N= 18 of females, and 40% N=12 of males.

The attitudes of medical practitioners towards the efficacy of using English in the medical context of Saudi hospitals are shown in Figure 1. A large proportion of participants (80%, N=24) thought that English is highly effective. As shown in the figure, none of the participants thought English is less effective. This finding demonstrates that English was perceived as a highly effective language of communication among medical practitioners in Saudi hospitals.

Figure 1. Medical Practitioners' Attitudes Towards the Efficacy of English Language.

A five-Likert scale questionnaire was distributed to elicit medical practitioners' responses towards the effective use of the English language in the medical context. Items were clustered around the four main axes: understanding, satisfaction, language policy and rights, and language of communication. More than half of the participants (66.6% N=20) found difficulties when communicating with Saudi patients in English, whereas only 13.3% (N=4) disagreed to 'I find difficulties to communicate with Saudi patients in English'. They also found it difficult to understand the needs of Saudi patients who do not speak English. This is illustrated in item 2 when 60% (N=18) agreed, and only 30% (N=9) disagreed to the statement 'I find difficulties to understand the needs of Saudi patients who cannot communicate in English'. Regarding medical practitioners' satisfaction of using English as the primary language, 60% (N=18) were satisfied, whereas 23.3% (N=7) were not. The majority of participants (73.3%, N=22) were able to communicate effectively in English with Saudi patients who can speak English. A very few participants (16.6%, N=5), however, could not communicate effectively in English with Saudi patients. When medical staff members were asked about the language policy and rights, over half of them (56.7%, N=17) responded that the use of English in the medical context is compatible with the needs and rights of Saudi patients. The rest of them were either not sure (23.3%, N=7) or not content (20%, N=6) with the idea that English meets

Saudi patients' needs. Similarly, when participants were asked about developing policies which govern the use of the Arabic language to improve service quality, 86.7% (N=26) agreed to this improvement. Finally, the last couple of items (7 and 8) elicited medical staff members' responses towards their preferred language of communication. The majority of respondents (63.3%, N=19) agreed that communication with Saudi patients is easier when Arabic is the primary mode of communication. A similar number (56.6%, N=17) preferred to provide the service in Arabic instead of English. However, 30% (N=9) and 33.3% (N=10) were not sure about either language in item 7 and 8, respectively.

To answer the first research question which explored the impact of language barriers on spoken communication between medical practitioners and patients, the means for each axe were analysed. Figure 2 shows the medical practitioners' means for understanding, satisfaction, policy and rights, and language of communication. 'Policy and rights' received the highest mean (3.90), which indicates that the majority of medical practitioners are inclined to agree and have similar responses to this axe. Thus, this axe was the most affected one by language barriers. Similarly, 'language of communication' and 'satisfaction' were high in means (3.88 and 3.73). Contrary to expectations, the least affected axe was 'understanding' (3.47), but it still showed that understanding is moderately affected.

Figure 2. Medical Practitioners' Means

An independent samples t-test was carried out to see whether gender affected medical practitioners' responses regarding the impact of language barriers on spoken communication. There was no significant difference in terms of gender among medical practitioners because the p-value was 0.253 (greater than the alpha 0.05).

Moreover, the analysis of variance (ANOVA) was applied to test the effect of age and education on participants' responses towards the effective use of English language in the medical context. Participants were divided into three age groups: group 1= 20-30; group 2= 31-40; and group 3= 41 and above. Results showed that there was no significant difference among age groups because the significance value was 0.712 which was greater than 0.05. Hence, there was not statistical difference in the means of each group: group 1 was 3.71, it was 3.73 for group 2, and 4.13 for group 3.

Participants were also divided based on their education: group 1= less than university, groups 2= bachelor's degree, and group 3= higher degrees such as Master's or PhD's. The ANOVA test showed that there was no statistical difference between participants according to their education since the significant value was 0.852 and hence greater than 0.05. The means were also similar; 4.13 for group 1 and 3.73 for group 2, and 3.73 for group 3. The total mean for participants based on their education was 3.75 which was exactly the same of their total mean based on their gender. Therefore, neither age nor education had an effect on respondents' answers.

