Investigating Medical English as a Lingua Franca: Determining the Effectiveness of Communication between Healthcare Practitioners in Hospital Settings in Saudi Arabia

by

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Declaration

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Summary

This thesis investigates the effectiveness of communication among healthcare practitioners in the multilingual contexts of three government (public) hospitals in Buraidah, Saudi Arabia. Central to this inquiry is the role of medical English as a lingua franca (MELF), in the context of diverse cultural and linguistic backgrounds. Drawing upon a pragmatist paradigm, this study underscores the practical implications in healthcare settings, urging a flexible and interpretive approach to the complexities inherent in medical communication across different languages and cultures.

An exploratory cross-sectional study incorporating a triangulation of three research phases: a scoping review of secondary data, surveys, and semi-structured interviews. These phases collectively through the lens of linguistic mediation as a foundation theoretical framework evaluate the communication of healthcare practitioners in Medical English as a lingua franca environments. The semi-structured interviews were analysed using Braun and Clarke's (2021) thematic analysis approach, offering insights into the dynamics of medical communication.

The findings indicate a variety of communication strategies are utilised by healthcare practitioners, ranging from direct questioning to simplification and repetition, to mediating texts, communication, and concepts. The study highlights the profound impact of language diversity, educational backgrounds, and linguistic competencies on effective communication in healthcare. Participants expressed challenges in utilising MELF within their professional practice, implicating patient safety and care quality.

Chapter 1 sets the stage for the thesis, outlining the rationale, research aims, and epistemological underpinnings of the study. It provides a comprehensive overview of the research context and the research questions that guide the investigation.

Chapter 2 provides insights into the concepts of medical English as a lingua franca, contextualising it within the broader spectrum of English as a lingua franca. It discusses the literature on medical English, medical English education and medical terminology.

In Chapter 3, the focus shifts to communication within healthcare settings, with a particular emphasis on interprofessional team communication. The chapter explores various barriers to effective communication, ranging from diverse backgrounds of healthcare practitioners, language competence, code-switching and mixing, technology to sociocultural aspects. Strategies to mitigate the risk of miscommunication are then examined , along with a foundation of the linguistic mediation.

Chapter 4 outlines the research methodology, summarizing the study's objectives and the timeline of data collection. It elaborates on the rationale behind the chosen methodology and describes the design and implementation of the scoping review, surveys, and interviews. Ethical considerations and the analytical framework, as proposed by Braun and Clarke (2021), are also thoroughly discussed.

Chapter 5 presents the outcomes of the scoping review, discussing the methodology, its strengths and limitations, and the thematic findings that shed light on current research trends in healthcare communication within multilingual contexts.

Chapter 6 reports on the survey findings, focusing on the use of English as a Lingua Franca in medical communication across the research context. It presents a statistical analysis of the surveys, describing the frequency, and importance of communication challenges and strategies in medical settings.

Chapter 7 presents the thematic findings from the interviews, describing the demographic profiles of the interviewees and the initial coding process. It details the study's five main themes, including language challenges in healthcare communication, the 'medical language world', cultural awareness, institutional language management gaps, and the utilisation of all available resources for communication.

Finally, Chapter 8 reviews the findings from all three research phases, discussing them in the context of previous studies and through the lens of linguistic mediation. It concludes by emphasising the pivotal role of linguistic mediation in healthcare communication, advocating for the necessity of professional interpreters, language assessments, and the implementation of multilingual documentation policies to enhance patient care and safety.

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Table of Contents

List of Tables

List of Figures

List of Abbreviations

EFL   English as a foreign language

ELF   English as a lingua franca

EMP   English for medical purposes

ENL   English as a native language

ESP   English for specific purposes

KSA   Kingdom of Saudi Arabia

MELF   Medical English as a lingua franca

MoH   Ministry of Health

TA   Terminology Awareness

UK   United Kingdom

Chapter 1. Introduction

1.1. Introduction

This thesis explores the effectiveness of communication among healthcare practitioners in multilingual healthcare settings. The main objective of the project is to investigate the nature of medical communication at three government (public) hospitals in Buraidah city in the Central Region of the Kingdom of Saudi Arabia (KSA). Through examining the communication experiences of diverse healthcare practitioners from different language backgrounds, this study seeks to gauge the success or otherwise of communication between such practitioners in medical settings.

Effective communication within interprofessional healthcare teams is crucial to provide high-quality patient care, reduce errors and achieve optimal healthcare outcomes (Bry et al., 2016; Song et al., 2017). Interprofessional team communication is a complex process involving both direct and indirect communication (Lobchuk et al., 2021). Interprofessional communication refers to collaboration and communication between healthcare teams from different disciplines, such as physicians, nurses, pharmacists and consultants, involved in providing essential care (Botis & Tweedie, 2022; Reeves et al., 2013). This type of communication can take various forms, including verbal communication, such as medical meetings and hand-offs, and non-verbal communication, such as writing medical documents, ordering, and using gestures and body language (Conn et al., 2009; Nadzam, 2009; Philip et al., 2019).

Good interprofessional team collaboration has been linked to enhanced patient safety and improved healthcare delivery. Interprofessional education (IPE) has received considerable attention in the literature as a learning process that enhances the competence of healthcare practitioners from different disciplines to improve patient care (Centre for the Advancement of Professional Education [CAIPE], 2002; Claramita et al., 2019; Foronda et al., 2016; Interprofessional Education Collaborative Expert Panel [IPEC], 2011; Pfaff et al., 2014). Various frameworks and techniques, such as Crew Resource Management, Patient Safety, the Reasoning Approach and Situation, Background, Assessment and Recommendation (SBAR), have been developed to promote responsible collaboration within team dynamics (Gausvik et al., 2015; Packard et al., 2012; Rodgers, 2007). These approaches empower healthcare professionals with leadership strategies, decision-making skills and the ability to analyse various medical cases and provide recommendations to improve patient safety (Claramita et al., 2019).

The effectiveness of communication between healthcare practitioners is not a black-and-white issue; rather, it exists on a spectrum of effectiveness. While some communication breakdowns may be minor, others can result in devastating consequences, including the loss of human life. Effective interprofessional communication in a multilingual medical environment is affected by many external factors, such as work-related issues, cultural differences, different medical language training, language barriers and social challenges (Botis & Tweedie, 2022; Hull, 2022; Kamimura et al., 2017; Klingler & Marckmann, 2016; Lum et al., 2016; Moyce et al., 2015; Zawawi & Al-Rashed, 2020), which can make communication difficult and lead to information gaps.

Despite the growing literature on provider–patient communication, a research gap remains in understanding the unique challenges of interprofessional communication in multicultural, multilingual and MELF settings (Tweedie & Johnson, 2022). It is unclear whether current training and education initiatives adequately address and resolve communication barriers that can have life-threatening consequences for patients.

When healthcare practitioners communicate effectively, positive outcomes are achieved in terms of patient care, improved health systems and patient satisfaction (Badowski, 2019; Chandler et al., 2015; Ericson et al., 2012). Ineffective communication contributes to high-stakes errors and miscommunication among healthcare professionals (Alvarez & Coiera, 2006; Buckley et al., 2021; O'Daniel & Rosenstein, 2008; Peebles et al., 2012; Roat & Crezee, 2015). The study employs the concept of linguistic mediation as a theoretical foundation for studying the effectiveness of communication. An exploratory cross-sectional study was designed, employing three research phases: a scoping review of secondary data, two instruments, surveys and one-to-one interviews. Following the scoping review, primary data were collected through an investigation conducted in three governmental hospitals in Buraidah where English as a lingua franca (ELF) is used to facilitate interprofessional communication and patient care: King Fahad Specialist Hospital, Buraidah's Central Hospital and the Maternity and Children's Hospital.

The scoping review sought to investigate existing findings from empirical findings related to communication and miscommunication in healthcare settings. The surveys and interviews then examined medical language obstacles, the communication strategies used by healthcare practitioners and how these strategies influence the effectiveness of communication in healthcare settings, as well as how healthcare practitioners' cultural and linguistic diversity influences the effectiveness of communication.

1.2. A Note on Terminology

Throughout this thesis, the terms "healthcare practitioners" and "interprofessional team" will be used interchangeably to refer to the key stakeholders in the study. The term "healthcare practitioners" pertains to certified individuals who practise within healthcare settings. The term "interprofessional team" denotes a collaborative group of healthcare professionals from diverse disciplines operating within the healthcare context, effectively communicating and working together to provide comprehensive care to patients. It should be noted that the two terms are interconnected and employed interchangeably within the literature, as in this thesis. This is attributable to the nature of the participants, as the study encompasses professionals from various healthcare disciplines. Thus, both the concept of individual healthcare practitioners and the collaborative dynamics inherent in interprofessional teams are relevant and interconnected aspects within the scope of this investigation.

Second, it might be useful to highlight how this thesis defines "effective communication". Communication is a fundamental aspect of human interaction, allowing the exchange of messages, ideas and thoughts through various verbal and nonverbal means. Communication requires both the transmission and reception of information, active listening and constructive feedback, whether in conversations, written notes, or gestures (Hornby & Deuter, 2015). Through communication, we can connect with others, understand different cultures and build personal and professional relationships.

Effective communication is crucial in healthcare settings, as it is vital for patient safety and satisfaction (Eggins & Slade, 2015; Lingard et al., 2004). Von Gunten et al. (2000) suggest that using appropriate vocabulary and actively listening to patients' needs, concerns and feedback are essential for effective communication in healthcare. Effective communication in healthcare teams requires language skills, such as writing, grammar and active listening (Botis & Tweedie, 2022; Folorunso, 2022; Hull, 2022), using plain language (Dunn & Conard, 2018; Hadden et al., 2018; Johnson et al., 2022; Warde et al., 2018), improving medical and language literacy (Hull, 2022), and engaging in different strategies to mitigate the risk of miscommunication. The notion of "miscommunication" is also within the scope of this study. In line with Tzanne (2000), this study understands miscommunication as referring to unintentional differences in understanding and occurring "when no message is received or when the message that is received is not what the sender intended" (Eisenberg et al., 2017, p. 32).

1.3. Rationale

Effective communication is the cornerstone of high-quality healthcare services. Doctors, nurses, consultants and other healthcare professionals rely on efficient and timely communication to provide patients with the best possible care. A breakdown in communication can lead to miscommunications, mistakes and even life-threatening situations. Therefore, maintaining strong communication practices in medical settings is crucial, especially in multilingual ELF environments, where cultural and linguistic differences can pose challenges.

The genesis of this research can be traced back to the personal experiences I had while caring for my mother during her illness. During a discussion with a nurse regarding my mother's medication dosage, there was miscommunication because of differences in the expression of numerical concepts. The nurse prescribed a dosage of 1,555 mg instead of 1,000 mg, owing to confusion between the Arabic number "٥" and the Roman numeral "0". I should have checked whether this originated in the clinical notes written by the doctor or if the nurse made the mistake, but I was too shocked to speak. This incident led me to question the extent to which errors occur in multilingual healthcare settings and the risks they pose to patients' safety. Had I not double-checked the dosage with the nurse, the consequences could have been disastrous. This experience compelled me to explore the prevalence and impact of miscommunication owing to linguistic and cultural differences in healthcare settings. I discovered that such miscommunication can pose a significant risk to patient safety, resulting in medication errors, missed diagnoses and other adverse events. Given that English is a lingua franca in multilingual settings such as Saudi Arabia, effective communication practices are critical to ensure high-quality care.

Furthermore, a second personal experience during the COVID-19 pandemic led me to delve deeper into the communication practices of healthcare practitioners. During a visit to Saudi Arabia from Ireland, I was quarantined at one of the hospitals in this study because of flu-like symptoms. In an effort to contain the virus, the Ministry of Health (MoH) implemented precautionary measures, including swab tests, to confirm my condition. During my stay, I observed handovers and communication among healthcare practitioners in real time. Throughout my interactions with nurses and doctors, I found communication to be a barrier in the hospital. Some nurses used their first language during handovers and discussions in which team members from different nationalities were engaged in the conversation. Due to language barriers, other practitioners avoided communicating in English at the ELF hospital. In addition, some healthcare providers employed various strategies to overcome miscommunication in multilingual health

settings. While previous literature has highlighted such issues, my first-hand experience highlighted the pressing need to explore communication in healthcare settings.

Subsequently, I enquired about the existence of language policy to address this issue. Surprisingly, healthcare providers at hospitals in Buraidah confirmed the lack of such a policy. To corroborate this, I reached out to the hospital director and Qassim Health Cluster, who also confirmed there was no language policy. This could lead to information gaps, medical errors and miscommunication among healthcare practitioners (Almalki et al., 2021; Alshammari et al., 2019; Al Muqahwi, 2021; Alsubaiai, 2019; Au et al., 2019; Foronda et al., 2016; Meuter et al., 2015). Thus, my next question was whether the MoH hired interpreters to bridge the communication gap. Despite the crucial role of medical interpreters in facilitating effective communication among healthcare providers in multilingual settings (Samsudin, Abdul Rahman, & Ismail, 2021), none of the hospitals in this study employed them. The situation at the Qassim Hospitals, particularly in Buraidah, motivated me to explore the challenges of communication in such diverse linguistic settings. As a researcher, I posited at the outset of this project, based on my own experiences, that communication among healthcare practitioners in multilingual healthcare settings may result in miscommunication, including high-stakes errors.

In summary, effective communication is critical to provide high-quality healthcare services (Johnson et al., 2022). My personal experience, coupled with the lack of language policy and medical interpreters in the hospitals under study, prompted me to investigate healthcare practitioners' communication practices at King Fahad Specialist Hospital, Buraidah's Central Hospital and the Maternity and Children's Hospital.

1.4. Epistemological Considerations

Central to research lies the philosophical underpinnings, or in specific terms, the research paradigm. These principles encompass fundamental assumptions about the nature of the world and knowledge concerning it (Guba & Lincoln, 1994). Epistemological considerations concern our perceptions of knowledge and what is considered valid or not, while ontology pertains to our interpretations of reality and how we perceive its construction (Gray, 2014). In a nutshell, one could say it reflects the researcher's stance and his/her contextual interpretation of reality, whether that is objectivist, viewing reality as a singular entity, or subjectivist, perceiving multiple realities (Creswell & Poth, 2017).

This study engages deeply with the human element of communication within healthcare settings, focusing on how individuals communicate, adapt and shape their contextual environment using various communication strategies. It investigates a dynamic

process, in which actions and activities occur continuously, either simultaneously or independently, within the medical context. Consequently, this research aligns with the pragmatist paradigm, a philosophical worldview that forms the foundation of this study. Pragmatism provides a flexible interpretive framework, directing attention towards achieving the desired outcomes and answering the research questions (Tashakkori & Teddlie, 1998). Within this paradigm, knowledge is viewed as a synthesis and synergy of epistemology and ontology, emphasizing that knowledge emerges from a combination of actions and circumstances (Creswell, 2008; Tashakkori & Teddlie, 2010).

My personal standpoint in this research aligns with the view that no specific facts or truths exist in isolation (Morgan, 2014). Rather, the focus lies on effective communication within the medical context and the study explores the strategies and techniques healthcare practitioners employ to achieve their communication goals and adapt to the medical context.

1.5. Study Purpose and Research Questions

Given the prevalence of MELF in Saudi hospitals, effective communication assumes significant importance in ensuring successful healthcare delivery. Hence, it is essential to comprehend the potential impact of communication strategies, medical language and the cultural and linguistic background of healthcare practitioners on the overall effectiveness of communication. Drawing on the theoretical framework of linguistic mediation, the study seeks to provide some evidence-led insights into the nature of healthcare communication, the factors influencing its effectiveness or challenges and what is needed to improve communication in medical settings. The primary focus of this research is on determining the success or otherwise of professional communication among healthcare practitioners operating in multilingual healthcare settings. Considering the confidential nature of these medical settings, formally capturing such communication is difficult. The decision was therefore made to focus uniquely on communication between healthcare practitioners in the hospitals, without attempting to address communication with patients.

The following research questions were articulated:

RQ1: What are the key current research findings related to communication and miscommunication in healthcare settings?

RQ2: Does medical language represent a particular obstacle to the effectiveness of communication between healthcare practitioners? If so, what communication strategies are used to overcome this obstacle, and how do these strategies impact the effectiveness of communication?

RQ3: Does the linguistic and cultural background of healthcare practitioners have an impact on the effectiveness of communication?

RQ4: What do healthcare practitioners perceive is needed to improve the effectiveness of communication in healthcare settings?

1.6. Research Context

Due to the rise of globalization and multilingualism, healthcare is now a multidisciplinary field involving workers from around the world. Healthcare members communicate with each other and with patients; in many settings, non-native English speakers participate in a significant percentage of communication. In Saudi Arabia, which serves as the research setting, English is the official language of work in healthcare. Although Arabic is a national language, many hospitals, including public hospitals, use ELF. Healthcare practitioners in medical settings are expected to communicate daily in English. Like its neighbours in the Gulf countries, Saudi Arabia hosts a diverse workforce of healthcare professionals. Approximately 70% of doctors, nurses and allied healthcare practitioners are from overseas, for example the Philippines, India, Pakistan, Bangladesh, Indonesia and Western countries (Alhamami, 2019). In addition, Arabic-speaking staff are employed, with significant differences in the varieties of Arabic spoken (for example Egyptian and Moroccan Arabic). Research indicates that while multilingual settings have many positive attributes, such as increased creativity, capital and employment, there are also negative aspects, such as information gaps, language barriers and miscommunications (Tweedie & Johnson, 2019).

As a prelude to understanding the context of this study, I here review the steps taken by the Saudi government to transform various industries. One of the most significant events was the launch of Saudi Vision 2030 in 2016. This proposes a long-term framework to restructure the Saudi economy in various fields, such as healthcare, education, economics and tourism, to decrease the country's reliance on petroleum profits (Alasiri & Mohammed, 2022).

Efforts are being made to improve the quality of living in the KSA through initiatives such as improving healthcare services and providers' well-being, offering home

care and rehabilitation for the elderly and increasing bed capacity in hospitals around the Kingdom (Frank, 2018). In this regard, Saudi Arabia will witness a rise in its population, which is expected to reach 39.5 million by mid-2030 (MoH, 2021). Consequently, the Kingdom's activities are geared towards achieving its vision, and the quality of the services provided is in line with the quality of the future. As part of this process, and in line with the rise in globalization, the entry application process to Saudi Arabia for various visa categories has been fast-tracked.

A primary concern of Vision 2030 is the healthcare transformation programme, which aims to improve healthcare delivery for the citizens and residents of the Kingdom (Alasiri & Mohammed, 2022). The MoH regulates healthcare in Saudi Arabia and aims to promote significant improvements in public and private healthcare systems by focusing on preventing diseases and ensuring accessibility to care (Al-Hanawi et al., 2019). Funding for health research, increasing public health insurance coverage, upgrading facilities and other comprehensive and effective measures are being put in place to contribute to achieving this objective.

Saudi Arabia depends greatly on expatriate medical staff in public and private hospitals. With approximately 40% of Saudi medical staff employed in the healthcare system, Saudization is another aim of Vision 2030. As a step towards achieving this transformation, the programme aims to expand the Saudi health workforce and provide broader health directions for nationals. According to the recent MoH statistical yearbook for 2021, the programme has succeeded in providing vacancies for Saudi pharmacists and dentists and the number of Saudis working in the sector has increased. As of 2021, there were 1,679 Saudi dentists compared to 319 non-Saudis in government hospitals throughout the Kingdom and 2,375 Saudi pharmacists compared to 539 non-Saudis (MoH Statistics, 2021). However, difficulties arise when attempting to implement the Saudization programme in other medical specialties, especially among nurses and physicians. Studies suggest that more attention and effort are required to train Saudi healthcare practitioners, improve medical education and encourage nationals, especially females, to join the health workforce (Albejaidi & Nair, 2019; Al-Hanawi et al., 2019). It is important to note that the private sector continues to depend on expatriates to a greater degree than national medical staff due to the lower wage costs (Albejaidi & Nair, 2019).

Furthermore, healthcare transformation aims to improve health services by investing in eHealth and providing digital health services. According to the World Health Organization (WHO), eHealth refers to using updated information technology in the healthcare sector (WHO, 2022). The MoH proposes that medical information, diagnoses

and access to appointments and clinics will be available to health providers and patients through the effective use of eHealth. This would improve patient safety and reduce medical errors. Indeed, the benefits of using eHealth were witnessed during the COVID-19 pandemic. The MoH offered practical eHealth applications to help reduce the spread of the virus by providing health services such as the ability to locate the virus, establishing the quarantine period and delivering test results (Khan et al., 2021).

The MoH distributes healthcare policies and programmes while regulations are enforced and follows a careful consideration and approval process to ensure that healthcare services are provided efficiently. Among the public governmental hospitals operated by the MoH are those providing primary, secondary and tertiary care (Alasiri & Mohammed, 2022). Demonstrating commitment to Vision 2030, health clusters have been established to manage guidelines in the 13 regions of the Kingdom. These health clusters manage medical services and decision-making in the region in collaboration with the MoH. The three hospitals selected for this study were managed by the Qassim Health Cluster.

Qassim is one of Saudi Arabia's 13 provinces, located in the central region northwest of the capital city of Riyadh. The region is known as the "alimental basket" of the Kingdom, the heart of agriculture and the home of date production. There are 19 hospitals in the Qassim region, including tertiary and secondary care facilities with more than 2,900 beds (MoH Statistics, 2021). The capital city of Qassim is Buraidah, which is the site of three tertiary government hospitals used to collect data for this study. The first site was King Fahad Specialist Hospital (KFSH), the largest hospital in Buraidah, with over 600 beds. The second site was the Maternity and Children's Hospital (MCH), one of the primary hospitals in Qassim specializing in children, maternity and childbirth. Multiple departments are part of MCH, including those devoted to children, blood, obstetrics and gynaecology. The third hospital used for this study was Buraidah Central Hospital (BCH), one of the main hospitals in Buraidah, providing care for patients consisting of specialized clinics and outpatient services.

The three hospitals are considered primary and serve patients from neighbouring provinces and cities in the Kingdom. A unique feature of these hospitals is that they have physicians and nurses from both Arab and other countries. Most non-Arabic medical staff are not literate in Arabic as they have no Arabic language background and are not required to take any language assessments in Arabic. Other staff, such as allied health professionals, administrators and human resource staff, speak only Arabic. For them, English is a lingua franca and a daily means of communication, leading to serious communication barriers and

increased work complexity. Urgent investigation is required to bridge this gap and ensure patient safety in diverse medical environments.

1.7. Thesis Structure

This thesis is divided into eight chapters, starting with this introductory chapter, Chapter 1, which introduces the thesis background. It summarizes the study problem, context, design and research questions and the thesis structure. Chapter 2 defines and contextualizes medical English as a lingua franca (MELF). A review of the literature on communication among healthcare practitioners is presented in Chapter 3, which establishes the theoretical framework for linguistic mediation. Chapter 4 addresses the methodology, outlining for the reader how the study was approached. It explains the design of this study, the research participants, phases, data analysis methods and the collection procedure. Chapter 5 presents a scoping review exploring available studies on communication and miscommunication between healthcare practitioners. In addition, it investigates communication barriers and the strategies employed by healthcare practitioners in multilingual medical settings. In Chapter 6, survey data are analysed and the findings are reported. Chapter 7 provides analysis and findings of the interview data. Chapter 8 offers answers to the research questions and discusses the study findings drawing on the whole dataset of secondary and primary data. It also discusses limitations, implications and recommendations for future work.

Chapter 2. Medical English as a Lingua Franca

2.1. Introduction

This chapter defines, describes and exemplifies medical English as a lingua franca (MELF). It first contextualizes it in the frame of English as a lingua franca (ELF), before continuing to examine what sets MELF apart. It discusses the literature on medical English, medical English education and medical terminology.

2.2. English as a Lingua Franca

With the rapid growth and development in various fields, including tourism, business, education, technology, health and politics, human communication has become easier than ever before. English has become a global lingua franca that helps people navigate the world together, making communication accessible, particularly when interlocutors have different linguistic backgrounds. In English language education and linguistics literature, the term "lingua franca" refers to the globally preferred choice of English in communication. According to Samarin (1987), "lingua franca" refers to any chosen linguistic method of communication among people who speak various first languages, even though English is their second language. Historically, MacKenzie (2014) states that it refers to the contact language spoken early in the Eastern Mediterranean.

Since 1987, studies of ELF have flourished (Andersen, 1993; Firth, 1990; House, 1999; Jenkins, 1996; Meierkord, 1998; Samarin, 1987). These studies developed a distinct approach to understanding ELF, providing insights into its definitions and features. The ELF school aims to move away from viewing English as a foreign language and instead embraces the World Englishes paradigm, which accommodates all English speakers, regardless of whether they are native or non-native, without judging them against native English-speaker norms (Jenkins et al., 2011, pp. 283-284).

To define ELF, Firth (1996) describes it as a "contact language between persons who share neither a common native tongue nor a common national culture, and for whom English is the chosen foreign language of communication" (p. 240). Similarly, House (1999) explains ELF interactions "as interactions between members of two or more different linguacultures in English, for none of whom English is the mother tongue" (p. 74). Mauranen (2003) refers to ELF as "a vehicular language spoken by people who do not share a native language" (p. 513). The Vienna-Oxford International Corpus of English (VOICE) defines ELF as a second-language system that enables communication among speakers of various mother tongues. Although McArthur (2002) notes that English is often

used as the default language by interlocutors for whom it is not their first language, he also acknowledges that these speakers agree to communicate using a lingua franca to reach mutual understanding.

Mauranen (2012) demonstrates the nature of ELF as an exceptional context for understanding complex communication. Perhaps this is an answer to the various ELF definitions and how researchers emphasize various concepts. Although there are diverse definitions of ELF, Mauranen's (2018) definition is used to refer to the context of this study, namely that it is the functional language used to communicate in multilingual environments.

Current assumptions regarding ELF call for a re-evaluation of English as a global language because of its frequent association with native English varieties. It is necessary to acknowledge the linguistic variations and diverse ethnicities present worldwide (Seidlhofer, 2001). According to these assumptions, ELF primarily refers to a variety spoken by non-native English speakers of English (Kecskes, 2019), with English being the preferred language of communication among such individuals who do not share a common first language.

Some researchers have highlighted that a fundamental characteristic of ELF is the exclusion of non-native speakers, leading to a distinction between inner-circle and outer-circle speakers in Kachru's (1985) three-circle model. In this model, the Inner Circle comprises native English speakers, for example from North America, the United Kingdom (UK), Australia, etc., while the Outer Circle encompasses countries where English is a (relatively) newly established norm and is used as a second language, such as Singapore and India. The Expanding Circle includes countries such as Japan and China, where English continues to be considered as a foreign language and the English variety used depends on inner-circle speakers (Kachru, 1985).

However, this classification has been challenged by scholars who argue that it underestimates two critical factors (see e.g. Matsumoto, 2011). First, it allows for the inclusion of non-native English in the Outer Circle, where English is considered one of the spoken languages within that circle. Second, it tends to overlook the role of English as a second language in the Expanding Circle (Matsumoto, 2011). Furthermore, the limited research undertaken in the 1990s failed to provide explanations for the legitimacy of different English varieties (Jenkins, 2007). Consequently, the classification of World Englishes based solely on geographical boundaries appears fragile (Pennycook, 2003).

Another argument presented by Jenkins et al. (2011) adds weight to the importance of native English speakers attaining proficiency in ELF to facilitate effective

communication with non-native speakers. They reference Firth's (1996) contention that ELF is categorized as a foreign language and cannot encompass native English speakers, as English is their first language. They consider that ELF belongs to the Global and International Englishes paradigm, according to which non-native speakers engage in communication to achieve mutual understanding. In contrast, EFL falls under the purview of the Modern and Foreign Languages paradigm, involving communication between both native and non-native English speakers with the aim of achieving native-like proficiency (Jenkins et al., 2011, p. 284).

However, Kecskes (2019) challenges the aforementioned scholars, such as Firth, Seidlhofer, Mauranen and House, suggesting that they have not considered ELF as a distinct variety of languages. Kecskes believes that considering EFL as a paradigm is questionable, as English is predominantly used by speakers with different mother tongues, whether native or non-native English speakers. In fact, non-native speakers aim to communicate with proficient native English speakers (Graddol, 2006; Kecskes, 2019).

While there is a wide body of research on ELF, Mollin (2006) contends that ELF is a distinct variety of English that effectively functions as a global language for communication. However, fully comprehending its forms and usage remains challenging. In contrast, some researchers view ELF as an international language for speakers communicating in English, including both native and non-native speakers (Llurda, 2004), others prefer to associate it with communication among speakers who do not share English as their first language (McKay, 2002).

Andersen (1993) notes that there is no clear standardization of EFL features, given the absence of a definitive consensus on elements such as pidginization, code-switching, first language transfer and proficiency levels. Similarly, in an analysis of ELF interactions, Leyland (2011) suggests that there are no standardized rules or proficiency levels in ELF and speakers develop their own variety based on their interlocutors. In this regard, speakers "express themselves more freely, without having to conform to norms that represent the sociocultural identity of other people" (Widdowson, 2004, p. 361). In doing so, speakers do not attach significant importance to a specific variety of English; instead, they create a temporary and flexible variety to negotiate and share linguistic meanings when communicating with others (Jenkins, 2009; Leyland, 2011). In other words, they develop their own variety of English, influenced by their native languages, such as Arabic English, Chinese English, Korean English and so on (Kecskes, 2019).

Numerous studies have explored the various strategies employed by ELF users. Similar to native English speakers, ELF users adapt their language and use different

strategies to accommodate their interlocutors' speech (Jenkins, 2009). These strategies encompass paraphrasing, code-switching, structural and lexical simplification, repetition, repair and the repetition of phrases and words to minimize errors (Björkman, 2013; Cogo & Dewey, 2006; Gilner, 2016; Kirkpatrick et al., 2008; Matsumoto, 2011). Notably, ELF lexico-grammatical strategies involve distinct elements compared to English as a native language ([ENL], Jenkins, 2009). For instance, these strategies may involve the omission of third person "s" (e.g. "she like", "he believes"), article omission and the misuse of uncountable nouns (e.g. "sugars", "hope") Breiteneder, 2005; Ranta, 2013. However, researchers have shown that these strategies perform similarly to ENL and thus should not be considered errors (Dorn, 2011; Jenkins, 2006; Meierkord, 2004).

To fully understand the diversity of strategies utilised by ELF users, including techniques such as paraphrasing, code-switching, and simplification, it is essential to understand the underlying language learning strategies. Such strategies, as discussed by Rose (2015), are employed by second language learners to enhance their language learning acquisition and facilitate their language use. In an earlier work, Rose (2011) examined strategic learning, underscoring the role of self-regulation alongside specific cognitive and behavioral strategies in the process of language acquisition. Building on this concept, in multilingual healthcare settings, such strategies can be seen managing external influences and interpersonal interactions. This concept demonstrates how ELF users, including healthcare practitioners, navigate linguistic challenges by adapting their communication to diverse situations and individuals, often relying on a mix of independently adopted and external strategies. This understanding is pivotal to comprehending the complexities of communication in multilingual environments.

2.3. Medical English as a Lingua Franca

The global mobility of healthcare professionals has led to the widespread use of English as the primary language of communication (Lu & Corbett, 2012). Hence, Tweedie and Johnson (2019) stress the need to investigate MELF. Previous studies have primarily focused on analysing lexis and grammar production in medical discourse (Lei & Liu, 2016; Yang, 2015), while others have focused on exploring English for specific purposes (ESP) and English for medical purposes (EMP) discourse, comparing the language patterns of non-native speakers with those of native speakers through linguistic analysis and corpus linguistics (Wette & Hawken, 2016).

However, these studies typically neglect the unpredictable nature of medical English communication, often further complicated by the situational context and the

linguistic and cultural backgrounds of patients and healthcare practitioners. In healthcare settings, every word, medical abbreviation or written document counts since medical errors can have grave consequences for patient safety and care. Unlike student–teacher or business interactions, in which mistakes are manageable, the sensitive environment of healthcare settings demands the utmost precision and accuracy. This is particularly relevant in Gulf countries, especially Saudi Arabia, where migrant healthcare practitioners are prevalent and English may not be their first language (Almansour et al., 2023; Al Shamsi et al., 2020). Therefore, further research on MELF is crucial to address the communication challenges that arise in healthcare settings.

While this thesis primarily focuses on ELF strategies in healthcare practitioner communication, there are significant differences between ELF in medical settings and other domains, such as higher education or business (Jenkins et al., 2011). To the best of my knowledge, the domain has not extensively examined ELF in hospital settings, as evidenced by the lack of references to MELF in the recently published ELF handbook by Jenkins et al. (2018) and the scarcity of related studies (Tweedie & Johnson, 2019). The reality is that high-stakes medical settings require further investigation and demand attention. The following sections will examine what sets medical English apart from other forms of English language discourse in terms of medical language and medical language education.

2.4. Medical Language

The importance of medical language cannot be overstated in the increasingly multilingual healthcare landscape. It serves as the fundamental tool that enables the smooth execution of procedures (Jackson, 1998, p. 65, as cited in Tweedie, 2022). In healthcare settings, effective communication is paramount because misunderstandings and errors can have severe consequences for patients. Medical language, encompassing a specialized language within the healthcare domain, plays a pivotal role in facilitating communication between healthcare professionals and patients (Džuganová, 2019a; Hull, 2013). It encompasses terminology, jargon, acronyms, abbreviations, expressions and phrases specific to healthcare. Particularly in multilingual healthcare environments, where language barriers can hinder effective communication and jeopardize patient care outcomes, proficiency in medical English is of the utmost importance (Alqurashi, 2016; Hull, 2016). This section will review medical terminology and medical English education.

2.4.1. Medical Terminology

Understanding medical terminology is crucial for developing medical language skills (Džuganová, 2019b; Watermeyer et al., 2021). It is essential to differentiate medical terminology from medical language, as laypeople may assume that they have the same concepts, without considering the technical and precise words, terms and phrases that comprise medical terminology. As Hull (2013) notes, medical terminology refers to the specialized, consistent and precise words and phrases employed in fields like medicine, anatomy, physiology and pharmacology.

The practical application of medical terminology plays a critical role in various clinical scenarios and its inaccurate use can lead to severe consequences (Džuganová, 2018). A comprehensive understanding of the context, synonyms and morphological and semantic changes that occur in medical terminology is needed (Džuganová 2013; Hull, 2016). These changes may broaden or narrow the meaning of a word or alter its origin and significance through the addition of prefixes and suffixes (Džuganová, 2013). Indeed, as highlighted by Džuganová (2008), many words used in medicine to describe symptoms can capture a wide range of meanings, often due to the presence of negative prefixes derived from Greek or Latin languages, such as the term "(dis)ease". Whilst specific medical terminology is vital for effective communication, a combination of medical and standard language competence is also needed (Hull, 2022).

In terms of the historical development of medical terminology, it originated during the time of Hippocrates, one of the most influential figures in medicine. Hippocrates advocated the use of precise language, recognizing its importance for accurate diagnosis and prescribing appropriate treatments (Džuganová, 2018; Vit, 2022). He used Greek roots, prefixes and suffixes to formulate a set of medical terms that could easily be understood and used by physicians in the same field.

During the Arab Empire, medical knowledge flourished and was preserved even after the fall of the Roman Empire, which marked a significant achievement (Džuganová, 2018). Ibn Sina, also known as Avicenna, was one of the most notable figures who contributed to the development of medical terminology during this period. At the height of the Middle Ages, Ibn Sina authored a medical encyclopedia in Arabic, which was later translated into Latin and widely used as a comprehensive medical reference. This encyclopedia, known as the *Canon of Medicine*, is highly regarded by the medical community and has played a significant role in advancing medical terminology in Europe (Nasser et al., 2009; Vit, 2022). Throughout the *Canon of Medicine*, Ibn Sina used Greek and Arabic roots, prefixes and suffixes to create medical terms that are still in use today.

Many words derived from Arabic, including "alcohol", continue to be used in medicine (Džuganová, 2018). Moreover, Ibn Sina introduced new medical terms to describe previously unrecognized diseases and conditions, such as pharyngitis, an inflammation of the throat (Mahdizadeh et al., 2015).

Throughout the Middle Ages and Renaissance period, Greek and Latin medical terminology experienced significant evolution, resulting in the creation and standardization of various terms (Bujalkova & Dzuganova, 2015). The development of medical terminology today reflects the continuous advancements in scientific knowledge and clinical practice, keeping pace with changes in medicine and society (Džuganová, 2018).

Acquiring such medical terminology is essential for healthcare professionals to navigate diverse clinical scenarios effectively. Moreover, Bakó (2022) argues that healthcare professionals need a comprehensive understanding of the etymology and linguistic foundations of medical terminology across various disciplines. However, although medical terminology is critical for effective communication in the healthcare field, it can only generate meaning in isolation and may not always convey comprehensive communication messages (Hull, 2022). A broader perspective integrates effective medical communication with the acquisition of medical terminology. This approach acknowledges the constant evolution of medical terminology owing to the emergence of new diseases and the creation of new terms and abbreviations. Healthcare professionals must continuously update their knowledge to communicate complex medical information effectively to patients and other healthcare providers in a clear and understandable manner.

The challenges posed by medical terminology and the need for effective communication in healthcare have been discussed extensively in the scholarly literature, since discrepancies in medical terminology, acronyms, eponyms and abbreviations used in clinical settings can create significant obstacles to mutual understanding among healthcare practitioners (Botis & Tweedie, 2022; Džuganová, 2018; Nickel et al., 2017; Watermeyer et al., 2021). These challenges are further compounded by variations in medical terminology across different languages, leading to confusion and misunderstandings, particularly among healthcare professionals who have received their medical education in different linguistic environments. Hull (2022) highlights the potential for such misunderstandings through an analysis of English medical acronyms and their corresponding acronyms in French and Spanish. For instance, the immune deficiency disease known as AIDS is referred to as "el SIDA" in Spanish and as "le SIDA" in French. Given these challenges, it is necessary to enhance awareness of medical terminology and

establish a common, standardized ML to facilitate effective communication and ensure optimal patient outcomes.

While medical interpreters are commonly employed in healthcare settings to facilitate communication between healthcare providers and patients in different languages (Patriksson et al., 2019; Suarez et al., 2021), there are specific situations in which healthcare professionals must rely solely on their language skills for effective communication. For example, during a surgical procedure, a surgeon may need to communicate with a nurse in the absence of an interpreter. This highlights the crucial role of a comprehensive understanding of medical terminology among healthcare professionals in minimizing misunderstandings and ensuring patient safety. Bakó (2022) argues that education in English for specific purposes (ESP) and English for medical purposes (EMP) equips healthcare professionals with the foundational framework to acquire the necessary linguistic proficiency to navigate various clinical scenarios with confidence. Furthermore, Bakó (2022) emphasizes the need for an additional Terminology Awareness (TA) framework for effective medical communication, encompassing mastery of medical terminology, active engagement in creative problem solving and adaptability to diverse contexts. Within this proposed TA framework, Bakó underscores the cognitive process in which the listener automatically responds to the medical terminology encountered, manages ongoing conversations and uses appropriate medical terminology that aligns with the specific context of the discussion. However, developing such terminology awareness requires consistent and deliberate exposure to English for Specific Purposes and English for Medical Purposes communication in the medical setting (Bakó, 2022).

Considering the case of healthcare practitioners whose primary language is not English, they may face challenges in comprehending the medical terminology and jargon used by their colleagues. In such instances, proficiency in medical language enables healthcare professionals to communicate effectively and deliver the best possible care. Furthermore, proficiency in medical language is vital to foster seamless communication among healthcare providers and ensure a shared understanding of a patient's condition and treatment plan.

Although medical language may appear to be a technical language used solely by healthcare practitioners, it is an integral part of the healthcare system infrastructure. According to Hull (2013), it encompasses various words, terms, jargons, abbreviations and expressions used not only for discussing patient conditions but also for effective communication among peers and ensuring clarity during patient interactions.

2.4.2. Medical Language Proficiency

Medical language proficiency has been linked to positive healthcare outcomes (Hull, 2016). These positive outcomes manifest as improved communication among healthcare practitioners, reduced medication errors, decreased hospital admissions and more efficient healthcare delivery (Almalki et al., 2021). Healthcare practitioners often encounter difficulties deciphering medical language, particularly when it differs from their native language. Furthermore, medical language is influenced not only by the contextual and linguistic backgrounds of healthcare practitioners but also by the religious and cultural aspects of healthcare practice (Hull, 2022).

Džuganová (2019b) defines medical language as a scientific, technical and contextual language used by healthcare experts to facilitate communication in healthcare settings. Hull (2016) characterizes medical language as a universal language that transcends specific languages, such as medical English, Arabic, French and others (Hull, 2016). Medical language exists in various languages and there are significant foundational similarities concerning its treatment, medical terms, biology and anatomy (Hull, 2022; Mićić, 2013). To clarify this point, consider a non-native English-speaking healthcare practitioner working in an English-speaking hospital. Despite the language difference, discussing different medical cases in English would still be comprehensible because of the universal foundation of the medical language (Hull, 2022).

It is important to distinguish medical language from standardized languages within specific healthcare professions. As Hull (2016) points out, while medical language serves as the basis, it should not be conflated with the standardized language used in nursing practice for instance. Standardized nursing language represents specific terminology and language derived from medical language; however, it serves different purposes during the nursing diagnosis process and functions as an integral component of the nursing process (Hardiker et al., 2000). In addition, it contributes significantly to charting, writing medical reports and promoting effective communication among nursing professionals, broadening their perspectives and competencies (Alrajhi et al., 2018).

Hull's (2022) research, which focused on the role of medical language within the field of ELF, aligns closely with the primary focus of this study. In her discussion of medical language, Hull assumes that it is universally understandable by all healthcare practitioners, as exemplified by the sentence: "Yes, we've got sinus rhythm again. Heart rate's normal, O2Sats within limits, BP as well. Patient's coming back. Monitoring" (Hull, 2022, p.171). Considering Hull's (2016) argument that medical language is universal and exists in any language, one might then pose the question how an Arab healthcare

practitioner who has studied medicine in Arabic or an Algerian doctor who has studied medicine in French would interpret this sentence in medical English. It is necessary to ask this question to understand how medical language is enacted, particularly in multilingual healthcare settings, where English serves as the primary language of communication. Linguistic diversity in such settings can give rise to various misunderstandings, including high-risk errors related to patient care resulting from language miscommunication (Badowski, 2019). Thus, linguistic diversity may contradict Hull's (2022) claim, as there cannot be any guarantee that no information gaps will arise and that all healthcare practitioners will fully comprehend the English medical language and its terminologies.

The increasing prevalence of mobile healthcare practitioners, driven by economic factors in the globalized world, often leads to ELF being adopted as a means of communication, particularly in medical settings (Džuganová, 2019a; McArthur, 2002; Tweedie & Johnson, 2022). Teaching medical English to healthcare providers can be seen as a temporary solution to address this challenge, considering that healthcare providers in lingua franca healthcare settings come from diverse educational backgrounds and have varying levels of English proficiency based on their educational experience. In this regard, there is considerable appreciation for ELF as a means of facilitating communication and access to knowledge for healthcare providers and medical students through English versions of medical journals and conferences (Džuganová, 2018; Wulff, 2004). Medical English, in particular, contributes significantly to enhancing communication among healthcare professionals from diverse backgrounds. It eases the translation of borrowed English words, such as "screening" and "scanning", and their interpretation for healthcare practitioners who do not speak English as their native language (Džuganová, 2018).

2.4.3. Medical English Education

The use of English as a lingua franca for medicine and science originated in Europe in the 1950s (Baethge, 2008) and it has since become the primary language in medical settings. Currently, English is the language used to prepare healthcare professionals to navigate medical settings worldwide (Azzhrani & Alghamdi, 2020). Medical English plays a crucial role in healthcare practitioners' and providers' communications with patients and colleagues. Studies have highlighted the importance of English proficiency in healthcare communication, particularly in multilingual settings (Chan et al., 2022; Ortega et al., 2022). As mentioned previously, some research suggests that finding a common and accessible language for communication among healthcare practitioners and patients is feasible (Hull, 2022; Warde et al., 2018). However, owing to the technical nature of the

language and the potential for diverse linguistic backgrounds within a team, it can be challenging to make definitive judgments in such a sensitive environment. When the cultural and linguistic background of the healthcare practitioner shapes communication (Knutsen et al., 2020), what may be accepted in one linguistic background can be rejected in another.