A Qualitative Analysis

To explore the impact of language barriers on the spoken communication between medical practitioners and Saudi patients, an interview was conducted. Ten medical practitioners were asked questions related to understanding, satisfaction, language policy, language of communication, and solutions. Some participants did not find any difficulties when communicating with Saudi patients who did not speak English since both shared Arabic as their mother tongue. Yet, the majority faced difficulties, even though they were Arabs and Saudis due to the lack of medical terminology.

“Yes, there are difficulties because there is a gap between both languages when explaining the case to the patient. The patient cannot understand their medical situation because they do not know English. There are so many instances where the Arabic translation does not convey the same meaning in English. For example, the term glomerulonephritis is related to kidney diseases, when I use the Arabic equivalent, it is not the same and it is not common. The patient does not understand it in Arabic, and they do not understand it in English, either”.

Most medical practitioners were satisfied with the use of English as a primary language in Saudi hospitals. English was preferred for a number of reasons, for example, it helped medical practitioners to communicate with one another when they did not speak the same first language. English also facilitated access to recently updated medical research and the impact of particular medications. There were a few participants who were not satisfied because they thought English did not meet the needs of elderly patients and patients coming from remote villages, usually lacking proper education.

Through the interviews, it was clear that the majority of medical practitioners were aware of language policies. However, some of them referred directly to where such policies were coming from, whereas others explained what was known as ‘practices in the hospital’. Most participants reported that the language policy in Saudi hospitals required medical employees to speak either in English or Arabic. Medical practitioners whose first language was neither English nor Arabic were not allowed to speak in their languages during work hours. According to the protocols followed in the hospital, English was used among medical practitioners for documentation, and Arabic was mostly spoken with patients.

All the medical practitioners, except two, preferred speaking English with their colleagues and Arabic with patients. English was easier for them because the hospital had employees from different

countries with different language backgrounds and the only language that was shared by everyone was English.

When participants were asked to suggest some solutions for the problem of language barriers, they provided fruitful suggestions. The first solution was providing an interpreter. One of the doctors suggested “there should be videos on YouTube or any other similar platform to explain the disease in a simpler way and in Arabic. It is also beneficial if they are available in clinics to play these videos for patients.” Another doctor suggested teaching medical terminology in schools. He also pointed out that the problem is that the Arabic translation is not always accurate because a slight change can change the original meaning. Therefore, he thought English medical terms should not be translated into the classical Arabic, but the informal Arabic because it is the language that is used in everyday life. He further explained that the classical Arabic was difficult even when it was spoken with Arabic speakers.

Analysis of Saudi Patients’ Responses

A Quantitative Analysis

Patients who participated in this study were representative of the population in terms of gender, age, and education. The number of females and males was equally distributed, 15 each. The age ranged from 20 to more than 41. The majority of patients had educational qualifications less than university (43.3%, N=13) or bachelor’s degree (46.7%, N=14). However, there were patients who were illiterate, and they were grouped under ‘less than university’ (group 1). A few patients (10%, N=3) had high studies degrees.

The attitudes of Saudi patients towards the frequency of using the English language in Saudi hospitals are given in Figure 3. Almost half of the participants (40%, N=12) found English to be used sometimes. A similar number (30%, N=11) found English to be used often. A number of 30% (N=9) of patients also thought English was rarely or less often used.

Figure 3. Saudi Patients’ Attitudes Towards the Frequency of Using English in Saudi Hospitals.