To address these challenges, ESP courses have gained significant attention since the 1960s. According to Orr (2001), ESP education aims to enhance learners' English proficiency and equip them with the skills necessary to handle specific professional tasks. An ESP curriculum is designed to meet the language, grammar, lexis and communication needs of learners and is tailored to specialist fields, such as aviation or medicine (Dudley-Evans, 1998). As a more specialized form of ESP, English for medical purposes (EMP) courses have been developed to prepare doctors and medical students to handle medical situations (Bakó, 2022) and to equip healthcare practitioners with the knowledge of medical terminology and essential medical English proficiency required for their work (Porcaro, 2013). However, the effectiveness of such approaches in preparing students for healthcare careers remains uncertain. There are still significant challenges and gaps in the MELF environment that need to be addressed to meet the needs of a diverse workforce (Azzhrani & Alghamdi, 2020; Bakó, 2022).

With respect to ESP/EMP courses, studies have indicated a lack of comprehension of current and future medical situations among the participants (Bakó, 2022; Widdowson, 2003). Vahdany and Gerivan (2016) conducted a study examining 110 medical students and healthcare practitioners at the Guilan Medical University in northern Iran. Their findings suggest the need to revise EMP courses to equip future medical staff with the enhanced linguistic skills and awareness required for real-life hospital situations. The researchers note that that patient safety should be a fundamental component of these courses, not just a focus on developing English skills, such as reading medical articles or listening to scientific documentaries (Hull, 2022; Vahdany & Gerivan, 2016).

This need for improvement is not limited to ELF environments; even in native English-speaking medical education, the integration of ESP courses may be necessary. The concept of language concordant care, in which healthcare practitioners and patients share the same language, has been advocated in the United States (US) (Diamond et al., 2019). However, a major challenge arises in determining whether healthcare practitioners truly understand medical English, including its terms and syntax, to provide optimal care (Hull, 2022). This is particularly challenging in diverse contexts, for instance in the US, where over 350 languages are spoken (Molina & Kasper, 2019). Therefore, appropriate training

and a foundation for language concordance in medical education are needed to enhance patient safety, build rapport and increase trust (Ali & Johnson, 2016; Molina & Kasper, 2019). To ensure that medical students acquire the necessary communication and clinical skills to provide quality care, it is essential to provide scientifically supported strategies when addressing medical literacy and language abilities (Molina & Kasper, 2019).

Shifting the focus to medical English education from the perspective of Saudi authors, Alqurashi's (2016) insightful quantitative study examined the English language needs of 156 Saudi doctors and students enrolled in Australian medical courses. This diverse participant group included individuals from various healthcare disciplines, such as nursing, medical laboratories, pharmaceutics and other health fields. Employing a survey, the participants were tasked with evaluating the effectiveness of the four language skills in different classroom activities. The results revealed that Saudi doctors and medical students studying and working in Australian hospitals and universities recognized the paramount importance of English proficiency in their curriculum. They exhibited strong motivation to enhance their English skills to enable them to navigate the complexities of diverse communicative strategies effectively. Alqurashi strongly emphasized the need to refine EMP/ESP courses in Saudi Arabia, cautioning against relying solely on English medical textbooks, which he found to be insufficient as a means of preparing future healthcare practitioners adequately for lingua franca environments. However, it is worth noting that the context of the study, in which English was the first language, differs from the Saudi context, in which English is used as a lingua franca. Therefore, the generalizability of the findings to the Saudi context may be limited. For a more comprehensive understanding, it would have been of value to have conducted follow-up interviews exploring the participants' awareness of medical English and encounters with terminology, going beyond evaluation of the four English language skills alone.

In a similar study conducted at Najran University in Saudi Arabia, Khan (2020) examined the effectiveness of ESP courses offered to medical and science students. The findings revealed that the instructors teaching these courses should have knowledge of medical and scientific backgrounds to ensure effective instruction. In addition, students expressed the challenges they encountered when learning complex medical terminology, which often led to an urgent need to enrol in additional supplementary courses. These findings emphasize the ongoing need for improvement in ESP/EMP courses within the Saudi education system, with the aim of bridging the gap in understanding and equipping future healthcare practitioners with the essential skills they require (Khan, 2020).

As Azzhrani and Alghamdi (2020) point out, in a multilingual healthcare setting, effective communication requires medical English proficiency, an understanding of medications and diseases and strong decision-making skills. The lack of medical English proficiency among healthcare providers, clinicians and patients can lead to life-threatening situations, particularly in multicultural environments. They note that in light of Saudi Vision 2030, enhancing healthcare practitioners' communication skills and medical English proficiency has become crucial to ensure full compliance with the healthcare infrastructure (Azzhrani & Alghamdi, 2020).

Finally, most studies conducted in the Saudi context have focused on the perspectives of teachers and students (Alnahdi et al., 2021; Alqurashi, 2016; Khan, 2020) and only limited attention has been paid to the viewpoints of healthcare practitioners in the medical fields (Albougami, 2015; Azzhrani & Alghamdi, 2020; Zawawi & Alrashed, 2020). Therefore, it is worth attempting to shed light on understanding and use of medical English from the perspective of healthcare practitioners, as they can provide a realistic and first-hand understanding of the challenges and needs in the field (Albougami, 2015; Almalki et al., 2021; Azzhrani & Alghamdi, 2020; Zawawi & Alrashed, 2020).

2.5. Conclusion

This chapter has presented existing literature pertaining to MELF. It began with an exploration of the concept of ELF, reviewing its historical context, various definitions and its role as a global language. Subsequently, the discussion narrowed to focus specifically on the domain of medical English, examining its distinctive characteristics as a lingua franca. This was followed by an overview of medical language, encompassing aspects such as medical terminology, proficiency in medical English and pedagogical approaches to medical English education. A critical argument was presented, highlighting the vital role of medical English education in equipping future medical professionals, particularly given existing uncertainties surrounding the efficacy of current educational methodologies. It has also been argued that medical language proficiency is associated with better patient care outcomes. The forthcoming chapter aims to further this review by addressing effective communication in healthcare settings and exploring challenges and potential improvements. It will then introduce linguistic mediation as a theoretical framework for this study.

Chapter 3. Effective Communication in Healthcare Settings

3.1. Introduction

This chapter explores the literature on communication in healthcare settings, focusing particularly on research on interprofessional team communication. Research on various barriers to effective communication is examined, including the diverse backgrounds of healthcare practitioners, language competence, code-switching and mixing, technology and sociocultural aspects. Strategies to mitigate the risk of miscommunication are then examined in the second half of the chapter through the theoretical lens of linguistic mediation.

3.2. Communication in Healthcare Settings

Communication challenges in healthcare settings have been shown to be persistent and complex. Tam and Lau (2000) conducted a study on the quality of care and patient satisfaction in Hong Kong's emergency departments between 1995 and 1998. Of the 71 patient complaints retrieved during this period, nearly half contained negative feedback on communication. Key factors affecting communication between healthcare providers and patients include miscommunication, inadequate interpersonal skills and insufficient time allocated for medical consultations and handovers.

Studies have found that healthcare providers and patients report facing serious communication barriers and this problem persists from the past. Moreover, patients who experience pain may not be attentive to communication quality, which can result in serious illness, stress, medical errors and miscommunication due to communication barriers (Albougami, 2015; Alshammari et al., 2019; Alsubaiai, 2019; Au et al., 2019; Foronda et al., 2016; Meuter et al., 2015; Wong & Wong, 2022).

Healthcare practitioners trained in English may also face language barriers in non-English health settings, where patients share a different mother tongue (Hull, 2022; Slade et al., 2015). Abdelrahim et al. (2017), investigated provider–patient communication challenges in Qatar. They observed that patients preferred to speak with a doctor who spoke their native language prior to booking an appointment. Patients believed that this was the primary factor underlying an effective medical consultation relationship and communication.

Studies have shown that the presence or absence of language interpreters in MELF settings may also aid or impede the communication process (Cox, 2017; Flores et al., 2012; Floridis, 2022; Green et al., 2005; Jacobs et al., 2001; Lázaro Gutiérrez, 2014; McCorry &

Mason, 2020; Ritala, 2022; Wong & Wong, 2022). It is also possible that family, relatives and other healthcare workers interfere with the translation process (White et al., 2018), resulting in potentially inaccurate translations between providers and patients (Elderkin-Thompson et al., 2001). Medical language barriers, including the use of medical jargon and terminology when communicating with patients, have been identified as major causes of overwhelming communication, resulting in significant stress for patients and their families (Centers for Disease Control and Prevention [CDC], 2019; Floridis, 2022).

Other factors that contribute to miscommunication in provider–patient communication include insufficient medical data due to the lack of information, omission of medical words, missing medical notes and illegible writing in medical reports, as noted by Humphries et al. (2019) and Pun et al. (2015). In addition, the differences between traditional and alternative medicine, particularly in Asian countries, may also lead to fragile doctor–patient relationships and poor communication, as healthcare practitioners may not be aware of these applications (Chang et al., 2019; Kim & Jeon, 2012; Quartey et al., 2012; Tangkiatkumjai et al., 2020).

The role of gender differences has also been examined in communication between healthcare providers and patients. Studies indicate that female practitioners communicate more effectively with patients and ask more questions about medical cases than their male peers (Uskul et al., 2003; Van Dulmen & Bensing, 2000). A recent study found that female patients find it challenging to communicate with male doctors during medical consultations (Alsubaiai, 2019).

In MELF settings, effective provider–patient communication remains a persistent challenge. There are ongoing efforts to improve verbal and nonverbal communication and research continues to identify solutions that can enhance this crucial aspect of healthcare delivery. However, it is equally important to examine the communication practices of healthcare practitioners in MELF settings as they play a central role in devising and implementing medical treatment plans. The quality of communication and relationships with colleagues can have significant implications for patient outcomes, including the occurrence of medical errors. Therefore, the next section of this literature review will address the barriers to effective communication within healthcare teams and review the relevant literature.

3.3. Barriers to Effective Communication Among Healthcare Practitioners

While there have been increasing efforts to improve communication in multilingual healthcare settings (Valero-Garcés, 2018), interprofessional team communication can be challenging. Communication can take various forms, such as spoken, written, technological and face-to-face (Philip et al., 2019). Miscommunication in healthcare settings is unfortunately a well-known phenomenon and significant efforts are being made to understand the nature of healthcare settings and to find solutions to reduce medical errors resulting from miscommunication (Alahmadi et al., 2022; Tiwary et al., 2019).

3.3.1. Diverse Language Backgrounds

In multilingual settings, where interprofessional teams are of various nationalities, one of the significant obstacles is the presence of different language backgrounds, which risks leading to misinterpretations, misunderstandings, inadequate translations and so forth (Hull, 2022; Tweedie & Johnson, 2019). These challenges are particularly pressing in multilingual healthcare settings, where migration and globalization have resulted in an ever more diverse workforce (Squires & Jacobs, 2016), with healthcare teams comprising members from a wide range of nationalities and training backgrounds (Hull, 2016). Varying levels of language proficiency among team members with diverse cultural and linguistic backgrounds can result, for instance, in mispronunciation of medical terminology or names of medication (Hull, 2022).

Communication, whether verbal or non-verbal, depends heavily on situational and contextual factors (Halliday, 2006). In a medical context, this includes a comprehensive understanding of the medical scenario, the patient's current condition, full medical reporting and collaboration with other healthcare practitioners involved in the case. To overcome the likelihood of miscommunication and to exchange information effectively, it is essential to negotiate meaning and understand the linguistic, social and pragmatic context of the message (Botis & Tweedie, 2022; Ting & Cogo, 2022).

3.3.2. Language Competence

In recent years, there has been growing concern about the language competency and communication skills of migrant nurses, as they play a crucial role in facilitating effective interprofessional team communication in healthcare settings. In response to this concern, Lum et al. (2016) conducted a study in Canada to investigate the effectiveness of a nursing bridging education course provided to migrant nurses from different cultural backgrounds.

Although they found that some nurses were dissatisfied with the re-examination process and language assessments in Western countries, they argue that it is a critical component of ensuring language competence and communication skills among healthcare professionals. Their analysis of 22 multicultural nurses pointed to language barriers and issues related to English proficiency, particularly in writing, which impeded their ability to gain career licenses and to participate fully in the healthcare workforce in Canada. Notably, their study did not focus on the role of proficiency in medical English in facilitating effective interprofessional team communication.

Similarly, Moyce et al. (2015) conducted a systematic review to investigate the language competence and communication skills of global migration nurses. They found that even highly educated nurses from diverse linguistic backgrounds encountered challenges with both English language proficiency and medical terminology. Lack of language competence and confidence may hinder nurses' ability to communicate effectively with patients and healthcare providers and lead to difficulties transcribing medical orders via phone, which can lead to medical errors. Moyce et al. (2015) emphasize the critical role of promoting patient safety in nursing education and the importance of developing language proficiency, interpersonal skills and a focus on medical English to ensure effective communication and safe healthcare delivery. Botis and Tweedie (2022) reinforce this point, noting that in multilingual contexts, nurses typically use their first language where they can when discussing medical scenarios with colleagues, which can lead to complications when translating medical terms into the language used in the hospital.

In a recent qualitative study conducted in Riyadh, the capital city of Saudi Arabia, Zawawi and Alrashed (2020) explored the experiences of 16 foreign healthcare practitioners from various professions. The study revealed that language barriers were closely linked to cultural barriers and posed significant challenges to effective communication among healthcare teams. The study highlighted that the hospital's human resources staff struggled to communicate with non-Arabic-speaking medical staff and that foreign healthcare practitioners faced additional cultural issues related to working and living in the Kingdom.

3.3.3. Code-Switching and Code-Mixing

The use of different language varieties simultaneously when communicating with colleagues among whom several varieties, termed in the literature as code-switching or code-mixing (Horner & Weber, 2017), has been addressed in a few studies in multilingual hospitals (Alhamami, 2019; Alkhlaifat et al., 2020; Almathkuri, 2016; Odebunmi, 2013; Wood, 2019). It is common for multilingual speakers to employ code-switching and co-mixing as a means of bridging an information gap, especially in multilingual settings in which there is a diverse range of mother tongues, dialects and accents (Alhamami, 2019).

Alhamami's (2019) study examined the motivations for code-switching and identified positive and negative themes. The study found that participants often used the strategy of code-switching for various reasons. On the positive side, the study indicated that code-switching fosters more effective communication among healthcare practitioners and patients, particularly between speakers of different Arabic varieties, such as Gulf country speakers, Sudanese, Egyptians, Syrians and others, as well as standard and local Arabic. In addition, participants used code-switching to facilitate understanding, build relationships and translate medical reports and unfamiliar jargon, as well as to acquire new languages such as Arabic and English. On the negative side, the participants expressed feelings of disrespect, miscommunication and information gaps in situations in which code-switching was employed, particularly when discussing medical cases. This study is significant and relevant to this research as it sheds light on healthcare experiences in a multilingual Saudi context.

3.3.4. Technology

The use of mobile technology applications is an important consideration for effective communication among healthcare teams. While mobile technology has the potential to improve communication (Martin et al., 2019), it can also be an impediment. Several studies have indicated that the use of mobile technology may lead to nonprofessional and informal discussions among healthcare practitioners (Scholl & Groth, 2012; Wu et al., 2014; Wyber et al., 2013). The use of mobile technology can have negative consequences, such as breaching patient confidentiality (Moore & Jayewardene, 2014; Moon et al., 2014) and inaccuracies when using translation applications (Al Shamsi et al., 2020; Hull, 2022; Irfan & Ginige; 2018; Rahman, 2016). Indeed, an increased reliance on technology can exacerbate communication breakdowns, particularly when interpreting medical orders and patient diagnoses. These breakdowns can lead to significant litigation costs, as evidenced in the US (Slade & Sergent, 2023). Despite these potential drawbacks, healthcare

practitioners continue to employ available resources such as technology to improve communication. Therefore, it is essential for healthcare practitioners to be aware of the potential pitfalls associated with communication technologies and online resources and to use them in a responsible and effective manner to ensure optimal patient outcomes (Hull, 2022; Panayiotou et al., 2019).

3.3.5. Sociocultural Aspects

The impact of sociocultural aspects on language, and medical language specifically, is an important consideration for communication in interprofessional teams. Linguistic diversity in these teams can be a powerful tool as it allows members to bring their unique perspectives and communicate effectively with colleagues (Heist et al., 2020). However, differences in attitudes, pronunciation, social knowledge and gestures can lead to miscommunication and misunderstanding, particularly when team members rely on certain assumptions and sociocultural norms (Knutsen et al., 2020; Verma et al., 2016). Even body language and gestures can be influenced by a person's first language and culture and what may be acceptable in one culture may not be in another (Hull 2022). For example, a greeting like "hey, love" may be impolite and inappropriate in Gulf countries but considered a polite greeting in other cultures. In addition to linguistic and cultural differences, other factors, such as professional identity, power and cognitive aspects (e.g. thoughts), can also affect communication within interprofessional teams (Alshamarri et al., 2019; Botis & Tweedie, 2022; Hull, 2016; Shi, 2018; Triscott et al., 2016). For instance, a preference for one accent over another or the use of jargon can create barriers to effective communication.

3.4. Improving the Effectiveness of Interprofessional Team Communication

In healthcare settings, interprofessional teams commonly use various strategies to facilitate communication. However, due to time constraints and the nature of some jobs, gaps in communication may occur, leading to the risk of miscommunication, as discussed in the previous section. Strategies such as reading back medical requests and medications, reformulation, clarification, repetition and asking direct questions have all proven to be effective in ensuring accurate and prompt information sharing. In MELF environments, in which multilingual foreign-trained interprofessional teams are common, the use of such strategies is essential to ensure mutual understanding among interlocutors. The use of these types of strategies among interprofessional teams in MELF settings is under-researched, although studies have investigated their use in doctor–patient communication,

demonstrating that doctors and patients frequently use them to ensure correct diagnosis and to confirm understanding (Jin & Watson, 2020; Ting & Cogo, 2022).

Botis and Tweedie (2022) highlight the importance of pragmatic strategies in facilitating communication among interprofessional teams in MELF settings. The authors provide an example of miscommunication between the first author and a nursing student, when the author requested a medication plan for a patient that included taking only PO medication, meaning liquid medication (from the Latin "*per os*"). The nursing student misunderstood the abbreviation and used an approximation technique to determine that PO meant pills, thereby making sense of unfamiliar words from limited information. The student incorrectly assumed that "PO" meant pill form, which could have led to an error in medication. This example illustrates the importance of using pragmatic strategies, such as clarification, reformulation and repetition, to avoid miscommunication and ensure mutual understanding among interlocutors in MELF settings.

Notwithstanding the potential drawbacks of technology, it has been proposed as a solution offering effective communication and patient care. Studies have shown that the use of technology in medical settings results in expedited questions, requests and information exchanges (Alotaibi & Federico, 2017; Ganasegeran et al., 2017; Hsiao & Chen, 2012). In addition, pre-departure culture orientation courses, language assessments and accent accommodation have been noted in the literature as effective communication approaches in healthcare teams (Almutairi, 2015; Hull, 2022; Michalski et al., 2017; Molina & Kasper, 2019). The next section turns to the construct of linguistic mediation, which provides a useful theoretical lens for the study of communication in a multilingual setting such as healthcare.

3.5. Linguistic Mediation

The concept of mediation is an important aspect of successful communication. Piccardo et al. (2019) provide a full account of linguistic mediation, which can be defined as the process of constructing meaning through language, not only to express ideas but also as a means of accessing and conveying unfamiliar concepts across cultures and languages. The explanatory potential of linguistic mediation for this study lies in (i) the inclusion of cultures as well as languages, (ii) the ways in which research on linguistic mediation allows a better understanding of multilingual settings with plurilingual speakers, and (iii) the importance of constructing meaning through language and conveying concepts. These three elements are closely related to the aims of this thesis.

Mediation, originally a device used to overcome cultural and linguistic barriers (Engeström, 1999), entails the crafting of meanings for individuals participating in action-oriented tasks. This includes the activities mentioned above (Piccardo & North, 2019). Mediation aids in deciphering information and eliminating differences, thereby facilitating mutual understanding (Coste & Cavalli, 2015). The *Common European Framework of Reference for Languages* ([CEFR], Council of Europe, 2001) has supported the inclusion of linguistic mediation in the framework, advocating its integration into traditional language skills and portraying learners as proactive contributors to societal discourse. In the Companion Volume to the CEFR, linguistic mediation is highlighted as a vital conduit, bridging all four language skills (Piccardo & North, 2019). Along with reception, production and interaction, mediation is positioned as a key linguistic competence for speakers (North & Piccardo, 2016). This combination of skills is embodied in language activities such as delivering written recommendations or conducting diplomatic dialogues, showcasing the unified application of reception, production, interaction and mediation in communication (Council of Europe, 2001, p. 157).

Originally, the linguistic trajectory outlined in the CEFR was predominantly aimed at foreign language education, perceiving learners as social agents fulfilling tasks based on the construction of internal and external meanings (Piccardo, 2017). This perspective offers educators tangible goals and frameworks for collaborative tasks, such as presenting or drafting assignments (North & Piccardo, 2016). It proposes an integrated approach to language teaching, going beyond traditional methods and encouraging a dynamic learning environment. Moreover, it highlights the importance of sustained social and cognitive engagement during mediation, regardless of the task (Vygotsky, 1978, as cited in North & Piccardo, 2016). Hence, language becomes an engaging activity that employs a range of competencies and extends beyond educational settings into everyday life. However, it should be noted that the concept of mediation in the 2001 edition of the CEFR was undeveloped and remained so until recently.

The CEFR has evolved to address the need for more extensive validation, embracing globalization and plurilingualism, rather than viewing languages as separate units (Trim, 2007). This evolution aligns with the increasing emphasis on linguistic description scales (CEFR, 2020). The framework is now shifting towards a more interactive model, highlighting the significance of mediation and mediation strategies. Mediation, no longer restricted to the classroom, is shown to be relevant in real-world situations, such as diplomatic negotiations or counselling sessions (Piccardo, 2014). This practical application has extended the reach of mediation into diverse domains, resulting in

various interpretations across the linguistic, social, cultural, pedagogical and textual fields and even the media (Piccardo et al., 2019). Mediation can take place within a single language or plurilingually across languages, encompassing both source and target languages (CEFR, 2020).

Mediation encourages plurilingualism and pluriculturalism, bridging diverse languages and integrating multiple aspects and theories – including affordances, cognitive aspects and sociocultural theory – in the mediation process (Piccardo et al., 2019). This is manifested in the CEFR through the three stages of mediation: mediating texts, mediating communication and mediating concepts (Council of Europe, 2018). The framework's language descriptors aim to demonstrate plurilingualism by employing both linguistic and non-linguistic tools, individual competencies and spoken and written languages to minimize miscommunication.

The importance of mediation is self-evident, especially when updating educational materials or curricula using CEFR descriptors. It can play a critical role in medical English education, providing a range of strategies for mastering the medical language essential for healthcare communication. Since mediation is context-dependent (North & Piccardo, 2016), focusing on the mediation strategies used by healthcare practitioners could dramatically enhance communicative proficiency in healthcare. This study, focusing on communication among healthcare practitioners, aligns with this perspective. It advocates for the application of mediation strategies in diverse contexts, such as those referred to by the CEFR, i.e. plurilingual or pluricultural (Piccardo, 2017).

In linguistically diverse healthcare environments, miscommunication can have severe consequences. Mediation mitigates communication challenges, supporting a better understanding of the medical scenario and treatment plan. This is particularly relevant in MELF settings, where healthcare practitioners originate from various cultural backgrounds and have different levels of English proficiency. The CEFR Companion Volume specifically refers to mediation in the context of clinical interviews, in which interactions with patients or healthcare practitioners often involve decoding medical jargon or using existing information to clarify health procedures and prescribe medications (CEFR Companion Volume, p. 80).

The increasing movement of refugees and migrants across different regions in Europe has led to the creation of intercultural mediators by the WHO European regional office. These mediators aim to overcome barriers such as issues with the accessibility of healthcare, including legal and financial restrictions, as well as linguistic and cultural barriers (Verrept, 2019). In their role as linguistic mediators in healthcare settings, they

translate spoken or written information between doctors and patients, resolve miscommunication and address social and cultural issues to bridge these gaps (Čebron et al., 2017; McCorry & Mason, 2020; Qureshi et al., 2010). Their role provides support for equitable and positive patient care delivery (Ciordia, 2017). However, the intercultural mediator project appears to lack effectiveness and implementation in other countries (Verrept, 2019).

Furthermore, in regions where interpreters are scarce, healthcare practitioners often mediate, breaking down information gaps to clarify complex medical concepts for colleagues. This could be viewed as a form of self-mediated communication, conveying complex ideas in a manner comprehensible to individuals lacking specific knowledge. In such instances, it is crucial to re-evaluate the medical language used, exercise creative thinking and adapt care provision to diverse sociocultural contexts (Molina & Kasper, 2019).

3.6. Conclusion

This chapter has offered valuable insights into the nature of communication in healthcare settings, narrowing the focus to explore interprofessional team communication. It has examined various barriers to effective interprofessional communication, attributing these to a range of factors, such as diverse language backgrounds, language proficiency, code-switching and mixing, technology and sociocultural influences. In addition, this chapter has outlined strategies aimed at enhancing the effectiveness of communication among interprofessional teams. It culminated in aligning these discussions with the framework pertinent to the study, specifically linguistic mediation. The next chapter details the methodology, including the three research phases and steps involved in conducting this study.

Chapter 4. Methodology

4.1. Introduction

This chapter presents the research objectives and questions and outlines the rationale underlying the choice of the research methodology. It also illustrates the processes involved in conducting this qualitative exploratory cross-sectional study. It discusses the design and rationale for the three research phases applied, the selection of study participants, the procedural steps for data collection, the analytical steps used for data interpretation and ethical considerations.

4.2. Research Objectives and Questions

The central focus of this research is on investigating MELF and determining the effectiveness of communication among healthcare practitioners in multilingual healthcare environments, specifically in the three hospitals used in this study. The study aims to provide answers to the following research questions:

RQ1: What are the key current research findings related to communication and miscommunication in healthcare settings?

RQ2: Does medical language represent a particular obstacle to the effectiveness of communication between healthcare practitioners? If so, what communication strategies are used to overcome this obstacle, and how do these strategies impact the effectiveness of communication?

RQ3: Does the linguistic and cultural background of healthcare practitioners have an impact on the effectiveness of communication?

RQ4: What do healthcare practitioners perceive is needed to improve the effectiveness of communication in healthcare settings?

To fulfil the research objectives, three research approaches were planned and completed sequentially:

1. A scoping review of research on medical English as a lingua franca (MELF)

2. A survey of healthcare practitioners

3. Semi-structured interviews with healthcare practitioners

4.3. Research Design

This research project comprised a qualitative exploratory cross-sectional study, using a mixed-method approach that consisted of three phases: a scoping review, surveys, and interviews. To ensure the validity of these findings, I implemented triangulation as advised by Merriam (1998). Triangulation is an approach in which the researcher uses multiple sources and techniques for data collection to ensure validity. This method was employed through conducting a scoping review and the collection of data using surveys and interviews.

According to Tashakkori and Creswell (2007), a mixed-methods design is defined as "research in which the investigator collects and analyses data, integrates the findings, and draws inferences using both qualitative and quantitative approaches in a single study or program of inquiry" (p.4). The preference for a mixed-methods approach utilizing a concurrent design was influenced by two predominant factors.

Initially, the focus on healthcare practitioners required rapid data collection, constrained by the limited time availability typical of this profession and the challenges associated with accessing participants. This urgency justified the adoption of a design that could efficiently handle the complexities of the research context within the available timeframe.

Subsequently, this approach's efficacy lies in its capability to provide an encompassing comprehension of a specific phenomenon, allowing for simultaneous resolution of research questions and issues while taking advantage of both qualitative and quantitative methods at any research phase (Yin, 2006). Using a variety of mixed methods for analysis paves the way for accommodating a wide range of perspectives and integrating various approaches to achieve the intended objective, demonstrating the validity and efficacy of mixed methods (Johnson & Onwuegbuzie, 2004; Teddlie & Tashakkori, 2009).

However, Cohen, Manion and Morrison (2007) underscore that although relying on a single method of investigation might be beneficial for tackling problems and addressing research questions in fields such as medicine, chemistry, and physics, it may be insufficient when investigating phenomena, cultures, or behaviors encompassing human communication. Johnson and Onwuegbuzie (2004) echo the significance of using mixed method, stating that in today's globalisation and interdisciplinary world, necessitate a methodological integration to ensure more robust conclusions and enhanced understanding.

Nevertheless, the implementation of mixed-methods designs is not without criticism. Doubts surrounding the use of a mixed-methods design in research stem from constraints pertaining to time, resources, and skills (Zou, Sunindjio, & Dainty, 2014).

Furthermore, the fact that quantitative and qualitative designs are distinct methods that prove challenging to integrate in a single study due to the objective role of quantitative research (theory testing with a fixed numerical structure) and the subjective role of qualitative research (theory development with a more flexible structure for in-depth analysis) adds to this criticism (Antwi & Hamza, 2015).

As a result of the scoping review, two instruments were adopted to develop this study, which can be classified as QUAN+QUAL, using a concurrent design with balanced dominance between the two instruments. The goal of using this design is to mitigate bias and to accommodate the strengths of both quantitative and qualitative methods, thereby reducing their weaknesses (Johnson & Onwuegbuzie, 2004). In my view, combining both methods equally, rather than focusing solely on one, will allow me to obtain a detailed picture of healthcare practitioners' communication in multilingual health environments, as well as the impact of medical language and strategies employed in such critical situations.

To gain insights into healthcare practitioners' perspectives this approach was implemented at three government hospitals in Saudi Arabia. The following sections present the three research phases, beginning with the scoping review. This is followed by an outline of the survey, including the design, administration and piloting. Finally, the interview protocol and sampling are explained.

4.4. Research Phases

4.4.1. Scoping Review

In this study, the first phase was a scoping review, which was instrumental in shaping the subsequent survey and interview protocol. Adopting the framework of Arksey and O'Malley (2005), this review focused on communication strategies among healthcare practitioners in multilingual settings, a critical area in the context of globalization. The primary objective was to uncover key research findings related to communication and miscommunication in these settings, thereby informing the development of the research instruments used to collect primary data. The methodology, findings and implications are comprehensively detailed in Chapter 5.

The scoping review was selected for its ability to explore literature systematically, highlighting under-researched areas and identifying research gaps. This exploration is crucial to develop informed research questions and tailor the study instruments. Specifically, the review in this research targeted literature related to healthcare practitioners, excluding patient perspectives to maintain alignment with the research objectives. This focused approach was key in ensuring that the outcomes of the review

would be directly applicable to the development of the survey and interviews, thereby enriching the overall methodology.

For a more in-depth discussion of the scoping review, including the methodology, research questions, thematic analysis and detailed findings, see Chapter 5. This chapter elaborates on the scoping review process and its significance in the context of the study, illustrating how it served as a foundational element in shaping the research methodology.

4.4.2. Survey

As part of the study methodology employed in this research, a survey with close-ended items was designed and administered. Surveys have been recognized as an instrumental and uncomplicated means of data collection, offering direct access to participants (Marshall, 2005). Survey tools can be analysed using either quantitative or qualitative techniques. The design selected for this study included mostly close-ended questions, to be analysed using descriptive statistics, along with a small number (5) of open questions.

Considering the objective of this study, i.e. to explore healthcare practitioners' beliefs and attitudes regarding effective communication, communication strategies and medical language, careful consideration was paid to the survey design. This research employed a survey adapted from a small-scale study by Kwan and Dunworth (2016), focusing on ELF and communication strategies used between Filipino employees and Hong Kong employers in the Hong Kong domestic workplace (see Appendix A).

As suggested by Dörnyei (2007) and Harkness (2010), using an existing survey to investigate a new demographic or context is permissible, provided alterations to the adapted instrument are acknowledged and tailored to suit the requirements of the current study. The decision to adapt Kwan and Dunworth's (2016) published survey was influenced primarily by the relevance of their study to the aims and objectives of this research and secondarily by the desire to examine a larger scale within a unique context. Adjustments were made to the format of the pre-existing adapted survey to better meet the study's needs, including considerations of cultural differences and the specific population group (see Appendix B). These modifications will be elaborated on below.

The distribution of surveys can be facilitated via various methods, such as distributing physical copies or administering digital versions. Electronic surveys are increasingly recognized as an efficient medium for securing immediate responses from a designated population or in a challenging context (Wright, 2005). Online surveys grant researchers the advantage of efficiency while mitigating the inconvenience of traditional methods. Dillman (2007) underscores the temporal benefits of online surveys, saying:

…the time required for survey implementation can be reduced from weeks to days, or even hours. Most importantly, the introduction of electronic survey methodologies offers the potential for dramatically reducing the close correspondents between sample size and survey costs. (p. 352)

Moreover, administering online surveys offers flexibility and convenience. In today's modern global climate, participants may experience less pressure to complete the survey and be able to do so at their convenience. Moreover, automatic data storage simplifies the subsequent data analysis process (Paltridge & Phakiti, 2015). Nevertheless, as with any data collection method, employing online surveys is not without its drawbacks. It is necessary to recognize and address these limitations with care to safeguard anonymity and avoid potential complications.

Wright (2005) believes that concerns regarding online surveys often stem from validity, sampling procedures and implementation difficulties. In this study, I adopted several measures to address these issues, such as following up with participants via WhatsApp and in person during hospital working hours. In addition to providing a brief overview of the study and contact details in case of queries, the survey included demographic information, such as age, gender, nationality, first language and the language used during work hours and breaks. A specific question was included to ascertain the variety of modern standard Arabic spoken by those who selected Arabic as their first language. In view of its importance in fulfilling the research objective, this question was a practical means of ensuring participants' self-awareness when responding to the survey. Microsoft Forms was used to design and deliver the survey link, restricting access to a single entry per participant and requiring completion of all questions in a section before progressing to the next. These precautions were taken to safeguard privacy and trust (Andrews et al., 2003). Further discussions concerning the validity and reliability of these measures, along with details concerning the survey design, will be elaborated in the following sections.

Survey design

As previously mentioned, the design of the study survey built upon the framework established by Kwan and Dunworth (2016) and was tailored to address the cultural and contextual specificities of the participant group. Since their study focused on two small specific groups (Filipino employees and Hong Kong employers), the relevance of their study to my objectives attracted my attention to the suitability of applying the survey to

explore communication among many healthcare practitioners from all departments in the three hospitals, irrespective of nationality.

The original 17-item Likert-type scale, assessing both frequency and importance, was expanded in this study to comprise a 28-item scale across three dimensions: frequency, importance and their intersection. This sought to capture a more detailed view of participants' perceptions, enhancing the depth of the data collected.

Lexical adjustments were made throughout to accommodate the MELF context of the participating healthcare practitioners, ensuring clarity and reducing ambiguity. This involved, for instance, including "in English" in items in the first and second sections, allowing participants to focus only on the use of English in the hospital. In the first section, the questions focused solely on the frequency of communication challenges, while the latter sections focused on rating the importance of these communication aspects in the hospital environment. The adjustments allowed the participants to reflect first on the challenges faced when using English in patient care, setting the stage for their responses in the latter sections.

Items from the original survey that referenced domestic work environments were adjusted to reflect medical settings. For example, Item 1, which probed challenges due to varying expectations, was refocused to ask about challenges when following English instructions in medical scenarios. The original Item 4, related to issues of "face" in politeness theory, was excluded due to its lack of relevance in the immediate medical context. Item 4 in the revised survey was "tweaked" to suit the Saudi context and be more specific: the original question asked about the "challenges of 'implied' meanings that are not or may not be understood, such as, 'we're out of sugar' to suggest that we need to buy sugar", which was unlikely to be understood by a practitioner in a Saudi workplace. Instead, I provided an everyday example: "saying it's cold in here may mean we need to turn off the air conditioning". Similarly, Item 9 was altered from addressing "cultural vocabulary" to "common vocabulary in general conversation"; this aligned better with ELF and culture was then discussed extensively in the interview. Two additional items were introduced in the first section, addressing language structure and challenges with medical terminology in English (Items 8 and 10).

The second section, which was not present in the original survey, replicated the items in the first section, but shifted the focus to their importance in the hospital setting. In the third section, specificity was increased by including: "my colleagues' words" in Items 21–24 to facilitate understanding. I refined the strategies discussed, replacing "clarification after being misunderstood" with "correcting my language", in addition to adding an item

on simplifying language as a communication strategy (Items 26 and 27). A detailed description of the survey is presented below.

Cover page: This section provided a brief introduction to the study, including its aim and purpose. It also informed participants of their voluntary participation, the ability to withdraw, the name of the university and the data controller's office and contact details for the supervisor and researcher. Additionally, it contained an option for participants to give their consent to take part in the study.

Section 1: This section aimed to assess the frequency of various challenges experienced by the participants during their work in the hospital. Items 1–10 focused on how often the participants faced different challenges related to communication. Each was rated on a Likert-type scale from 1 (never occurs) to 4 (occurs all the time).

Q1, "I notice that challenges can arise among colleagues when receiving instructions in English in medical scenarios (e.g. completing medical tasks at work)", sought to understand how often participants faced difficulties due to language barriers while receiving instructions in English in a medical context. This could highlight issues with English language proficiency or comprehension among healthcare practitioners.

Q2: Aimed to identify how frequently participants encountered challenges due to differences in politeness norms when communicating in English. This could shed light on potential cultural miscommunication or conflicts that might arise due to diversity among healthcare practitioners.

Q3: Sought to determine the frequency of issues arising from different expectations of etiquette. This could reveal the impact of cultural differences on effective communication in the medical contexts.

Q4: Assessed how often indirect messages or implied meanings in English cause communication challenges. This might indicate issues understanding nuances or idioms in English.

Q5: Measured the frequency of difficulties due to the manner of addressing each other in English. This could reveal problems related to formality/informality, professional hierarchy, power dynamics, or cultural norms.

Q6: Sought to understand how often participants struggled with positive or negative answers to "Yes/No" questions in English. This might indicate difficulties understanding English language syntax or conventions.

Q7: Evaluated how frequently the participants faced challenges due to their colleagues' pronunciation when speaking English. This could indicate issues with accents, dialects or clarity of speech.

Q8: Aimed to determine how often the language structure used by colleagues in English posed challenges. This might reveal problems understanding complex sentence structures or grammatical forms.

Q9: Explored how often different vocabulary was used in general conversations and posed a challenge. This could highlight issues with regional dialects or variations in English usage.

The last question in this section, Q10, measured how often different medical terminologies used in English cause difficulties. This could reveal issues with specific professional jargon or technical language use.

Section 2: This section aimed to understand the perceived importance of several aspects of effective communication during participants' work in the hospital. Items 11–20 mirror those in Section 1 but ask participants to rate their importance rather than frequency, from 1 (not important) to 4 (very important). The questions in this section aimed to help highlight which aspects of communication the participants viewed as most crucial for their work, helping to prioritize areas for potential attention or support.

The first question in this section, Q11, assessed the perceived importance of understanding instructions in English in different medical scenarios. This might indicate how crucial clear communication of tasks and procedures is considered within the medical environment.

Q12: Was intended to determine the importance of politeness norms when communicating with colleagues in English. This could provide insights into the role of cultural norms in the participants' work environment.

Q13: Measured the perceived importance of shared expectations of etiquette. This could shed light on the significance of mutual understanding and respect for cultural norms in fostering a collaborative work environment.

Q14: Evaluated the importance of understanding indirect messages or implied meanings when speaking English. It indicated the significance of understanding small details and nuances in communication.

Q15: Focused on the importance of a shared, acceptable way of addressing one another in English. This could reveal the perceived significance of maintaining professional relationships and hierarchies in communication among colleagues in medical settings.

Q16: Measured the importance of understanding positive and negative responses to "Yes/No" questions in English. This sought to highlight the importance of correctly interpreting the intent of such responses.

Q17: Identified the importance of clear pronunciation when colleagues speak English. This could indicate the value placed on clarity of speech for effective communication.

Q18: Investigated the importance of clear language structure when colleagues use English. This could indicate the importance of grammar and syntax in understanding and conveying information.

Q19: Measured the importance of using common vocabulary in general conversations in English. This could highlight the significance of shared language in promoting clear communication.

Q20: Illustrated the importance of using common medical terminology when English is used. This shows the significance of using standard professional terms for efficient and accurate information exchange.

Section 3: This section contained Items 21–28 and was designed to identify the importance and frequency of various effective communication strategies that participants employ when interacting with their colleagues.

Q21: Assessed the frequency and importance of the strategy of focusing on content and reformulating unclear sentences to enhance understanding.

Q22: Examined how often and how important participants found the strategy of letting unclear words pass and relying on the progression of conversation for clarification.

Q23: Measured the frequency and importance of correcting language errors immediately as a strategy to improve understanding.

Q24: Sought to identify how often and how important participants found the strategy of asking direct questions to clarify unclear statements.

Q25: Measured the frequency and importance of correcting one's own language errors to make the language more understandable when a colleague misunderstands them. In Q26, the participants were asked how often and how important they found the strategy of correcting their language structure to improve understanding when a colleague misunderstands them.

Q27: Assessed the frequency and importance of simplifying language to enhance understanding when there is a misunderstanding between colleagues.

Q28: Measured the frequency and importance of repeating statements to reach mutual understanding when a colleague misunderstands them. The strategies in Section 3 could reveal common methods used by participants to overcome miscommunication and offer insights into potential training or guidance that would help improve communication further.

Section 4: The final section of the survey collected data on the participants' demographic characteristics to enrich the understanding of their experiences and perspectives:

- Age provided insights into factors like experience, adaptability and familiarity with communication styles.
- Gender explored possible influences on communication styles and perceptions.
- Nationality and First Language offered an understanding of cultural and linguistic background, vital in a medical context.
- For those identifying Arabic as their first language, the specific Variety of Modern Standard Arabic was noted to determine differences between or challenges related to various Arabic dialects.
- Other Languages Used and the Language Used Most Often at Work (both for medical tasks and during work breaks) reveal the linguistic diversity and primary language of communication within the hospital.
- English Language Competence assessed self-reported proficiency, giving context to responses and highlighting areas for possible language support.
- Other Challenges and Additional Comments allowed for open-ended responses, offering insights into issues not covered previously and feedback on the survey.

Survey piloting

As part of the assessment of a survey instrument, reliability pertains to the consistency of measurement outcomes, which is crucial for ensuring the accuracy of the data collected (Nunan, 1992). This concept encompasses several key aspects: (1) repeatability, which refers to the ability to obtain consistent measurements under unchanged conditions; (2) stability over time, ensuring that measurements remain consistent across different time points; and (3) consistency, which denotes consistent measurements within the same timeframe (Kirk & Miller, 1986). Reliability, alongside validity, plays a vital role in the reduction and estimation of measurement errors when employing specific instruments for data collection (Streiner et al., 2008). In other words, reliability is the degree to which an instrument consistently produces the same results, whereas validity is how well an instrument measures our objectives (Watson, 2015).

Moreover, Watson (2015) highlights that the enhancement of reliability and validity may necessitate modifications to the instruments utilized, particularly when their initial levels prove insufficient. For instance, in survey methodologies, refining questions, eliminating ambiguities, and eliminating unclear items are common practices aimed at improving measurement instruments. These enhancements can subsequently be evaluated through empirical analysis, using tools such as the SPSS program to calculate mean values and reliability scores. Cronbach's Alpha, a widely recognized statistical measure for assessing internal consistency, is frequently used to evaluate the reliability of survey items (Singh, 2017). This method is particularly valued for its ability to detail the cohesion of related items within a survey instrument. Despite the acknowledged effectiveness of such measures for enhancing instrument reliability, it is important to note that the survey instrument employed in this study was not subjected to reliability testing using statistical measures such as Cronbach's Alpha.

Establishing the validity of research instruments is fundamental to ensure their quality. Specifically, they should accurately measure what they are designed to measure based on the research objectives and questions (Dörnyei & Csizér, 2012). In this study, even though adaptations and modifications were made to the survey items, considerable attention was paid to ensuring their validity and reliability. This was aimed at guaranteeing the quality of the research instruments and the data they generated.

The role of content validity in this study was particularly critical and entailed examining the representativeness of the content in addressing the study purpose (Creswell, 2005). The survey was rigorously reviewed and I received feedback from my supervisor and three experienced individuals, including two professors from a university in Saudi Arabia and a member of Qassim's Scientific Research Committee. Following these reviews, amendments were made to the content before distribution.