Saudi patients were given a five-Likert scale questionnaire to elicit their responses towards the effective use of the English language in Saudi hospitals. The items of the questionnaire targeted each of the following axes: understanding, satisfaction, policy and rights, and language of

communication. Surprisingly, a high number of patients (46.6%, N=14) disagreed with the first item which stated, “I find difficulties to understand medical practitioners when they speak in English.” The number of those who agreed was 11 (36.7%). However, over half of the participants

(56.6%, N=17) did find it difficult to know their health status due to the use of medical terminology (item 2). The rest (30%, N=9) disagreed or chose 'neutral' (13.3%, N=4). As expected, a large number of responses (63.3%, N=19) were not satisfied with the use of English as the primary language in the medical context. For item 4, half of the participants (53.4%, N=16) disagreed with noticing a difference in doctors' treatment with the patients, in favor of patients who speak English. A number of 9 participants only agreed that they noticed such a difference. For item 5, responses were almost equally distributed making it difficult to know whether patients found the use of English language in Saudi hospitals compatible with their needs. Results showed that (40%, N=12) answered that it was incompatible, whereas 30.3% (N=10) thought it met their needs as Saudi patients, and 26.7% (N=8) did not choose either side. On the other hand, results for the last three items (6, 7, and 8) clearly showed participants' stance regarding policy and rights as well as the preferred language of communication. All the participants except 20% (N=6) agreed to improving policies which govern the use of Arabic language in the hospital. Similarly, 83.3% (N=25) found that communication with medical practitioners is easier when Arabic is the primary mode of communication. The Arabic language was preferred by most Saudi patients (76.6%, N=23).

Moreover, results showed the impact

of language barriers on spoken communication between medical practitioners and patients (see Figure 4), which was analysed with regard to the means scored by patients for understanding, satisfaction, policy and rights, and language of communication. The most affected axes were the language of communication (M=4.23) and policy and rights (M=3.55). Language barriers affected Saudi patients' understanding (M=3.20) moderately, as well and the least affected area was patients' satisfaction with the mean score of 2.53.

An independent samples t-test was run to find the impact of gender on the patients' responses. The p-value is 0.292 which is greater than the alpha (0.05) and hence insignificant. This indicates that there was no significant difference between male and female patients. The mean for males was 3.25 which was close to the mean score of females 3.51.

To explore the impact of age and education on patients' responses, an analysis of variance (ANOVA) was applied. Participants were divided into three different groups according to their age. The age of participants were grouped as follows: group 1 from 20-30 years, group 2 from 31-40, and group 3 from 41 and above. The p-value (0.225) is greater than the alpha (0.05) which indicates that there was no statistical difference between groups based on their age. Thus, age was not a crucial factor and did not affect the patients' responses towards language barriers.

Figure 4. Saudi Patients' Means.

Patients were also divided into three distinct groups based on their educational qualifications. Participants who belonged to group 1 had 'less than university' qualifications or were illiterate. Group 2 was for participants with university qualification such as bachelor's degree, and group 3 was for participants with higher degrees such as Master's/PhD's. Results showed a statistically significant difference among groups due to the effect of education. The p-value in Table 1 is less than the alpha (0.05) which indicates that there was a difference. The difference was specifically between group 1 and group 3 because the p-value is 0.029 as revealed by the Tukey test.

Table 1. One-Way Analysis of Variance of Saudi Patients' Education.

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>P</i>
Between Groups	2	3.425	1.712	5.000	.014
Within Groups	27	9.247	.342		
Total	29	12.671			

A Qualitative Analysis

When Saudi patients were interviewed to explore the issue in more depth, it was surprising to find out that half of them did not face difficulties in understanding English-speaking medical practitioners. Nevertheless, there were some non-educated patients who experienced difficulties due to language barriers. For example, an old lady talked about her gland surgery and how she was afraid because "Saudi doctors were talking to Philippine nurses in English and I was nervous because maybe they were saying something about me, and they did not want to scare me."

The majority of patients were not satisfied with the use of English as the primary language. There were patients who did know English, but preferred Arabic to be the primary language. Reasons for their dissatisfaction included the fact that Saudi Arabia is a country where the official language is Arabic, and therefore it should be the language used in its hospitals. Another reason was that not all Saudi citizens speak English. Interestingly, some patients found it an opportunity to practice English in Saudi hospitals even though they admitted that they were not fluent speakers

of English. They believed English has become a global language and the only way to keep up with the world is to learn it.

All the interviewed Saudi patients were not aware of language policies in the hospital. However, they were familiar with the procedures followed in Saudi hospitals which required medical practitioners to speak either in English or Arabic. The Arabic language was more preferable by over half of the participants because it was easier for them to express themselves in their first language. One patient demanded that "I prefer the Arabic language because I am Saudi, and this is my language. I should not be struggling to find someone who can translate to serve me, I should be provided with the healthcare in Arabic." Another patient did not prefer one language over the other because he was fluent in both languages. On the other hand, one of the patients preferred English because he was working on improving his language skills.

During the interview, patients were asked if they had ever encountered language barriers and what they did to resolve it. All of the patients sought help from other Saudi or Arab medical practitioners. One patient said "honestly, I become very anxious because there was nothing I can do. If the doctor does not understand me and I do not understand him, then I just leave." The participants had different opinions regarding what could be the solution for this issue. One of the most common suggestions was having an interpreter available. Others suggested to learn English as a second language after Arabic. One patient disagreed with recruiting interpreters for only interpretation due to the high costs to the hospital. He rather suggested to have medical practitioners, like those who work at the reception, who is qualified to interpret and has experience in the medical field as well.

Discussion

The results revealed that medical practitioners had different responses to the impact of language barriers on spoken communication from Saudi patients. Nonetheless, there were similarities between both groups. The medical staff members faced difficulties just as Saudi patients did during the spoken communication. For the medical

practitioner, the difficulty stemmed from the lack of accurate Arabic equivalents. As for patients, the difficulty was due to their inability to understand English. In previous studies, (e.g. Carrasquillo et al., 1999; Ali & Watson, 2018; De Moissac & Bowen, 2019) the issue of language barriers was usually found between two groups who did not speak the same language. However, findings of the present study showed that even Saudi medical practitioners who were Arabic speakers faced difficulties when explaining the medical condition to Saudi patients due to the lack of accurate Arabic equivalents for the English terminology. Therefore, concerns were raised regarding the current status of the Arabic language and whether it accounted for the scientific field which is rapidly evolving. One of the influential theories in the field of language policy and planning was presented by Haugen (1966, 1983, as cited in Johnson, 2013, p.28) who identified four essential steps in the process of language planning. Elaboration was one of these steps which was mainly concerned with the continuous process of updating the language in order to “meet the needs of the modern world.” As witnessed by patients of the current study, the English language was used frequently in Saudi hospitals. Therefore, the Arabic language should be reformed to be used alongside the English language for a better healthcare provision. However, the process is not straightforward, but Arabic linguists may investigate to find Arabic words or explanations for most frequently used terminology in the medical field to fill this gap between both languages.

Due to the urgent need of using English to communicate with non-Saudi colleagues, all the medical practitioners were satisfied with the use of English as the primary language in Saudi hospitals. This explained why most medical practitioners perceived English as a highly effective language in the Saudi medical context (see Figure 1). On the other hand, Saudi patients were not satisfied because they did not speak English and Arabic was easier for them. Similarly, Schenker's et al. (2007) found Latino patients were less satisfied with the care they received in the emergency department than did the English-speaking patients.