To further confirm validity and reliability, a pilot study was carried out, as advocated by Cohen et al. (2007). Due to the limited time available to travel to Saudi Arabia and collect data within the constraints of the PhD schedule, the pilot study encompassed 15 participants, chosen to represent varied roles within the hospital setting. These individuals were contacted using my personal connections. Before conducting the pilot study, the survey was translated into Arabic, offering participants the choice between English and Arabic versions. I undertook the translation into Arabic and then had it thoroughly reviewed by two expert translators to confirm the accuracy of each statement. Feedback from the pilot study did not warrant any additional modifications to the survey. However, the exercise was beneficial in providing an estimation of the time required to

complete the survey, which ranged from 10 to 15 minutes. This was detailed in the online survey and the participants' information leaflet.

4.4.3. Interviews

In this study, the use of semi-structured face-to-face interviews was preferred, as this mode would foster an informal environment in which the participants and I could converse (DeJonckheere & Vaughn, 2019). This data collection procedure was perceived to be the most suitable given the time constraints and the medical context in which the study participants were working. Moreover, asking open-ended questions was instrumental in obtaining unique viewpoints and empirical evidence from the respondents (Polit et al., 2012).

Hence, semi-structured interviews were employed with the objective of gathering insights into healthcare practitioners' perspectives concerning the effectiveness, or failure, of communication among their colleagues within a multilingual medical context. The overarching aim was to identify and understand the linguistic and cultural challenges that arise in such settings and the impact of medical English on their communication, as well as to identify communication strategies healthcare practitioners implement to avoid or remedy miscommunication.

Interview piloting

The piloting phase involved a thorough review and discussion of the interview questions with my supervisor, thereby ensuring the clarity of the questions and avoiding potential misconceptions that could impede the data collection process. The purpose of this collaborative exercise was to establish content validity. Subsequently, a preliminary pilot interview was conducted with two physicians and one nurse, contacted through personal communication. The piloting step served to verify the clarity of the interview questions, as well as assess the efficacy of the research instrument. The insightful feedback gathered from medical professionals affirmed the clarity and relevance of the interview questions, thereby improving their potential to extract the necessary data for this research.

The interview questions were revised to ensure their relevance and appropriateness within the research context, thereby enhancing data collection. The questions were designed to explore effective communication in healthcare settings, identify barriers to medical language, examine communication strategies employed by healthcare practitioners, assess the impact of practitioners' cultural and linguistic diversity on the

success of communication and identify ways of improving communication in healthcare settings.

The final set of interview questions sought to strike a balance between structure and flexibility, using the semi-structured format to ensure topic coverage while allowing the participants' narratives to emerge naturally. As detailed in Appendix C, these adapted questions were pivotal to the ensuing insightful discussions, focusing on the efficacy of practitioners' communication. The questions were derived from Kwan and Dunworth (2016), albeit with modifications to align with the study objectives. Of the original eight questions, I adapted five, making minor yet significant changes. These included replacing "domestic environment" with "healthcare settings" and substituting "working overseas" with "Saudi hospitals" to concentrate on experiences in medical settings. Furthermore, in Question 4, "English language proficiency" and "English language communication" were rephrased to "medical English language proficiency" and "general English language communication skills" to better suit the study context. The final interview questions were as follows:

1. What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?
2. What kinds of strategies do you use to prevent misunderstandings with your colleagues?
3. What kinds of communication strategies would you advise medical staff to use in a work setting?
4. What do you think is more important in healthcare settings: medical English language proficiency or general English language communication skills? Why?
5. What knowledge, skills, attitudes and awareness related to language and communication do you think are important for staff in Saudi hospitals?

Interview administration

In obtaining the interview data, it was necessary to undertake a critical evaluation of healthcare practitioners' perspectives to address the research questions. Having been granted access to all hospital departments (see Appendix E), the interviews were conducted across various departments. This strategy was implemented to counter potential bias and ensure the representation of diverse roles, nationalities, and genders. Due to the delicate nature of the context and the constraints of accessibility for the participants, I conducted the interviews during regular working hours across the three hospitals from April to

September 2022, making myself available for both morning and evening shifts. Appointments were scheduled with the healthcare practitioners at their convenience.

This led to 59 interviews across different departments. The duration of the interviews varied significantly: the shortest interview lasted just 3 minutes, the most common length of interview was approximately 15 minutes, and the mean duration was 12 minutes, with the longest session lasting 36 minutes. The choice of language was left to the participants' preference (Arabic or English). The interviews were carried out in designated meeting spaces, thereby guaranteeing privacy and a conducive atmosphere for open discussion. The participants could freely articulate their views and perceptions, without feeling constrained by discomfort or pressure. Prior to each interview, an overview of the research goals, objectives and areas of interest was provided, facilitating a meaningful discussion. Most of the participants expressed interest and affirmed the significance of the research topic for their professional experience.

Each interview began with ice-breaker questions, fostering a smooth flow of conversation. This was followed by briefing participants about the research aims, objectives and interests, creating an engaging interview that included open-ended questions to allow for any concerns or questions to be addressed (Price, 2002). Throughout the conversation, I posed insightful questions such as, "Could you elaborate on…?", "What were your feelings about…?" and "How did you manage that situation…?". Incorporating these questions helped ensure I did not miss pertinent information (Creswell, 2013).

The intent of these interviews was to explore practitioners' perspectives on effective communication, the influence of medical language, the impact of cultural and linguistic diversity and the issue of miscommunication. Furthermore, questions were asked regarding the communication strategies employed to prevent potential miscommunication. The objective underpinning these interviews was to collect comprehensive data from the participants, facilitated by the interview questions presented in Appendix C.

4.5. Sampling, Distribution and Participant Recruitment

Selecting a sample that truly represents a given population poses a considerable challenge in research (Gray, 2014). This study aimed to gather a sample that embodied the characteristics of healthcare practitioners working in the three hospitals, i.e. from different cultural backgrounds and nationalities. The purpose of this was to ensure credible and in-depth rich data collection and to address the research questions effectively. Notably, the nature of the data collection environment in this study was sensitive, especially considering

access to participants across all departments, including the Emergency Department and Intensive Care Units.

While preparing for my research, I used one of my visits to Saudi Arabia to familiarize myself with the fieldwork locations, specifically the hospitals where my research was to be conducted. Crucial interactions were established with the gatekeepers, essentially the directors of each hospital and the head of the research committee within the Ministry of Health (MoH). These interactions were pivotal in illustrating the process of securing ethical approvals and authorization letters, which in turn greatly simplified my research preparations.

After securing ethical approval from the research committee at Trinity College (Appendix D), I reached out to the gatekeepers, providing them with the invitation letter, participant information leaflet, survey, interview questions, and informed consent forms. The gatekeepers required the completion of a six-hour online clinical practice course, covering modules on research integrity and the execution of research within medical settings (see Appendix F). Having satisfied the requirements in both English and Arabic, I submitted all relevant documentation in the two languages to the gatekeepers. They, in turn, approached potential participants across diverse departments, informing them of the research and inviting their participation.

Upon commencing the fieldwork, I was granted permission to access all three hospitals involved in the study (see Appendix E) to present my research, along with an ID card facilitating access to all three hospital facilities. At the interview stage, the participants were provided with a hard copy of the participant information leaflet, which outlined the interview process in detail. Once they had confirmed they understood their rights and the research process, informed consent was obtained. Considering the policy of gender segregation in Saudi Arabia, male participants were interviewed within designated meeting rooms in each medical department, whereas female participants were interviewed either in the meeting rooms or in their personal offices.

The survey (see Appendix B) was distributed to healthcare practitioners in all three hospitals. The administration of the survey was systematically coordinated to secure comprehensive and authentic feedback. Both electronic and paper-based formats of the survey were provided to accommodate various preferences. Electronic versions were distributed through official communication channels, such as email and WhatsApp, thereby offering participants convenient access, while physical distribution of the paper-based surveys was adopted, handing out 120 copies with assistance from the gatekeeper. Engaging directly with the participants was essential for laying out the research objectives,

a process that not only allowed immediate responses to inquiries but also fostered a transparent and trusting environment. I personally distributed the surveys, strategically doing so during morning and afternoon breaks to accommodate the schedules of the participants. The support of departmental gatekeepers was crucial, facilitating the smooth delivery of surveys across all departments, with some directors even requesting additional copies for a wider reach. Being present at the hospital during working hours was advantageous for the efficient dissemination of the surveys.

In all hospital departments, meticulous protocols were followed. In collaboration with the gatekeepers, relevant documents were distributed in advance, enabling healthcare practitioners to engage during shift changes without interruption. Prior to entering these departments, I was aware of the protocols and schedules, ensuring a smooth distribution process. To enhance participation, follow-up reminders were shared, as agreed in advance, through various channels, including WhatsApp and social media platforms, as well as through the assistance of gatekeepers, emphasizing the pivotal role of their contribution. The participants were guaranteed confidentiality and assured that their feedback would remain anonymous and be used exclusively for research.

In terms of sampling strategies, diverse methods were employed, considering factors such as sample collection timing and relationships (Onwuegbuzie & Collins, 2007). This study acquired survey and interview data concurrently, with the interviewees forming a small nested subset of the same population. The use of convenience and snowball sampling was deemed appropriate, given the nature of the research questions, objectives and the selected participants. In the initial phase, surveys were distributed to healthcare practitioners across all departments in the three hospitals after receiving ethical approval. This was achieved through the hospitals' main communication channels, such as their WhatsApp groups and emails. The hospital gatekeepers facilitated access to the various departments. The aim was to collect data from 100 participants from each hospital. A total of 303 surveys were received from the three hospitals. The availability of my contact information in the survey prompted some participants to reach out, expressing interest in the topic and arranging interview appointments. A total of 59 participants were recruited across the three hospitals for the interview phase: King Fahd Specialist Hospital (KFSH, N = 15), the Maternity and Children's Hospital (MCH, N = 20) and Buraidah Central Hospital (BCH, N = 24), encompassing both male and female participants.

Although the sampling techniques implemented in the study facilitated access to a diverse range of participants, it is also necessary to address potential limitations, particularly those related to participant selection. The primary sampling methods used were

convenience sampling and snowball sampling. Convenience sampling allowed for the efficient gathering of data from healthcare practitioners available during distribution periods. In snowball sampling, existing participants were referred to new participants, which helped reach a broader network.

In spite of their effectiveness, these techniques are not without their limitations. Convenience sampling may lead to a sample that is not fully representative of the entire population, as it tends to include those most readily available or willing to participate. Snowball sampling can introduce selection bias, as the network of participants might share similar characteristics or viewpoints, leading to biased results.

To mitigate these limitations, maximum variation purposive sampling, referred to as heterogeneous sampling, was employed. This method is highly regarded for its ability to lead researchers to deeper insights into the phenomena being studied by considering various aspects (Onwuegbuzie & Collins, 2017). By applying maximum variation purposive sampling, the study ensured the inclusion of a diverse range of healthcare practitioners from different departments and backgrounds, thereby enhancing the representativeness of the sample. This strategy aimed to capture a wide scope of experiences and perspectives, providing a more comprehensive understanding of the research topic. The target sample size was designed to achieve data saturation, with 100 participants per hospital for the survey phase and 59 participants for the interview phase, ensuring sufficient data to address the research questions comprehensively.

Despite these efforts, some degree of bias may remain. However, the combination of convenience, snowball, and purposive sampling was deemed appropriate for this exploratory study, aiming to capture diverse perspectives across different hospital departments. By addressing these limitations and employing multiple sampling strategies, the study strives to present a comprehensive and credible analysis of healthcare practitioners' experiences.

4.6. Ethical Considerations

To reinforce the ethical foundations of this research, I undertook ethical research training at Trinity College Dublin and participated in a mandatory online course provided by the MoH that focused on the unique challenges of healthcare settings and research integrity. This ensured that the research process was both trustworthy and ethical.

This study made the explicit decision to engage exclusively with healthcare practitioners, excluding patients and their families at all stages. This choice was based on the aim of mitigating any potential harm to patients and ensuring that the research did not

inadvertently affect the delivery of care. Furthermore, to ensure that the research process was ethically robust, several documents were prepared and used, such as the letter to the gatekeeper, the survey, the interview questions, consent forms and a detailed participant information leaflet.

Following the preparation of these documents, ethical approval was granted by Trinity College Dublin in March 2022 (Ethical Approval No. HT39). To access participants across various hospital departments, permission was sought from the Qassim Health Cluster and associated gatekeepers in three hospitals. After meeting all the requirements established by the research committee, approval for fieldwork was granted by the Saudi Arabian Cultural Bureau in Dublin. The research was conducted in adherence to the guidelines of the British Educational Research Association (BERA, 2011), ensuring that both surveys and interviews distributed to healthcare practitioners followed ethical guidelines.

Gatekeepers provided an initial introduction to the research. The study objectives and aims were clearly communicated to every participant through an information leaflet. The participant information leaflet, available in hard copy, emphasized participants' right to withdraw at any stage and set out the steps taken to ensure confidentiality and protect identities. Prior to data collection, signed informed consent forms were collected. Participants were explicitly informed that their interviews would be audio recorded, ensuring they were fully aware of the process. The participants were encouraged to raise questions throughout the interview. Whenever required, I rephrased questions in simpler Arabic or English to guarantee thorough comprehension. It should be noted that all the interviews were audio-recorded, as was clearly stated in the consent form.

For departments with heightened sensitivity, such as the Emergency and Intensive Care units, a collaborative effort was made in coordination with gatekeepers and the heads of the departments. The surveys, participant information leaflets and interview questions were distributed in advance. This approach allowed voluntary participation during shift changes, ensuring minimal disruption to critical medical services and maintaining the integrity of the research process.

To safeguard the participants' identities, their names and roles were omitted from every phase. During the preparation of the interview data, transcripts and analysis, pseudonyms were assigned and employed. To mitigate any harm, the interview questions were crafted with sensitivity, avoiding potentially triggering topics. The participants were frequently reminded that they could skip questions or stop the interview if they felt uncomfortable. While there was no direct financial compensation, they were apprised of

the broader implications of their participation for future research and policymaking. They were also given access to a summary of the findings. A post-study feedback mechanism was set up and the participants were guided on how to access the study outcomes.

4.7. Data Analysis

For the quantitative data, total of 303 surveys were initially returned in this study. To ensure the integrity of the data, a meticulous validation process was undertaken. This involved a careful review of each participant's responses, a crucial step in preparing the data for statistical analysis. The review showed that 112 of the surveys were incomplete and they were therefore excluded from the dataset to maintain statistical consistency. This was necessary, as partial responses could potentially compromise the reliability of the analysis (Dong & Peng, 2013). After removing the incomplete submissions, the final sample size comprised 191 fully completed surveys.

The data from these 191 participants were systematically organized in three separate folders, each representing one of the hospitals: King Fahad Specialist Hospital (KFSH), the Maternity and Children's Hospital (MCH) and Buraidah Central Hospital (BCH). Within each folder, Excel files corresponding to both the hard copy and online versions of the surveys were stored and further categorized into subfolders for the Arabic and English versions. This organization facilitated a rigorous process of merging the data from the hard copies and the online versions, ensuring both the Arabic and English versions were integrated without any loss of information. The subsequent statistical procedures were carried out in Excel and using IBM SPSS 29 Software. By employing a refined dataset of 191 surveys, the study aimed to draw reliable and comprehensive insights. The analysis was particularly focused on descriptive analysis, more specifically generating frequencies, percentages, means, and standard deviations, which collectively offer a comprehensive overview of the data patterns. Frequencies and percentages provided clarity on the distribution of responses, while means and standard deviations offered insights into the key patterns in the dataset.

In addition, the subsequent sections describe the three survey sections. For the first section of the survey (Q1–Q10), the total percentage of responses was calculated based on how frequently participants encountered challenges in their hospital work environment. Responses for each item in this section were given on a Likert-type scale, with a score of 1 indicating a challenge "never occurs" and a score of 4 denoting it "occurs all the time". In Section Two (Q11–Q20) concerning the perceived importance of various aspects of effective communication, responses were again given on a Likert-type scale anchored at 1

"not important" and 4 "very important". The third section of the survey (Q21–Q28) measured participants' perspectives on the significance and frequency of various strategies contributing to effective communication in healthcare environments using the same scales for frequency and importance outlined above.

For the qualitative data, given the extensive efforts and precision required to ensure data accuracy. The interviews, conducted in both Arabic and English, were organized into three password-protected folders on my personal computer, each representing one of the three hospitals in the study. Each hospital folder contained two subfolders for the interviews: one for Arabic and another for English. All interviews were transcribed verbatim in Microsoft Word, listening to the audio files multiple times to ensure the accuracy of the transcription. For a further reference to the transcripts of the audio-recorded interviews, see Appendix H. The study included a total of 26 interviews in Arabic, 29 in English and 4 interviews in which the participants code-switched between Arabic and English.

Drawing upon my translation expertise, I translated all the Arabic interviews, cross-checking the translations with the audio recordings for accuracy. Although this translation process was time-consuming, it fostered an intimate understanding and familiarization with the data, aligning with the principles suggested by Braun and Clarke (2021). Subsequent to preparation, the qualitative data underwent thematic analysis as delineated by Braun and Clarke (2021), a method incorporating six steps, which are elaborated on in the subsequent section.

4.7.1. Thematic Analysis

Thematic analysis, as a qualitative approach, enables researchers to identify, analyse and report themes within data in a comprehensive, meaningful and descriptive manner, aligning responses with the study's primary research questions and objectives (Braun & Clarke, 2006). Recognizing the inherent power of qualitative data, which can illuminate and contextualize participants' experiences of a phenomenon (Speziale et al., 2011), I incorporated Braun and Clarke's (2012) method in my study, chiefly due to its adaptability to various investigative frameworks. Moreover, I adhered to the recent six-phase approach proposed by Braun and Clarke (2021), following their suggestion to employ their updated framework. The six steps are as follows:

- *Familiarizing oneself with the data*

This preliminary phase involves an intensive review of the data to grasp the overall data set and understand the participants' perspectives. Engaging in thorough reading, note-taking and reflective questioning enhances the researcher's familiarity with the data, particularly if the researcher collected the data (Braun & Clarke, 2021). Benefiting from my fieldwork, I was exposed to the daily experiences of my participants, allowing me to gain profound insights into the full scope of the data set. This immersion deepened post-fieldwork, as I transcribed, took notes and translated the collected data, a meticulous process that took four months but was instrumental during the analysis phase (Braun & Clarke, 2006).

- *Generating codes*

The second phase, often referred to as initial coding, allows the researcher to mark significant elements in the data that capture attention. During this phase, the quantity of generated codes is less critical than their quality, as initial perceptions often evolve upon subsequent reviews of the data. This ongoing process facilitates the generation of data clusters and initial themes, with codes potentially reflecting semantic meanings or denoting specific perspectives and ideas (Braun & Clarke, 2006, 2021). I conceptualized this process as constructing a puzzle, with the codes representing individual pieces and the final image symbolizing the emerging themes. As a visual learner, I used coloured notes posted on my office walls to visually manage and manipulate these codes, allowing me to comprehend the data more fully and ensure no essential element was overlooked. As in any thematic analysis, understanding the story of the data in relation to the research investigation is a critical strategy (Braun & Clarke, 2021).

- *Generating themes*

Once initial codes are generated, the subsequent step is to transition towards formulating themes. This phase necessitates the strategic merging and organization of codes to form potential themes, mapping the narrative of the data in a manner that meaningfully contributes to the study's conclusions (Braun & Clarke, 2019, 2021). In this phase, I employed a visual strategy, physically moving sticky notes, creating thematic maps and generating preliminary themes, subthemes and clusters. This process was facilitated by multiple readings of the data set at different times, stimulating varied cognitive perspectives and enhancing comprehension.

- *Reviewing potential themes*

Reviewing the generated codes and themes is a continuous process, but this stage calls for additional focus to determine the salient characteristics of potential themes (Braun & Clarke, 2021). It is crucial to assess whether the data provide substantial support for these themes (Braun & Clarke, 2021). Revisiting the interview extracts was essential to maintain data integrity and mitigate the risk of inaccurate analysis. Crucial decisions regarding what data to incorporate or exclude played a pivotal role in reviewing the themes and subthemes at this stage.

- *Defining and naming themes*

Braun and Clarke (2006) contend that "[o]ne test for [defining themes] is to see whether you can describe the scope and content of each theme in a couple of sentences" (p. 92). In line with this, I drafted two drafts of theme maps, which I presented to my supervisor for collaborative review. We then collectively examined themes and subthemes. Furthermore, a table describing emerging themes and subthemes was constructed, accompanied by brief statements explaining their origins and connections to specific data extracts. This collaborative discussion, thematic mapping and graphing facilitated the drafting of my interview findings chapter. A detailed account of the initial coding phases, including the development of themes, subthemes and clusters, is presented in Chapter 7, which focuses on the interview findings.

- *Producing the report*

The final phase of Braun and Clarke's (2021) flexible methodology involves composing a comprehensive analysis of the data set. This involves finalizing the analysis, supported by salient extracts that illustrate each theme and subtheme. The analysis must be meaningfully connected to the literature, research objectives and questions. Importantly, while the analysis aims to tell a coherent, study-relevant narrative, it does not need to mirror the entire story (Braun & Clarke, 2021).

4.8. Conclusion

This chapter has outlined the study aims and objectives. It has also provided the rationale for the selection and design of research phases and the processes employed to conduct the study, including the use of a scoping review tool to comprehensively address the research questions. The chapter has also outlined the data analysis techniques for both the survey

and interviews and addressed participant recruitment and ethical considerations. In the next chapter, the findings derived from the scoping review are presented.

Chapter 5. Scoping Review

5.1. Introduction

This chapter presents in further detail the steps involved in conducting the scoping review designed to identify current research patterns in the domain of healthcare practitioners' communication in multilingual contexts and its outcomes. The review was designed to locate empirical studies that focused on communication among healthcare practitioners.

5.2. Overview of the Scoping Review Method

This investigation used the scoping review methodology, a systematic approach to reviewing pertinent literature within a specified area of interest (Arksey & O'Malley, 2005). While narrative reviews, predominantly penned by academics, are subject to bias and ambiguity (Duff et al., 2007), systematic research reviews, such as meta-analyses, are an effective strategy for overcoming such limitations in terms of subjectivity. Scoping review studies are inherently exploratory, investigating the evidentiary basis of findings, pinpointing existing gaps and proposing recommendations for further research (Daudt et al., 2013). The key characteristic of systematicity in scoping reviews is manifested through extensive literature searches, delineated inclusion criteria and thematic analyses (Chong & Plonsky, 2021).

In contrast to traditional literature reviews, scoping reviews concentrate on assessing trends, themes and directions in a given field rather than the explicit results and deliberations of the articles compiled (Arksey & O'Malley, 2005). Initially appearing in the domain of health sciences, scoping reviews echo meta-analyses and serve a variety of purposes, such as spotting knowledge gaps, mapping the extant literature, refining terminologies and scrutinizing research methodologies (Arksey & O'Malley, 2005; Munn et al., 2018).

In scenarios in which the literature remains partial or the evidence embodies complexity or diversity, scoping reviews are effective because comprehensive systematic evaluations are challenging (Peters et al., 2015). Remarkably, miscommunication among healthcare practitioners has not been adequately explored. This gap in knowledge sparked the scoping review, aimed at highlighting current research findings related to communication and miscommunication in multilingual healthcare settings.

A scoping review presents several strengths, primarily represented by the robust and transparent strategy implemented to search and map the existing literature. The

scoping search strategy, covering highly pertinent databases, facilitates comprehensive identification of relevant academic literature. An additional strength is the application of independent coding by two researchers during the thematic analysis, which contributes to the reliability and consistency of the procedure. This method ensures that the themes identified accurately reflect the data rather than expressing an individual coder's viewpoint.

Despite its strengths, this approach also has some limitations. Initially, determining the eligibility of studies proved challenging due to the lack of clear definition of training programmes in some studies. In addition, the information provided about the reliability and validity of research tools was inadequate. The review was also restricted to the past 20 years, hence necessitating further exploration of the evolution and potential shifts in the field over earlier decades. The specific questions and inclusion/exclusion criteria of the scoping review also entailed the risk of unintentionally neglecting certain studies. The focus was primarily on peer-reviewed publications, excluding dissertations, book chapters, reports and unpublished work. Some might question the need to include such literature and it was necessary to establish clear boundaries to ensure a comprehensive yet manageable volume of studies.

The review was also restricted to English-language publications as most relevant studies were written in English. This restriction simplifies the analysis by preventing complications related to the translation of non-English language studies. Moreover, the review emphasized healthcare practitioners as the primary participants, as their perspective yields unique insights compared to patients and medical students. Finally, the data synthesis was based on inductive coding, involving interpretation and the potential bias inherent in qualitative research. Nevertheless, although the study was time-constrained due to the timescale of the PhD programme, the review served as a valuable springboard, enriching understanding of advancements in the field and potential future research directions. Future syntheses should consider incorporating both primary research and broader theoretical studies.

5.3. Scoping Review Protocol

The pioneering work of Arksey and O'Malley (2005) established a methodological framework for conducting a scoping review and served as the foundation for this study. This framework encapsulates five stages: identification of the research question(s), identification of relevant studies, study selection, charting the data, and the collation and summary of the results.

5.3.1. Identifying the Research Questions

The methodology begins by articulating the research questions. These questions were carefully developed, taking into account the fundamental elements of the concepts being explored (communication/miscommunication), the target demographic (healthcare practitioners) and the anticipated outcome (communication strategies in multilingual settings). These elements were shaped in accordance with the guidelines proposed by Levac et al. (2010). As a result, the main research question formulated for this part of the investigation was as follows:

- What are the key current research findings related to communication and miscommunication in multilingual healthcare settings?

Adopting a relatively broad perspective was deemed advantageous since it would encapsulate various perspectives on engagement, thereby facilitating the development of a comprehensive search strategy for the scoping review. In consultation with my supervisor, I formulated two supplementary questions to refine the project scope, specifically concerning the targeted groups (healthcare practitioners) and the anticipated outcome (barriers and strategies in healthcare communication). These were articulated as two distinct research questions for the scoping review:

- What kinds of barriers to communication are identified in multilingual healthcare settings?
- What kinds of communication strategies are suggested in the literature to address such barriers in multilingual healthcare settings?

5.3.2. Identifying Relevant Studies

A systematic approach was implemented to formulate a research plan with the goal of identifying pertinent studies related to the scoping questions. This plan involved determining the relevant sources for exploration and selecting suitable search terms in consultation with my supervisor and adhering to Arksey and O'Malley's (2005) framework. Table 5.1 lists the databases chosen for identifying relevant studies.

Table 5.1. Databases Used to Identify Studies for Inclusion in the Scoping Review

Database	Description
Applied Social Sciences Index & Abstracts (ASSIA)	The database compiles and summarizes research articles from various applied social sciences disciplines, including but not limited to health care, social work, education and public policy.
Health Source: Nursing/Academic Edition	The database specializes in indexing and abstracting scholarly literature within the nursing field, covering a range of topics such as clinical practice guidelines, patient care management and research related to nursing education.
Medical Literature Analysis and Retrieval System Online (MEDLINE)	The database contains references to biomedical literature obtained from sources such as MEDLINE, life science journals and online books. These references may include hyperlinks to access the complete text from PubMed Central and publishers' websites.
PubMed	The database comprises citations for biomedical literature from life science journals and online books. Citations may include links to full text content from PubMed Central and publishers' web sites.

The subject librarian at Trinity College Dublin and I generated the search terms and synonyms through a collaborative effort (see Table 5.2). In addition, I employed the Medical Subject Headings (MeSH) within the PubMed database giving access to the controlled thesaurus indexing relevant studies. The search terms were precisely constructed by combining these variations. To cover a broad scope, several alternative terms and synonyms were selected for each of the three concepts (target population and outcomes). The Boolean operator OR was employed to link synonyms within each term, while the operator AND was used to connect the concepts and identify relevant literature featuring evidence of communication among healthcare practitioners.

Table 5.2. Scoping Review Search Terms

Concept	Search strings
Population	Doctor* OR nurse* OR physician* OR health care OR health-care OR healthcare OR "hospital administration" OR Caregiver* OR "Delivery of Health Care" OR "Hospital Administration" OR "cultural diversit*" OR "Healthcare professional*" OR "Healthcare Practitioners" OR "inter-professional team" OR "Medical care team"
Communication strategy	"Linguistic mediation" OR "language mediation" multilingual* OR bilingual* OR "english as a foreign language" OR "EFL" OR "english as a second language" OR "ESL" OR "medical english" OR linguistic* OR pragmatic* OR "socio-pragmatic" OR "health literacy"
Communication barriers	interaction OR communicat* OR mis-communicat* OR mis communicat* OR miscommunicat* OR "language barrier" OR "limited English proficiency" OR "Social Communication Disorder"

5.3.3. Study Selection

Having identified studies in the initial phase, additional screening was required. The studies included were subjected to two phases of screening: an initial screening based on relevant titles and abstracts, followed by a secondary screening based on specific inclusion

and exclusion criteria. Both screening phases were conducted independently by the primary reviewer (me) and a secondary reviewer to ensure accuracy.

Arksey and O'Malley (2005) suggest achieving a balance between familiarity with the literature and the application of inclusion and exclusion criteria. Achieving this balance proved challenging due to time constraints and the limited research on communication difficulties among healthcare practitioners. Table 5.3 presents the criteria used to include or exclude studies for further analysis.

Table 5.3. Scoping Review Inclusion and Exclusion Criteria

Criteria	Inclusion	Exclusion
Time	Last two decades	Sources before 2003
Language	Studies published in English	Studies published in languages other than English
Context	Medical settings	Education studies/sectors including medical education
Type of publication	Peer-reviewed empirical articles	Reports and policy documents, book chapters, PhD theses (published and unpublished), Master's dissertations. Literature reviews and other syntheses.
Population	Healthcare providers/practitioners, interprofessional healthcare teams	Studies of healthcare students and worker/patient communication

There were several justifications for the formulation of the inclusion and exclusion criteria in Table 5.3. First, the inclusion of studies published within the last 20 years was justified to ensure the inclusion of recent and contemporary research. Concentrating on recent studies took account of new discoveries, methodologies and technologies, thereby permitting an examination of current trends, emerging issues and potential research gaps. Moreover, focusing solely on studies published in English ensured broad accessibility and comprehensibility. Given the prominence of English as the international language of scientific research and the feasibility issues posed by time constraints and limited resources for professional translation, the inclusion of non-English studies was deemed impractical.

Furthermore, including only peer-reviewed journals in the scoping review ensured that it would cover reliable, high-quality research. Peer review entails rigorous evaluation and validation by experts, enhancing the credibility and validity of the studies included. This process minimizes bias and ensures research meets scholarly standards. By selecting peer-reviewed journals, this review sought to prioritize trustworthy and ethical sources, enhancing the overall quality. In addition, the decision to include only empirical studies prioritized objective, evidence-based research, providing a robust foundation for the review and facilitating meaningful comparison and synthesis of results.

Identification of studies via databases and registers

Identification

Studies identified from databases search (*N* = 2893) :
- ASSIA (*N* = 407)
- Health Source: Nursing / Academic Edition (*N* = 332)
- MEDLINE (*N* = 1873)
- PubMed (*N* = 217)
- Additional records identified from citation searching (*N* = 64)

Studies removed *before screening*: Duplicate records removed (*N* = 650)

Screening

Studies screened (*N* = 2243)

Studies excluded (*N* = 2026)

Full-text studies assessed for eligibility (*N* = 217)

Studies excluded : (*N* = 199)
  Wrong population (*N* = 116)
  Irrelevant content (*N* = 32)
  Non-empirical study (*N* = 27)
  Wrong publication type (*N* = 5)
  Bilingual work setting (*N* = 19)

Included

Studies included in review (*N* = 18)

Figure 5. 1 PRISMA Flow Diagram Presenting the Selection of Studies in the Scoping Review

Adhering to the guidelines for the Preferred Reporting of Items for Systematic Reviews and Meta-Analyses, the selection process is visualised using a PRISMA flow diagram, as shown in Figure 5.1. The study selection stage elaborates on the eligibility and screening components of PRISMA, justifying the inclusion of the studies.

Overall, 217 studies were identified for further investigation across the three phases of the research process. Applying the inclusion criteria, 18 studies were then deemed suitable for inclusion, with 199 studies being excluded. The rationale for this selection is that although numerous studies have addressed communication breakdowns between

healthcare practitioners and patients, the primary focus of this scoping review was to investigate communication barriers among healthcare practitioners working in multilingual settings and the resulting impact on healthcare services. Therefore, the studies included necessarily encompassed discussions related to the research questions of this review, including the strategies proposed to prevent miscommunication among healthcare practitioners.

5.3.4. Charting the Data

The selected studies were collated using Microsoft Excel. This step involved the synthesis of existing knowledge from the scoping review. During the charting process, variables were extracted and developed, and the collected data were evaluated based on the following attributes: title, author(s), year of publication, study location, number of hospitals, organization types, research design, research instruments, themes and key findings.

The headings selected were deemed suitable as they covered essential information about the studies and would enable insightful data filtering methods. Classifying the papers by data collection instrument served to broaden perspectives on potential tools useful for investigating the topic, thus enhancing future research methodologies. Examining the study location would illustrate the geographical distribution of research on specific topics. The "Themes" and "Findings" columns facilitated the recording of salient points from relevant papers. This, in turn, aided the process of collating, summarizing and reporting results by identifying recurrent themes and observations.

5.3.5. Collating, Summarizing and Reporting Results

The analysis phase of the scoping review is of paramount importance and yields significant insights. During this stage, the compiled data are subjected to both numerical and thematic analysis. In qualitative research, such as this scoping review, descriptive statistics serve as an instrument for achieving as comprehensive understanding of the phenomenon under investigation as possible (Arksey & O'Malley, 2005). The results of the analysis are presented and discussed in alignment with the objectives of the scoping review. The following sections elaborate the results derived from the analysis, preceded by an explanation of how both the numerical and thematic analyses were undertaken.

Numerical Analysis

Numerical analysis is recommended as a means of effectively determining the scope, nature and distribution of pertinent studies within a certain field (Arksey & O'Malley, 2005). This procedure employs graphs and tables to present key attributes, such as geographical location, type and number of organizations involved, sample size and instruments employed. Pursuing this strategy enables broad comprehension of areas of interest and/or gaps, making them readily apparent within the literature reviewed. Consequently, for this investigation, an Excel spreadsheet was implemented to chart the pertinent data. This scoping review used filters for the chosen fields, making it possible to gather and analyse the data in a coherent and effective manner.

Thematic Analysis

Thematic analysis was used as a technique to elucidate the research findings and to highlight critical issues (Braun & Clarke, 2021). The review adopted the six-step framework outlined by Braun and Clarke (2021) as the analytical basis:

- Step 1: The initial phase of thematic analysis entails familiarization, seeking to attain a comprehensive grasp of the data. This is a crucial step in forming the foundation for data analysis and interpretation.
- Step 2: After becoming familiar with the data, the next step involves the creation of thematic codes, identifying and tagging specific data elements pertinent to the research question(s).
- Step 3: With the codes in place, the next step involves critically examining the codes for patterns, similarities and differences, detecting and clustering them into meaningful themes.
- Step 4: To ensure accuracy and consistency in the coding process, it is necessary to review and refine the codes generated, removing any potential inconsistencies from the initial coding process.
- Step 5: Once the codes have been refined, the next step is to define and label each theme, providing clarity and structure in the thematic analysis. Table 5.4 illustrates the themes defined in this scoping review.

Table 5.4. Themes Defined in the Scoping Review

Theme	Definition
1. Interpretation barriers in healthcare	Refers to inadequate or inaccurate translation or communication services, either due to interpreter skills or the organizational system.
2. Multicultural communication challenges	Refers to the healthcare working environment, in which healthcare workers face communication obstacles that originate from workers having diverse cultural and linguistic backgrounds.
3. Organizational communication strategies	Refers to the system adopted in healthcare involving the use of standardized protocols, advanced technology and structured training to improve clarity, accuracy and efficiency in communication among healthcare practitioners.
4. Socio-pragmatic and communication skills	Refers to employing understanding of the social context, non-verbal cues and effective language use to enhance clear, empathetic and efficient communication among healthcare practitioners.
5. Interpretation mechanisms in healthcare	Refers to strategies such as employing professional interpreters or translation services, ensuring language proficiency among staff, or using assistive technology to bridge linguistic and cultural gaps, thereby reducing miscommunication among healthcare practitioners.
6. Linguistic and cultural adaptation in healthcare	Involves tailoring healthcare communication to accommodate diverse languages and cultures, implementing cultural competency training and fostering an inclusive environment, thereby minimizing miscommunication among healthcare practitioners.
7. Language simplification	Refers to the practice of using clear, concise and simple language to ensure comprehension among all healthcare workers, thereby reducing the potential for miscommunication.

To ensure inter-rater reliability in developing the themes, I shared the codes with a second rater and we discussed the themes in several meetings. Having multiple coders helps minimize the potential bias of a single coder, resulting in a more accurate and robust analysis. Although there are alternative statistical methods, such as Cohen's kappa, the preference in this study was to attain agreement through written communication and discussion. The written and conversational approach to consensus-building was better suited to the nature of this investigation (McDonald et al., 2019), which focused on complex issues related to multilingual communication practices among healthcare practitioners. Furthermore, the 18 studies yielded for analysis in the scoping review were manageable employing a qualitative approach for reliability checking.

- Step 6: The final step involves composing a comprehensive discussion of each theme, allowing an in-depth analysis of each theme and its relevance to the research questions.

As outlined by Braun and Clarke (2021), this six-step approach offers a robust framework for conducting qualitative data analysis.

5.4. Summary of Numerical Findings

This section provides a thorough review of the findings from the 18 research studies identified in the scoping review based on the numerical analysis using descriptive

statistical methods. This is followed in Section 5.5 by a summary of the findings from the thematic analysis.

5.4.1. *Year of Publication*

This scoping review offered an overview of the frequency of specific research themes over the last three decades. Data are represented by counts and corresponding percentages of their recurrence in scholarly works. The periods under review are the 2000s, 2010s and 2020s, as illustrated in Figure 5.2.
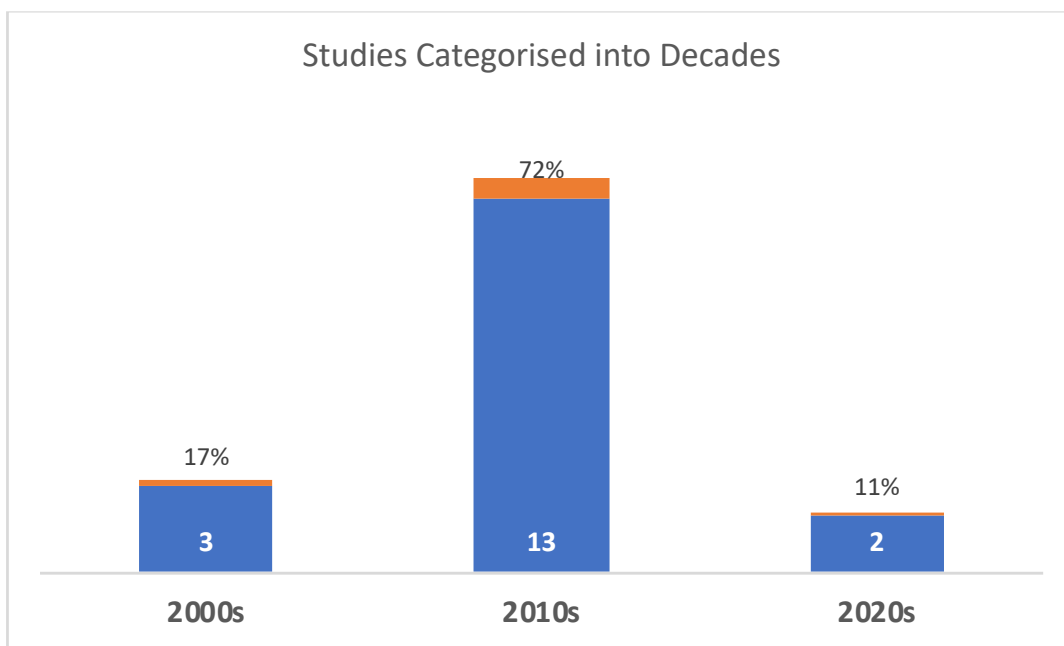
Figure 5. 2 Scoping Review Studies Categorised According to Decade

The data revealed a distinct distribution of themes over the decades. A total of three studies explored the topic of communication/miscommunication in multicultural healthcare settings in the 2000s, an early phase in this research area, accounting for 17% of the total studies.

Transitioning to the 2010s, a significant increase in the frequency of research in this area was evident. Thirteen studies addressed this focus, constituting 72% of the total. This contrasted sharply with the 2000s and represented a significant rise in interest and research. However, Figure 5.2 shows only two studies from the 2020s, a decrease from the previous decade.