The findings also showed that medical

practitioners were aware of the different language policy types in Saudi hospitals as opposed to patients. Some of the medical practitioners referred directly to the lists of rules and policies in the hospital. When rules are explicitly written in documents or verbally stated they are considered language policies (Johnson, 2013, p.10). All the patients were not aware of this type of policy and they did not know that their linguistic rights required the medical practitioner to speak in Arabic as stated in the bill of patients' rights and responsibilities. The document was written by the Saudi Ministry of Health which explicitly states that the patient should be treated based on a language she or he understands (Health Statistics Annual Book, 2012, p.26). The patients were, however, aware of the protocols and procedures followed in Saudi hospitals. These procedures and protocols are considered implicit language policies as they are created from agents. An agent is a powerful individual whose practices and decisions could influence language policies. Thus, medical practitioners can be viewed as agents due to their potential role in the creation of De facto (implicit) policies. For example, the English and Arabic languages were the only languages used by medical practitioners. They can be referred to as ‘language policy arbiters’ as this notion describes any individual who can influence the language policy process (Johnson, 2013, p.100). Therefore, the notion of governmentality can be seen applied by medical staff members in Saudi hospitals.

English was more preferred by medical practitioners during their communication with their colleagues, and Arabic was used more with patients. Arabic was, on the other hand, preferred by Saudi patients because it was easier for them to express themselves accurately. Most of the participants in both groups believed that providing interpretation services in Saudi hospitals would solve the problem of language barriers. However, interpretation was examined in previous studies such as Tschurtz et al. (2011) and revealed that even with interpreters, some terminologies were difficult and resulted in miscommunication.

Limitations

The study at hand has some limitations that could have influenced the results. A few illiterate

participants were grouped under the educational category 'less than university' in which there were participants who held school diplomas. It would have shown a significance if they were included in another separate category. Additionally, the number of hospitals was limited to only one public hospital even though the researcher obtained an approval from The Institutional Review Board (IRB) for another public hospital. However, the researcher could not pursue the study due to the outbreak of Coronavirus (Covid19) epidemic which was threatening the well-being of individuals at the time the study was being conducted.

Conclusion

Language is used to serve a purpose which is mainly communication. The spoken communication can be affected by several factors including gender, age, and education. According to the results, the impact of language barriers was mainly found in the 'policy and rights' and the 'language of communication'. Neither gender nor age had any significant influence on participants' responses regarding the impact of language barriers on spoken communication between medical practitioners and Saudi patients. On the other hand, Saudi patients with Master's or PhD's Degrees (group 1) had different responses from patients with less educational degrees (group 3). Consequently, the interaction of these variables can result in miscommunication. It was found in the literature that language barriers were an issue in the medical context. The present study examined this issue in the Saudi medical context to find the impact of language barriers on the spoken communication between medical staff members and Saudi patients.

Based on the results, language barriers affected the spoken communication between medical practitioners and Saudi patients. Moreover, language policies that were performed by medical practitioners in the Saudi hospital unintentionally contributed to these language barriers. A further research is needed to examine medical practitioners' practices in relation to official written documents of language policies such as the bill of patients' rights and responsibilities. This would give insights into

how policies can arise despite of written records. One of the frequently suggested solution was providing interpretation services. Thus, it is also recommended to examine Saudi hospitals which provide these services.

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Appendix

Participants' consent form

You are invited to participate in a web-based online survey which attempts to explore how the dominance of English in medical practice among the medical practitioners affects service delivery to patients. This is part of a research project which is conducted by Wejdan Alkahtani, a master student at King Saud University, under the supervision of Dr. Mona Turjoman. The title of this study is Language Policy as a Barrier Between Practitioners and Patients: A Study on Spoken Communication at Saudi Hospitals. The survey should take approximately 5-10 minutes to complete.

Your participation is voluntary, and you can withdraw at any time. There are no risks to you as a participant and your personal information will be strictly kept confidential. Your responses will be submitted anonymously at Microsoft Forms in which no one could identify you. The results of this study may be published in scientific research journals or presented at professional conferences. However, none of your personal information including your name and identity will be revealed and it will remain anonymous.

If you have any questions concerning the study, the procedures, or the results, you can contact the researcher at Wajdan-ksul@hotmail.com.

Would you like to participate in the audio-recorded interview?

- ☐ Yes
- ☐ No

Name:

Phone number:

Signature:

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