5.4.2. Study Locations

The geographical analysis of the studies, as illustrated in Figure 5.3, highlighted marked discrepancies in the contributions from different countries. The US was in leading position with seven studies, making up 39% of the total sample, reflecting the importance of the topic in this area. In close second were Saudi Arabia and South Africa, each with three studies, forming 17% of the overall count, demonstrating their considerable research contributions. Australia was the next most significant contributor with two studies, accounting for 11% of the total sample, which indicates a fair degree of involvement in this field. In contrast, the UK, Japan and Norway each had only one study, comprising 5% of the total.
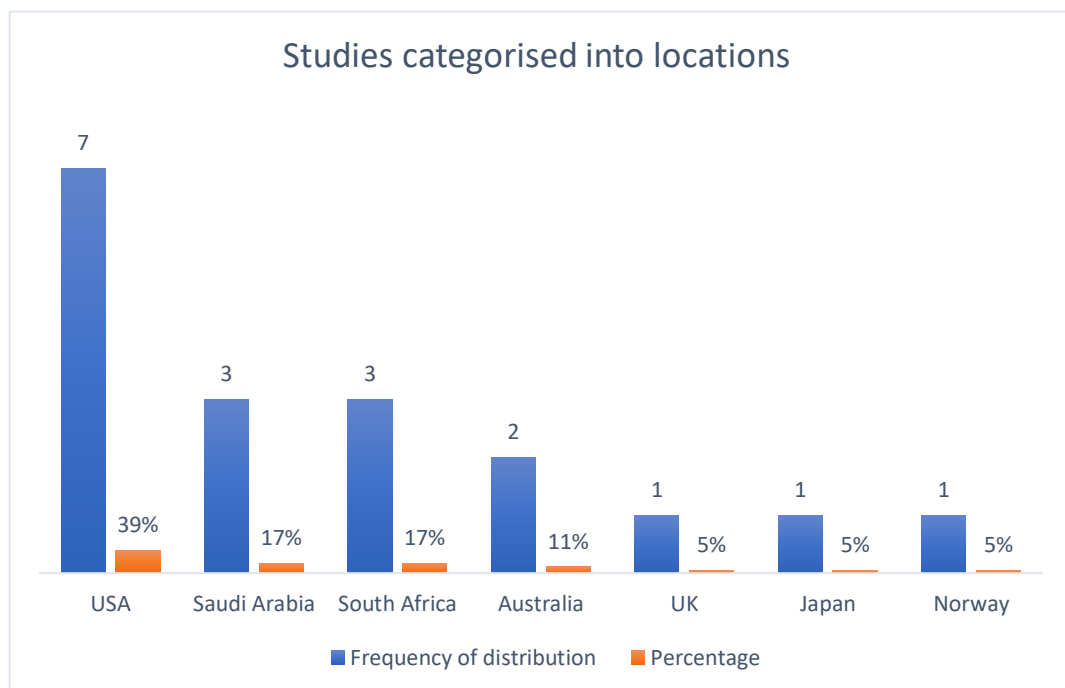
Figure 5. 3 Scoping Review Studies Categorised According to Location

5.4.3. Number of Hospitals

Evaluating the dataset revealed distinct trends concerning the number of hospitals involved in the studies. These are categorized into five groups, as presented in Figure 5.4. A significant portion, 34% (6 of the 18 studies), focused on a single hospital. Studies involving two to five hospitals were substantially less common, representing just 11% of the total with two studies. However, studies involving six or more hospitals comprised 34% of the representation.
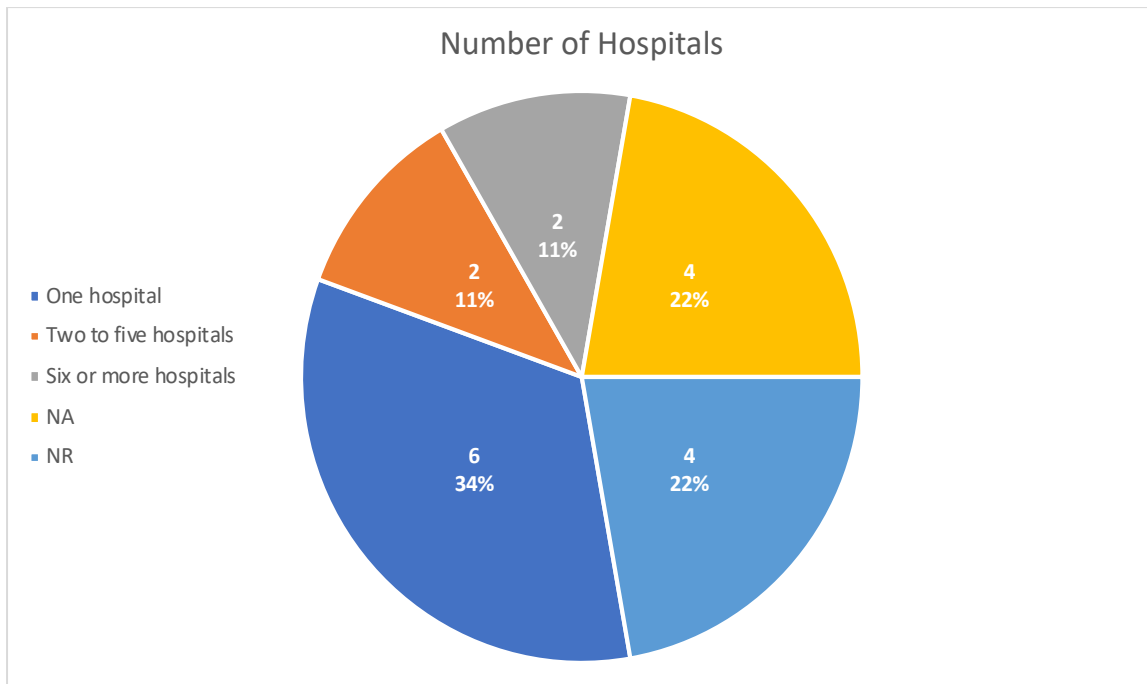
Figure 5. 4 Scoping Review Studies Categorised According to Number of Hospitals

5.4.4. Organisation Types
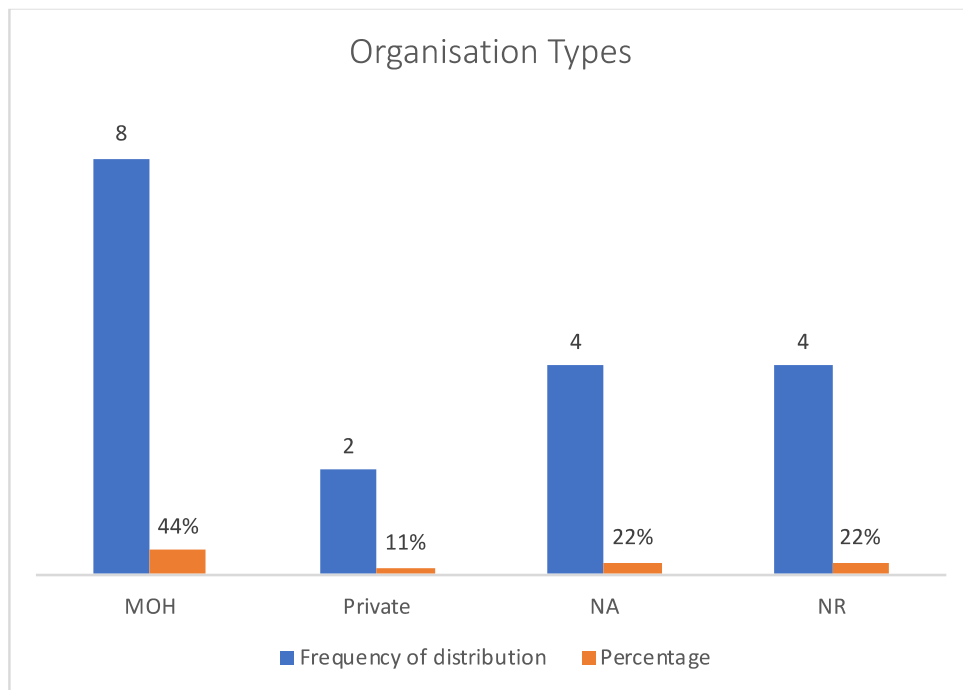
Figure 5. 5 Scoping Review Studies Categorised According to Organisation Type

A distinct categorization according to organization type could be discerned across the 18 research papers reviewed, as shown in Figure 5.5. The MoH was the subject of eight studies, amounting for 44% of the total. The study showed a marked interest in investigating public health institutions, particularly the MoH. In contrast, a relatively small portion of studies, 11% (2 studies) were conducted within the private medical sector. This suggests that research focusing on private entities in this academic sphere may be scarce.

5.4.5. Research Design
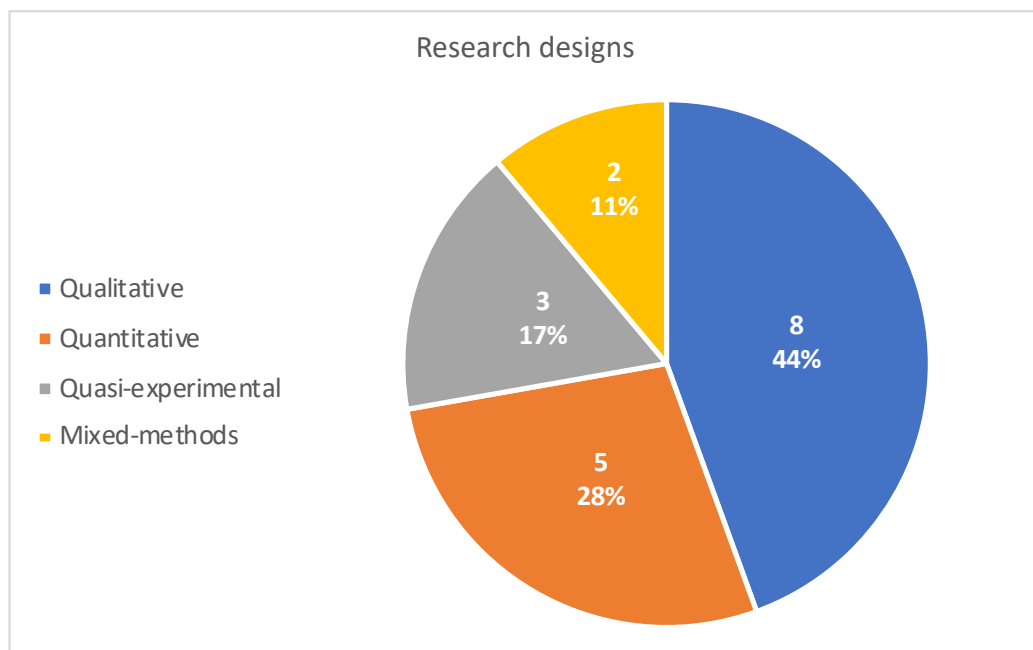
Figure 5. 6 Scoping Review Studies Categorised According to Research Design

Analysis of the research designs adopted in the studies revealed a slight predominance of qualitative methods, constituting 44% (8 studies), as shown in Figure 5.6. Quantitative designs followed closely, being employed in 28% of the studies (5 out of 18). The quasi-experimental design also constituted a distinct trend, accounting for 17% of the distribution (3 studies). The mixed-methods design, which integrates qualitative and quantitative methods, was the least represented, constituting only 11% of studies (2 out of 18).

5.4.6. Research Instruments

The instruments employed for data collection and the measurement of dependent variables in these studies ranged from surveys and interviews to tests, field notes, document analysis and focus groups, as shown in Figure 5.7.
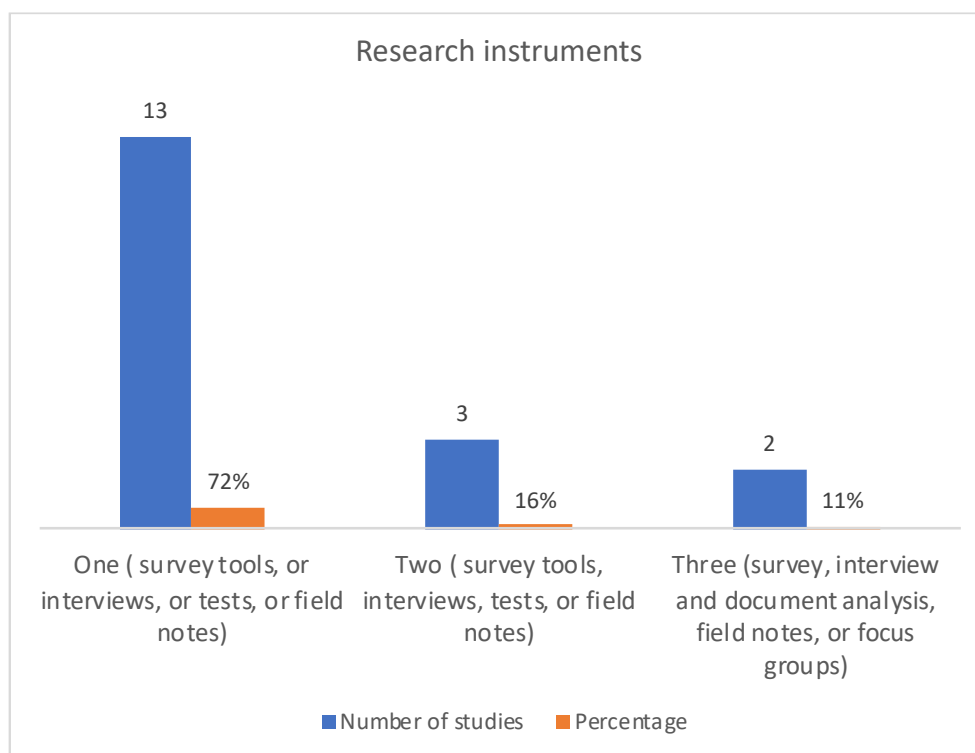
Figure 5. 7 Scoping Review Studies Categorised According to Research Instruments

A majority of the studies (13, 72%) used a single instrument for data collection and analysis. These instruments were primarily survey tools, but also included interviews, tests, or field notes. A smaller number (3, 16%) used two types of research instrument, such as a combination of survey tools, interviews, tests and field notes. Only 2 studies (11%) adopted three research instruments, implementing surveys, interviews and document analysis, although field notes and focus groups could also be used.

5.4.7. Population Size and Profession

Figure 5.8 illustrates the distribution according to the participants' professions in studies of communication among healthcare practitioners. The studies included a total of 2,700 participants. Among these, nurses were the most frequent, numbering 848 across 9 studies. Interpreters participated in 3 studies with 866 participants. Physicians participated in 5

studies involving 252 individuals. Therapists were represented by only two individuals in one study. Five studies were conducted involving health team members whose specific roles were not identified, making up 732 subjects. For two studies, the exact number of participants and their professions were not documented.
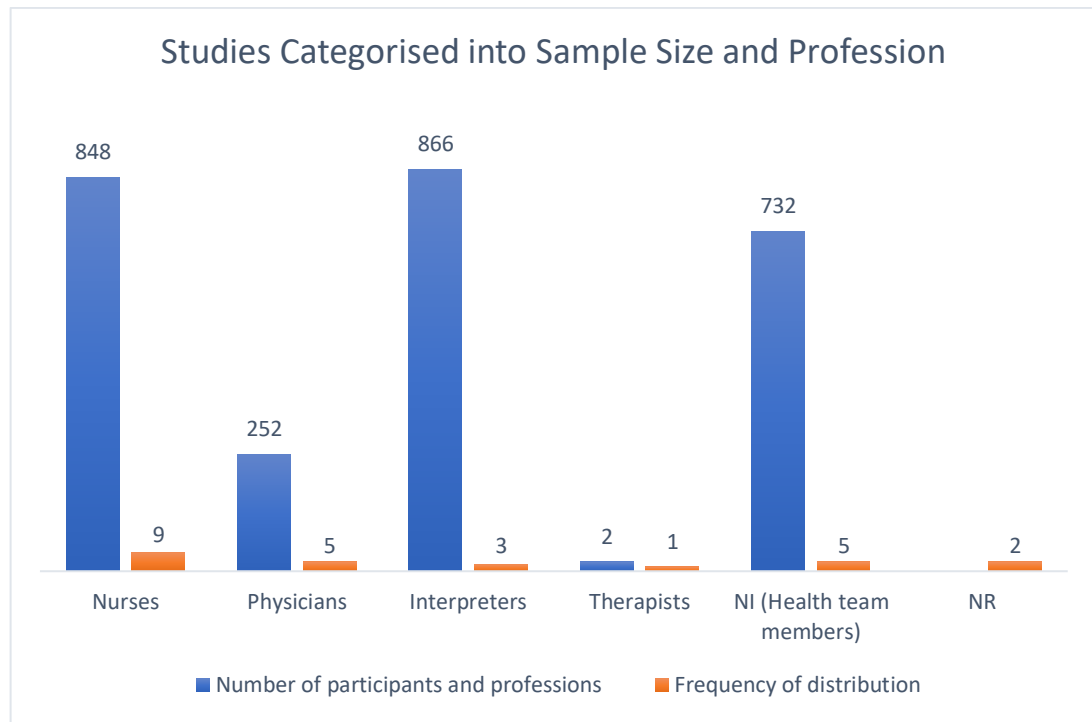
Figure 5. 8 Scoping Review Studies Categorised According to Number of Participants and Professions

5.5. Summary of Thematic Analysis Findings

A coding schema was developed in response to the research questions, enabling the visualization of the data provided in Table 5.5. The schema constituted two main analytical categories, comprising seven main themes. Detailed information on how the themes emerged from the initial codes can be found in Appendix G.

It is important to note that most of the themes that emerged from the analysis of the studies were relatively marginal in terms of the frequency of distribution. Despite this, they held considerable significance within the framework of the investigation as suggested by Arksey and O'Malley (2005). They covered a range of barriers to communication among healthcare practitioners, as well as proposed strategies for overcoming them. The seven main themes are as follows:

1. Interpreting barriers in healthcare
2. Multicultural communication challenges
3. Organizational communication strategies
4. Socio-pragmatic and communication skills

5. Interpretation mechanisms in healthcare

6. Healthcare linguistic-cultural adaptation

7. Language simplification

Table 5.5. Scoping Review: Primary Themes

Reference	Theme
Alhamami, M. (2020). Language barriers in multilingual Saudi hospitals: Causes, consequences, and solutions. *International Journal of Multilingualism*, *19*(4), 1–13.	1. Interpreting barriers in healthcare 2. Multicultural communication challenges 4. Socio-pragmatic and communication skills 5. Interpretation mechanisms in healthcare 6. Healthcare linguistic-cultural adaptation 7. Language simplification
Al-Harasis, S. (2013). Impact of language barrier on quality of nursing care at armed forces hospitals, Taif, Saudi Arabia. *Middle East Journal of Nursing*, *7*(4), 17–24.	3. Organizational communication strategies 4. Socio-pragmatic and communication skills 6. Healthcare linguistic-cultural adaptation 7. Language simplification
Allenbaugh, J., Spagnoletti, C., Rack, L., Rubio, D., & Corbelli, J. (2019). Health literacy and clear bedside communication: A curricular intervention for internal medicine physicians and medicine nurses. *MedEdPORTAL*	3. Organizational communication strategies
Almutairi, A. F., Gardner, G., & McCarthy, A. (2013). Perceptions of clinical safety climate of the multicultural nursing workforce in Saudi Arabia: A cross-sectional survey. *Collegian*, *20*(3), 187–194.	2. Multicultural communication challenges 3. Organizational communication strategies 4. Socio-pragmatic and communication skills
Baurer, D., Yonek, J. C., Cohen, A. B., Restuccia, J. D., & Hasnain-Wynia, R. (2012). System-level factors affecting clinicians' perceptions and use of interpreter services in California public hospitals. *Journal of Immigrant and Minority Health*, *16*(2), 211–217.	1. Interpreting barriers in healthcare 3. Organizational communication strategies
Benjamin, E., Swartz, L., Chiliza, B., & Hering, L. (2016). Language barriers in health: Lessons from the experiences of trained interpreters working in public sector hospitals in the Western Cape. *South African Health Review*, *2016*(1), 73–81.	1. Interpreting barriers in healthcare 3. Organizational communication strategies 5. Interpretation mechanisms in healthcare
Chang, D., Thyer, I., Hayne, D., & Katz, D. (2014). Using mobile technology to overcome language barriers in medicine. *The Annals of the Royal College of Surgeons of England*, *96*(6).	1. Interpreting barriers in healthcare 3. Organizational communication strategies 5. Interpretation mechanisms in healthcare
Claassen, J., Jama, Z., Manga, N., Lewis, M., & Hellenberg, D. (2017). Building freeways: Piloting communication skills in additional languages to health service personnel in Cape Town, South Africa. *BMC Health Services Research*, *17*(1).	3. Organizational communication strategies
Coleman, C., Hudson, S., & Pederson, B. (2017). Prioritized health literacy and clear communication practices for health care professionals. *HLRP: Health Literacy Research and Practice*, *1*(3), e91–e99.	3. Organizational communication strategies

Reference	Theme
Dysart-Gale, D. (2005). Communication models, professionalization, and the work of medical interpreters. *Health Communication*, *17*(1), 91–103.	1. Interpreting barriers in healthcare 3. Organizational communication strategies
Gazmararian, J. A., Beditz, K., Pisano, S., & Carreón, R. (2010). The development of a health literacy assessment tool for health plans. *Journal of Health Communication*, *15*(S2), 93–101.	3. Organizational communication strategies
Goto, A., Lai, A. Y., & Rudd, R. E. (2015). Health literacy training for public health nurses in Fukushima: A multi-site program evaluation. *Japan Medical Association Journal: JMAJ*, *58*(3), 69–77.	3. Organizational communication strategies
Hussey N. (2012). The language barrier: The overlooked challenge to equitable health care. *South African Health Review*, *2012/2013*(1), 189–195.	1. Interpreting barriers in healthcare 2. Multicultural communication challenges 3. Organizational communication strategies 4. Socio-pragmatic and communication skills 5. Interpretation mechanisms in healthcare
Isibel, D. (2020). Improving health literacy at the organizational level. *Journal of Doctoral Nursing Practice*, *13*(1), 79–83.	3. Organizational communication strategies
Kale, E., & Syed, H. R. (2010). Language barriers and the use of interpreters in the public health services. A questionnaire-based survey. *Patient Education and Counseling*, *81*(2), 187–191.	1. Interpreting barriers in healthcare 3. Organizational communication strategies 5. Interpretation mechanisms in healthcare
Moreno, M. R., Otero-Sabogal, R., & Newman, J. (2007). Assessing dual-role staff-interpreter linguistic competency in an integrated healthcare system. *Journal of General Internal Medicine*, *22*(S2), 331–335.	1. Interpreting barriers in healthcare 3. Organizational communication strategies
O'Neill, F. (2011). From language classroom to clinical context: The role of language and culture in communication for nurses using English as a second language. *International Journal of Nursing Studies*, *48*(9), 1120–1128.	2. Multicultural communication challenges 6. Healthcare linguistic-cultural adaptation
Sedgwick, C., & Garner, M. (2017). How appropriate are the English language test requirements for non-UK-trained nurses? A qualitative study of spoken communication in UK hospitals. *International Journal of Nursing Studies*, *71*, 50–59.	4. Socio-pragmatic and communication skills

Thematic analysis for barriers to communication among healthcare practitioners
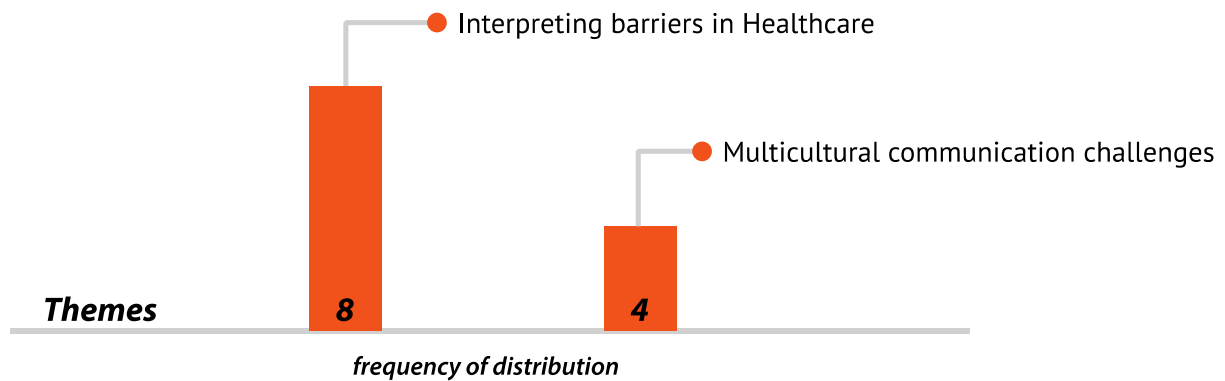
Figure 5. 9 Thematic Analysis for Barriers To Communication Among Healthcare Practitioners

Figure 5.9 presents the themes derived from thematic analysis addressing the first research question in the scoping review together with their corresponding frequency of distribution in the literature. These themes correlate with distinct barriers to communication among healthcare practitioners. The most prominent recurring theme is "interpreting barriers in healthcare", evidenced in 8 of the 18 studies. This theme highlights the challenges embedded in interpretation procedures and its consequential impact on healthcare communication. The other theme worth noting is "multicultural communication challenges", identified in four studies. This illustrates the complexities involved in communication within culturally diverse environments, thereby pointing to the potential difficulties such cultural diversity might impose on healthcare contexts.

Thematic analysis of strategies for communication among healthcare practitioners
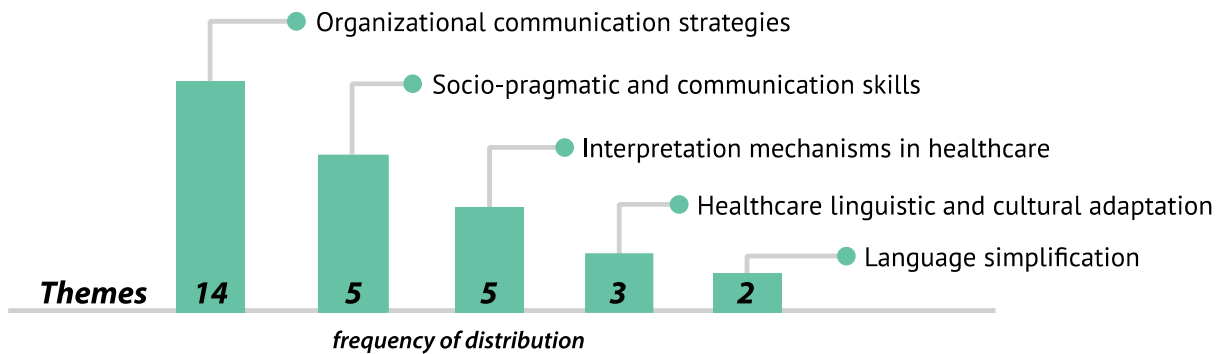
Figure 5. 10 Thematic Analysis of Suggested Coping Strategies for Communication Among Healthcare Practitioners

Figure 5.10 illustrates the emerging themes from analysis addressing the second research question in the scoping review. Five key themes were identified in the research studies. The most prominent theme was "organizational communication strategies", appearing in 14 of the 18 research studies reviewed. This suggests a significant impact of organizational strategies in enhancing communication, reflecting its fundamental role in healthcare settings. The theme "socio-pragmatic and communication skills" was identified in five studies, thus underscoring the importance of interpersonal communication and individual-level communication proficiencies within healthcare contexts. Likewise, "interpretation mechanisms in healthcare" was a prevalent theme noted in five research papers, which emphasizes the need for effective strategies in understanding and assimilating health-related information. Two less frequently discussed themes were "linguistic and cultural adaptation in healthcare" and "language simplification". These themes are related to the importance of cultural sensitivity and plain language in healthcare communication.

5.6. Scoping Review Themes

5.6.1. Theme 1: Interpreter Barriers in Healthcare

Among the main themes that emerged during the collation and presentation of the research findings, "interpreter barriers in healthcare" was the most recurrent. This theme signifies that the limitations and constraints on interpreter services greatly influence communication among healthcare practitioners, imposing considerable barriers and includes both the availability and competency of interpreters.

Multiple studies in the review shed light on various challenges in terms of limitations concerning interpreter services. For example, Chang et al. (2014) underscore the economic implications of hiring professional interpreters, along with the logistical complexities associated with telephonic interpreting services. In a similar vein, Dysart-Gale (2005) reports on the inappropriate delivery of medical tasks to interpreters and Hussey (2012) notes the complications surrounding the training of existing nursing staff to undertake interpreting roles. Furthermore, Kale and Syed (2010) point to the issue of the underutilization of interpreters, potentially stemming from budgetary constraints, and the lack of standardization and quality assurance regarding interpreter usage. Benjamin et al. (2016) discuss the struggles in assimilating interpreters in healthcare systems, including issues with ambiguous role descriptions and deficits in performance evaluation standards.

Concerning interpreter availability and skills, Chang et al. (2014) explore the challenges nursing staff face when servicing patients without an interpreter. Furthermore, Kale and Syed (2010) highlight a trend for the underuse of professional interpreters in healthcare settings and found that they are often substituted with non-professional individuals or even family members, despite the potential risks of this. Alhamami (2020) also reference the lack of translators or interpreters. Bauer et al. (2012), Moreno et al. (2007) and Hussey (2012) note the problems ensuing from the use of ad-hoc or dual-role staff interpreters, such as deficient linguistic proficiency and an increased possibility of interpretation errors. They found the latter to be particularly evident among junior and student nurses with inadequate English skills. Physicians and nurses also expressed dissatisfaction with interpreters' competence (Kale & Syed, 2010). Finally, Benjamin et al. (2016) highlight the sense of vulnerability among interpreters, who feel inadequately prepared for hospital environments, especially psychiatry, and the issue of interpreters not receiving standard orientation or induction training.

5.6.2. Theme 2: Multicultural Communication Challenges

"Multicultural communication challenges" emerged as the second most important theme in relation to barriers to communication among healthcare practitioners, referenced in 4 out of 20 studies. The analysis of barriers to effective communication among healthcare practitioners brought to light several noteworthy issues related to multicultural communication. One salient issue concerned complications arising from comprehending accents and dialects. As Alhamami (2020) highlight, both Saudi and non-Saudi healthcare practitioners can face communication issues with Arabic speakers from western Arab

countries due to linguistic variations. These can create communication gaps, escalating the risks of miscommunication. This challenge extends to the understanding of accented English, with healthcare practitioners from diverse nationalities struggling to communicate effectively due to differences in accent. These differences can hinder effective communication, potentially leading to disruptions in critical healthcare settings.

Another significant barrier is associated with language proficiency. Alhamami (2020) addresses the problems arising from the employment of individuals with inadequate English or Arabic skills. Such linguistic disparities can lead to miscommunication and misinformation, which may subsequently lead to adverse health outcomes. In a similar vein, difficulties deciphering handwriting, especially when interpreting doctors' notes on medical prescriptions and patient files, could present sensitive issues. Furthermore, the lack of a common language among non-Arabic speakers, who are limited to communicating in other languages, can impede the communication process. This lack of a shared linguistic platform can lead to communication breakdowns, impairing collaboration among healthcare practitioners.

Cultural differences comprise another crucial factor. Hussey (2012) discusses how such differences can create various communication challenges. Similarly, O'Neill (2011) highlights the considerable adjustment required by nurses when working in a setting with an unfamiliar language and culture, which could potentially contribute to miscommunication. Furthermore, Almutairi et al. (2013) point to barriers related to working in a multicultural environment, stating that distinct cultural attributes affecting language, lifestyle, beliefs, values, customs, traditions and behaviours can amplify communication issues. They warn that cultural diversity in healthcare can have a direct influence on the delivery of care and patient safety.

5.6.3. Theme 3: Organizational Communication Strategies

The analysis affirms that organizational communication strategies offer the most promising approach to overcoming communication barriers in healthcare contexts. There are three primary objectives within the healthcare sector: incorporating and managing interpreters, promoting health literacy and enhancing linguistic and cultural competency. The crucial role of interpreters in healthcare communication is the initial focus. Moreno et al. (2007) delineate the dual role of interpreters who bridge linguistic divides whilst facilitating communication, suggesting their linguistic abilities should be evaluated to ensure effective communication. Dysart-Gale (2005) underscores the need to integrate interpreters fully in hospital routines

and adherence to standards. In addition, Benjamin et al. (2016) and Baurer et al. (2012) advocate the continuous monitoring of interpreter services and employing professional interpreters to boost care quality. They further argue for organizational backing for the use of advanced interpretation technologies, i.e. software that empowers clinicians to collaborate with interpreters, and an increase in on-site interpreter resources.

The second focus revolves around boosting health literacy. According to various studies, it is the responsibility of healthcare organizations to raise health literacy awareness, proposing that nurses should integrate health literacy principles in their practices due to their close patient communication. Alongside this, Gazmararian et al. (2010) endorse the use of institutional health literacy assessment tools and the promotion of plain language training. Isibel (2020) also argues for the use of a reliable health literacy assessment tool and the design of a comprehensive plan for personalized interventions following the assessment.

The final focus concerns training in linguistic and cultural competency. Al-Harasis (2013) advocates for Arabic language courses for nurses, while Almutairi et al. (2013) highlight the advantages of a structured continuous education programme to enhance cultural competency. Gazmararian et al. (2010) also note the importance of local and national training programmes for efficacious public communication, especially during public health crises. Similarly, Claassen et al. (2017) suggest that healthcare practitioners should receive instruction in their patients' language to gain a better understanding of their cultural background.

5.6.4. Theme 4: Socio-Pragmatic and Communication Skills

Effective navigation of healthcare communication requires solid socio-pragmatic and communication skills, including aspects such as multimodal communication, empathy and active listening. These elements combine to form a unified strategy designed to reduce miscommunications. Multimodal communication offers a variety of strategies for healthcare practitioners. Code-switching, as Hussey (2012) points out, functions as a linguistic channel that eases communication among diverse practitioners, bridging language and cultural divides. Similarly, Sedgwick and Garner (2017) emphasize the importance of nurses adapting their language to suit the context, whether in giving explanations to patients or engaging in team discussions, as a vital element of effective healthcare communication. Al-Harasis (2013) also highlights the role of nonverbal communication, for example complementing verbal communication with gestures and facial expressions, as this results in a more comprehensive communication environment.

Empathy in healthcare is intertwined with multimodal communication. As Almutairi et al. (2013) suggest, leaders who listen attentively and exhibit empathy towards staff boost motivation while fostering a supportive and open communication environment. This relationship emphasizes the crucial role of empathy in promoting understanding and collaboration within healthcare settings. Active listening is another integral component contributing to the effectiveness of communication strategies. Alhamami (2020) posits that healthcare practitioners who actively listen, strive to comprehend diverse accents and employ communication strategies, such as asking for clarification, demonstrate a proactive approach towards preventing miscommunication.

5.6.5. Theme 5: Interpretation Mechanisms in Healthcare

Interpretation strategies in healthcare have been acknowledged as critical methods for mitigating communication issues among healthcare practitioners and include four significant elements. First, Alhamami's (2020) study endorses the use of co-workers to provide interpretive assistance, indicating that doctors frequently depend on colleagues for this purpose. This approach leverages internal resources within healthcare settings to foster seamless communication. In addition, interpreters are recognized as cultural mediators. As Hussey (2012) and Benjamin et al. (2016) point out, interpreters can go beyond merely translating words, encompassing semantic details and cultural nuances, thereby acting as mediators and reducing potential miscommunications stemming from cultural differences.

Interpreter competency and the level of collaboration form another substantial element of effective interpretation. As Kale and Syed (2010) emphasize, linguistic proficiency and adherence to technical and ethical standards, such as neutrality and confidentiality, are foundational skills for interpreters. Moreover, effective collaboration between healthcare practitioners and interpreters relies on mutual understanding of each other's roles. Furthermore, Chang et al. (2014) propose that digital interpretation solutions offer potential as another effective element of interpretation, suggesting the use of free translation software on mobile devices as a cost-effective, convenient alternative to employing interpreters. They argue that instant ad-hoc translation tools, such as Google Translate, could be more widely integrated in clinical settings.

5.6.6. Theme 6: Linguistic and Cultural Adaptation in Healthcare

Navigating the cultural diversity of healthcare requires a sophisticated approach to ensure a comprehensive understanding of the cultural context within which healthcare practitioners operate. This was addressed by three studies in the scoping review. Al-Harasis (2013) encourages the use of in-service activities to enhance practitioners' understanding of their professional and cultural context. Alhamami (2020) describes an array of strategies used by healthcare practitioners, including independent learning of local culture and careful observation of one's surroundings to refine communication abilities.

Peer assistance is also crucial in this process, providing significant support for colleagues adjusting to a new cultural setting. Examples of cooperative learning are evident, with practitioners helping new colleagues from their home countries to gain a better understanding of the local culture and language. O'Neill (2011) posits that transitioning to unfamiliar linguistic and cultural environments requires substantial effort and self-awareness, especially for healthcare practitioners and particularly for nurses employing English as a second language. They need to be aware of the linguistic, intercultural and social preparation required to function effectively in an unfamiliar setting. The vital role of language and culture in facilitating communication becomes apparent in this transition. Moving from language classrooms to clinical settings involves intricate decisions related to language, culture and social interactions, often with limited support. This underscores the critical nature of self-guided efforts in these areas.

5.6.7. Theme 7: Language Simplification

Language simplification emerged as a coping strategy among healthcare practitioners in the studies of Al-Harasis (2013) and Alhamami (2020). These authors emphasize the importance of plain language in mitigating communication issues and streamlining healthcare setting communications. Al-Harasis (2013) suggests that nurses can enhance clarity by prioritizing simple, everyday words over complex medical jargon, especially when language barriers exist. The use of common, comprehensible language promotes understanding, reducing the likelihood of miscommunication, which can have significant consequences in healthcare. Alhamami (2020) extends this perspective, advocating the use of simple language and medical terms not only in professional dialogue but also in casual conversations within the healthcare environment. This represents a strategic approach aimed at continually reducing language barriers and improving overall communication. These studies indicate that language simplification, applied as a communicative strategy, can boost comprehension and

collaboration among healthcare practitioners, particularly in diverse settings where language barriers may be prevalent. This approach can potentially lead to safer and more efficient healthcare delivery.

5.7. Discussion of Scoping Review Results

The numerical review shows a marked increase in scholarly attention directed towards the communication strategies of healthcare practitioners over the last 30 years. The outcomes of the scoping review also show a significant concentration of research originating from the US, a multicultural and multilingual nation which attracts a multitude of migrant healthcare professionals, a potential reason for this trend. Further contributing factors could be the numerous countries that sponsor their medical students and recent graduates to enrol in health profession scholarship programmes based in the US, hence fostering an environment favourable for the generation of research. However, there are comparable conditions in countries such as the UK and Australia, yet their representation in the studies examined here is limited. This underscores the need for wider geographical representation in future research and supports a call for further investigation.

Furthermore, the existing literature appears limited in terms of the size and types of organizations studied, leaving an evident gap in research involving large-scale entities and private hospitals. As for data collection instruments and methodologies, the predominant strategies, such as interviews and surveys, do not always offer the depth of insights that can be obtained from long-term observations or case studies. The limited application of more sophisticated and resource-demanding methodologies, such as quasi-experimental and experimental techniques, further narrows the scope of investigations thus far. A noteworthy observation is the predominant representation of nurses and interpreters in these studies, with a stark absence of physicians, therapists and those in other healthcare roles. This implies a potential bias in research and underscores the need for more balanced and inclusive participation across medical disciplines in the future.

Thematic analysis suggests that communication barriers in healthcare often arise from interpretation difficulties, with the most impactful solutions typically originating from healthcare organizations themselves. Using technology to devise systems that support healthcare services, mitigate costs and enhance interpretational proficiency seems a promising approach.

Concerning the communication skills featured in this scoping review, it seems that the significance of employing various strategies to ensure effective communication in multilingual healthcare environments is often underestimated. Focusing on cultural adaptation, empathy, active listening and non-verbal communication is doubtless of value and there is a pressing need to probe the prevalence of these features among healthcare practitioners further and investigate their role in hindering or facilitating communication, ultimately seeking to avert miscommunication and improve patient safety.

A potentially fruitful methodology is the development and application of health literacy assessment tools, specifically tailored to an organization's objectives. Such tools could assess practitioners' health literacy, detect deficiencies in knowledge and offer ways of bridging these gaps. This could result in improved communication and enhanced service quality in healthcare. Despite the potential benefits of the various approaches evidenced in this scoping study, they require additional research for validation.

5.8. Conclusion

This chapter has presented the design, implementation and results of a scoping review conducted to identify empirical findings pertinent to understanding communication and miscommunication within multilingual healthcare environments. The following chapter will present the findings derived from the anonymous survey of healthcare practitioners.

Chapter 6. Survey Findings

6.1. Introduction

This chapter outlines the findings obtained from the survey, with a particular emphasis on communication among healthcare practitioners within multilingual healthcare environments. Central to this research was an exploration of English as a lingua franca (ELF) in medical communication across three prominent government hospitals in Buraidah, located in the Central Region of the Kingdom of Saudi Arabia (KSA). Surveys were distributed to ascertain both the frequency and nature of challenges faced by participants in their professional settings and the strategies they employed to mitigate them. The survey data and findings are presented in the following sections.

6.2. Demographic Characteristics

Tables 6.1 to 6.4 present data on age, gender, nationality and spoken English language competence. Most of the participants were Arabs, but there were a few from other demographic and linguistic backgrounds.

Table 6.1. Age of Participants

Age (Years)	N	%
18–29	47	24.6
30–39	49	25.7
40–49	41	21.5
50–59	42	22.0
60–69	12	6.3
Total	191	100

As can be seen from Table 6.1, most of the participants were aged 18–39 years, constituting (50.3%, n=96) of the total sample. This was followed by the age groups 40–49 (21.5%, n=41) and 50–59 (22.0%, n= 42). The age group least represented was the 60–69 year category, comprising (6.3%, n=12) of the participants.

Table 6.2. Gender of Participants

Gender	N	%
Male	105	55
Female	86	45
Total	191	100

Table 6.2 shows that of the 191 participants in the survey, a slight majority were male (55%, n=105). There was a fair balance of gender in the sample, with 86 (45%, n= 86) female participants, meaning that the perspectives of both male and females were represented.

Table 6.3. Nationality of Participants

Nationality	N	%
Saudi Arabian	78	40.8
Filipino	27	14.1
Egyptian	21	11.0
Indian	19	9.9
Sudanese	8	4.2
Nigerian	7	3.7
Pakistani	7	3.7
Yemeni	4	2.1
Jordanian	4	2.1
Syrian	5	2.6
Indonesian	6	3.1
Algerian	5	2.6
Total	191	100

In terms of the nationality of the survey participants, Table 6.3 reveals a diverse range of backgrounds. The majority of participants were Saudi Arabian, comprising 40.8% (n=78) of the total sample. Other significant nationalities included Filipino (14.1%, n=27), Egyptian (11.0%, n=21), and Indian (9.9%, n=19). Participants from Pakistan, Sudan, and Nigeria each made up approximately (3.7%, n=7). Meanwhile, the representation of Yemeni, Jordanian, Syrian, Indonesian, and Algerian participants ranged from 2.1% to 3.1%, with Yemeni and Jordanian participants each constituting (2.1%, n=4), Syrian and Algerian participants each making up (2.6%, n=5), and Indonesian participants comprising (3.1%, n=6).

Table 6.4. First Language of Participants

First language	N	%
Arabic	140	73.3
Tagalog	21	11.0
Urdu	8	4.2
English	7	3.7
Hindi	4	2.1
Malayalam	4	2.1
Bahasa	3	1.6
French	2	1.0
Tamil	2	1.0
Total	191	100

The data in Table 6.4 show the linguistic diversity among the participants, with Arabic as the predominant first language spoken by (73.3%, n=140). A notable (11%, n=21) spoke Tagalog, reflecting a significant Filipino population. The data also indicate a marked South Asian influence, with Urdu, Hindi, Malayalam and Tamil together accounting for nearly (10%, n=18) of the first languages of participants. English speakers comprised 3.7%, while Bahasa and French further enriched the linguistic diversity to a lesser extent, with Bahasa spoken by (1.6% , n=3) and French by (1.0%, n=2).

Table 6.5. Variety of Modern Standard Arabic (MSA) Spoken by Participants

Variety of MSA	N	%
Gulf Arabic	84	44.0
Egyptian Arabic	26	13.6
Sudanese Arabic	15	7.9
Other	58	30.4
NA	8	4.2
Total	191	100

The data in Table 6.5 relate to linguistic diversity in terms of the MSA dialects spoken by the participants. Gulf Arabic emerged as the predominant dialect, spoken by (44%, n=84) of participants, indicating a strong influence from the Gulf region. Egyptian Arabic, spoken by (13.6%, n=26), underscores the prominence of the influence of modern Egyptian Arabic among the participants. Sudanese Arabic, represented by (7.9%, n=15), points to a notable Sudanese presence. Interestingly, (30.4%, n=58) of the participants responded "Other", highlighting the wide linguistic variety in the Arabic-speaking community.

Table 6.6. Language Spoken with Colleagues for Medical Tasks at Work

Language spoken for medical tasks	N	%
English only	128	67.0
Arabic only	23	12.0
Both English and Arabic	34	17.8
Both English and other (not Arabic)	2	1.0
Other only (not English or Arabic)	2	1.0
English, Arabic and other	1	0.5
Arabic and other (not English)	1	0.5
Total	191	100

Table 6.7. Language Spoken with Colleagues During Work Breaks

Language spoken during breaks	N	%
English only	54	28.3
Arabic only	102	53.4
Both English and Arabic	23	12.0
Both English and other (not Arabic)	6	3.1
Other (not English nor Arabic)	2	1.0
English, Arabic and other	2	1.0
Mix but unstated	2	1.0
Total	191	100

Table 6.8. Competence in Spoken English

English language competence	Frequency	Percent	Cumulative Percent
Native speaker	36	18.8	18.8
Advanced, near-native speaker	62	32.5	51.3
Intermediate-level speaker	73	38.2	89.5
Beginner-level speaker	20	10.5	100
Total	191	100	

As can be seen in Table 6.8, the distribution of participants based on their self-reported competence in spoken English presents a relatively normal distribution. Of the 191 participants, 36 (18.8%) classified themselves as native speakers. The largest groups categorised themselves as intermediate level speakers (73, 38.2%) and advanced or near-native speakers (62, 32.5%). The smallest group comprised beginner-level speakers (20), making up just 10.5% of the total.

6.3. Survey Results

This section presents the survey results, starting with the challenges healthcare practitioners face using MELF (6.3.1), followed by communication aspects in MELF (6.3.2), then strategies for effective communication in MELF (6.3.3).

6.3.1. Section 1: Challenges in using Medical English as a lingua franca for Communication

Based on the responses to Q1, shown in Table 6.9, the majority (74.8%, n=143) of healthcare practitioners believed that challenges occurred either often or all the time. This indicates a significant concern about understanding instructions in English in medical scenarios. Only a quarter (25.1%, n=48) believed that challenges occurred either never or sometimes. The "often occurs" and "occurs all the time" categories present similar frequencies, indicating a relatively even distribution between those who viewed the challenges as frequent but not constant and those who viewed them as constant.

Table 6.9. Challenges Arising When Receiving Instructions in English in Medical Scenarios

	Frequency	Percent	Cumulative Percent
Never occurs	10	5.2	5.2
Sometimes occurs	38	19.9	25.1
Often occurs	73	38.2	63.4
Occurs all the time	70	36.6	100
Total	191	100	

The responses to Q2, shown in Table 6.10, show that a significant majority (75.9%, n=145) considered that challenges linked to politeness norms either frequently arise or are a constant issue ("often occurs" or "occurs all the time") when communicating with colleagues in English. Only (24.1%, n=46) believed that these challenges are either non-existent or arise only occasionally ("never occurs" or "sometimes occurs"). These results indicate that the participants were concerned about problems arising from politeness norms in English communication.

Table 6.10. Challenges Arising hen Communicating with Colleagues in English Linked to Politeness Norms

	Frequency	Percent	Cumulative Percent
Never occurs	14	7.3	7.3
Sometimes occurs	32	16.8	24.1
Often occurs	85	44.5	68.6
Occurs all the time	60	31.4	100
Total	191	100	

Q3 concerned participants' expectations of etiquette. Table 6.11 shows that (68.1%, n=130) of the participants believed that challenges due to different expectations of etiquette occurred frequently or constantly ("often occurs" or "occurs all the time"). This represents a significant portion, suggesting a prevalent issue. Only (31.9%, n=61) ("never occurs" or "sometimes occurs") believed that such challenges were rare or occur only occasionally. The results suggest that the participants held different perceptions or standards of etiquette, which may lead to miscommunication.

Table 6.11. Challenges Due to Differing Expectations of Etiquette

	Frequency	Percent	Cumulative Percent
Never occurs	17	8.9	8.9
Sometimes occurs	44	23	31.9
Often occurs	75	39.3	71.2
Occurs all the time	55	28.8	100
Total	191	100	

Table 6.12. Challenges Arising Due to Indirect Messages or Implied Meanings When Speaking English with Colleagues

	Frequency	Percent	Cumulative Percent
Never occurs	18	9.4	9.4
Sometimes occurs	36	18.8	28.3
Often occurs	82	42.9	71.2
Occurs all the time	55	28.8	100
Total	191	100	

As shown in Table 6.12, the participants indicated concern about indirect messages and implied meanings when communicating in English with colleagues in response to Q4. A substantial portion (71.7%, n=137) believed that indirect messages or implied meanings in English posed a constant or frequent challenge ("often occurs" or "occurs all the time"). In contrast, only (28.3%, n=54) participants believed that these challenges occured rarely or occasionally.

Table 6.13. Challenges Arising as a Result of Addressing Each Other in English

	Frequency	Percent	Cumulative Percent
Never occurs	19	9.9	9.9
Sometimes occurs	25	13.1	23
Often occurs	83	43.5	66.5
Occurs all the time	64	33.5	100
Total	191	100	

Q5 explored challenges that arise due to how colleagues address each other in English (e.g. manner of speaking to others, formality/informality, relationships, power and distance). As shown in Table 6.13, (77%, n=147) of participants considered issues arising from addressing one another in English to be frequent or constant ("often occurs" or "occurs all the time"). This suggests a prevalent challenge in navigating the complexities of interpersonal communication among healthcare practitioners when speaking English. In contrast, only (23%, n=44) felt such challenges to be non-existent or arising only occasionally ("never occurs" or "sometimes occurs").

Table 6.14. Challenges Arising from Positive or Negative Answers to "Yes/No" Questions in English

	Frequency	Percent	Cumulative Percent
Never occurs	22	11.5	11.5
Sometimes occurs	41	21.5	33
Often occurs	68	35.6	68.6
Occurs all the time	60	31.4	100
Total	191	100	

Q6 asked about the challenges that arise from positive or negative answers to "Yes/No" questions in English. As shown in Table 6.14, a significant portion (67%, n=128) believed that such challenges were frequent or constant ("often occurs" or "occurs all the time"). This

suggests that there might be some ambiguity or cultural differences affecting how such questions are understood or answered in English.

Conversely, only (33%, n=63) believe that these challenges are either rare or occasional ("never occurs" or "sometimes occurs"). This could be due to linguistic nuances as in some languages, the way affirmative or negative responses are framed might differ from English. Furthermore, it emphasizes the importance of clear communication: if there is any ambiguity, it could be beneficial to seek further clarification rather than responding simply with "Yes" or "No".

Table 6.15. Challenges Arising from Colleagues' Pronunciation When Speaking English

	Frequency	Percent	Cumulative Percent
Never occurs	11	5.8	5.8
Sometimes occurs	29	15.2	20.9
Often occurs	78	40.8	61.8
Occurs all the time	73	38.2	100
Total	191	100	

Q7 explored challenges associated with colleagues' pronunciation in English. Table 6.15 shows a striking portion (79%, n=151) believed such challenges to be a frequent or constant issue ("often occurs" or "occurs all the time"). For many participants, pronunciation is a significant barrier to effective communication. Only (20.9%, n=40) felt that these challenges were either non-existent or occurred only occasionally ("never occurs" or "sometimes occurs").

Table 6.16. Challenges Arising from Colleagues' Use of Language Structure When Speaking English

	Frequency	Percent	Cumulative Percent
Never occurs	13	6.8	6.8
Sometimes occurs	33	17.3	24.1
Often occurs	88	46.1	70.2
Occurs all the time	57	29.8	100
Total	191	100	

Q8 explored the challenges arising due to the language structures used by colleagues when speaking English. Table 6.16 indicates that a notable (75.9%, n=145) believed these challenges to be frequent or persistent ("often occurs" or "occurs all the time"). This suggests

that the way colleagues construct sentences or the grammatical structures they employ can be barriers to effective communication. This could stem from differences in first language grammar patterns influencing English speech, which can sometimes lead to ambiguity or misinterpretation. While for a significant portion of participants the language structure used by colleagues posed communication challenges, (24.1%, n=46) viewed these challenges as either rare or occasional ("never occurs" or "sometimes occurs").

Table 6.17. Challenges Arising due to Different Vocabulary Used by Colleagues in General Conversations in English

	Frequency	Percent	Cumulative Percent
Never occurs	16	8.4	8.4
Sometimes occurs	34	17.8	26.2
Often occurs	89	46.6	72.8
Occurs all the time	52	27.2	100
Total	191	100	

As shown in Table 6.17, Q9 examined challenges related to the vocabulary used by colleagues in general conversations. More than (73%, n=141) of participants believed the variations in vocabulary used by colleagues in general English conversations to be a frequent or constant challenge ("often occurs" or "occurs all the time"). It appears that differences in vocabulary, perhaps due to linguistic variations and different levels of English proficiency, hinder effective communication. Conversely, (26.2%, n=50) viewed these challenges as either non-existent or occasional ("never occurs" or "sometimes occurs").

Table 6.18. Challenges Arising from Medical Terminology Used by Colleagues When Speaking English

	Frequency	Percent	Cumulative Percent
Never occurs	18	9.4	9.4
Sometimes occurs	28	14.7	24.1
Often occurs	84	44	68.1
Occurs all the time	61	31.9	100
Total	191	100	

The responses to Q10 regarding challenges arising due to different medical terminology used among colleagues when speaking English, shown in Table 6.18, indicate that (75.9%, n=145) believe they are frequent or ever-present ("often occurs" or "occurs all the time"). This points towards a significant barrier to communication, especially considering the critical nature of

the medical field, in which clear and precise communication is vital. Moreover, medical terminology can be complex and varies based on training, geographical differences and even individual preferences. A minority (24.1%, n=46) perceived these challenges to be either rare or occasional ("never occurs" or "sometimes occurs").

Table 6.19 Mean Scores of Challenges in Using Medical English as a Lingua Franca for Communication

	M
Q7. Challenges arising from colleagues' pronunciation when speaking English	3.11
Q1. Challenges arising when receiving instructions in English in medical scenarios	3.06
Q5. Challenges arising as a result of addressing each other in English	3.01
Q2. Challenges arising when communicating with colleagues in English linked to politeness norms	3.00
Q8. Challenges arising from colleagues' use of language structure when speaking English	2.99
Q10. Challenges arising from medical terminology used by colleagues when speaking English	2.98
Q9. Challenges arising due to different vocabulary used by colleagues in general conversations in English	2.92
Q4. Challenges arising due to indirect messages or implied meanings when speaking English with colleagues	2.91
Q3. Challenges due to differing expectations of etiquette	2.88
Q6. Challenges arising from positive or negative answers to "Yes/No" questions in English	2.87

As shown in Table 6.19, the means for the challenges in using Medical English as a lingua franca for communication have been reordered from the highest to the lowest mean score. The responses indicate that challenges arising from colleagues' pronunciation when speaking English (Q7) and challenges arising when receiving instructions in English in medical scenarios (Q1) are considered the most significant, with the highest means of 3.11 and 3.06 respectively, indicating these areas as key issues in MELF communication. Similarly, addressing each other in English (Q5) and challenges linked to politeness norms when communicating with colleagues in English (Q2) also showed relatively high means, reflecting significant difficulties in maintaining clarity and structure in communication. Conversely, challenges arising from positive or negative answers to "Yes/No" questions in English (Q6) and differing expectations of etiquette (Q3) received lower mean scores, though still substantial. This suggests these areas are less problematic but still relevant. There were also moderate means for challenges with less explicit forms of communication regarding

different vocabulary used by colleagues in general conversations (Q9) and indirect messages (Q4).

Overall, the results highlight that while pronunciation and receiving instructions are the most significant challenges, there are still notable difficulties across various aspects of communication. The means range from 2.87 to 3.11, indicating that all areas are recognized as challenges to some extent, emphasizing the complexity and dynamic nature of using Medical English as a lingua franca.

6.3.2. Section 2: Aspects of Effective Communication in Medical English as a Lingua Franca

In this section, Q11–Q20 examined the importance of the various aspects of effective MELF communication on a scale from 1 "not important" to 4 "very important". As shown in Table 6.20, the results of the questions have been reordered from the highest to the lowest mean score. The responses shown in the table indicate that clarity in understanding instructions in English in medical scenarios (Q11) and clear pronunciation (Q17) are considered highly important, with the highest means of 3.52 and 3.46 respectively, indicating the value of precision in medical communication. Politeness (Q12) and an acceptable manner of addressing each other in English (Q15) also attained relatively high means, reflecting the value placed on interpersonal relations in healthcare.

In contrast, expectations of etiquette (Q13) and clarity in indirect communication (Q14) received lower ratings for importance, albeit still above the midpoint, suggesting cultural variations and differing experiences with communication styles. The responses concerning precise "Yes/No" responses (Q16), clear language structure (Q18) and common vocabulary (Q19) show recognition that they are very important, with means ranging from 3.26 to 3.37. This highlights general agreement on the need for clear communication in healthcare. Notably, the use of common medical terminology (Q20) scored slightly higher than general vocabulary in English (Q19), emphasizing the imperative for specific, standardized language in medical settings to ensure effective communication.

Table 6.20. Mean Scores and Standard Deviations for the Importance of Effective Communication Aspects

	M	SD
Q11. Clarity in understanding instructions in English in different medical scenarios	3.52	0.75
Q17. Clear pronunciation when speaking English	3.46	0.81
Q12. Politeness when communicating with colleagues in English	3.45	0.79
Q15. A Shared acceptable manner of addressing each other in English	3.42	0.76
Q20. Common medical terminology when English is used	3.38	0.79
Q18. Clear language structure when using English	3.37	0.80
Q14. Clarity regarding indirect messages or implied meanings when speaking English	3.28	0.85
Q19. Common vocabulary in general conversations when English is used	3.28	0.80
Q16. Clarity regarding positive and negative answers to "Yes/No" questions in English	3.26	0.87
Q13. Same expectations of etiquette	3.18	0.84

6.3.3. Section 3: Strategies for Effective Communication in Medical English as a Lingua Franca

Section 3 of the survey (Q21–Q28) examined the importance and frequency of effective communication between healthcare practitioners. Taking a closer look at the first question of this section, Q21, the responses in Table 6.21 indicate that a significant majority (80.6%, n=154) of participants believed that concentrating on content and reformulating unclear statements from colleagues is either "very important" or "slightly important". This indicates a strong preference for proactive efforts to clarify unclear communication rather than allowing them to pass or ignoring them. Regarding how often they employ this strategy, the majority (74.9%, n=143) reported either "often" or "always" focusing on content and reformulating unclear statements. This high frequency is consistent with perceived importance, suggesting that the participants actively try to bridge communication gaps in practice. Overall, comparing the two scales, these results present a noticeable association. Those who recognize the strategy's importance are likely also the ones practising it frequently. Only a small portion (6.3%, n=24) did not regard it as important and would never use this strategy.

Table 6.21. Simplifying or Modifying Sentences to Make Them More Understandable

	Frequency	Percent		Frequency	Percent
Not important	12	6.3	Never occurs	12	6.3
Slightly unimportant	25	13.1	Sometimes occurs	36	18.8
Slightly important	68	35.6	Often occurs	83	43.5
Very important	86	45	Occurs all the time	60	31.4
Total	191	100	Total	191	100

The responses to Q22, shown in Table 6.22 revealed that the majority (76.4%, n=146) of participants considered the strategy of letting unclear words pass and relying on context to bring clarity to be either "very important" or "slightly important". This approach suggests an inclination towards passive interpretation, with professionals leaning on their intuition or subsequent conversation to understand the meaning of the message. Further analysis shows that the frequencies reflect the importance they attach to this strategy. Most participants (62.8%, n=120) reported "often" or "always" employing this strategy in communication. This indicates a general tendency to prioritize the flow of conversation and use contextual clues for comprehension over interrupting or seeking immediate clarification. Indeed, the relationship between perceived importance and frequency indicates that many participants prefer to navigate unclear communication segments by relying on context. This might be influenced by the nature of their professional settings, in which continued communication often brings clarity and constant requests for clarification might impede the flow.

Table 6.22. Using Common Sense, Knowing That the Meaning of Unclear Words Will Become Clearer as the Conversation Progresses

	Frequency	Percent		Frequency	Percent
Not important	17	8.9	Never occurs	23	12
Slightly unimportant	28	14.7	Sometimes occurs	48	25.1
Slightly important	77	40.3	Often occurs	60	31.4
Very important	69	36.1	Occurs all the time	60	31.4
Total	191	100	Total	191	100

The responses to Q23, shown in Table 6.23, indicate that the majority (61.8%, n=118) of participants believe that immediately correcting language errors made by colleagues is either "very important" or "slightly important". This suggests a focus on precision and accuracy,

with many practitioners emphasizing clear and correct communication, especially if they believe that immediate feedback can enhance mutual understanding. The frequency values are closely aligned with the importance values, showing that most participants (59.1%, n=113) either "often" or "always" actively correct language errors as they arise. What emerges from these results is that the participants appear not only to value immediate language correction but also actively apply it. It suggests that in real-time interactions, a significant portion of the participants prioritize linguistic accuracy and believe in the value of instant feedback.

Table 6.23. Correcting Language Errors Made by Colleagues Immediately When There is a Lack of Clarity

	Frequency	Percent		Frequency	Percent
Not important	29	15.2	Never occurs	30	15.7
Slightly unimportant	44	23	Sometimes occurs	48	25.1
Slightly important	54	28.3	Often occurs	53	27.7
Very important	64	33.5	Occurs all the time	60	31.4
Total	191	100	Total	191	100

Based on the responses to Q24, shown in Table 6.24, clearly the vast majority of participants (94.2%, n=180) recognized the importance of directly seeking clarification when confronted with unclear statements from colleagues. This signifies a preference for proactive communication, emphasizing clarity and mutual understanding over passive interpretation or assumption. The frequency of responses is consistent with the importance ratings. Most participants (85.3%, n=163) reported "often" or "always" engaging in direct questioning in their interactions, reflecting a proactive stance on ensuring clarity in communication. Overall, the link between the perceived importance and frequency of direct questioning suggests that most of the participants prioritized clarity in their professional interactions. By seeking immediate clarification, they aimed to prevent potential misunderstandings or misinterpretations, which could have repercussions for their work, especially in fields requiring precision.

Table 6.24. Asking Direct Questions to Gain Clarification

	Frequency	Percent		Frequency	Percent
Not important	2	1	Never occurs	2	1
Slightly unimportant	9	4.7	Sometimes occurs	26	13.6
Slightly important	47	24.6	Often occurs	60	31.4
Very important	133	69.6	Occurs all the time	103	53.9
Total	191	100	Total	191	100

The responses to Q25, shown in Table 6.25, reveal that the overwhelming majority (95.8%, n=183) of participants believed that correcting their own language errors would improve understanding when a colleague misunderstood them. The frequency data reflect the importance values, with most (82.2%, n=157) of the participants "often" or "always" proactively correcting their language errors when they feel they have been misunderstood. The relationship between perceived importance and frequency suggests that the participants not only recognize the value of immediate language correction but actively integrate it in their communication. Across these scales, there is a consistent pattern of proactive communication, characterized by mutual understanding.

Table 6.25. Correcting One's Own Errors to Make One's Language More Understandable

	Frequency	Percent		Frequency	Percent
Not important	5	2.6	Never occurs	5	2.6
Slightly unimportant	3	1.6	Sometimes occurs	29	15.2
Slightly important	59	30.9	Often occurs	66	34.6
Very important	124	64.9	Occurs all the time	91	47.6
Total	191	100	Total	191	100

The results for Q26, shown in Table 6.26, demonstrate that a significant majority (92.1%, n=176) of participants perceived the strategy of correcting their language structure to improve understanding as important ("very" or "slightly"). Reflecting the recognition of the value of this strategy, a substantial majority (80.6%, n=154) of the participants stated they either "often" or "always" adjust their language structure when they identify a misunderstanding. In sum, the alignment between perceived importance and the frequency of correcting language structure signifies that many participants prioritize clear and structured communication. The

results demonstrate that they actively make efforts to ensure that their message is understood as intended.

Table 6.26. Correcting One's Own Language Structure to Make it More Understandable

	Frequency	Percent		Frequency	Percent
Not important	6	3.1	Never occurs	9	4.7
Slightly unimportant	9	4.7	Sometimes occurs	28	14.7
Slightly important	52	27.2	Often occurs	55	28.8
Very important	124	64.9	Occurs all the time	99	51.8
Total	191	100	Total	191	100

As shown in Table 6.27, the responses to Q27 indicate that almost all (95.3%, n=182) of the participants believed in the value of simplifying their language to promote understanding when a colleague misconstrues their statements. This reflects an awareness of the importance of adaptability in communication and the willingness to adjust their language for the sake of clarity. The frequency values are closely aligned with those for importance, with a notable majority (80.1%, n=153) of participants "often" or "always" simplifying their language when facing a misunderstanding. This behaviour points to a proactive and adaptive communication style among participants. In sum, the agreement between the perceived importance and frequency of simplifying language signifies that many participants not only recognize its value but also actively practice it.

Table 6.27. Simplifying One's Language to Make it More Understandable in the Case of Misunderstanding

	Frequency	Percent		Frequency	Percent
Not important	2	1	Never occurs	11	5.8
Slightly unimportant	7	3.7	Sometimes occurs	27	14.1
Slightly important	39	20.4	Often occurs	59	30.9
Very important	143	74.9	Occurs all the time	94	49.2
Total	191	100	Total	191	100

The responses to Q28, shown in Table 6.28, demonstrate that almost all (94.2%, n=180) of the participants recognized the value of repetition as a means of clearing up misunderstandings. This shows a strong tendency among professionals to ensure that their message is clearly understood, even if it requires repeating it. The frequency values reinforce

the importance values, with a notable majority (78.5%, n=150) of participants "often" or "always" using repetition as a tool to ensure clarity. This reveals a proactive approach to communication, emphasizing understanding over the convenience of brevity. Overall, the consistency between perceived importance and the frequency of repetition demonstrates that many participants both value and employ this strategy in their communications.

Table 6.28. Repeating Utterances to Make One's Language Understandable

	Frequency	Percent		Frequency	Percent
Not important	1	0.5	Never occurs	4	2.1
Slightly unimportant	10	5.2	Sometimes occurs	37	19.4
Slightly important	44	23	Often occurs	59	30.9
Very important	136	71.2	Occurs all the time	91	47.6
Total	191	100	Total	191	100

Table 6.29 Mean Scores of Strategies for Effective Communication in Medical English as a Lingua Franca

	Importance M	Frequency M
Q27: Simplifying one's language to make it more understandable in the case of misunderstanding	3.69	3.24
Q28: Repeating utterances to make one's language understandable	3.65	3.24
Q24: Asking direct questions to gain clarification	3.63	3.38
Q25: Correcting one's own errors to make one's language more understandable	3.58	3.27
Q26: Correcting one's own language structure to make it more understandable	3.54	3.28
Q21: Simplifying or modifying sentences to make them more understandable	3.19	3.00
Q22: Using common sense, knowing that the meaning of unclear words will become clearer as the conversation progresses	3.04	2.82
Q23: Correcting language errors made by colleagues immediately when there is a lack of clarity	2.80	2.75

As shown in Table 6.29, the means for both the importance and frequency of effective communication strategies between healthcare practitioners have been reordered from the highest to the lowest importance mean score. The responses indicate that simplifying one's language to make it more understandable in the case of misunderstanding (Q27) and repeating utterances to make one's language understandable (Q28) are considered the most important, with the highest importance means of 3.69 and 3.65 respectively, and corresponding frequency means of 3.24 and 3.24. These practices are crucial for effective communication in healthcare settings.

Similarly, asking direct questions to gain clarification (Q24) and correcting one's own errors (Q25) also attained high importance means, highlighting the importance of clarity and self-correction in communication. Their frequency means of 3.38 and 3.27 further underscore their relevance in medical scenarios.

Conversely, correcting language errors made by colleagues immediately when there is a lack of clarity (Q23) received a lower importance mean score, which indicates that it is considered less critical but still important. The challenges related to using common sense to clarify unclear words as the conversation progresses (Q22) and simplifying or modifying sentences to make them more understandable (Q21) also show moderate importance means, indicating these are essential yet slightly less prioritized strategies.

Overall, the results highlight that while simplifying language and asking direct questions are the most important communication strategies, there are still notable strategies across various aspects of effective communication. The importance means range from 2.80 to 3.69, indicating that all areas are recognized as important to some extent, emphasizing the complexity nature of effective communication in MELF settings.

6.4. Conclusion

This chapter has presented the survey findings and highlighted that healthcare professionals prioritize clear instruction, proper pronunciation and standardized medical terminology to ensure effective communication. The study underscores the importance placed on communication strategies, particularly given the diverse linguistic backgrounds of healthcare professionals and the complexity of medical terminology. These findings point to the need for clear and proactive communication strategies in enhancing healthcare communication. In Chapter 7, I will present the findings of the semi-structured interviews.

Chapter 7. Interview Findings

7.1. Introduction

This chapter presents the results of semi-structured interviews conducted in three hospitals. In this chapter, we discuss their communication strategies as well as the impact of cultural, linguistic and medical English on effective communication among colleagues. Additionally, the chapter explores practitioners' views on improving healthcare communication. The chapter begins with the demographic profile of interviewees, followed by the initial coding process, leading to the presentation of five main themes.

7.2. Demographic Profile of Interviewees

This section provides an overview of the demographic characteristics of interviewees from King Fahad Specialist Hospital (KFSH), Maternity and Children's Hospital (MCH), and Buraidah's Central Hospital (BCH), as a starting point before exploring the interview findings. By reviewing these characteristics, it is apparent that the participants represent a diverse demographic. Understanding this diversity is crucial for evaluating the effectiveness of the healthcare practitioner's communication and strategies explored in subsequent sections. To begin with, figure 7.1 shows the different departments within KFSH to illustrate the varied health settings contributing to the study.
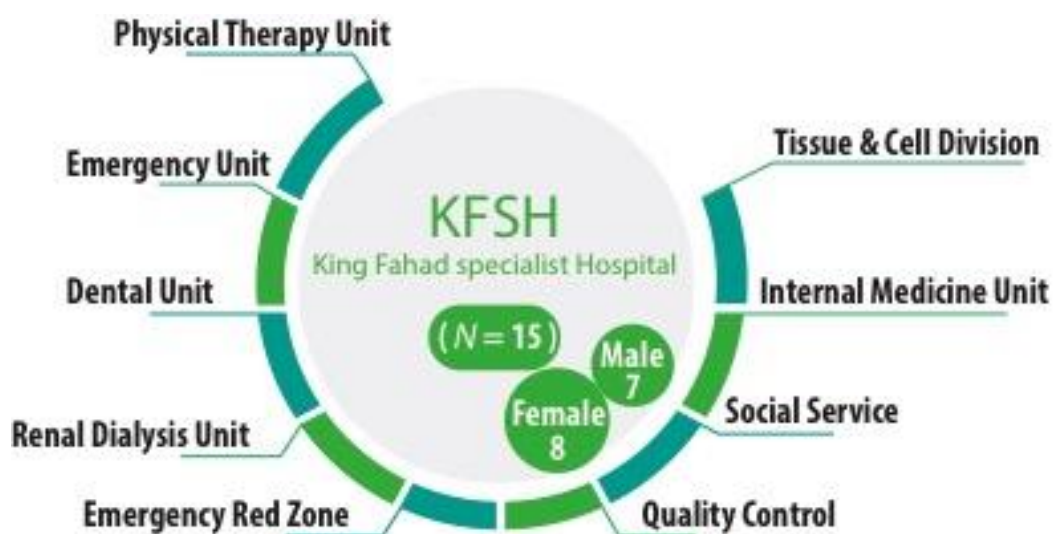
Figure 7. 1 KFSH Demographic Characteristics

Figure 7.2 below provides an overview of the various departments at MCH, noting that this hospital specializes in children's and maternity care, and features specialised departments accordingly.
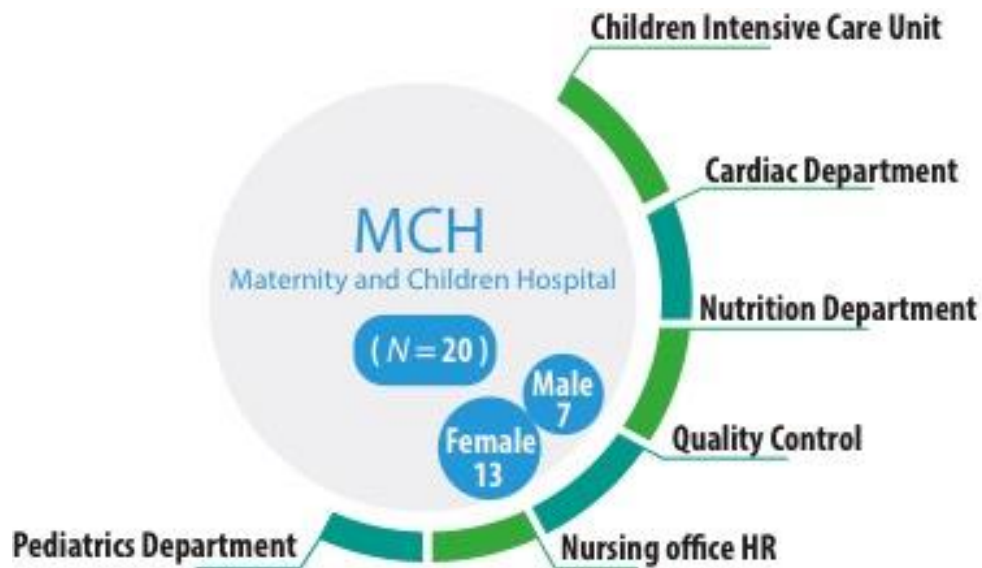
Figure 7. 2 MCH Demographic Characteristics

Figure 7.3 below presents the departments at BCH from which practitioners were recruited.
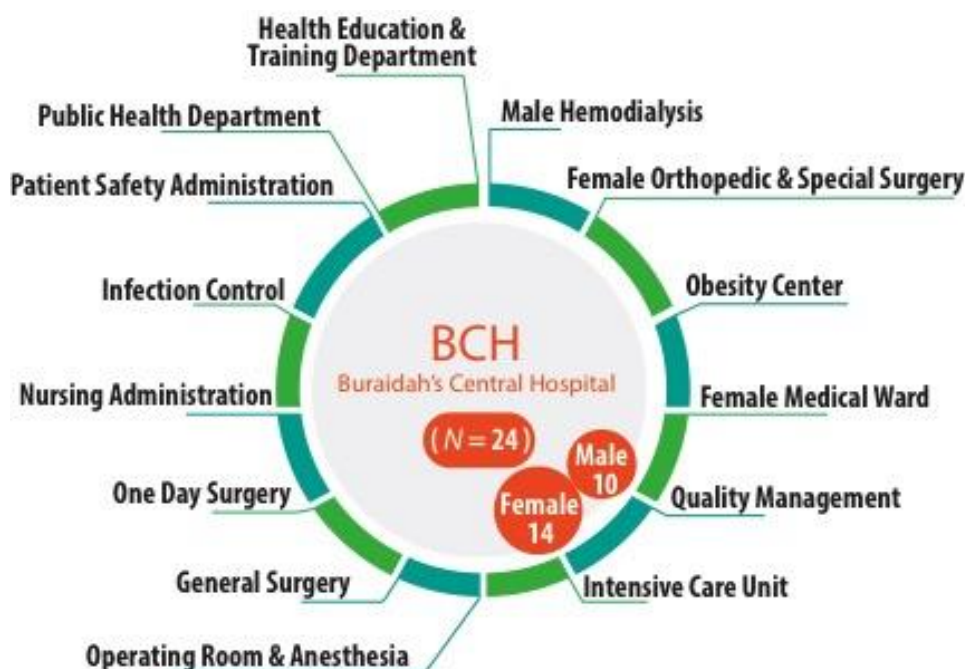
Figure 7. 3 BCH Demographic Characteristics

The participant group showed a diverse range of nationalities, with Saudi Arabian individuals unsurprisingly forming the majority, reflecting the study's local context. Followed by individuals from various Arabic nations including Syria, Sudan, Egypt, Algeria, and Yemen. Additionally, some participants were from Asian countries, notably the Philippines and India. Lastly, one participant was from the African continent, specifically Nigeria. Of the total participants, there were 35 females occupying diverse roles within these hospitals, and 24 males. A comprehensive breakdown of participants' L1 details for the three hospitals is illustrated in Figure 7.4. It is important to clarify that for maintaining anonymity, their roles have been removed, and each participant has been referred to through a unique identifier - a number suffixed by the abbreviated name of the respective hospital, for instance, King Fahad Specialists Hospital as KFSH1, KFSH2, and so forth. A detailed record, inclusive of the duration and specific dates of each interview, can be found in Appendix H.

Figure 7. 4 L1 Interviewees Characteristics

7.3. Initial Coding and Theme Generation

The process of thematic analysis, as outlined by Braun and Clarke (2021), involves a rigorous, six-step approach detailed in Chapter 4. In this section, I will briefly describe the initial coding and theme generation process. As shown in figure 7.5, the sticky notes I created illustrate the initial coding process I followed.
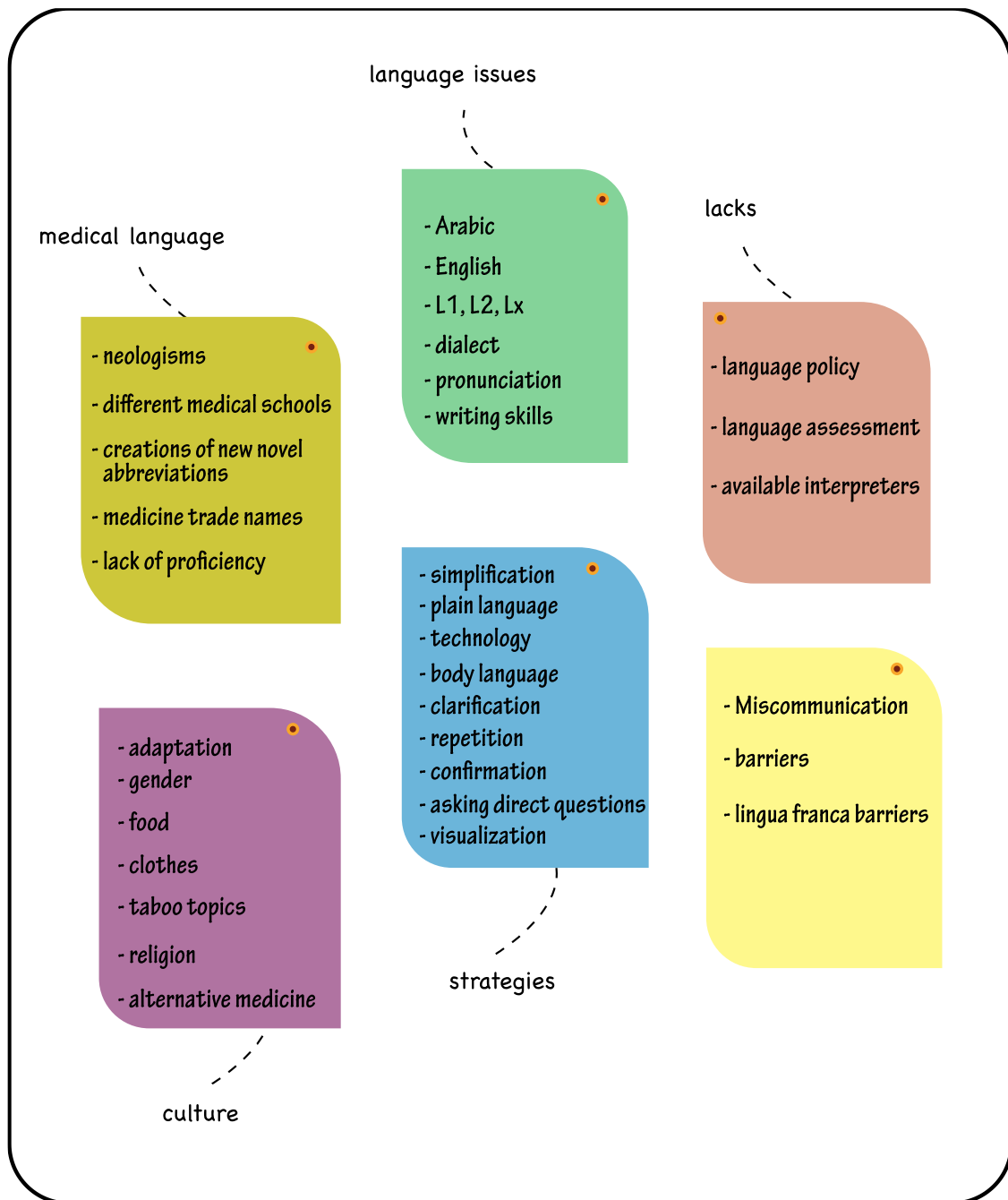
Figure 7. 5 Sticky Notes of the Interviews' Initial Coding

In the next stage of analysis, I focused on identifying initial themes by marking them alongside the codes on sticky notes. Revisiting the interview extracts multiple times was crucial to ensure data integrity and reduce the risk of inaccurate analysis. This thorough approach was instrumental in laying the foundation for generating themes. Figure 7.6 below illustrates these initial themes: 'Medical Language World', 'Language', 'Lacks', 'Translation', 'Culture', and 'Using all Resources'. During this stage, the connections between these themes

began to emerge. To explore these relationships within the narrative, I drew arrows between each theme, visually mapping out the thematic story.
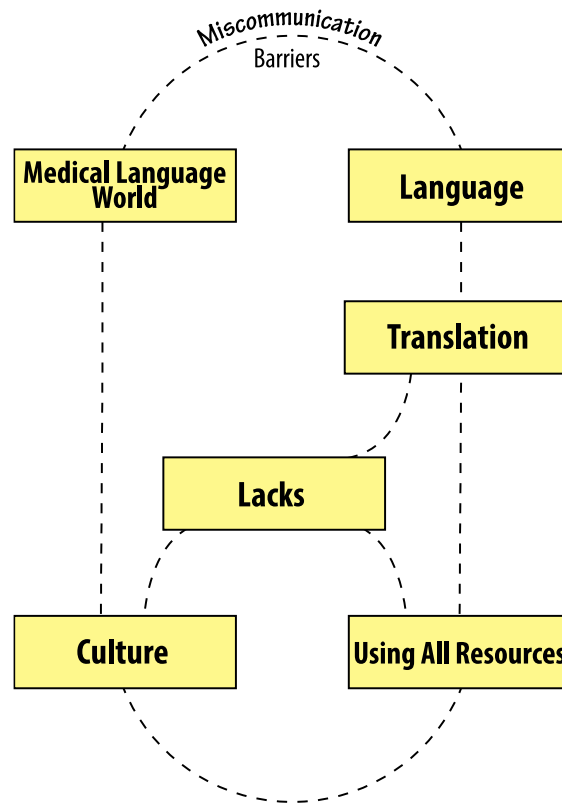
Figure 7. 6 Generating Initial Themes of the Interviews'

Continuous review of the generated codes and themes is a critical component of the thematic analysis process, demanding close attention to understanding their significant characteristics. At this stage, I began grouping the codes into clusters and subthemes, further refining the thematic structure. This led to a detailed review of the data in light of the initial themes, facilitating the construction of a thematic map. Ultimately, the process led to the identification of five primary themes, fifteen subthemes, and ten clusters. In Figure 7.7, the final presentation of the thematic analysis of interviews is shown. It also illustrates the dynamic interrelationships among the five primary themes, subthemes, and clusters, incorporating them within a model of circular communication dynamics. This visual diagram demonstrates the challenges associated with ELF, the Arabic language and medical English. This figure shows "Institutional Gaps in Language Management", emerging as a recurring

shared concern across the three hospitals. While deficiencies and communication barriers exist on the ground, healthcare practitioners consistently mediate through using all available linguistic and non-linguistic resources. These strategies act as a form of linguistic mediation, ensuring effective communication that, in turn, enhances patient outcomes.

Legend:
- ⬭ Theme
- ⬭ Sub-theme
- ▭ Cluster

Language in Healthcare Communication Theme
- Arabic Language Obstacles
  - Diverse Arabic Dialects
  - Arabic Illiteracy
  - Arabic Documentation
- English as a Lingua Franca
  - Pronunciation and Accent
  - English Illiteracy
  - Illegible Writting

The Medical Language World Theme
- Neologisms and Knowledge Gaps
- Diverse Medical Education

Institutional Gaps in Language Management Theme
- Absence of Language Policies/Assessment
- Absence of Language Interpreters

Culture Awareness Theme
- Alternative Medicine
- Cultural Variances and Miscommunication
- Evolution of Cultural Understanding

Barriers   *Barriers*

Coping   *Coping*

Utilising All Available Resources Theme
- Translation and Interpretation
  - Formal and Informal Translation
- Gestures and Body Language
- Pragmatic strategies
  - Illustration & Visualisation
  - Repetition
  - Confirmation through Asking Direct Questions
- Plain Language
- Using Mother Tongue
- Using Digital Technology

Figure 7. 7 Final Interviews' Themes

7.4. Exploring Themes: Subthemes and Clusters

Having illustrated the five main themes in Figure 7.7 above, the following section will return to each theme each in further detail, breaking the themes down into their subthemes and clusters and drawing on the interview data to describe these.

7.4.1. Theme 1: Language in Healthcare Communication

This theme explores the linguistic variations employed by healthcare practitioners, highlighting the pivotal role of communication in healthcare. It is not merely important for routine professional tasks but is also crucial in decision-making and care delivery to patients. There were a majority of participants who identified barriers associated with the Arabic language, as well as English as the lingua franca. The theme consists of two subthemes and six clusters. In the following section, I will present these subthemes, along with their clusters, beginning with the Arabic subtheme :
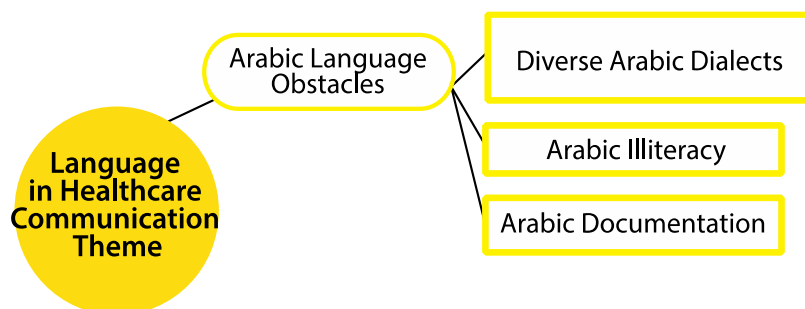
Figure 7. 8 Clusters for the Subtheme "Arabic Language Obstacles"

7.4.1.1. Subtheme 1: Arabic Language Obstacles

Data on the subtheme of Arabic obstacles revealed three principal concerns expressed by participants: diverse Arabic dialects, Arabic literacy, and Arabic documentation. In the following discussion, pertinent participant quotes support these findings.

7.4.1.1.1. Cluster 1: Diverse Arabic Dialects

A pressing challenge consistently reported by participants pertains to the wide-ranging and varied dialects within the Arabic language. These dialects, originating both from within Saudi Arabia and extending to other Arab nations, often pose barriers, leading to potential miscommunication and misinterpretations in healthcare settings. To illustrate, a participant from KFSH (KFSH7:10) shared:

> *The biggest problem that causes misunderstanding is that sometimes they explain the words in another way; for example, I use Arabic (local Sudanese), and they do not understand me.*

It is apparent that even the lexicon can become a hurdle, especially when specific terms associated with patients' conditions are filtered through different dialects. One interviewee (BCH16:8) pinpointed specific issues in decoding the Saudi dialect, especially in discerning affirmative or negative responses and the cultural nuances of certain words:

> *I suffer from understanding some of the cultural words in different dialects. I swear to Allah that a simple term like (ĀLĀ= a Qassimi dialect meaning yes) constantly confronts me; I still do not understand whether it means yes or no.*

Dialectal barriers are not solely experienced by native Arabic speakers. Non-native practitioners, such as one from India, articulate similar struggles, particularly with the nuanced Qassimy dialect:

> *I struggle to understand Arabic because they speak deep Arabic in the Qassimy dialect. So, I cannot express my thoughts or explain. (BCH11:12)*

Saudi Arabia has a rich dialectal diversity due to its size:

> *The difference in dialects between us Saudis, whether from the south, the Hijaz, or the Badia, i.e., rural areas, leads to ineffective communication, and it is not easy to comprehend such dialects. (MCH9:111)*

One participant, a native of Qassim, expressed frustration when communicating with colleagues in the healthcare setting. Given the multilingual nature of the medical field, some colleagues reacted with surprise upon encountering healthcare practitioners who spoke in diverse dialects.

123

I am originally from Qassim, and I have a particular way of pronouncing specific words that are not well-known. This surprised my colleagues, so they must accept it. Sometimes they see this matter as an insult, and they see that I speak my colloquial dialect and do not appreciate the existence of different dialects in the work environment. (MCH20:64)

7.4.1.1.2. Cluster 2: Arabic Illiteracy

Proficiency in Arabic is described as fundamental to effective communication in Saudi hospitals. While there have been attempts to adopt English as a lingua franca in both educational and certain professional contexts, there remains a predominant reliance on the use of Arabic. Within the medical sector, the multilingual competencies of healthcare practitioners present certain challenges. A considerable number may not possess fluency or even basic competency in Arabic. This language barrier poses significant risks, potentially resulting in life-threatening scenarios due to miscommunication in the shared Arabic language.

We are asked to use English in the hospital. So we know more about the diseases and illness conditions if it is in English. So, the main challenge is fluency in Arabic; I face difficulties when medical procedures are written or expressed in Arabic. I mean, we can face every challenge if we speak English. (MCH18:13)

A participant from BCH underscored the criticality of bilingualism, particularly in Arabic and English, for optimal functioning in Saudi hospitals:

Here, the acceptable languages are Arabic and English, especially for the staff who have been in Saudi they speak Arabic very well. However, you will have to speak English if you cannot speak Arabic. Here in the hospital, even during endorsement, you are allowed to use English and Arabic; there is no way around it. (BCH12:51)

Speaking and comprehending Arabic is indeed a challenge that must be overcome. Therefore, it is necessary to reflect seriously about this matter to run the medical tasks smoothly, especially since running the tasks relies heavily on effective communication. Thinking of healthcare practitioners who have never been in a situation to face or engage in Arabic communication, this presents a significant challenge:

The situation here is complicated for us as staff from India and Pakistan. People do not understand other than Arabic. (BCH22:18)

Proficiency in one aspect of Arabic language skills may not necessarily indicate comprehensive mastery of all its components. A striking example is presented by a participant from KFSH, who is a native of the Philippines. Although the participant has a religious familiarity with Arabic through the recitation of the Holy Quran, proficiency in Arabic was limited initially to affirmatives and negatives.

We don't use Arabic in the Philippines. We do not hear it anywhere. Although we read the Holy Quran in Arabic. But we do not speak Arabic, which is not very easy. (KFSH10:6)

Interdepartmental communication in healthcare settings illustrates another dimension of the language challenge. Many participants emphasised difficulties in daily communication with health staff from other departments, notably Human Resources and administration. The majority of these workers reportedly have limited proficiency in English, which often leads to communication breakdowns. Some have shown a willingness to improve their English skills; however, others have resisted, suggesting their colleagues should instead adapt by learning Arabic. A participant from BCH reflects on this:

I faced challenges because some of the staff here do not speak English, there is no proper communication. (BCH1:17)

The data shows that the majority of participants however expressed the necessity of learning Arabic, especially before coming to work in a Saudi hospital, as shown in the following example:

Non-Arabic staff must be fluent in the Arabic language well, or even the least basic. Many doctors come here who do not know Arabic. Although they speak English very well, their Arabic is weak. (MCH19:50)

7.4.1.1.3. Cluster 3: Arabic Documentation

All three hospitals highlighted concerns related to the documentation of medical reports and orders in the Arabic language. Participants frequently pointed to the challenges they face understanding Arabic-written documents, describing it as an urgent issue.

> *Although they try their best to speak in English when they go to the system, it's Arabic. So it is challenging for them and for us. (MCH14:95)*

It is not just medical reports that pose challenges. Participants highlighted that even consent forms are predominantly in Arabic, leading to comprehension difficulties. However, some positive experiences were shared, as exemplified by MCH18, who described a reciprocal relationship with Saudi staff in navigating language barriers, particularly when Arabic consent forms had to be translated prior to signing them up:

> *They cannot understand English very well. Sometimes, they ask me how: "I say this word in English". Yeah, and I learn Arabic from them; it is a lovely experience. We exchange. I'm glad to teach them English, and then they teach me Arabic. Sometimes I struggle with written consent in Arabic, and I will ask them: "please can you do it for me?" (MCH18:6)*

Conversely, a participant from BCH expressed concerns about signing consent forms without fully understanding them due to the language barrier:

> *They mostly use Arabic, especially for the written document. Even the consent forms are written in Arabic, and you do not have a choice but to sign only! (BCH9:39)*

Inquiring further, when the participant was asked for interpretation or translation assistance, the participant's response highlighted the nuances of their experience, which starkly contrasted with that of MCH18:

> *I don't know. They just told me to sign. Even they will explain. Still, I did not understand because of the language. (BCH9:44)*

The cluster addresses the difficulties faced by non-Arabic speaking healthcare staff in comprehending medical documentation written in Arabic within Saudi hospitals. These challenges range from navigating the hospital system to understanding and signing consent forms.

126

7.4.1.2. Subtheme 2: English as a Lingua Franca

In exploring the subtheme of English as a lingua franca, the data yielded three principal areas of concern expressed by participants: pronunciation and accent, English illiteracy, and illegible writing. The subsequent discussion presents these findings, supported by pertinent participant quotes. The clusters are presented in figure 7.9 below:
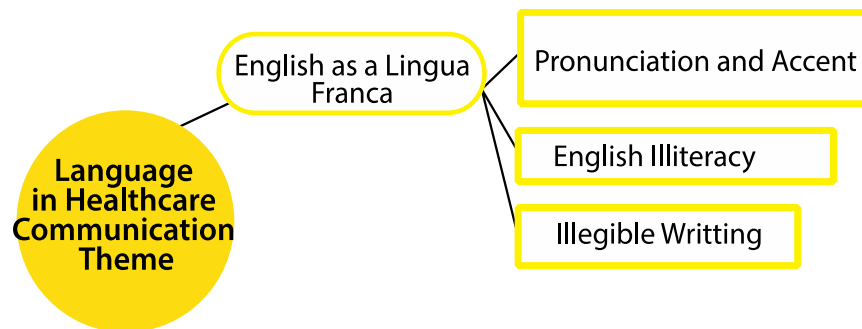
Figure 7. 9 Clusters for Subtheme "English as a Lingua Franca"

7.4.1.2.1.   Cluster 1: Pronunciation and Accent

A predominant challenge illuminated by the data pertains to accent and pronunciation. The majority of participants identified these aspects of spoken English as recurrent obstacles to communication with colleagues. It is imperative to note that these linguistic impediments are not restricted to any particular ethno-linguistic group. The data underscore that participants often suffered from understanding the accents and pronunciations of colleagues from various national backgrounds. Such difficulties, as participants reported, can lead to miscommunication, especially when medical care is involved:

> *But the accent is a problem. I mean a problem in some nationalities, particularly Nigerians, their accent is an issue, it is challenging to take endorsement over the phone, I always feel the miscommunication. (KFSH7:4)*

For some, the challenges associated with accent and pronunciation were temporary, requiring an adjustment period to become familiar with the diverse range of accents in the workplace:

At the beginning of my work, I needed help understanding accents in English and dealing with medical staff in English. But communication in English became easier when interacting more. (MCH3:3)

A related concern mentioned by participants was the influence of native/first languages on English pronunciation and vocabulary choice:

Some Egyptian medical staff have language errors because they mix their accent with the Egyptian dialect when speaking English. (MCH10:24)

As this was an issue for most participants, one participant from MCH expressed acceptance of it as a normal difference in a multilingual setting and especially for practitioners who do not speak English as a second language. While insisting that miscommunication can be avoided by asking directly whenever there is a hint of confusion, the participant asserts that colleagues' pronunciation diversity makes it difficult to comprehend pronunciation challenges:

We differ in pronunciation. Let us say, You have the Irish diction, and I have the Filipino diction, yeah. They have their diction. So if I mispronounce and they need help understanding, they should ask me. Sometimes misunderstandings occur. They did not understand my pronunciation because their pronunciation or diction was different. (MCH14:7)

Yet, the significance of clear communication in the medical field cannot be understated. This can be seen in the next quotation, where the participant describes it as a critical situation specifically when it comes to medical orders and requests. Despite using the repetition strategy to resolve pronunciation difficulties, a recent serious incident has still resulted in miscommunication, leading to the participant looking for an alternative solution to resolve the issue:

Sometimes my non-Arabic colleague has different pronunciations of some letters. A little while ago, there was a critical condition, and my colleague was trying to discuss the case with me. I told him: "Repeat, I do not get you" he repeated the words five times, and I did not understand. So, I had to meet another colleague to understand the scenario of the critical situation and the request. (MCH20:21)

7.4.1.2.2. Cluster 2: English Illiteracy

The impact of English illiteracy stands out as a significant barrier among medical practitioners within Saudi hospitals, despite the clear challenges of Arabic illiteracy. Lack of English language proficiency impedes effective communication in healthcare settings, thereby affecting the standard of patient care. Even though Saudi Arabia predominantly speaks Arabic, given its status as a Muslim Arabic nation, English plays an important role in hospitals. This is especially true during formal interactions such as meetings and endorsements. Conversely, Arabic is essential for patient interactions, primarily for precise diagnosis and gathering medical history, as not all medical staff, especially nurses and other aligned medical professionals, are proficient in Arabic. The consequences of this linguistic gap can be severe.

Interview data from KFSH shed light on this issue. A bilingual professional expressed surprise at the English language skills of peers, particularly during medical discussions. Despite their expertise, the lack of English proficiency was apparent, often necessitating a shift to Arabic to overcome communication difficulties.

> *They told me to do a round-round about one of the topics here in rehabilitation with the medical department. And they gathered most of the staff, and then I started talking about the topic, noticing that no one was literally paying attention. No one was paying attention! Then I just stopped for a while and asked: "Guys, what is going on? Are you following me?" And then a guy stood up and said, literally: "Doctor, can you please say that in Arabic? No one knows what you are talking about. (KFSH1:26)*

Elaborating on this, the participant observed that many medical practitioners do not view English as an effective medium of communication, often describing it as a "solid language". As a result, there is often a preference for speaking Arabic, especially during complex medical discussions:

> *But the problem, unfortunately, here is that they need to look at the English language as a very solid language to be communicated. And yeah, I mean inside the hospital walls. For example, go outside the corridor, okay? And just listen to the conversations. No one speaks English, even when we talk about medical scenarios. (KFSH1:43)*

Moreover, BCH11, a non-Saudi practitioner, was in agreement with KFSH1's observations. While acknowledging that a segment of practitioners display a desire to embrace and learn English, there is also a significant group that exhibits direct resistance to its usage:

> *Some of my Saudi colleagues are willing to learn, asking me: "Can you write this for me in English" I help them a lot. But other colleagues refuse to learn English; they stick only with the Arabic language. (BCH11:45)*

KFSH8 further underscored the significance of language as a bridging factor, bridging the diverse medical specialisations and the diversity of nationalities represented in the medical field.

> *Language is the language of communication that connects a Saudi with a non-Saudi, a technician, a patient, a medical staff, or a specialist. (KFSH8:4)*

The imperative for English proficiency among Saudi practitioners remains a dominant concern. The question arises: without adequate proficiency in English, how can urgent medical emergencies be addressed effectively?

> *I also hope the Saudi staff nurses and doctors improve their English proficiency. Oh, yeah, what happens if there is an emergency case, and they order something, and they cannot understand? (KFSH10:80)*

It is clear that the consequences of limited English proficiency are profound. As a result, it creates fear in practitioners, manifesting as resistance to engaging in medical procedures, a hesitancy to pose questions, and an avoidance of interactions with proficient English speaking colleagues. This phenomenon is evident in the claims of MCH1 and MCH19:

> *Sometimes, I have many questions, but I do not ask them because my English is weak. Especially when it comes to explaining and clarifying my points, I suffer a lot. (MCH1:53)*

> *The fact that most of the nursing staff are foreign, so communication problems occur. I prefer to avoid doing my job, so I do not confront the language. I avoid communicating with colleagues due to their professional language. (MCH19:12)*

The issue extends beyond language barriers. Participants highlighted the potential for confusion in patient care when practitioners opt not to communicate in English, especially

during endorsements and case discussions. This lack of compliance not only compromises team harmony but also impedes the efficient documentation of medical cases by non-Arabic speaking nurses:

> *Most of the nurses here are non-Saudi; only a few are Saudi nurses. The Saudi nurses primarily work the morning shift and the non-Saudi nurses in the evening. Yeah, so during that time, all were non-Saudi and could not communicate very well with a physician. Understanding the discussion in English is essential for nurses. (BCH7:9)*

Alongside the overarching challenge of English proficiency, grammatical precision is critical in interprofessional communication in medical settings. A participant highlighted the risk of significant miscommunications arising from verb misuse during medical discourse.

> *Indeed, I need help with the verb to be. When I discuss or speak, for example: "the patient is going to have or will have", that means we still did not start the procedure. But some non-medical and medical staff understand that the procedure has already been done. I find myself being attacked and argued with. For example, they are discussing the patient's situation, and I wonder if this is his current or future situation. I can't even estimate or speculate, so I need to repeat the question more than once and go deeper to understand the details, and this sometimes annoys them; the speaker gets annoyed. (BCH14:9)*

It is clear that organisational practices that permit the hiring of medical practitioners without sufficient English proficiency continue to compromise effective communication and, by extension, patient safety:

> *We are receiving Indonesian staff. I am not downgrading them, but their English is very weak. (BCH10:5)*

The pursuit of ensuring patient safety through a common language remains problematic. An incident reported by BCH21 serves as a stark reminder of the risks associated with English illiteracy. The challenge of explaining anaesthesia machine settings in English to a colleague could have had serious consequences if not addressed promptly:

> *I was trying to explain to my non-Arabic colleague about the anaesthesia machine, in which there is a setting that should not be changed from case to case. He did not understand me, so he changed the setting of the device, and it would have caused a medical error. (BCH21:10)*

The cluster explores the significant barrier to English illiteracy among medical practitioners in Saudi hospitals, affecting the quality of patient care. With English being crucial for formal MELF communication and Arabic for patient communication, the lack of proficiency in either language leads to resistance to language adoption, communication breakdowns, and potential risks to patient safety.

7.4.1.2.3. Cluster 3: Illegible Writing

Written documentation, whether in traditional formats or digital systems, serves as a cornerstone for coordinating among healthcare practitioners. Yet, the prevalent issue of illegible English writing in medical reports and requests stands out as a significant challenge that urgently requires attention: "At least we should promote legible". (KFSH10:39)

The emphasis on clear and accurate written documentation cannot be overlooked. It is paramount for interprofessional team members to convey information precisely and without errors. Alarmingly, feedback from participants suggests a tendency among practitioners to replicate documentation from previous shifts verbatim. Such a practice is packed with risk, as the dynamics of each medical case evolve continually. The ramifications of such replicated reports can harm patient safety goals, as underscored by statements from KFSH10 and KFSH11:

> *They will just copy what was written in the previous shift. This is the scenario we are facing most of the time, and this absolutely will cause medical errors and miscommunication. (KFSH10:82)*

> *We're using narrative format charting of the patient report, and you will see it copied and pasted from the previous shift without noticing it. Plus, our nursing care plans have to formulate their own, but we tend to see a duplicate of the previously written documents. (KFSH11:33)*

Some practitioners perceive documentation as a burdensome task, seeking ways to sidestep it. It has been noted among practitioners that they request transfers to departments like the ER or prioritise other medical tasks over written documentation.

> *The medical staff prefer E.R. because of less documentation. They say: "Ma'am, I can perform the procedures, I can help, I can do bedside". But in the reality, the*

documentation is taking a lot of their time and eating their heads like they don't want to document. (KFSH11:29)

While some practitioners prefer to refuse this responsibility, other practitioners request assistance from nursing staff, asking them to draft orders on their behalf. However, this may not always be feasible, given the myriad duties nurses perform on wards, making such requests time-consuming:

For orders, the doctors will still ask nurses: "how do I write the order in English, sister?" So, we tend to order them to give the order, to write the order, especially recently joined doctors like residents. It matters a lot with time management because, especially in the ward now, they are handling 8 to 10 patients, sometimes 12. (KFSH11:58)

Illegible writing encompasses not just inaccurate writing but also spelling errors and incorrect usage of medical terminology in written records. A case is outlined by BCH6:

I found many spelling mistakes in some doctors' and nurses' notes; spelling is complicated for us. Once I read on the doctor's note that instead of writing the surgery that removes gallbladder "lap chole", he wrote "lab calling", which means something else. (BCH6:36)

The prevalence of illegible writing and the tendency to duplicate past records in medical documentation significantly hinder clear communication and could jeopardise patient care, highlighting the necessity for meticulous and legible medical documentation.

7.4.2. Theme 2: Medical Language World

Within this theme, data collected from participants underscore significant challenges intrinsic to medical language, subsequently impacting interprofessional communication within the context of clinical care. There are two subthemes within this theme, as shown in Figure 7.10
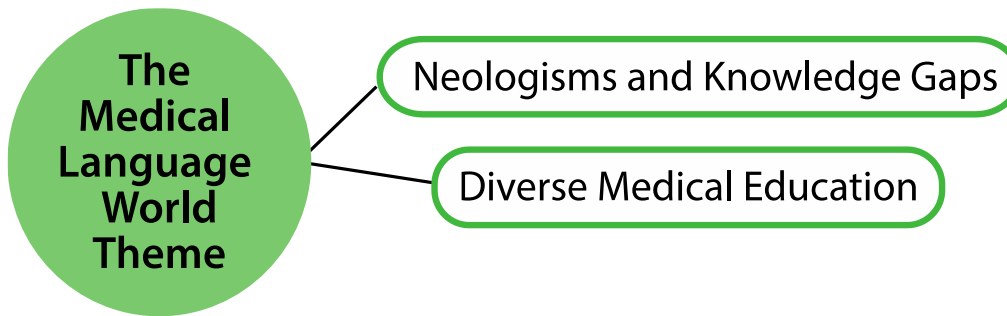
Figure 7. 10 Subthemes for the "Medical Language World Theme"

7.4.2.1. Subtheme 1: Neologisms and Knowledge Gaps

There are two primary concerns in this subtheme, as articulated by several participants, pertaining to the tendency among medical practitioners to craft their own neologisms and inadequate knowledge of medical language. This encompasses the invention of distinct medical terminologies, abbreviations, and acronyms, especially when interfacing with peers or authoring medical reports. While minor variations in linguistic choices within the medical community can be expected, given the diverse linguistic and cultural backgrounds of health practitioners, such deviations could potentially compromise patient care and safety.

> *Nowadays, they do not use the standard medical English because some medical staff have their own abbreviations. Sometimes, also you will see them on orders, especially the doctor's order. (KFSH12:36)*

Disparities in the use of medical terminologies can result in misconceptions regarding the actual meaning of terms or abbreviations.

Mastering medical English is also essential because if we do not use medical terms properly, we will have errors, especially in terminologies and abbreviations. As for me, what I know about specific medical terms is that they use them differently. (KFSH12:66)

This dilemma is further complicated when practitioners, perhaps unintentionally presuming universal comprehension among peers, invent neologisms. Such practices implicitly question their familiarity with the standardized lexicon, acronyms, and abbreviations commonly used in the medical profession. This view is underscored by the apparent lexical confusion observed in the responses of participants KFSH6 and KFSH12.

When I am saying abbreviations, we face many problems with other abbreviations; some people like to write their abbreviations like they write 'IRT' which means 'in relation to'. (KFSH6:74)

Unfortunately, some staff are using and creating their medical terms. So, I keep asking: "Doctor, what do you mean by this?". (KFSH12:73)

It appears that some practitioners might overlook the collective, interprofessional nature of healthcare delivery. Participants described the complexities inherent in deciphering medical terminologies and abbreviations, especially when assimilating medical data transferred from different departments. This often necessitates additional clarifications, but this is not always feasible given the limited availability of practitioners.

I face some doctors who write the report, small paragraphs full of terminologies that are not from my field or might not be apparent to me. I used to call my colleague who wrote the unclear report about the patient, the transfer etc. (BCH24:92)

Especially in the cardiology department, because there are various cases, and the words are long. They often use different abbreviations that need to be discovered in my field, and this causes me some problems. (MCH20:51)

Practitioners strongly advocate for eliminating the invention of neologisms, urging adherence to the standardized version of medical English. This encompasses crafting specific, concise, and unambiguous medical reports and orders:

The language is supposed to be straightforward because we often hear vague vocabulary and see abbreviations of things we have not come through, especially in writing abbreviations. I frequently open my mobile and search for some abbreviations and find that they mean more than one meaning. (MCH20:53)

While the generation of neologisms can be traced to a lack of competence in medical English amongst healthcare practitioners, it is presumptive to think that creating these terms simplifies communication, especially when English is the lingua franca. Contrary to this belief, the adoption of such neologisms may lead to serious miscommunications in critical scenarios. For instance, a participant from BCH acknowledged the challenges stemming from an inadequate grasp of medical English, describing it as a "superficial language." The complexities of their profession further contributed to the comprehension difficulties:

> *I think terminology is the most challenging because our language is superficial and straightforward, and we do not engage in deep conversations in English. Therefore, sometimes when we encounter a doctor who is advanced in the language, we find it difficult to understand. (BCH15:5)*

Yet, this participant underscored the undeniable importance of achieving proficiency in medical English, particularly in grasping medical terminologies. Merely being fluent in English does not equate to mastering medical jargon:

> *Those proficient in their field of work must be familiar with the terminologies. I encountered a practitioner who is very proficient at speaking English, but his terminology is weak. (BCH15:28)*

Many participants strongly emphasised the imperative for medical practitioners to enhance their proficiency in medical English across all its facets. For them, this linguistic competency is an indication of professionalism in the medical field. As explained by KFSH11, practitioners must continually refine, incorporate, and actively employ their medical English vocabulary:

> *For example, they are inserting the cannula. They will say: "right hand?" as if there is no specific term for it, for example, the Metacarpal vein, the Cephalic vein etc. We are medical people; we must not just impress people but use this knowledge so it will not be stopped somewhere in our brains. It sounds more professional, like if I say: "the cannula is inserted on the right hand". So, where exactly on the right hand? (KFSH11:114)*

Practitioners' familiarity should not be limited solely to their specialised medical terms. It should encompass a broad range of terminologies, including abbreviations and acronyms prevalent in other departments, fostering effective interprofessional communication. If

referring to a dictionary is what it takes to ensure clarity in exchanges, practitioners should readily resort to such aids:

> *A medical staff should know a brief background on every department in the hospital. For example, I have some cases next week in the emergency department. I must begin to know essential terms in the emergency department; for example, if I hear (code blue) or (RTA), I know that there is an emergency case that requires immediate action and cannot wait. If you work on yourself using a dictionary for a week, you will learn words that make medical communication easier. (BCH21:70)*

Overall, the subtheme describes the issues arising from healthcare practitioners' use of self-invented medical terminologies and a lack of standard language, which can lead to misunderstandings and jeopardise patient safety. It emphasises the necessity for a universally understood medical language to ensure clear and effective communication across different medical specialisations.

7.4.2.2.Subtheme 2: Diverse Medical Education

The varied linguistic backgrounds of healthcare practitioners' medical language across different Arabic regions were mentioned by interviewees. Some regions, such as Syria, predominantly employ Arabic as the medium of medical instruction, whereas in Algeria, French holds this role. This linguistic diversity presents tangible challenges in Saudi hospitals, particularly when confronted with practitioners from countries like the Philippines, Saudi Arabia, and Egypt, where English is the primary medium for medical education.

> *Among the doctors in the department, we have the Egyptian, the Algerian, the Syrian, the Sudanese and the Palestinian. They all studied medical languages in different schools, which teach medicine using different languages and methods. We in Egypt learn medicine in English or Latin; in Syria, for example, they study it in Arabic; and in Algeria, they learn it in French. All the terms differ, and there is an overlap of terminologies in the medical field. (BCH16:22)*

Geographical location does not necessarily translate into effective communication among practitioners from Arabic-speaking regions. External factors, such as Algeria's historical colonization, further complicate the linguistic landscape. The act of translating or adapting terms to Arabic to bridge these gaps has proven insufficient, especially given that French is neither a commonly spoken language in Saudi Arabia nor a standard in its hospitals:

*Some colleagues are from Algeria; their first language is French, and they have
few words in Arabic. Communicating with them is a challenge. (BCH17:3)*

Contrastingly, a participant stated that employing English as a lingua franca, coupled with
foundational general English, proves effective when medical education is in Arabic, as
seen with practitioners from Syria and Jordan:

*Colleagues have been awarded a medical degree and studied the medical
language, but not in English. So, just using general English to explain will make
them understand without needing good medical English. (BCH21:52)*

Despite these challenges, there is evident determination to establish a shared linguistic
foundation. Practitioners trained in non-English mediums often find themselves learning
medical terminologies in English for the first time to ensure unified communication for the
well-being of patients. However, adaptability and a substantial amount of time are
necessary in this process:

*Often, with colleagues, we have had to unify the common language in medicine.
We appreciate my other colleagues, the Syrian and Algerian, are tired because they
are learning medicine from scratch and the medical terminology in English.
(BCH16:31)*

Additionally, overlaps in medical education can lead to overlaps in the use of certain
medicines. A participant noted challenges due to this varied terminology, particularly with
medicine trade names. Miscommunications can arise when medicine trade names are used
instead of generic names. The participant emphasised the importance of using standardized
generic names for effective communication among medical professionals.

*It is necessary for the medical environment to unify and use universal names for
any tool or medicine related to our field, whether in French, English, or any
language. I use the scientific name, not the trade name for drugs and medicines.
Because it will lead to the exact meaning whether I studied in the Philippines or
any other language. (BCH19:15)*

In order to clarify this viewpoint, the participant cited common medicines as examples:

*(Amoxicillin) is the scientific name, but sometimes they use Omexil or another
trade name that is an entirely different name. And Paracetamol is the scientific
name, but it could be Perfalgan or, for example, we use Efferalgan in Algerie.
(BCH19:19)*

138

The subtheme reflects the communication hurdles caused by varied linguistic backgrounds in medical education, which affect comprehension among practitioners. It emphasises the need for a standardised medical lexicon to ensure effective communication.

7.4.3. Theme 3: Cultural Awareness

The concept of cultural awareness plays a pivotal role, focusing on the influence of diverse linguistic and cultural backgrounds on the efficacy of communication among multilingual healthcare practitioners. A substantial proportion of the participants admitted a lack of familiarity and comprehension of the cultures they are exposed to, particularly Saudi culture. Their responses reflected this unawareness, reflecting visible miscommunication rooted in cultural differences. Data collected from participants elaborated on the theme of cultural awareness, which consists of three subthemes as shown in Figure 7.11.
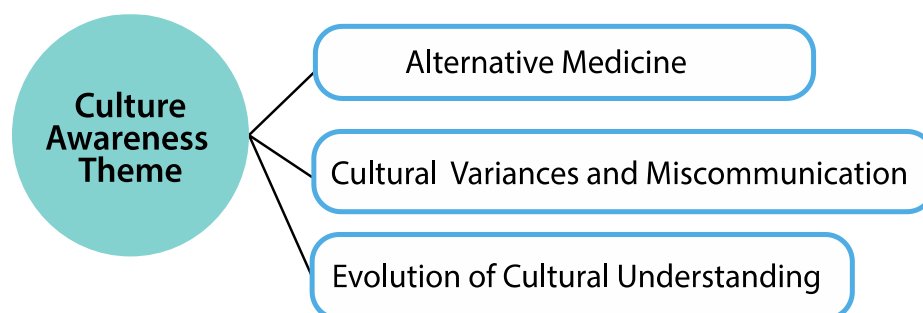
Figure 7. 11 Subthemes for the "Culture Awareness Theme"

7.4.3.1. Subtheme 1: Alternative Medicine

The presented subtheme, while based on a limited set of data findings, offers interesting insights worth considering. Two participants, one of Saudi nationality from MCH and another of non-Saudi nationality from KFSH, drew attention to the challenges healthcare practitioners face due to a lack of familiarity with Saudi cultural practices, specifically regarding the use of alternative medicine. Interestingly, even the Saudi participants acknowledged difficulties understanding specific terms associated with these practices.

However, this lack of understanding can have serious implications, potentially jeopardizing patient safety. In an in-depth interview, participant MCH9 highlighted the critical importance of this issue, saying:

> *Since we work in Saudi hospitals, we must be aware of Saudi culture, not just our individual culture but also the broader culture of the city and its surroundings, there is a particular culture in medicine that varies among doctors, especially regarding alternative and traditional medicine, we must be aware of this. (MCH9:66)*

While the participant does not critique the patients' choices to use alternative medicine, the participant underscores the ensuing communication barriers, more pronounced when interacting with non-Saudi practitioners: " It is difficult for the non-Saudi staff. I faced such issues with the medical staff from the intensive care department because non-Saudis always needed clarification." (MCH9:96)

The participant expressed the frustration over the time-consuming process of deciphering these practices and herbal medicines, sharing a recent experience: "As an example, the term 'fatigue - FSṬ فسط' is prevalent in alternative medicine. Another term, 'SʿWṬ - سعوط', remains ambiguous to me. For instance, a mother from a remote area, unfamiliar with specific medical terminologies, once described her child's treatment using a term I was unfamiliar with, even though both of us are Saudis". (MCH9:77)

The participant even sought explanations from family members and colleagues to enhance his understanding and improve patient care: " I often consult my aunt for clarity, but sometimes even she's unaware. I've also shared such experiences with my department colleagues on WhatsApp groups to collectively decipher the meaning and improve our knowledge base". (MCH9:108)

Similar to this perspective, another participant highlighted the potential for medical errors due to this gap in understanding: " Patients, influenced by their faith and religious beliefs, often lean towards herbal treatments (alternative medicine). This belief system poses a challenge for us, as we're oriented towards surgery and modern medicine, and are often unaware of how these herbs are used or their potential interactions with prescribed medications". (KFSH13:3)

In sum, the subtheme identifies a crucial gap in understanding Saudi cultural practices related to alternative medicine among healthcare practitioners, which poses risks to patient safety.

7.4.3.2. Subtheme 2: Cultural Variances and Miscommunication

Several participants identified disparities in communication styles, cultural differences, and the discussion of sensitive and taboo subjects as primary contributors to miscommunication among colleagues. A strong emphasis was placed on this by an Egyptian participant, BCH16, who stressed the importance of raising awareness about diverse cultures, especially Saudi culture, to prevent communication barriers. The participants noted the variance in cultural taboos within the Arab world, with some subjects being prohibited in Gulf countries but permissible in others, such as Egypt. BCH16 illustrated this with an example, questioning the taboo nature of an Arabic term equivalent to "gluteus maximus":

> *For instance, the term (MKWH, meaning - gluteus maximus) this term you have in the Gulf is a defect, and you are not allowed to say it out loud, whereas in Egypt it is a common term. I still do not understand what is wrong with it? We are Egyptian Arabs, and we do not consider it a defect. (BCH16:76)*

Correspondingly, reflections from Saudi practitioners in MCH10 and MCH15 underscore the imperative for all staff members, particularly those from diverse countries, to assimilate an understanding of Saudi culture and traditions as a means to reduce potential conflicts:

> *Anyone who plans to work in Saudi hospitals must have a background in our culture. (MCH15:47).*

Specific instances were cited where practitioners from more liberal cultures, like those of the Philippines, might accidentally touch on taboo subjects, such as those of a sexual nature. Although it is recognised that such discussions are unintentional, there is a distinct emphasis on the vital role of cultural awareness:

> *I encounter much recent staff of different nationalities, especially Filipinos; they usually do not have red lines due to the nature of their culture, and their culture is more open and free. They must avoid speaking or asking very personal questions to any Saudi staff, especially Saudi females. I mean some taboo topics in Islam and*

Saudi culture, such as personal questions and sexual topics. I know my colleague does not mean to embarrass me. They are unfamiliar with the culture and our Islamic religion, but I cannot accept it. (MCH10:44)

From a Filipino standpoint, BCH9, revealed the cultural shock experienced due to the restrictions imposed on physical interactions and discussions on specific topics in Saudi culture, contrasting starkly with the more liberal norms prevalent in the Philippines. This participant illustrated the clash of cultural values and emphasised the pressing need for heightened awareness and adaptation to local cultural norms and prohibitions.

I was shocked that we are not allowed to mention sex and bring jokes regarding this topic. It was a shameful and taboo topic; sometimes, I joked about it and felt they took it seriously. I noticed that in Saudi culture, it is prohibited, especially if you are single. (BCH9:27)

Subsequent analysis of interview data highlights the experiences of numerous medical practitioners of diverse nationalities, notably those from the Philippines, confronted with frequent misinterpretations of their natural tone of voice. These practitioners perceive their tone as being misinterpreted as aggressive or overly loud, leading to a spectrum of miscommunications:

The tone of our voice sometimes we have high pitch sounds. But other nationalities think that we are angry. We have to consider this point; if we are dealing with them, we use our normal tone and clarify that we are not angry, which is our normal voice. (KFSH12:20)

Another Filipino participant from BCH echoes this sentiment: " My voice is so loud, and some patients do not want it like that; some physicians also get irritated. So I modulate my voice". (BCH7:20).

The responses from participants demonstrate that, despite prevailing communication disparities, they are attempting to modulate their voices and emphasise that such tone is a cultural norm in their native countries. Nevertheless, it is also apparent that such efforts may not always eliminate miscommunications, particularly within the high-stress context of a medical working environment, as illustrated in the subsequent extracts:

They need to understand that this is a high-pressure environment. As much as possible, they should consider the tone of voice and the choice of words because

142

sometimes unintended transgressions occur no matter what pressure and work. (MCH20:69)

Okay, cultures vary from one nationality to another. Sometimes, a high tone of voice is acceptable in certain nationalities, but for me, I cannot accept it; I see it as a loud voice. (MCH11:4)

The unfamiliarity with colleagues' cultural practices goes beyond these issues. It encompasses the challenges and discomfort stemming from diverse food habits and hygiene routines among staff of varied nationalities. Such disparities have negative effects, influencing interprofessional communication, the work atmosphere, and, by extension, patient care. A minority of participants pointed out that the distinct odours related to specific cultural practices and food habits hindered their communication. For instance, a participant from the Philippines, BCH9, highlighted the initial cultural shock concerning food habits. The participant also pointed out the obstacles faced due to the strong odours originating from colleagues, which affected focus and productivity:

When I came here, I was shocked by the food because, in our culture, we are used to having a heavy meal at the start of the day. But here in Saudi Arabia, they only have bread and cheese, like a light meal. Also, I am not degrading some nationalities, but they smell, I mean heavy smell and sometimes while working you will get annoyed, and have a headache and cannot concentrate. (BCH9:3)

Echoing similar concerns, KFSH9 provides insight into the hygiene habits of staff from diverse backgrounds. This participant particularly notes the strong odours, especially from food habits of Filipino colleagues, which often leads to discomfort. Such observations resonate with the experiences shared by the Filipino participant, BCH9. KFSH9's account provides profound insights into the consequences of communication:

Some colleagues, their hygiene' is entirely different. They have certain traditions to the extent that they smell bad at work to the point where you find it difficult to talk to them, and inadequate communication affects the patient and the work. Concerning Filipino nationality, I encounter different foods related to their culture, as some bring their food to the hospital. It is heavy and has unpleasant smells and garlic, which is annoying, especially early in the morning; when we communicate, communication is difficult with the presence of annoying odours. I prefer not to communicate with them because I know what I will smell. (KFSH9:11)

Within the context of the cultural variances and miscommunication subtheme, non-verbal cues, mainly gestures and body language, emerge as pivotal in shaping communication

143

dynamics among healthcare practitioners. The data underscore that these non-verbal cues are intrinsically intertwined with cultural norms and vary in interpretation across diverse cultural backgrounds, ultimately resulting in communication discrepancies.

A participant from KFSH describes this phenomenon by shedding light on the dramatic influence of the phrase "I will kill you!" While in some cultures, this might be perceived humorously, for those unfamiliar, it can trigger feelings of panic:

> *They will say, I will kill you! That is the most common example, but I will kill you! It's an expression that I later found out is just an expression. However, when I first came and heard it, I felt like, "Oh my gosh, he will kill me!" (KFSH11:10)*

Such misinterpretations can fuel feelings of disrespect, anxiety, or offense, jeopardizing professional rapport and the quality of patient care, as emphasised by KFSH11. This participant focused on their experience to enlighten new staff, underscoring the critical role of cultural orientations for new staff to grasp linguistic nuances and sidestep potential pitfalls.

> *So, whenever I have orientations, I will tell them, if you hear the expression, I will kill you! Do not panic, and don't be afraid. So, I will kill you. Why just now? So, I give it for orientation because I have experienced it before, and I do not want them to feel any panic whenever they hear those words. (KFSH11:12)*

Conversely, even innocent gestures, perceived as benign in one culture, might be interpreted as derogatory in another. For instance, finger snapping, within the Saudi culture, might denote urgency. Yet, for an Indian colleague, this gesture was misinterpreted, resulting in professional friction (MCH13).

> *One situation I faced related to the culture of my colleague from India. Finger snapping to them is an insult. While the purpose was to draw attention. We had a misunderstanding regarding this matter. Because finger snapping in their culture refers to the dancer, in Saudi culture, finger snapping means asking the listener to get the task done as soon as possible and to point out the importance of something. (MCH13:9)*

The paramount importance of body language in communication is highlighted by participants from BCH, who delineate culturally specific gestures, such as nodding the head, which are subject to diverse interpretations across cultures: " Some Nigerian staff,

when they want to say "yes", they move their heads, but in the Philippines, it means to say 'no', and when we want to say "yes," we nod". (BCH4:5).

A simple example to illustrate the point is how different cultures interpret rolling eyes or speaking with one's hand in one's pocket: " Rolling your eyes, for some cultures, this is an insult, but for other cultures, it means maybe". (BCH12:8)

As a matter of nonverbal communication, cultural awareness is paramount to foster respect and avoid offenses. In light of the growing diversification within the Saudi Arabian healthcare sector, it reinforces the need for comprehensive cultural orientation and training. Such efforts, besides improving interprofessional relationships, are pivotal in ensuring exceptional patient care within a harmonious work environment.

Moreover, the practitioners underscored the significant consequences of a lack of awareness and respect for cultural and religious norms, especially those associated with Saudi and Islamic traditions. The emphasis on these norms is rooted in the broader aim of preventing potential miscommunication and conflicts within healthcare settings.

A critical aspect emphasised by participants was understanding the religious obligations of colleagues. This was illustrated by a Saudi nurse who mentioned the challenges related to prayer breaks: " When you ask permission from your non- Saudi director to break for prayer, she thinks it is very simple for us and could be postponed, but we must perform our prayers on time". (MCH1:15)

Moreover, it was noted with consternation that some actions, seen as a lack of respect, could harm professional relationships. A particular incident was recounted where a colleague, from a different religious background, challenged the existence of God during a work-related discussion, leading to heightened conflicts:

> *I was working with doctors of different religions, I was in a meeting, and we were talking, and I said: Allah is willing, we will strive and persevere, and Allah will reward us. We want Allah's wages even if our work is hard. The important thing is Allah's satisfaction and the patient's satisfaction. Then, my colleague suddenly said: "There is no Allah/God!" This caused me harm in communication. We had big issues because he always objected to religious matters in our culture. So I could not deal with him at any point. (BCH14:134)*

Within the confines of Saudi Arabia, the dimension of gender contact occupies a distinctive position within the realm of professionalism and respect. The cultural context, deeply embedded in religious principles and traditional practices, plays a profound

influence on the dynamics of gender-based communication. For instance, (KFSH1:21) underscores the foundational challenges inherent in the Saudi cultural landscape, stating, " The stigma of segregation between males and females. So, exposure or contact between males and females, in general, is very limited ".

According to MCH15, newcomers to the Saudi healthcare environment must be knowledgeable about the local culture. MCH15 elaborates:

> *Anyone who plans to work in Saudi hospitals must have a background in our culture. I mean, we are Saudis and Muslims. There are limits and boundaries. The foreign staff must know their limitations when dealing with Saudi people, and females know their limitations within the work. They should be formal and polite. (MCH15:48)*

In summary, the participants explore the nuances nature of gender interactions within the Saudi healthcare sector, taking into account the diverse religious backgrounds of the practitioners. Emphasis is placed on the paramount importance of cultural awareness, understanding, and respect in facilitating effective communication.

7.4.3.3. Subtheme 3: Evolution of Cultural Understanding

Transitioning from the previously discussed subthemes highlighting a notable lack of awareness, the present subtheme delves into the evolving landscape of cultural understanding. Participants' narratives unveiled a slight shift in comprehending and embracing cultural differences. This shift suggests a promising direction towards improved multicultural communication, with reduced barriers stemming from cultural and linguistic backgrounds.

While linguistic and cultural variances are commonplace among healthcare practitioners, advanced preparation prior to departing for work can significantly smoothen the integration process into a new work environment. Filipino practitioners in the hospitals underscored the pivotal role of their government in facilitating this preparation. Before departing for Saudi Arabia, they undergo comprehensive cultural orientations, as exemplified by the following statements:

> *Regarding cultural challenges, there is a minor challenge, but it is not difficult because before we came here to Saudi, we attended a cultural orientation in the Philippines. This orientation aimed at introducing Saudi Arabia's culture, i.e., what*

146

are the cultures here in Qassim, and how we will deal with our patients because here, our patients are not liberated. (KFSH12:7)

I can adjust. Because in the Philippines and before coming here, they oriented us to what we will expect in this country. In our country, we are hired through the government. So our government, before we fly to Saudi Arabia, we have the PDOS, we have the 'Pre-Departure Orientation Seminars', which give us some ideas about the culture, so we know what to expect. (MCH14:11)

The Filipinos practitioners show that there is adjustment, thanks to the pre-departure orientation seminar they attended before coming to Saudi, which may prepared them for what they would encounter. In fact, this may facilitate cultural understanding.

Conversely, a contrasting experience was narrated by a Nigerian practitioner at BCH, who possessed significant doubts and misconceptions about Saudi cultural norms, fearing for her life: "I want to say that coming here, as I said, I came with false assumptions in mind. I was afraid. I hope they will not cut my neck in Saudi Arabia!" (BCH8:130). The participant's experience elucidates the repercussions of pre-existing misconceptions, emphasising the necessity for comprehensive pre- and post-departure cultural orientations.

Yet, despite the initial misconceptions, the Nigerian participant's experience evolved over time, leading her to embrace Saudi Arabia as her "home". This sentiment resonated with another participant (BCH7:35), who remarked, " However, somehow the new staff were okay with the culture and adapted. I, myself, adapted for 13 years. But I love this place; I love it. This is my second home after the Philippines ".

Some perspectives offer invaluable insights into the development of intercultural understanding in this setting. While the previous subtheme touched upon cultural conflicts, BCH14's viewpoint underscores the positive shifts in cultural assimilation and respect. In recounting their experiences, they bear witness to the evolving cultural landscape and the efforts taken towards Vision 2030.

Now I am pleased because there are Filipinos and other nationalities who are not Muslims. However, when communicating, I find them saying some of the phrases we use, such as "Praise be to Allah, Alhamdulillah, Inshallah". This gives me the impression that she respects me very much. I have worked here in the kingdom since 2007. Mashallah, the kingdom is in tremendous development, and at all levels, it contains all nationalities and religions. (BCH14:140)

147

This evolution also finds agreement with an Indian participant who has observed progressive changes over a decade, noting, " Nowadays, you know, there has been much difference. Now you can see that females are driving cars, which is the change we want". (BCH22:10)

The extracts presented underscore the evolving nature of cultural understanding within the Saudi healthcare context, highlighting both the challenges and attempts at navigating this journey.

7.4.4. Theme 4: Institutional Gaps in Language Management

This theme highlights systemic and institutional deficiencies, emphasising the need for defined language policies/assessments, and the availability of interpreters in healthcare. It underscores the significance of these challenges as more than individual obstacles, but as evidence of a broader institutional neglect. The theme advocates for hospitals and the healthcare system to enhance communication through comprehensive language management strategies. There are two subthemes shown in Figure 7.12.
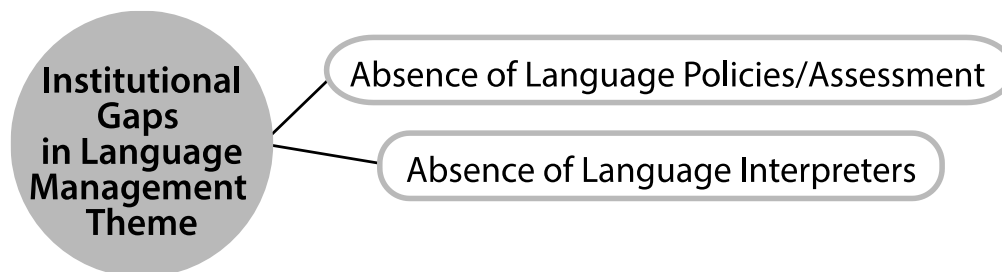
Figure 7. 12 Subthemes for the "Institutional Gaps in Language Management Theme"

7.4.4.1. Subtheme 1: Absence of Language Policies/Assessments

From the statements of several participants across the three hospitals, it is evident that a defined language policy and assessments are lacking. Such an absence fosters ambiguity among healthcare practitioners about the appropriate language for communication,

especially given the diversity of nationalities. Even though directives from the heads of the medical departments advise practitioners to communicate in English during medical discussions and endorsements, the apparent lack of enforcement coupled with unclear expectations creates problems. Which forces practitioners, less proficient in English, to navigate towards hospital departments where the language is not as intensively required:

> *Unfortunately, we don't have a specific language policy, but the director informed us to speak English all the time. Some Saudi staff who didn't know the basics of English were suffering in inpatient, so they moved their roles to the outpatients. Because the outpatient in the hospital does not require intensive communication in English. (KFSH9:138)*

In despite of having a language policy within the ICU, it is often ignored. This could be attributed to the policy's limited circulation and recognition across the hospital:

> *We have an English policy only in our intensive care unit, But sometimes it's being violated. They are unaware that they have to use English, especially during rounds. Physicians tend to discuss the case in the Arabic language. So for us nurses, we need to understand 80% or 70% plans. (MCH2:3)*

Given the dominance of Indian nurses, there is an unintentional shift towards their native languages. There is a consistent emphasis on the importance of English, particularly in medical contexts, in order to ensure mutual understanding:

> *Around 36% of the nurses and patients in the ICU are Saudi, 60% are Indians, and Filipinos are around 4% and 3% only. So the Indian nurses tend to speak in their language because they are the majority. Usually, if they are endorsing, the endorsement is good because they use English. But sometimes, if they are discussing things like the Indian to India and where we are also included in the discussion, so they will speak in Hindi or their mother language. Also, for Filipinos, when we are together, we will say excuse me: "excuse me, can you speak Filipino please ! because it expresses more".(MCH2:8)*

An interviewee from BCH stressed the urgency of introducing a language policy, linking its absence directly to communication pitfalls: " Unfortunately, we do not have a language policy, and this is the cause of poor communication. All governmental hospitals here are rising and progressing, but specific issues are still pending and must be developed". (BCH14:151)

A lack of language policy in the Qassim region is evident from the data and the healthcare system, in contrast to other cities like Riyadh the capital and Jeddah. The example highlighted by BCH5 sheds light on how it is imperative to always speak English:

> *In my previous work experience in a hospital in Jeddah, there was a policy to always use English. There were warning tags on the walls that if we used languages other than English, we would get a warning. But here, in Buraidah's Central Hospital, we do not have a language policy. We all should speak English.. (BCH5:22)*

A predominant concern among participants was the absence of a systematic language proficiency assessment, particularly emphasising the need for assessments equivalent to IELTS to foster better communication. One participant from KFSH expressed uncertainty regarding the existing curricula or the requisite English exams, noting: " So, I am not really sure and do not know the curriculum or the specific qualifying English exams they must take". (KFSH11:61)

Drawing parallels with other Arabic nations, another participant highlighted that several countries mandate language assessments for healthcare professionals. This participant expressed concern about the non-mandatory nature of such exams in Saudi Arabia:

> *In Saudi Arabia, there is currently nothing compulsory in employment like in some other Arab countries. I mean, in other Arab countries, they are required to have TOEFL and IELTS. Therefore the requirements of these assessments mean that medical staff's language improves significantly. (MCH4:39)*

MCH4 asserted that such English language assessments are crucial in improving the linguistic competencies of practitioners. The participant advocated for the Saudi healthcare system to adopt these assessments as a prerequisite for employment, emphasising their value in enhancing communication, especially in medical discussions:

> *These assessments enhance our skills, especially in a work setting. In Saudi Arabia, of course, there is nothing mandatory. Some countries require such assessments as IELTS or (OTA) tests to improve the English language. And it does help with communication. (MCH4:44)*

Another participant, comparing global practices, underscored the importance of language assessments. This emphasis was not only for facilitating efficient communication among

healthcare practitioners but also to mitigate potential miscommunication hazards due to language proficiency disparities:

> *If we go to Japan or Korea, like for us as nurses, I'm mainly speaking English. They ask us to take their language; in Japan, their language is "Nihongo". If we pass their language assessment, we can apply for a job. As I said, most people need to speak more English in the place they are working at. So, we have to consider that when going to the hospital, some professionals may speak English, and others do not speak English. (MCH14:58)*

The discussion extended beyond English, with many participants highlighting the need for Arabic language proficiency assessments for non-Arabic speaking practitioners. This is crucial for effective communication with both peers and patients. Considering that most patients in Qassim primarily communicate in Arabic, the lack of such assessments presents a significant challenge. How will diagnosis and treatment proceed if there's a language barrier between patients and practitioners? The following extracts address this issue:

> *I advise the non-Arab staff to learn Arabic basics, and the ministry of health should implement similar tests like we take the English assessments such as, (IELTS-STEP). There should be similar assessments but for the Arabic language so they can communicate well and clearly. (KFSH14:57)*

> *As much as possible, all staff should speak Arabic, or at least like what European countries do. There is a language assessment, and this is the patient's right. As far as I know, there is no Arabic language assessment for non-Arabic speakers. They cannot communicate with the patient, which I expect is a problem. (MCH3:24)*

Thus, the analysis highlights a critical lack of formal language policies and assessments in Saudi Arabian hospitals, leading to communication barriers among multilingual staff and impacting patient care. It highlights the need for standardised English and Arabic language proficiency assessments to ensure effective communication across diverse healthcare teams.

7.4.4.2. Subtheme 2: Absence of Language Interpreters

In any healthcare system, prioritising patient safety is paramount. This becomes particularly crucial in multilingual contexts. Notably, the healthcare system in Qassim, as shown by this study, exhibits a marked deficiency of professional language interpreters. The importance of proficient interpreters is underscored in the observation: " It is essential

to have an interpreter for the non-Arabic speakers to convey their messages for medical procedures and the medical staff ". (KFSH5:35)

Miscommunication, with its potentially serious implications in a medical environment, is highlighted in a statement from MCH3: " Sometimes, communication between the patient or the patient's family and the medical staff is an obstacle if the doctor or the medical staff needs to speak Arabic and the patient speaks Arabic. This situation here is an obstacle and sometimes needs the presence of an interpreter in the middle. If there is no one to translate, miscommunication occurs". (MCH3:21)

Another participant pinpointed the loss of communication efficacy when multiple parties engage in translation. The integrity of translation can be compromised, leading to biases, misinterpretations, and potentially, poor care quality due to individual prejudices, unawareness, and cultural variances: "All the doctors who come from abroad do not speak Arabic, so they need a translator. The translation may have a lack of words or a misunderstanding. The misunderstandings increase when so many untrained people get involved in the translation process". (MCH19:53)

An economic challenge was highlighted by MCH8, emphasising the financial and emotional burdens families face when compelled to seek external translation services: " Do you imagine we have advised the family to go to any translation centre to translate the report and pay the translation fees? There are no interpreters, and some patients want it translated into Arabic and others into English". (MCH8:56)

Beyond patient-centric challenges, even practitioners occasionally grapple with linguistic barriers, impacting comprehension: " Sometimes we know the disease in English, but we do not know it in Arabic, so we keep asking them to translate it to a translation centre and translate it from English to Arabic and vice versa". (MCH8:60).

All in all, the pressing necessity for skilled language interpreters within Qassim's healthcare system cannot be overstated. As globalization progresses and societies become increasingly diverse, ensuring robust communication in critical domains, such as healthcare, is imperative. The extracts underscore the urgency of addressing existing shortcomings to safeguard patient well-being.

7.4.5. Theme 5: Utilising All Available Resources

This theme examines how healthcare practitioners overcome cultural and linguistic barriers to communication, emphasising the need for rapid responses in medical settings. It highlights the various methods and strategies used to ensure effective patient care communication. Despite uncertainties about their efficacy, these resources are recognised for their role in facilitating communication. The theme consists of six subthemes and four clusters that delve deeper into these strategies.

7.4.5.1. Subtheme 1: Translation and Interpretation

7.4.5.1.1. Cluster 1: Formal and Informal Translation

The gap in institutional interpreter availability has led practitioners to explore alternative translation methods. These can be classified into formal and informal strategies, as presented in Figure 7.13 below.
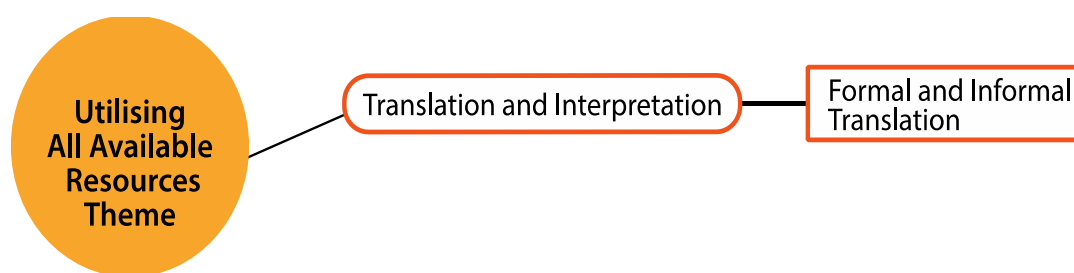
Figure 7. 13 Cluster of the Subtheme "Translation and Interpretation"

In the realm of formal translation, practitioners lean towards services from authorised translation centres. For instance, as one participant articulated: "Translation services, some translation offices take the money and translate for you". (BCH22:41)

In situations demanding meticulous attention, such as case-sensitive investigations, participants exhibit caution by seeking formal interpretation, as highlighted by the statement: "We do not want to write anything which is not what we do not know, so I write my answer in English and go to a formal translator, and they convert it into Arabic". (BCH22:35)

Meanwhile, a considerable number of practitioners rely on informal translation mechanisms. This preference could be attributed to perceived inefficiencies and delays associated with formal translations. Data suggests that practitioners predominantly resort to colleagues for assistance, particularly colleagues who are fluent in English and Arabic, as exemplified by: "If I cannot talk to them, if they do not understand what I am saying, I seek help from any available Saudi staff who knows English and Arabic fluently". (MCH17:13)

Echoing this sentiment, another shared: " If I cannot explain, I will call other doctors who can understand English to translate it for me. Or I will call the social worker or patient to explain to my colleague". (KFSH13:22)

The imperative of seeking a colleague's assistance to face communication gaps is emphasised by participants' acknowledgment of their limited English proficiency and the consequent necessity of seeking assistance from colleagues with more advanced English skills: " There will be a misunderstanding if there is no English language proficiency, so there must be another party to explain your position. Therefore, if I have difficulty communicating in English, I have to seek help from someone better than me to help me solve the misunderstanding". (KFSH15:9)

Reinforcing this point of view, another participant remarked on the importance of self-awareness regarding language proficiency: " I show the speaker my level and tell them about my capabilities in the English language" (MCH13:16). This acknowledgment is perceived as instrumental in mediating communication, as elucidated by: "to save time, convey the information, and simplify it more easily.

While colleague assistance might be more efficient in real-time communication, it might not always be readily available. This is evident when asked about the availability of colleagues for translation, surprisingly the participant said: " If they are busy, we postpone this case to a convenient time for the doctor and me". (MCH13:26)

The data suggest that seeking colleagues' assistance with translation is not confined to a single language direction, such as from L1 to L2 or L3. Participant responses predominantly indicated translation in the target language. For instance, a scenario highlighted the necessity of translation even within the same language: "At first, he did not understand English, and one of his colleagues spoke in his first language, so we asked him to explain and translate the matter". (BCH21:15)

Further analysis of the data indicates that participants often resort to alternative, informal translation methods, primarily utilising translation applications for language mediation. In scenarios where colleagues were unavailable for translation, one participant remarked: " If she is not available ! now Google Translate is available" (MCH16:22). Indeed, a significant number of practitioners lean on Google Translate when faced with language barriers, and to translate specific medical terminology: " I used Google to translate the term 'pneumoperitoneum' into Arabic". (MCH8:66)

This reliance on Google Translate for fostering mutual comprehension was reiterated by another participant: " For me, with my Indonesians colleagues, I am searching for one who knows more knowledge of the language, and I am using the translation app, or else I will speak to them in English. Then they will reply to me by translating in the Google App". (BCH10:16)

When informal translation methods are employed, practitioners predominantly seek a colleague's assistance or employ other communication strategies. However, if these avenues prove insufficient, they often turn to translation software. While Google's tools proved to be the most popular among participants, utilising these tools is not without challenges. A recurring sentiment among interviewees was that while Google Translate can be beneficial, it frequently becomes a source of confusion: " But, sometimes, the translation is different even when using translation applications. Because I translate two parts, I solve one part, but I need to translate the whole text to understand, and machine translation is only sometimes correct". (MCH14:74)

This sentiment was echoed by another participant who highlighted challenges in translating specific segments using Google Translate: "even Google Translate causes challenges; sometimes I wonder: 'what is that word?' We still need help in breaking down the words. Words are different because Google Translate is not accurate". (KFSH11:69)

The potential for miscommunication was further illustrated by an experience shared by BCH7, in which participants investigated a Saudi colleague's referral of patients who had no appointments on the system. The mistranslation led to unintended consequences: " I wrote my inquiry in Google Translate from English into Arabic. I do not know what's written in Arabic, but I am sure about what's written in English. I said: 'If you are directing your patients here, you are automatically giving them an appointment" (BCH7:55). The situation exceeded the participant's expectations, when the participant was surprised to be

called to meet the director, due to Google's mistranslation which caused confusion. It was surprising that the translation included names and did not accurately translate the message: " The director told me: 'you are telling him to speak to those people?', and then I had to explain the situation again'". (BCH7:62)

Taken together, while informal translation strategies, especially application-based translation, can serve as a mediation strategy and communication aid, participants consistently conveyed the nuanced implications of these methods, especially in a critical medical setting where precision in communication is paramount.

7.4.5.2. Subtheme 2: Gestures and Body Language

Within healthcare communication, the subtheme of gestures and body language emerges as a crucial non-verbal strategy, enabling healthcare practitioners to successfully navigate the complexities of their multilingual and multicultural environments. As shown figure 7.14, the body language functions as a resource, more specifically a mediation, bridging linguistic gaps to foster effective communication.
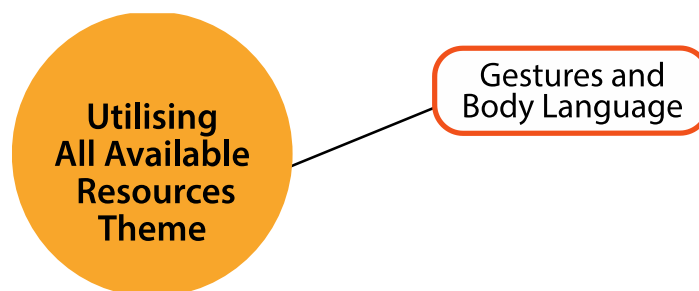
Figure 7. 14 "Gesture and Body Language" Subtheme

Participants consistently refer to their reliance on body language as an effective strategy to overcome linguistic obstacles. This is especially relevant when adapting to the predominant regional language or when liaising with colleagues and patients when lacking fluency in a shared language. As one interviewee put it:

> *If they cannot understand you in any way, you have to act. Like if you ask them and they cannot understand what you are saying, then you have to act and explain through actions. (KFSH4:15)*

This dependency on non-verbal cues transcends mere functionality, evolving into a nuanced art of expression. Successfully deciphering others' emotions and ensuring mutual understanding, especially in contexts where patients' health is at stake, demands a harmonious interplay between verbal utterances and non-verbal indicators.

> *I measure it by facial expressions and their reaction, and if they provide me with the answer that I expect, if not, I ask them again for mutual understanding. (MCH11:12)*

Highlighting the significance of positive facial expressions, particularly smiling, brings to the forefront the imperative of fostering a positive and open environment in healthcare settings. Communication is not solely about verbal content but is equally influenced by the manner of its delivery, wherein non-verbal cues assume a key role. This sentiment resonates in the reflections of KFSH7 and BCH23:

> *Body reactions and facial expressions. I can smile and greet. Simple things that give a good impression and facilitate communication between us. (KFSH7:31)*

> *Body language is very important. The smile gives the impression that you are social and willing to make relationships and communicate. (BCH23:26)*

Gestures, especially hand movements like pointing, emerge as pivotal means of directing and guiding communicative exchanges, especially in clinical situations demanding the utmost precision: "Hand gestures, by pointing with your hand: 'stop please, stop please do not continue, sorry, I do not like this topic!'. You showed signs of nervousness in expressing your point and communicating with others". (BCH23:27)

Overall, the extracts illustrate the intricate balancing act between verbal and non-verbal communication in healthcare settings. Body language is a crucial strategy for healthcare practitioners in an environment where clarity, empathy, and understanding are paramount.

7.4.5.3. Subtheme 3: Pragmatic Strategies

Practitioners in ELF environments use diverse communication strategies with colleagues, forming the basis of effective communication. This subtheme explores these strategies as described by participants. They are viewed as practical tools for bridging comprehension

gaps and ensuring clarity. As shown in Figure 7.15, there are three primary pragmatic strategies.
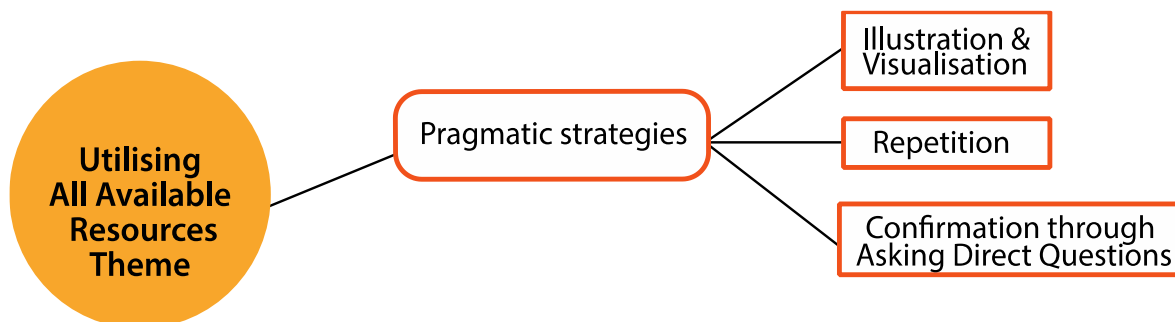
Figure 7. 15 Clusters for the Subtheme "Pragmatic Strategies"

7.4.5.3.1. *Cluster 1: Illustration and Visualisation*

One prominent strategy entails the utilisation of visual aids and illustrations to enrich communication and foster mutual understanding. Participants employ visual aids such as images, videos, and illustrations to convey their messages effectively. For instance, KFSH4 elucidates the use of visual images to clarify unfamiliar terms: "I do not know the Arabic word (milk), so I search for a picture of milk and explain it through visual images to facilitate understanding". (KFSH4:26)

Visual aids not only simplify comprehension of unfamiliar terms but also assist in conveying the names of medications through visualisation, thereby making concepts more accessible. As one practitioner, MCH19, articulates, " It is better to use Google and show them a picture of the medication or to ensure that the treatment is accurate". (MCH19:29)

Similarly, this strategy proves invaluable when elucidating the instruments used in medical treatments to colleagues due to the absence of a shared language: "I use pictures when I want a specific device or procedure that I know in French but do not know in English". (BCH19:11)

Furthermore, several practitioners emphasise the importance of visualisation, going beyond visuals to incorporate real-life examples in their explanations. KFSH12 and BCH14, for instance, draw upon everyday life or prior cases to help their audiences:

I always like to set an example, even if it is a simple example from our daily life. I always try to set an example, remind them of a previous patient's case, or write in documents. (BCH14:47)

When inquiring about effective strategies in communication, another interviewee opines that in interactions, listeners typically comprehend only 10 to 20% of the implied message. However, the use of illustrations and visualisations, such as images and posters, proves useful in guaranteeing comprehension:

We only understand about 10 to 20%. However, if you have associated illustrations, visuals of something, posters, written a pamphlet for those that can read, they will understand. (BCH8:71)

Healthcare practitioners emphasise the efficacy of visualisation in bridging communication gaps, with images and real-life scenarios notably improving the clarity and accuracy of medical discussions in multilingual environments.

7.4.5.3.2   Cluster 2: Repetition

Healthcare settings, known for their dynamic and high-stakes nature, require effective communication as a fundamental aspect. Ensuring accurate comprehension of medical information among professionals is crucial for safe and efficient patient care. The findings highlight repetition as a key communication strategy used by healthcare practitioners across different departments and specialties.

As a result of the complex nature of medical terminology and the potential consequences of misinterpretations underscore the significance of this strategy. As evidenced by statements such as, "I keep asking them: 'Did you understand me?' I always use repetition to clarify things more" (MCH5:14) and "I repeat what I said until we reach an agreement of understanding" (BCH18:9), practitioners ensure that crucial details are effectively articulated and comprehended.

In high-pressure medical situations, as mentioned by KFSH8, repetition becomes a standard practice for confirming crucial steps in procedures. This underlines the need for absolute clarity in these situations. As KFSH8:25 points out, "repetition until it is confirmed. For instance, the medical team must repeat until everything is confirmed".

The application of repetition extends to cross-cultural communication, where names and terminologies may vary. Reliance on repetition serves as a tool to validate and

confirm information. KFSH2 emphasises the importance of this strategy, stating, " We must follow international patient safety goals! First, the patient's full name because here in Saudi Arabia, some names you hear about are repeated. You should carefully select words because sometimes the words may be misunderstood. And there is no harm if you repeat". (KFSH2:7)

Repetition plays a crucial role in patient safety, especially when it comes to medical orders. A participant underscored the importance of "reading back" verbal orders to ensure their accuracy. This practice aims to mitigate the risk of medication errors. According to MCH2, " We have to repeat back the order. Verbal orders, like telephone orders; whenever the physicians are away from the unit, we will call them to discuss the patient's case, and then they will give their orders; we have to write them down. After writing the orders, we have to read them back to them to confirm if that is the case or the order" (MCH2:28).

Added to that, some healthcare practitioners consider repetition essential for fostering collaboration among interprofessional teams. As collaboration lies at the core of teamwork in the medical context, repetition is seen as a means to enhance teamwork and facilitate group discussions. KFSH3:9 state, "We repeat and discuss if there is a misunderstanding and have meetings. We live as a family in the work environment here".

In summary, repetition emerges as a crucial and flexible communication strategy within healthcare environments, serving to enhance clarity, minimize errors, and promote effective teamwork among healthcare practitioners.

7.4.5.3.3. Cluster 3: Confirmation through Asking Direct Questions

This cluster provides insight into the proactive communication strategy employed by healthcare practitioners, where they utilize direct questions to ensure clarity and confirm comprehension during their interactions. These direct questions serve as a protective measure against any failure in communication.

A participant from KFSH stresses the importance of direct questioning to emphasise key points and ensure the recipient's understanding. By using repeated questions like "Do you get it?", KFSH1:40 highlights the necessity of confirming comprehension.

Another perspective on the use of direct questions is to validate comprehension, and serves to prevent potential misinterpretations stemming from language disparities or unclear communication. This is exemplified in the case of KFSH11, where the practitioner

states, "I need to verify, and I need to confirm." This is my understanding. Did I understand you correctly? I confirm, whenever I feel misunderstood." (KFSH11:52)

Practitioners employ specific questions to seek confirmation and eliminate ambiguity in their conveyed messages. The following excerpts from (MCH2) provide further insight:

> *I also validate what is being said: "ah, is it this?" For example, when sending the patient to the diagnostic exam, I say: "Do you mean we have to do CT brain without the contrast? If he/she says yes, then I proceed". (MCH2:22)*

Another participant highlighted the utility of posing direct questions to receive feedback for mutual confirmation and to identify and address knowledge gaps: "Get feedback, ask: 'Do you understand what I said?' Yes, I do. What did I say?" (BCH8:65).

For non-Arabic speakers, the use of direct questions, including Arabic inquiries such as "Do you understand?" appears to facilitate communication and serves as a universal means of comprehension, irrespective of language barriers: "Asking direct questions: 'Did you understand?' Even in Arabic, I say: 'Anta Tafham?'" (BCH7:70).

Thus, direct questions are a key communicative strategy used by healthcare practitioners to reinforce understanding and mitigate the risk of miscommunication across language barriers.

7.4.5.4.   Subtheme 4: Plain Language
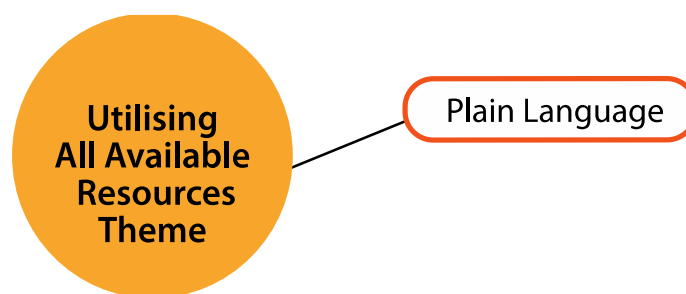
Figure 7. 16 "Plain Language" Subtheme

A prevalent perspective among interviewees underscores the significance of employing plain as an instrumental strategy to addressing language barriers. Several healthcare

practitioners, such as those from KFSH7 and BCH2, exhibit a deliberate effort to tailor their language choice according to the linguistic competencies of their colleagues. Specifically, these professionals resort to uncomplicated language when engaging with peers for whom Arabic or English is not a native language, thereby exemplifying an exceptional degree of linguistic adaptability and awareness. This strategy is outlined in the following interview extracts:

> *When I talk with the Bangladesh workers, I try to make my language as simple as possible. (KFSH7:18)*

> *The basic language that everyone can understand. If I notice that they do not know what I'm trying to say, I will try to make them understand. (BCH2:21)*

A number of participants supported the employment of basic English and plain language for communication, underscoring its adequacy for most medical tasks: " Basic English is sufficient, for example: "I want this, do this order, take the blood pressure, do the RPC, send the patient." You don't need to be at an advanced level of English; plain language will do the job" (KFSH9:108)

The suggestion is that an advanced level of English is not necessary, reinforcing the idea that clarity and simplicity are more crucial than linguistic proficiency: "Here in the hospital, they will not understand you when you speak English very well, you should use simple words like "You come; you go". I simplify my language and use basic English so the other staff can understand me." (KFSH10:20)

Practitioners stress the necessity of clarity over linguistic intricacy, endorsing the use of plain language. A focus on precision in communication, particularly in clinical settings where miscommunication can be a threat, is paramount: "Since we are in a work environment with different nationalities, the best strategy is to speak clearly and calmly. We must simplify the sentences to be more precise and restructure our language to avoid language errors". (MCH10:21)

The necessity of assessing the linguistic competency of the interlocutors was emphasised. MCH13 provides a useful strategy that colleagues should adapt to their peers' levels. The use of plain language facilitates communication in delivering the correct messages and demonstrates understanding and empathy between practitioners.

I advise my colleagues whose language, Masha Allah, is excellent that they must understand the level of English of the listener/speaker from one word or two and evaluate their level in English. For example, if they are not at your level in the language, respect them and shorten your speech and simplify or reform. The conversation and orders, in this case, must be simple, direct and precise. (MCH13:28)

BCH10's reflections shed light on the linguistic diversity even within nations like India, further reinforcing the need for utilising plain and basic language that everyone can understand: "There are a few issues with the language; some speak Malayalam, even though they are in India, but they have different native languages. Some of them do not understand English. So, one basic language should be given to all staff". (BCH10:21)

The strategy was also observed to enhance communication across diverse Arabic dialects, as articulated by a practitioner from Egypt: "When communicating with my Sudanese colleagues, I understand them more when they speak English, not Arabic, and I think it is necessary to have the basic and plain English language before coming to work here; indeed, it is imperative. If you have the basics of English, it will become more manageable with time and more observations". (BCH16:65)

What emerges from the results reported in this subtheme is that practitioners ensure effective communication through using plain language, understanding the need for being adaptable, and emphasising clarity over complexity.

7.4.5.5.   Subtheme 5: Using Mother Tongue

Figure 7.17 shows the strategy of using the mother tongue or code-switching to facilitate communication with colleagues.
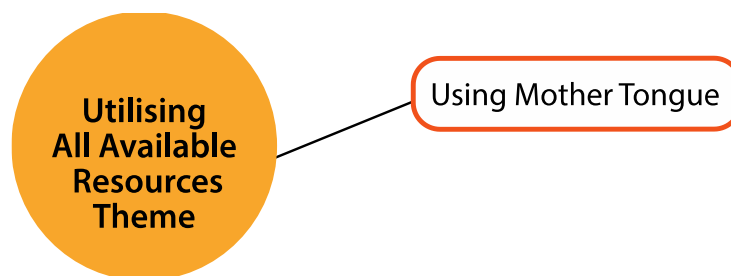
Figure 7. 17 "Mother Tongue" Subtheme

Although a few participants reported using their mother tongue, this subtheme explores the motivations behind this strategy. As one interviewee reported, due to limited English proficiency among colleagues, the participant emphasised the need to resort to the mother tongue to deal with the language barriers: " The English language is very weak here. This made me frustrated at the beginning, so I had to prevent this misunderstanding by speaking my mother tongue". (KFSH1:32)

Two interviewees reported using their mother tongue when communicating with colleagues of similar nationalities. To ensure clear communication with colleagues of similar nationalities, practitioners often switch to their mother tongue. Switching is often used when both parties understand that it can facilitate clearer and faster communication, especially when time is of the essence:

> *We commonly speak English, and other languages are spoken between the same nationalities; we use our mother language. (MCH6:5)*

> *Communication between Saudi and Arab nationalities is manageable because sometimes we speak Arabic. (MCH9:17)*

When referring to the use of mother tongues, there are implications due to the diversity within one nationality. BCH2 illustrates linguistic diversity even within nationalities. While the use of a mother tongue can aid communication among those from the same region, it can also pose challenges when individuals from the same country speak different native languages.

> *Although most of us are from India. In India itself, we have many languages. So it is difficult for us to understand each other. (BCH2:11)*

Overall, these hospitals have shown a willingness to use all available resources to navigate the challenges posed by linguistic diversity by using their mother tongue as a resource. In some cases, it can facilitate clear communication, but it can also pose challenges, especially if multiple native languages are present within a single nationality.

7.4.5.6. Subtheme 6: Using Digital Technology

Central to this subtheme is the exploration of how digital technology is utilised as a resource to support healthcare practitioners in eliminating miscommunication and ensuring successful communication.
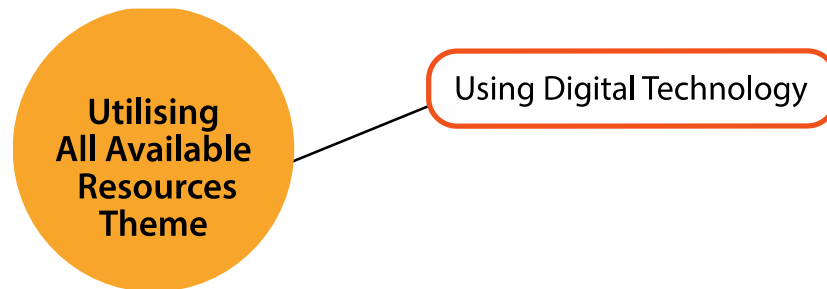
Figure 7. 18 "Using Digital Technology" Subtheme

The participants underscored the significance of electronic communication, predominantly for documentation. They emphasised the advantages of electronic documentation compared to verbal or paper-based alternatives: "Electronic is the best use because the filing and everything are adequately documented in the file. They can look it up whenever they like, whatever they want to retrieve or complete the patient's medical history". (KFSH6:25)

A notable incident highlighted the adverse outcomes stemming from an over-reliance on verbal communication and paper-based documentation. This incident underscores the profound implications of communication modes on clinical outcomes, potentially leading to medical errors:

> *Once, I had a patient; the orthodontist needed extraction of certain teeth and moved the other teeth to make space. So, he sent me a paper saying that these particular teeth must be removed. Then he called me again, saying, I sent a patient to you, and there are brackets on the teeth, and you are supposed to remove the tooth which does not have brackets. So, I did not see the written paper and followed his orders via phone and did the procedure. A week later, he returned, saying I did the wrong extraction. So, now I need to get back up to prove what happened. There is a paper with another procedure, and he told me something else. This paper did*

165

not go on file. So, ultimately, what happened? It is my fault; the patient lost the tooth because of miscommunication with the papers. (KFSH6:67)

The participant articulated the advantages inherent in digital documentation, remarking, "Now that everything is documented in the electronic system. Nobody will, like, back off from what they have written. It's going to be there forever". (KFSH6:74)

Highlighting the merits of digital documentation, another participant noted, "We record every detail related to the patient's condition on the computer. In my 8-hour shift, I record everything on the system in case any misunderstanding occurs; we can go through the previous notes, whatever the staff has written". (BCH1:23)

Another viewpoint echoed a similar sentiment: " In the meantime, 40% of the documentation is now electronic, so I prefer good system documentation to communicate well; we are dealing with lives, right?". (KFSH10:34)

Of particular note is the increasing recommendation for digital documentation, especially with the rapid adoption of instant messaging platforms like WhatsApp. The vast majority of participants emphasised the necessity of documentation and advocated for the use of specialised apps tailored for interhospital communication: " I advise my colleagues to communicate via email and WhatsApp for documentation or in any application dedicated to the same hospital" (KFSH8:14). The participants further emphasised the necessity of diverse communication channels: "Including having more than one communication channel, direct communication via email or WhatsApp, communication by frequency, and reference". (KFSH8:27)

The utility of digital tools, such as WhatsApp, was highlighted as an efficient method for coordinating and communicating across various hospital departments: "We use WhatsApp and can communicate with all the hospital's related departments to know what is going on. That is the best way of communication". (BCH1:27)

Other participants spotlighted the adoption of distinct strategies via instant messaging platforms. These strategies encompass order confirmation and repetition: "We confirm orders verbally or in a WhatsApp group. Our department settles WhatsApp groups, and we use WhatsApp to confirm orders and cases with other doctors". (MCH15:20)

The imperative of closed-loop communication ensures prompt feedback and mutual comprehension. This is especially pertinent for conveying urgent communications, as delineated by MCH17:

> *We also communicate through messages in WhatsApp or the department group. So we send all the urgent messages, including medical tasks. We send everything to the WhatsApp group, so any staff on vacation can read the message and acknowledge it in the group whether they read it or not. (MCH17:19)*

A participant referred to the pivotal role of fostering and nurturing relationships among healthcare practitioners, leveraging instant messaging and social media apps. Such interactions, including extending holiday greetings, are perceived as opportunities for enhancing collaboration among practitioners:

> *An investment in relationships is needed, as well as the stability of the place. Social communication creates a love continuum between the feeling of brotherhood and the feeling that we are one team. We help each other and support each other so that there is no obstacle between us. Communication is vital, whether over the phone, during holidays every year, Eid Mubarak, Happy Ramadan etc. ", or even through WhatsApp or social media applications. (BCH23:39)*

The incorporation of digital tools was also portrayed as a mechanism to navigate language barriers. While it represents a departure from verbal interaction, it is deemed by some participants as an approach to ensuring effective communication:

> *Even if I am speaking clearly, some of my colleagues may have difficulty understanding some of the words. So, I tell my colleague that there is no connection on the phone, I cannot hear you so we can communicate via WhatsApp, and I try to use all the synonyms of my words with a little effort of simplification. So, I try to avoid verbal communication. (MCH20:30)*

In this subtheme, the data demonstrate the importance of digital technology in mediating communication. Digital tools, especially electronic documentation, are recognised for eliminating ambiguities and minimising errors, as illustrated by instances of miscommunication in traditional methods. Participants emphasised the advantages of electronic communication, emphasising its permanence and accuracy over verbal or paper-based communication. A growing use of instant messaging platforms, notably WhatsApp, has been highlighted as an efficient means to coordinate interdepartmental efforts and

overcome linguistic barriers. It is evident that digital platforms facilitate collaboration and teamwork among practitioners.

7.5.   Conclusion

This chapter has reported on the analysis of the semi-structured interviews, describing the development of five primary themes, fifteen subthemes and ten clusters. In the final chapter, I draw together the findings from the scoping review, survey and interview, and respond to the study's research questions.

Chapter 8. Discussion and Conclusion

8.1. Introduction

This chapter responds to the study's interview questions by drawing on all of the study's data collection methods. Through an examination of these secondary and primary data, I explore implications through the lens of linguistic mediation. I then address the limitations of the present study, and make some recommendations for future research.

8.2. Research Question 1: What are the key current research findings related to communication and miscommunication in healthcare settings?

To address this research question, a scoping review detailed in Chapter 5 was conducted. It explored the current research findings on communication in healthcare. The key current research findings related to communication and miscommunication in healthcare settings can be understood according to the following topics areas:

1. **Interpretation Barriers in Healthcare:** Studies highlighted issues stemming from insufficient or inaccurate translation or communication services. These barriers are often linked to interpreter skills or organizational systems.
2. **Impact of Cultural and Linguistic Diversity:** The scoping review identified cultural and linguistic diversity among healthcare practitioners as a primary factor causing communication difficulties.
3. **Organizational Communication Strategies:** Effective organizational communication strategies are confirmed to mitigate communication barriers in healthcare.
4. **Socio-Pragmatic and Communication Skills:** To navigate healthcare communication effectively, socio-pragmatic and specific communication skills are essential.
5. **Interpretation Strategies:** The scoping review emphasizes strategies such as colleague assistance, ad hoc solutions, and digital tools acting as cultural mediators to enhance communication.

6. **Cultural Adaptation and Language Simplification:** The findings also advocate for cultural adaptation in the workplace and language simplification as means to address communication challenges and mitigate miscommunication in healthcare settings.

8.3. Research Question 2: Does medical language represent a particular obstacle to the effectiveness of communication between healthcare practitioners? If so, what communication strategies are used to overcome this obstacle, and how do these strategies impact the effectiveness of communication?

In addressing RQ2, it was anticipated that I would be able to draw on findings from the scoping review and the research instruments to understand the impact of medical language on communication effectiveness in healthcare. However, a notable observation is that the scoping review yielded no findings regarding medical language as an obstacle, suggesting a gap in the existing literature on this topic. In discussing the medical language obstacles, I draw on survey and interview findings only.

To consider whether medical language hinders effective communication, first let me revisit the definition of medical language provided at the start of this thesis. Medical language, the language used by practitioners is characterized by technical terms, acronyms, and abbreviations (Dzukanová, 2019; Hull, 2013). In response to the question whether medical language represents a particular obstacle to the effectiveness of communication between healthcare practitioners, it is clear that the diversity of healthcare practitioners' language varieties, education, linguistic and cultural backgrounds impacts on the effectiveness of communication rather than medical language in isolation in a MELF setting.

The diversity in healthcare practitioners' backgrounds can create challenges in ensuring that medical language is used effectively and understood consistently across different contexts. This study examined the diverse linguistic backgrounds of healthcare practitioners worldwide, many of whom do not use English as their first language. The project's data covered a range of English varieties, including Saudi English, Filipino English, Nigerian English, Indian English, among others.

A significant challenge that emerged was the understanding of English instructions in various medical scenarios. Quantitative data indicate that (74.8%, n=143) of participants face challenges in healthcare settings when using English. Additionally, (75.9%, n=145) report difficulties arising from the use of medical terminology in English, a factor potentially leading to serious medical errors as highlighted in previous studies (Botis & Tweedie, 2022; Nickel et al., 2017; Džuganová, 2018; Watermeyer et al., 2021).

In fact, it can be argued that the complexity of medical language communication among healthcare practitioners is primarily attributed to these varied linguistic, plurilingual and pluricultural backgrounds. For instance, one participant described the challenges in understanding between a foreign doctor and a Saudi doctor, especially concerning medical terminologies (BCH15:4).

The analysis further identified that a lack of proficiency in medical language and terms is a major barrier to effective communication. It highlights the necessity for practitioners to be well-versed in relevant terminologies: "Those proficient in their field of work must be familiar with the terminologies" (BCH15:28). Interestingly, the study findings suggest that proficiency in English does not automatically imply proficiency in medical language and terms. This is exemplified by a case where a practitioner proficient in English had weak terminology skills, affecting communication with colleagues (BCH15:32).

This observation aligns with Lum et al. (2016) that emphasises the importance of balancing medical literacy with language abilities. Similar research (Ali & Johnson, 2017; Molina & Kasper, 2019) illustrates how both linguistic and medical proficiency play a crucial role in ensuring effective communication in healthcare settings.

As a result, while the quantitative and interview data underscore the impact of limited medical language proficiency on communication effectiveness and patient care, it also shows that practitioners often create neologisms as a coping strategy. Despite the fact that this is a form of linguistic mediation, practitioners may mediate texts, communications, and concepts. However, when it comes to navigating the lack of proficiency and common medical language among staff, one cannot assume that this strategy will always enhance effective communication due to the lack of proficiency and common medical language.

However, this form of mediation can complicate communication and potentially compromise patient care. In this regard, interviews revealed obstacles to effective communication, with one participant observing, "We have to use medical terms because we have standard abbreviations, but nowadays, they do not use medical English because some medical staff have their own abbreviations, sometimes, also you will see them on orders, especially the doctor's order" (KFSH12:36). This necessitates the continuous employment of linguistic and non-linguistic tools to mediate miscommunication such as seeking clarification, as the participant highlighted, "Unfortunately, some staff are using and creating their medical terms. So, I keep asking: 'Doctor, what do you mean by this?' " (KFSH12:73). An example of this includes unique abbreviations that are mistaken for standard medical terms, as noted by KFSH6: "Some people like to write their abbreviations like they write 'IRT' which means 'in relation to'. But again, I will not understand, also my abbreviation! Others may not understand them" (KFSH6:88). Thus, it is the responsibility of healthcare systems to only approve the standardised list of abbreviations and acronyms to ensure patient safety (Hull, 2022).

Another barrier of the medical language to the effectiveness of communication is the unfamiliarity with medical terminology across different departments. Data from this study highlights instances where participants encountered confusion due to unfamiliar terms, abbreviations, and acronyms. This is particularly challenging in scenarios requiring collaboration across medical disciplines, as one participant noted: "Especially in the cardiology department, because there are various cases, and the words are long. Colleagues often use different abbreviations that need to be discovered in my field (MCH20:61)". The importance of understanding terms and abbreviations from other departments is further emphasized by another participant: " I have some cases next week in the emergency department. I must begin to know essential terms in the emergency department; for example, if I hear (code blue) or (RTA), I know that there is an emergency case that requires immediate action and cannot wait (BCH21:81)".

Additionally, participants highlighted the constraints of time in learning new terminology, underscoring the urgency in patient care situations. Bakó (2022) also argues for the necessity for healthcare practitioners to be educated in medical terminology across various medical fields. It can thus be asserted that a comprehensive understanding of

medical English and its terminology is crucial for effective decision-making and communication in patient care.

Building on the earlier argument I made about how healthcare practitioners' education and training influence how medical language is perceived, the data indicate a significant issue: diverse medical education backgrounds can lead to communication failures, particularly in patient case discussions. The plurilingual and diversity among practitioners often hinder finding common ground. This challenge is highlighted by the varying medical education languages in different countries: practitioners in Algeria are trained in French, in other Arabic countries in Arabic, and in Saudi Arabia, in the context of this study, in English. This diversity creates a substantial clash in understanding medical language, raising a critical question about ensuring effective communication despite such educational variety.

Participants' perspectives shed light on this issue: "Among the doctors in the department, we have the Egyptians, the Algerians, the Syrians, the Sudanese, and the Palestinians. They all studied medical languages in different schools, which teach medicine using different languages and methods. We in Egypt learn medicine in English or Latin; in Syria, for example, they study it in Arabic; and in Algeria, they learn it in French. All the terms differ, and there is an overlap of terminologies in the medical field. Not only when speaking of medical scenarios, but it was also a challenge to communicate mainly with my colleagues at the beginning. It was complicated to understand the intended meaning (BCH16:26)". Effective communication is threatened by this lack of comprehension.

While Moyce et al. (2015) acknowledge that miscommunication is a common issue in health communication. However, this problem is magnified by the variety of languages used even between practitioners in the Arabic region. In such situations, it is healthcare practitioners duty to ensure mutual understanding. As Skeggestad et al. (2017) suggest, it is imperative for healthcare professionals to clarify and adapt medical language as needed to achieve complete comprehension. The mediation strategies are crucial in overcoming the barriers posed by the diversity of medical education backgrounds.

Finally, an unexpected finding in the study was the confusion caused by the use of trade names for tools and medicines, as opposed to their generic or scientific names, leading to miscommunication among practitioners from diverse linguistic backgrounds. This issue was particularly evident in the experience of an Algerian participant, who

encountered difficulties with trade names and suggested standardizing scientific names for use in healthcare as a solution to educational diversity. The participant explained, "(Amoxicillin) is the scientific name, but sometimes they use Omexil or another trade name which is an entirely different name. So we should use only scientific terminologies because they are common nouns, on the one hand, no matter what the language is " (BCH19:19). This aligns with Alahmadi et al.'s (2022) findings, where they identified incorrect drug naming as a key contributor to medical prescribing errors, particularly in antibiotics, accounting for 53.4% of such errors. They recommend training practitioners to adhere strictly to standardized drug nomenclature.

Therefore, in sum, while medical language itself presents obstacles among healthcare practitioners, the challenge is not solely medical language. Many other factors, such as educational backgrounds, diverse English varieties, and the neologisms used, impact on the effectiveness of communication. Moving on to discuss the second part of the research question, I will examine the strategies used to mitigate these challenges.

To tackle these diverse challenges, healthcare practitioners employ a variety of strategies aimed at improving communication effectiveness. In MELF settings, effective mediation is key to resolving miscommunications that arise from differences in languages, cultures, texts, medical concepts and interpersonal interactions. To facilitate this, healthcare practitioners adopt various linguistic and non-linguistic strategies to overcome comprehension gaps such as plain language, mother tongue, digital technology, translation and interpretation, gestures and body language, and pragmatic strategies, including illustration and visualization, repetition, and confirmation through direct questions. The latter part of this discussion will analyse the impact of these strategies on communicative effectiveness. Findings suggest that the range of resources utilised by practitioners plays a critical role in mediating communication breakdowns to reach a mutual understanding, underscoring the effectiveness of these strategies in enhancing healthcare communication.

The data indicate that healthcare practitioners consistently employ various coping strategies to overcome communication barriers, with mediation strategies playing a pivotal role in ensuring effective communication and, consequently, enhancing patient care quality. One of the primary strategies identified was direct questioning for clarification. This strategy is a practical demonstration of linguistic mediation, where practitioners actively seek to construct meaning and bridge gaps in understanding. This is evident from the high

prevalence of direct questioning (94.2%, n=180) and its frequent use (85.3%, n=163) among practitioners. It aligns with the concept of mediation, which is particularly relevant in diverse healthcare settings to access and convey unfamiliar concepts.

Additionally, the use of simplification as a strategy, employed by (80.1%, n=153) of practitioners, resonates with the principles of linguistic mediation. Simplification involves breaking down complex medical language into more accessible terms, a key aspect of mediating communication and concepts as outlined in the CEFR framework. It reflects the practitioners' role in constructing meaning for individuals, especially in multilingual settings with plurilingual speakers.

Repetition, another key communication strategy identified in the study, serves not only to confirm comprehension but also as a means of mediating communication. This strategy ensures mutual understanding and plays a crucial role in establishing rapport and preventing miscommunication. The high percentage of practitioners who value and employ repetition (94.2%, n=180 and 78.5%, n=150, respectively) highlights its significance in achieving mutual comprehension and facilitating effective communication. Repetition in this context can be seen as a form of linguistic mediation where the same concept is communicated multiple times to ensure clarity, "We have to repeat back the order, and most importantly, from the medical side, For example, there are verbal orders, like telephone orders; after writing the orders, we have to repeat and read them back to them to confirm if that is the case or the order" (MCH2:28).

The significance of repetition in healthcare settings, particularly in MELF settings, cannot be overstated. Ting and Cogo (2022) affirm its critical contribution to negotiation processes and the reinforcement of mutual understanding. In spite of this, this study adds to the scarce amount of research on repetition as a communication strategy employed between healthcare practitioners.

Interview data reinforce the importance of linguistic mediation in healthcare communication, as practitioners employ a variety of strategies to facilitate effective communication. Gestures, body language, and the use of plain language are key facilitators for effective communication, aligning with findings from the scoping review (Alhamami, 2020; Al-Harasis, 2013). These non-verbal cues and simplified language forms are critical elements of linguistic mediation, aiding in conveying and clarifying meanings beyond words, especially in pluricultural and plurilingual healthcare environments.

The use of practitioners' mother tongues, as well as code-switching or code-mixing between languages, is highlighted as another crucial facilitator for achieving mutual understanding. This strategy resonates with the mediation concept of bridging linguistic and cultural barriers, as supported by Hussey (2012). The ability to switch between languages and the strategic use of the mother tongue can be seen as a form of mediating communication and constructing meanings in order to enhance comprehension and rapport between healthcare practitioners.

Interview results further indicate that formal and informal translation acts as a coping strategy among healthcare practitioners. In situations where interpreters are not available, practitioners rely on translations from approved centres. Although this approach is not frequently used, it is considered a reliable method to prevent miscommunication and address medical language discrepancies. This is exemplified by a practitioner's statement: "Sometimes we know the disease in English, but we do not know it in Arabic, so we keep asking them to translate it to a translation centre and translate it from English to Arabic and vice versa" (MCH8:60). In terms of informal translation, practitioners often turn to colleagues and digital tools, such as Google Translate, for necessary communication support. This practice of seeking colleague assistance for translation was also highlighted in the scoping review findings, with Alhamami (2020) noting that Arabic-speaking practitioners frequently serve as mediators to facilitate communication.

The study reveals that in spite of limited interpreter availability, language assessments, and training, healthcare practitioners have innovatively developed and used all available linguistic and non-linguistic resources and strategies to ensure effective interprofessional communication in MELF contexts. These strategies, which include simplification, illustration, and other tailored approaches, have successfully addressed communication challenges and mitigated systemic deficiencies in healthcare. This adaptive capability is exemplified by practitioners, such as: "Since we are in a work environment with different nationalities, We must simplify the sentences to be more precise and restructure our language to avoid language errors" (MCH10:21). Moreover, when verbal communication fails, visual aids like illustrations play a crucial role in bridging language gaps. As one practitioner describes: "Since I do not know the Arabic word (milk), so I search for a picture of milk and explain it through visual images" (KFSH4:26).

The role of digital tools in enhancing effective communication and patient safety is also highlighted in this study. These tools have proven effective in reducing medical errors, with practitioners noting the superiority of systematic documentation over verbal and paper orders: "We record every detail related to the patient's condition on the computer. I record everything on the system in case any misunderstanding occurs" (BCH1:23). An example of ineffective communication between healthcare practitioners can be seen in the narrative shared from (KFSH6:67). In one instance, an orthodontist had prescribed the extraction of certain teeth. The initial written instructions were later overridden by a phone call advising the removal of a different tooth, one without brackets. This verbal update was not recorded in the patient's file. Unfortunately, the lack of documentation led to the incorrect tooth being extracted. When the error came to light, the absence of paper documentation complicated matters, ultimately placing responsibility on the practitioner who carried out the extraction. This event highlights how vital it is to have thorough documentation to back up verbal communications and ensure that medical procedures are performed correctly. The use of digital technology could facilitate this process.

A further example from the data illustrates the benefits of using digital tools in effective communication. Participants frequently mentioned the use of social media, including WhatsApp, as a means of collaboration with other departments and staff within the same clinical department: "We also communicate through messages on WhatsApp or the department group" (MCH17:19).

Although participants recognised the benefits of various communication strategies, when addressing the question of their impact on effective communication, it becomes apparent that these strategies can simultaneously mediate to facilitate communication, confuse, and lead to miscommunication. Healthcare practitioners, using tools like digital aids, informal translation, and mother tongues, cannot be criticized for occasional confusion and miscommunication; their aim is to construct meaning and mediate to ensure optimal patient care. Interestingly, some practitioners are aware of these impacts yet continue to rely on these strategies due to gaps in hospital systems.

Having briefly explained how these strategies facilitate communication, I will now discuss how they also contribute to confusion and miscommunication, as evidenced by the data. To address the second part of this research question regarding the impact of these strategies on communicative effectiveness, I propose that among the strategies outlined

previously such as formal translation, gestures, body language, illustration, visualisation, repetition, direct questioning, clarification, confirmation, and the use of plain language are seen as facilitators of effective communication. In contrast, informal translation, the use of mother tongues, and digital technology can both facilitate and confuse communication, depending on the context.

To illustrate this, the preference for digital tools is often driven by a reluctance and avoidance to engage in verbal and direct communication with colleagues, stemming from low confidence and self-esteem. A telling example is a participant's comment: "Even if I am speaking clearly, some of my colleagues may have difficulty understanding some of the words. So, I claim a poor phone connection, I cannot hear you, so I can suggest that we communicate via WhatsApp, and I try to use all the synonyms of my words with a little effort of simplification. So, I try to avoid verbal communication" (MCH20:34). This may indicate that while digital tools serve as a coping strategy, overreliance on them presents significant drawbacks, particularly in affecting interprofessional communication. Such avoidance may be feasible in informal settings, but it poses challenges during rounds and formal meetings where digital tools are not an option.

These results support evidence from previous observations (e.g. Alshamarri, Duff, & Gulhermino, 2019; Botis & Tweedie, 2022) that have observed a pattern of avoidance, withdrawal, and hesitancy in communication. They link these behaviors to language proficiency and medical language competence issues, which further exacerbate isolation and hinder adaptation within medical teams. Hence, it could conceivably be presumed that in this study the reliance on digital tools contributed to this avoidance and low level of confidence, since practitioners may rely solely on technology.

It was found that while seeking formal translation from approved centres is generally viewed as beneficial for effective communication, while few examples are documented in this study, there are instances where it acts as a facilitator. In contrast, informal translation methods, including assistance from colleagues, family members, and digital tools like Google Translate, can simultaneously aid and hinder the effectiveness of communication due to potential confusion and miscommunication. For instance, practitioners often rely on colleagues for interpretation in the face of language barriers. A participant stated, "I seek help from one of my colleagues whose language is good or excellent to facilitate or deliver the order in an understandable English structure"

(MCH13:25). This reliance could stem from the scarcity of interpreters in hospitals. Indeed, literature from the scoping review, such as Alhamami (2020), Chang et al. (2014), and Kale and Syed (2010), indicate potential risks of interpretation errors that can endanger patient safety.

Furthermore, this study revisits the impact of diverse training backgrounds and English language varieties on medical language. For example, the accuracy of a translation from Arabic to English by an Algerian practitioner, whose first language is French, may remain questionable. Additionally, the data indicates that practitioners often resort to Google Translate when colleague support is unavailable. While this tool is popular for both general and medical language translation, its inaccuracies, especially in critical medical contexts, are concerning. A participant shared, "We still need help in breaking down the words. Words are different because Google Translate is not accurate" (KFSH11:69). The data also highlights instances of miscommunication, as illustrated by another participant: "I wrote my inquiry in Google Translate from English into Arabic. I do not know what's written in Arabic, but I am sure about what's written in English. I said: 'If you are directing your patients here, you are automatically giving them an appointment.' But in the Arabic translation, it was different! Later, my colleague came with his director to clarify things. The director told me: 'You are telling him to speak to those people?', and then I said: 'No sir, I told him if you are directing patients to us, you are automatically giving them an appointment, and that is not acceptable on the system" (BCH7:55).

Despite recognising these limitations, informal translation methods can be somewhat advantageous and facilitate healthcare communication (Rahman, 2016). However, practitioners must exercise caution with digital tools to avoid misinterpretations that could lead to medical errors and legal lawsuits, as highlighted in studies by Squires (2018) and Slade (2020).

Finally, utilising the mother tongue or first language emerges as another communication strategy in healthcare communication, aimed at reducing confusion and miscommunication. However, the data suggests mixed reactions among practitioners regarding its effectiveness as a coping strategy. Some practitioners experience difficulties, particularly comprehension and following medical orders. One nurse pointed out, "They are unaware that they have to use English, especially during rounds. Physicians tend to discuss the case in the Arabic language. So for us nurses, we need to understand 80% or

70% of the plans" (MCH2:3). This reliance on the mother tongue exacerbates complications, particularly in settings with a variety of languages. The complexity intensifies when different languages are spoken within the same nationality, as highlighted by a participant: "Although most of us are from India, in India itself, we have many languages" (BCH2:11).

Interestingly, this point aligns with Alhamami's (2019) findings, which indicate that the use of the mother tongue and code-switching can both facilitate and impede communication. While it proves beneficial in various Arabic dialects including the Gulf region, it can lead to withdrawal and miscommunication in other contexts. As part of previous work, Rose (2015) outlined a range of strategies that second language learners employ to enhance their language learning acquisition, such as paraphrasing, code-switching, and simplification, which are pivotal for managing communication. Similarly, findings from this study suggest that healthcare practitioners, as do learners, adopt various communication strategies to effectively navigate the complexities of MELF settings. Just as Rose (2011) highlighted the role of self-regulation in strategic learning, practitioners in this research also exhibit self-regulatory behaviours, adapting their communication strategies to the needs of each patient and situation. They need to be aware of cognitive and behavioural strategies to facilitate language use but also of the need for rapid decision-making in healthcare contexts. This enhances practitioners' understanding of communication where practitioners, like learners, must balance the use of independently adopted and external strategies to ensure optimal patient care in a diverse linguistic and cultural landscape.

It can be concluded that this study underscores that there is no fixed answer to this research question. While there are obstacles caused by medical language, practitioners must be fully aware of other factors such as the impact of educational backgrounds, diverse English varieties, and the neologisms used. Furthermore, practitioners should be aware of both the advantages and drawbacks of using communication strategies in patient care. This awareness is particularly vital in healthcare settings where quick action and decision-making are imperative. Overall, the communication strategies identified in this study underscore the complexity and adaptability required in healthcare communication. While these strategies generally enhance the effectiveness of communication and patient care, they also present challenges that healthcare practitioners must navigate.

8.4. Research Question 3: Does the linguistic and cultural background of healthcare practitioners have an impact on the effectiveness of communication?

With respect to the third research question, this study reveals that the linguistic and cultural backgrounds of healthcare practitioners significantly influence communication effectiveness. A key finding is that practitioners' language proficiency, particularly in English and Arabic, is a primary factor impacting communication in healthcare settings. The study highlights a diverse linguistic landscape within medical environments, encompassing various levels of proficiency in languages as appeared in the data, such as Indian, Pakistani, Filipino, Nigerian, and Egyptian English, along with the Arabic language.

The data underscore challenges stemming from insufficient English and Arabic proficiency. Considering that English is the primary communication medium in Saudi hospitals, yet Arabic remains the dominant language in the Kingdom, this presents a unique challenge. A participant indicated, "Non-Arabic staff must be fluent in the Arabic language" (MCH19:59). This inadequacy in language proficiency, as also supported by the scoping review findings, Alhamami (2020), relates to healthcare systems hiring practitioners with diverse linguistic backgrounds without ensuring dual language proficiency.

A poignant example illustrating the potential risks of this language gap leading to medical errors was shared: "In a situation that happened to me recently, I was trying to explain to my non-Arabic colleague about the anaesthesia machine, in which there is a setting that should not be changed from case to case. He did not understand me, so he changed the setting of the device, and it nearly caused a medical error" (BCH21:10). This incident highlights the dangers of lacking a shared linguistic platform, which can lead to communication breakdowns and hinder collaboration among healthcare practitioners, as emphasized by (Alhamami, 2020; Fadi Kharim, Wolsey & Hasnani-Samnani, 2022). The findings suggest that addressing language proficiency issues is crucial for effective communication and patient safety in multicultural healthcare settings.

Another significant challenge linked to language proficiency in healthcare communication is the variation in spoken English, including pronunciation, dialect, and accent. These variations can impede comprehension in critical medical scenarios. Previous

research, including works by Odisho (2005) and Hashmi (2020), has highlighted the potential complications arising from minor spoken errors in English.

A notable example from the interviews illustrates this issue: "One of the challenges regarding the Indian nationalities staff is the pronunciation in English; they always speak faster, their accent is unclear, and they swallow some letters" (KFSH9:3). This problem extends to perceptions of practitioners from non-Arabic backgrounds, as observed: "Some Egyptian medical staff have language errors because they mix their accent with the Egyptian dialect when speaking English" (MCH10:24). These findings resonate with scoping review results, particularly regarding Egyptian accented English (Alhamami, 2020).

Challenges in accents, dialects, and pronunciation are found not only among non-native speakers but also among individuals of the same nationality. The numbers are quite striking, as a significant (79%, n=151) of participants reported difficulties stemming from their colleagues' English pronunciation. This underscores a crucial point: communication barriers influence the flow of information from a first language (L1) to a second (L2) or even a third language (L3), as well as vice versa.

This study highlighted issues related to grammatical and writing skills impacting on professional communication, as observed in recent studies (e.g., Hull, 2022; Pun et al., 2015). Fluency in writing, coupled with grammatical competence, is vital for accurately documenting medical orders, cases, and requests. Inadequate proficiency in writing could jeopardize a treatment plan. A concerning finding from the data suggests a reported lack of proficiency among some practitioners, who often resort to replicating previous orders. As one interviewee revealed, "Sometimes they just copy what was written in the previous shift, copying and pasting from the night shift" (KFSH10:94).

The other concern is when doctors rely on nurses for writing orders in English. This raises a critical question: if both the nurse's and doctor's language proficiency may be debatable, how will an accurate medical report be conveyed? According to the scoping review, Alhamami (2020), asserts that difficulties deciphering doctors' written notes on medical prescriptions and patient files could present significant risks. This concern aligns with findings (e.g. Alrajhi, Sormunen, & Alsubhi, 2018; Humphries et al., 2019), underscoring the necessity of legible, and accurate writing in healthcare settings.

In contexts where interprofessional teams from various departments collaborate on treatment, effective communication is primarily executed through writing. This points to the necessity for continuous assessment and improvement of writing skills within the healthcare workforce. The ability to clearly document and convey complex medical information is not only vital for ensuring accurate and efficient treatment but also for facilitating seamless coordination among diverse healthcare professionals. As such, investing in the development and reinforcement of these skills should be a key priority in healthcare settings to optimize patient care and enhance overall treatment outcomes.

Turning now to examining the influence of healthcare practitioners' cultural backgrounds on communication effectiveness, the data present compelling examples. This section addresses how cultural differences can hinder communication, occasionally leading to miscommunication. An unexpected finding was the role of alternative medicine culture in communication and healthcare delivery. Regarding the interference of culture, language, and alternative medicine in practitioner communication, existing research appears scarce, if not absent, though studies by Kim and Jeon (2012), and Tangkiatkumjai et al. (2020) have acknowledged its impact on the patient-provider relationship and communication.

Practitioners expressed concerns about their limited understanding of cultural practices related to alternative medicine. This gap in understanding leads to communication challenges not only between patients and practitioners but also among practitioners which are the main focus of this study, as they seek to grasp these cultural concepts and spread the knowledge among peers. Even Saudi native practitioners may lack familiarity with specific cultural terms and practices. The challenge is more pressing for non-Saudi practitioners, necessitating frequent clarifications. According to this insight, "There is a particular culture in medicine that varies among doctors, especially regarding alternative and traditional medicine. It is difficult for non-Saudi staff" (MCH9:67).

An additional cultural factor, often unexpected, that influences the effectiveness of communication among healthcare practitioners stems from the intersection of personal hygiene habits and food preferences. Cultural practices, especially those related to food, can inadvertently affect communication. For example, differences in food odors have been identified as a challenge for some practitioners, leading to a preference to avoid communication in certain situations. As one practitioner succinctly put it, 'communication is difficult with the presence of annoying odours' (KFSH9:11). These reactions are not just

183

sensory but are embedded with cultural perceptions and stereotypes, which can result in significant barriers to effective communication in the healthcare setting.

Conversely, the process of cultural adaptation to local dietary habits emerges as another barrier among healthcare practitioners. Filipino participants, for instance, shared their initial shock and difficulty adjusting to the lighter Saudi breakfasts, contrasting with their tradition of having a heavy meal in the morning. One participant captured the essence of this cultural adjustment by noting, "I was shocked by the food" (BCH9:3). While odor-related discomfort poses one type of challenge to effective communication, the need to adapt to different food habits represents another layer of complexity in cultural integration within the healthcare environment.

This study identified particular gestures that, when translated across cultural backgrounds, lead to miscommunication. The study uncovers specific instances where cultural differences in non-verbal communication have led to challenges among practitioners, for example, "Some Nigerian staff, when they want to say 'yes', move their heads, but in the Philippines, it means 'no'" (BCH4:6), highlighting how the same gesture can convey opposite meanings in different cultures. Another cultural miscommunication was noted involving finger snapping, where a Saudi practitioner's gesture to draw attention was misconstrued by an Indian colleague, indicating diverse interpretations of the same action (MCH13:9). This is echoed in Hull's (2022) study, which highlights that snapping fingers to grab attention is considered impolite in Canada.

Nevertheless, the study also uncovered misunderstandings related to cultural norms in Saudi Arabia, particularly regarding gender and discussions of sensitive topics. For instance, practitioners from more liberal cultures, like the Philippines, sometimes face judgment for their openness to discussing topics considered taboo in Saudi society. A Filipino practitioner recounted an incident, saying, "I was shocked that we are not allowed to mention sex and bring jokes regarding this topic" (BCH9:27). This highlights cultural disparities in perceptions of appropriateness, especially in taboo topics such as sexual health and humour.

Sensitivities surrounding religious beliefs are another dimension of communication that the data brings to light, particularly in the context of healthcare. Misunderstandings can surface due to the diverse religious practices and expressions within a workplace. Highlighting this, a practitioner shared a personal experience, saying, 'I said: Allah is

184

willing, we will strive and persevere...' only to be met with a colleague's challenging response to the belief in God (BCH14:155). This incident underscores the need for increased awareness and sensitivity in MELF settings, especially among practitioners of different faiths. Practitioners must be cautious in religious conversations to maintain effective communication.

Attaining this level of cultural and religious awareness can be particularly challenging for practitioners from distinct backgrounds, such as Nigeria. For example, a Christian Nigerian practitioner expressed initial fears and misconceptions about working in Saudi Arabia: "I came here with misconceptions, I was afraid. I thought my life might be in danger in Saudi Arabia!" (BCH8:155). Detailed insights from this interview are documented in Appendix H. Practitioners arriving from diverse religious and cultural environments often carry preconceptions influenced by Saudi Arabia's predominant Islamic culture. While these assumptions are understandable, they can impede the practitioner's adaptation to the new work environment and potentially compromise the quality of patient care.

Finally, while the linguistic and cultural backgrounds of practitioners can hinder communication effectiveness, as previously discussed, adaptation to Saudi culture and work environment offers a promising solution. As evident in chapter 7, 'Evolution of Cultural Understanding', where practitioners gradually adapt and effectively communicate with their peers, regardless of their religious backgrounds. A practitioner remarks, "When communicating, I find them saying some of the phrases we use, such as "Praise be to Allah, Alhamdulillah, Inshallah" (BCH14:162), illustrating the adoption of local cultural elements by non-native individuals. Cultural adaptation is also advocated in studies from the scoping review, such as those by Alhamami (2020), Al-Harasis (2013), and O'Neill (2011). These authors encourage practitioners to independently learn and adapt to the culture, highlighting this as a key factor in successful communication.

To further underscore this adaptation, it is insightful to consider the tenure of practitioners in the Saudi healthcare system. A case in point involves a practitioner's reflection on their long-term adaptation, illustrating long-term cultural integration: "I, myself, have adapted for 13 years. But I love this place; I love it. This is my second home after the Philippines" (BCH7:43). This statement not only shows how practitioners gradually overcome initial communication barriers through mediation but also illustrates

their significant role in supporting the evolving health system, aligning with the Ministry of Health's Vision 2030 goals. Such examples vividly demonstrate how time, mediation, and experience in the MELF settings foster a unique blend of cultural understanding and professional integration, ultimately benefiting the healthcare environment.

As a whole, this study demonstrates that the linguistic and cultural backgrounds of healthcare practitioners significantly impact communication in Saudi healthcare settings. Challenges include language proficiency barriers and cultural differences affecting understanding and communication. However, long-term adaptation to local culture and language emerges as a key solution, facilitating improved communication, mediating cultures, and integration within MELF.

8.5. Research Question 4: What do healthcare practitioners perceive is needed to improve the effectiveness of communication in healthcare settings?

Healthcare practitioners perceive the following aspects as important to improving the effectiveness of communication. Firstly, hiring trained and professional language interpreters can facilitate communication among colleagues. The data indicate a lack of a common language among some colleagues: "It is essential to have an interpreter for the non-Arabic speakers to convey their messages more effectively" (KFSH5:35). Previous studies, such as those by Johnson et al. (2022) and Jacobs et al. (2018), have warned against relying on non-trained interpreters, including family members or colleagues, in order to avoid ethical pitfalls and medical errors. This underscores the critical need for hiring certified professional language interpreters.

Secondly, there is a need to reconsider the lack of multilingual documentation and language policies in healthcare settings. The data reveals that even formal documents are often provided only in Arabic: "Even the consent forms are written in Arabic, and you do not have a choice but to sign them only!" (BCH9:43). Language policies could bridge the language gap between practitioners. For instance, providing documents in languages practitioners can comprehend and establishing policies for a common language during medical discussions could be beneficial, suggesting the necessity for clear language guidelines.

Moreover, practitioners advocate for language assessments in both Arabic and English before working in Saudi hospitals. The necessity of language assessments was also highlighted in a study by Johnson et al. in 2022. This not only facilitates interprofessional communication but also addresses the language gap in practitioner-patient interactions, similar to findings in a study conducted in Bahrain (Al-Muqahwi, 2021), who found that practitioners felt worried about not understanding the Arabic language of their peers and patients. However, my study participants advocate for the need for language competence and assessments, which is contrary to previous research by Lum et al. (2016), where nurses expressed dissatisfaction with language assessments and training.

Participants also emphasized the value of cultural competence programs for understanding and adapting to new environments, thus enhancing effective communication. Previous studies like Almutairi (2015) and Hull (2022) also highlighted the importance of cultural orientation for practitioners. Interview data in this study establish a direct correlation between effective cultural adaptation and pre-departure orientations. For example, Filipino practitioners adapt quickly due to the 'Pre-Departure Orientation Seminars' provided by their government, equipping them with the necessary cultural knowledge: "I can adjust, because in the Philippines and before coming here, they oriented us to what we will expect in this country... we have the PDOS, which gives us some ideas about the culture, so we know what to expect" (MCH14:11). In contrast, other practitioners, such as the Nigerian practitioner featured in section 8.5, did not receive similar orientations and arrived with misconceptions and fears.

The critical need for cultural orientation is underscored by the varied experiences of practitioners, particularly when comparing the adaptation of Filipino and the fear of Nigerian practitioners. This marked disparity clearly demonstrates the pivotal role of cultural orientation in aiding practitioners' adaptation and facilitating their communication effectiveness within Saudi healthcare settings. This study not only identifies various factors influencing MELF communication but also sheds light on effective strategies to promote effective communication, as well as underscoring the unmet needs in healthcare settings. While there may not be a single definitive solution, it is heartening to observe that practitioners are aware of the hospital system's lacks and recognize the vital importance of effective communication in achieving success.

Overall, healthcare practitioners identify several key measures to improve communication effectiveness in healthcare settings. These include hiring trained interpreters, revising language policies for documentation, conducting language assessments in Arabic and English, and implementing cultural competence programs. These measures are crucial for bridging linguistic gaps and facilitating adaptation in multilingual, plurilingual and pluricultural MELF settings.

8.6. Implications of the Present Study

This study collected a substantial body of secondary and primary data on communication in healthcare settings. Utilising the lens of linguistic mediation as the process of constructing and conveying meaning through language across different cultures and languages (North, Piccardo & Goodier, 2019), highlights its profound significance in healthcare communication effectiveness. The findings emerge as a crucial means for navigating MELF challenges, showcasing the pivotal role of mediating communication, text, and concepts. This extends beyond the educational sector, confirming that mediation is context-based, allowing healthcare practitioners to access and construct meanings plurilingually, aligning with the theory of linguistic mediation (CEFR, 2020; North & Piccardo, 2016). Furthermore, it underlines the importance of translating and adapting medical language across various linguistic and cultural backgrounds, emphasizing that mediation is more than language conversion but involves contextualizing medical terms in a universally accessible and understandable manner.

The study also reveals that linguistic mediation goes beyond mere translation or interpretation, demanding a deeper ability to access meanings through both linguistic and non-linguistic resources, crucial for bridging the diverse linguistic and cultural backgrounds in Saudi Arabia's MELF settings. The data supports this, indicating that practitioners effectively employing various communication strategies can reconceptualize meanings, engaging more successfully in communication and overcoming barriers with peers.

Moreover, the study's findings carry practical implications for policymakers to enhance MELF communication effectiveness. Despite instances of self-mediated communication due to the lack of interpreters and documentation, the necessity for

professional interpreters, language proficiency assessments, and multilingual documentation policies is emphasised. These elements are fundamental to effective linguistic mediation, essential for accurately conveying unfamiliar concepts and navigating cultural nuances. Additionally, this study suggests integrating linguistic mediation into ESP/EMP courses, equipping future medical practitioners with the skills and strategies for building a plurilingual competence repertoire (Beacco et al., 2015), particularly pertinent when mediation project implementation is lacking in some countries (Verrept, 2019), as observed in Saudi Arabia. These aspects of linguistic mediation are not merely facilitative but integral to constructing shared meanings, clarifying communication, and fostering empathy in patient care. Thus, the study enriches our understanding of linguistic mediation as a dynamic, context-dependent process, vital for reducing miscommunication and enhancing healthcare delivery quality. The implications of this study advocate for a paradigmatic shift in healthcare communication, where linguistic mediation is not just an additional skill but a core competency integral to the profession.

The study also found various pragmatic strategies used by practitioners that could be suggested to policymakers to prepare practitioners to cope with communication challenges and mitigate miscommunication. Training healthcare practitioners in these strategies can help them navigate and resolve communication issues more effectively, thus enhancing overall patient care.

In terms of the Saudi context, the findings of this study may be used as a reference to facilitate the enhancement of the Saudi healthcare infrastructure, aligning with the Saudization policy and Vision 2030. Training Saudi practitioners to face medical encounters and improve patient care delivery is crucial and aligns with Saudi Arabia's priorities for advancing its healthcare system. By implementing these strategies, the Ministry of Health can better prepare its healthcare workforce to meet the demands of a diverse patient population, ultimately contributing to improved healthcare outcomes and patient satisfaction.

8.7. Limitations of the Study and Future Directions

The study is necessarily constrained by several important limitations. In terms of the subject matter, hospitals are a difficult research site to access, and my visits had to be flexible and respond to local requirements. The survey participants and interviewees were all extremely busy in their roles, and whilst I was able to interview a substantial number of people, the study would have benefited from further non-Arabic participants, especially in the survey where having a more balanced number of Arabic and non-Arabic participants would have been useful for comparative purposes. The primary data instruments also feature self-report, meaning that the data are subjective and filtered by a range of assumptions and perspectives that I cannot account for. It can be hard to determine whether participants tell a certain story in order to satisfy the researcher. Longer time spent at research sites, and perhaps even an ethnographic study could point to another narrative. As a researcher, I met staff on the fringes of their roles, in the coffee room or in meeting rooms – but I was unable to observe directly the types of communication they described. The study was conducted at three hospital sites, and it is difficult to ascertain whether there were on-the-ground discrepancies that led to certain local responses. A study of this type remains only a snapshot and cannot be viewed as generalisable. Additionally, the absence of statistical testing for the reliability of the survey instrument, such as Cronbach's Alpha, leaves uncertainty regarding the internal consistency of the survey items.

The study of the effectiveness of communication remains a subjective determination that depends on multiple variables. A project of this nature, constrained by time, resources and access, can only point to the experiences of the participants and scratch the surface of this complex and vital setting. The use of quasi-experimental methods and observational research could be crucial in developing effective health literacy tools, communication training curriculums, and online translation tools. Such strategies would help assess time efficiency and measure the real-world impact of these interventions.

Looking forward to future directions, this study has identified a gap in research on MELF communication. There is a clear need for more comprehensive research. Future studies should investigate medical language competence across various medical disciplines and settings, both public and private. A broader study, particularly in major Saudi Arabian

cities like Riyadh and Jeddah, could provide a richer understanding of MELF, especially considering the high proportion of native and non-native English speakers in these regions.

Additionally, this study found interesting findings regarding alternative medicine and its impact on effective communication in medical settings. There is a notable gap in understanding how alternative medicine interplays with language and culture. This aspect is crucial, as some medications may contradict alternative or traditional medicine practices. Understanding these practices is important for enhancing communication and ensuring safe and effective patient care.

In terms of training, there is a need for an in-depth exploration of the creation, validation, and accreditation of communication training courses, while making sure to balance the demands of job requirements with the need for such courses or the initiation of such programs. Furthermore, more MELF research could examine how healthcare practitioners use various strategies, including non-verbal cues, in their communication. Future research should also address the reliability of the survey instrument by conducting reliability analyses, to ensure the consistency of the data collected.

8.8. Conclusion

This thesis has explored Medical English as a Lingua Franca (MELF) in healthcare contexts within Saudi Arabia, with a specific focus on three public hospitals in the Qassim region. With linguistic mediation as a theoretical foundation, this study utilised three phases: an initial scoping review of current literature, followed by surveys and detailed one-to-one interviews to determine the effectiveness of communication among healthcare practitioners with diverse linguistic and cultural backgrounds.

The scoping review identified three main findings: multicultural communication challenges, communication strategies, and interpretation barriers. The review initially revealed that the cultural and linguistic backgrounds of healthcare practitioners, such as their proficiency in English and the languages used in specific medical environments, along with cultural differences, increased the risk of miscommunication. Furthermore, it was found that communication strategies, including socio-pragmatic and organizational strategies, though often underestimated due to a lack of studies, highlighted the importance of employing various strategies to bridge communication gaps and foster effective communication in healthcare settings. Additionally, interpretation barriers, arising from the

insufficient employment of professional interpreters and the reliance on certain technological applications, pose significant threats to the quality of care. These three key findings laid the foundation for the phases of the study, shaping the design and focus of the survey and interviews, particularly in terms of exploring the nature of MELF settings and strategies utilized by healthcare practitioners to achieve effective communication and enhance patient care.

The mean scores from the three sections of the survey highlighted key areas of strength and weakness in effective communication, particularly regarding pronunciation issues, which had the highest mean score of 3.11. Participants reported that clarity in understanding English instructions in different medical scenarios was considered the most critical aspect of effective communication, with a mean score of 3.25. Additionally, the importance of implementing language simplification as a strategy was emphasized, with a mean score of 3.69.

The semi-structured interviews further elucidated these points. Participants reported issues with speaking English, particularly pronunciation challenges, echoing the survey's identification of pronunciation as a significant barrier. The interviews also reinforced the survey findings about the critical role of language simplification strategies. Additionally, interviewees highlighted the necessity of asking direct questions to ensure clarity and understanding, expanding on the survey's emphasis on clear communication. These insights from the interviews align with the scoping review, which also identified pronunciation issues and the importance of pragmatic strategies such as language simplification. Together, these findings from the scoping review, survey, and interviews provide a comprehensive understanding of the communication dynamics in healthcare settings, highlighting the multifaceted nature of the challenges and strategies involved.

The main findings from the scoping review, survey, and interviews are linked to the epistemological and theoretical framework underpinning this study. This research is rooted in the pragmatist paradigm, which emphasizes the practical application of knowledge and the importance of achieving desired outcomes. The pragmatist philosophy aligns with the dynamic nature of communication in healthcare settings, where actions and activities occur continuously and contextually. The rich qualitative insights gained from the semi-structured interviews reflect this paradigm by highlighting how healthcare practitioners navigate and adapt to their environments using various communication strategies.

Additionally, linguistic mediation theory provided a lens through which the complexities of MELF communication could be explored. This theory underscores the interplay between language, culture, and healthcare strategies, revealing how practitioners construct and convey meaning across diverse linguistic and cultural contexts. The pragmatist paradigm's emphasis on the synthesis of epistemology and ontology is evident in the way knowledge about communication strategies emerges from the combination of practitioners' actions and the circumstances they encounter. Thus, the study's findings not only support the theoretical framework but also contribute to a deeper understanding of effective communication in healthcare environments.

The integration of findings from all three phases of the study aligns with key perspectives discussed in the literature review. First, the issue of pronunciation challenges identified across the scoping review, survey, and interviews resonates with the literature on medical language proficiency. Hull (2016) and Almalki et al. (2021) highlight that proficiency in medical language is crucial for effective communication, reducing medication errors, and improving healthcare outcomes. The identification of pronunciation issues in this study underscores the importance of language proficiency in minimizing miscommunication in healthcare settings.

Second, the critical role of language simplification strategies, as emphasized in the scoping review, survey, and interviews, mirrors the challenges highlighted in multilingual healthcare environments. According to Hull (2022) and Tweedie and Johnson (2019), diverse language backgrounds among healthcare professionals can lead to significant communication barriers, including misinterpretations and misunderstandings. As a key strategy for overcoming linguistic barriers in healthcare communication, this study emphasizes language simplification through reformulation of one's own language, body language, visualization, or technology.

Third, the three phases focus on the necessity of pragmatic strategies, such as direct questioning, to ensure clear communication. This aligns with the literature on sociocultural impacts on language use in interprofessional teams. Heist et al. (2020) and Knutsen et al. (2020) discuss how linguistic diversity and sociocultural differences can influence communication patterns, potentially leading to miscommunication. This study's findings underscore the need for direct questioning to navigate these sociocultural differences and facilitate effective communication within diverse healthcare teams.

Furthermore, the interview findings revealed that practitioners often used coping strategies such as interpretation applications to translate language, which sometimes resulted in miscommunication and inaccuracies in interpretation. This aligns with Al Shamsi et al. (2020), who highlight the limitations and potential issues with relying on translation applications in healthcare settings.

Additionally, this study confirms the findings of Almutairi (2015) and Molina and Kasper (2019) regarding the importance of pre-departure cultural orientation for medical practitioners. The interview data revealed that Filipino practitioners, in particular, were among the most adept at adapting to the cultural work environment, attributed to their pre-departure orientation programs.

Central to this investigation was the exploration of the impact of medical language, the effectiveness of diverse communicative strategies, and the influence of practitioners' linguistic and cultural backgrounds. The findings suggested that while medical language itself poses specific obstacles, the primary challenge lies in the diverse educational, linguistic, and cultural backgrounds of practitioners. These disparities often result in communication barriers, critically affecting the quality of patient care.

The research underscores the crucial role of linguistic mediation in healthcare communication. It is identified as a key mechanism for meaning construction and navigation, essential in bridging multilingual, plurilingual, or pluricultural contexts. The study highlights the utilization of various strategies—formal and informal translation, direct questioning, simplification, repetition, and the integration of verbal and non-verbal cues—by practitioners to navigate communication challenges. It also points to the necessity of professional interpreters, language assessments, and the implementation of multilingual documentation policies. These strategies, alongside cultural competence training, are not merely supportive solutions but fundamental elements in enhancing communication efficacy in healthcare settings.

In summary, the data collection process conducted for this thesis recorded a snapshot of real-life communication within MELF environments, ranging from effective (mediated by a range of strategies) to ineffective (hampered by various obstacles). It highlights the imperative for collaborative efforts, particularly from the Ministry of Health and the Ministry of Education, to prioritize and facilitate effective communication among healthcare practitioners. This would necessitate equipping medical practitioners with

essential training tools to navigate linguistic and cultural disparities, underpinned by relevant policies. The study advocates for a fundamental shift in addressing communication within multicultural and multilingual healthcare environments, aligning with broader objectives of delivering better care and ensuring patient safety. Effective communication in MELF settings is not merely a facilitative aspect but a cornerstone of healthcare excellence and patient safety.

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Appendix A- Adapted Survey and Interview Questions[1]

Appendix A. Basic interview questions (Employer version)

- *What criterion is used for selecting employees for overseas domestic work?*
- *What kind of abilities or qualifications do you look for?*
- *What cultural and linguistic challenges do/did you experience with your employee? Can you give an example?*
- *What kinds of strategies do you use in order to prevent misunderstandings with your employee?*
- *What kinds of communication strategies would you advise employees to have?*
- *Are there any specific communication strategies you would like to advise?*
- *What do you think is more important in the domestic environment: English language proficiency or English language communication? Why?*
- *What knowledge, skills, attitude and awareness do you think is important to work overseas?*

Appendix B. Questionnaire questions (Employer version)

Part A. Demographics

1. Age (in years): a. Under 25; b. 26 to 39; c. 40 or more
2. Gender: a. male; b. female
3. First language: a. English; b. Cantonese; c. Tagalog; d. Spanish; e. Putonghua; f. other _____
4. Nationality: a. Hong Kongese; b. Mainland Chinese; c. Filipino; d. other _____
5. Your highest level of education attainment: a. primary; b. secondary; c. graduate level; d. masters level and above
6. Language(s) you speak to your employee [tick as many as apply]: a. English; b. Cantonese; c. Tagalog; d. Spanish; e. Putonghua; f. other _____
7.1 Please state how long you have been working abroad (in months and years)
7.2 How long have you employed domestic worker(s) in Hong Kong (in years and months)?
7.3 How long have you been working with your current employee?
8. Please rate your English language competence: a. native; b. advanced; c. intermediate; d. beginner or lower intermediate; e. limited
9. Please rate your overall level of experience as an employer [including the position you currently hold and previous roles]: a. very experienced; b. somewhat experienced; c. not very experienced/new role

Part B. Challenges, in terms of pragmatics of communication

Please read the following statements and circle the rate of frequency by occurrence and your perspective of its importance (of acknowledging its cultural difference) as an employer in the domestic workplace setting.

Importance scale from 1 (not important) to 4 (very important); Frequency scale from 1 (never occurs) to 4 (occurs all the time)

1. Challenges that arise due to different expectations between you and your employee when it comes to the household. (E.g. completion of tasks in the domestic workplace)

Importance	1	2	3	4
Frequency	1	2	3	4

2. Challenges that are related to the notion of politeness when it comes to the conversations between you and your employee. (Apologizing for imposing, giving options of refusal, making the hearer feel good)

Importance	1	2	3	4
Frequency	1	2	3	4

3. Challenges that are related to 'face' when it comes to interacting with your employee. (Embarrassed, humiliated, or 'losing face')

Importance	1	2	3	4
Frequency	1	2	3	4

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[1] Adapted from:

Kwan, N., & Dunworth, C. (2016). English as a lingua franca communication between domestic helpers and employers in Hong Kong: a study of pragmatic strategies. *English for Specific Purposes*, *43*, 13-24. https://doi.org/10.1016/j.esp.2016.02.001

4. Challenges arising due to different perspectives of etiquette e.g. perspective of politeness, behaviours and rules of what are considered polite in your culture.

Importance	1	2	3	4
Frequency	1	2	3	4

5. Challenges of conversations that have 'implied' meanings that are not or may not be understood by your employee E.g. 'We're out of sugar' to suggest that we need to buy sugar.

Importance	1	2	3	4
Frequency	1	2	3	4

6. Challenges that arise from forms of addressing each other. E.g. formality, informality, relationships, power distance.

Importance	1	2	3	4
Frequency	1	2	3	4

7. Challenges that arise from a positive statement 'yes' and negative statement 'no'. (Agreeing with a suggestion or request) E.g. 'You don't like it, do you?' 'Yes, I don't' instead of 'No, I don't.'

Importance	1	2	3	4
Frequency	1	2	3	4

8. Challenges that arise from pronunciation or the language structure of the employee.

Importance	1	2	3	4
Frequency	1	2	3	4

9. Challenges that are related to the different cultural vocabulary in the domestic workplace.

Importance	1	2	3	4
Frequency	1	2	3	4

Part C. Strategies for successful communication
Please read the following statements and rate the frequency of occurrence and the importance of the strategy needed for successful conversation when talking with your employee. Importance scale from 1 (not important) to 4 (very important); Frequency scale from 1 (never occurs) to 4 (occurs all the time).

1. Make it normal: When it is unclear what the employee is saying, I would focus on the content of what he/she is saying and reformulate (change or revise) the sentence so that it is understandable.

Importance	1	2	3	4
Frequency	1	2	3	4

2. Let it pass: When it is unclear what the employee is saying, I would just ignore the unclear or unknown words and use my common sense, as it will become clear as the talk progresses.

Importance	1	2	3	4
Frequency	1	2	3	4

231

Survey

TRINITY COLLEGE DUBLIN

SCHOOL OF LINGUISTIC SPEECH AND COMMUNICATION SCIENCES

PARTICIPANT INFORMATION LEAFLET

Project Title: Investigating Medical English as a Lingua Franca: Determining the Effectiveness of Communication between Healthcare Practitioners in Hospital Settings in Saudi Arabia

You are being invited to take part in a survey that is being completed by Fatima Alhossaini. Please read this information carefully.

The study has been approved by the Research Ethics Committee of the School of Linguistics, Speech & Communication Sciences at Trinity College Dublin. This project is being carried out as part of Fatima's PhD degree at Trinity College Dublin.

The purpose of the survey is to investigate how cultural diversity, such as different national cultural backgrounds, different languages among consultants, physicians, nurses, pharmacists etc., and linguistic diversity (e.g., different mother tongues) impact the success of communication between healthcare staff who do not share English as their mother tongue.

You don't have to answer the questions that follow. If you decide not to take part or to stop answering, it won't affect you or your role in the hospital in any way. You do not have to give a reason for not taking part or for opting out. No names or job titles are collected in this survey. If any answers you provide identify you, this identifying information will be removed to avoid disclosing your identity. All information will be treated confidentially and stored securely.

If you give your consent to proceed, please check the box:

☐   **I consent to proceed with the survey**

Research Site	Tertiary hospitals, Buraidah, Qassim Saudi Arabia
Researcher & Supervisor	Ms Fatima Alhossaini, PhD candidate, Trinity College Dublin Alhossaf@tcd.ie Telephone: +966530260005 Professor Lorna Carson, PhD supervisor, Trinity College Dublin carsonle@tcd.ie Telephone: +353 1 896 1494
Data Controllers	Trinity College Dublin (for research data)
Data Protection Officer	Data Protection Officer Secretary's Office Trinity College Dublin, the University of Dublin Dublin 2, Ireland

Section 1: Communication Challenges in using Medical English as a Lingua Franca

Please read the following statements and rate the frequency of occurrence during your time working at the hospital.

Frequency: 1 = *never occurs* **and 4** = *occurs all the time*

1. I notice that challenges can arise among colleagues when receiving instructions in English in medical scenarios (e.g. completing medical tasks at work).

                    Frequency   1   2   3   4

2. When communicating with my colleagues in English, I notice that challenges arise linked to politeness norms (apologizing or not for imposing, providing refusal options or not, making the listener feel good or not).

                    Frequency   1   2   3   4

3. Challenges arise due to different expectations of etiquette (e.g. what is considered acceptable to say or not say in a culture)

                    Frequency   1   2   3   4

4. When communicating with my colleagues, challenges occur due to indirect messages or implied meanings when speaking English (e.g. saying *"It is cold in here"* may mean *"we need to switch off the air conditioning"*)

                    Frequency   1   2   3   4

5. Challenges arise as a result of how we address each other in English (e.g. manner of speaking to others, formality/informality, relationships, power and distance).

                    Frequency   1   2   3   4

6. Challenges arise from positive or negative answers to "Yes/No" questions in English (e.g. "Y*ou don't want it, do you*?", "*Yes, I don't*" instead of "*No, I don't*")

                    Frequency   1   2   3   4

7. Challenges arise from my colleagues' pronunciation when they speak English.

                    Frequency   1   2   3   4

8. Challenges arise from the language structure used by my colleagues (e.g. their word order) when they use English.

                 Frequency   1   2   3   4

9. Challenges arise that are related to different vocabulary used by my colleagues in general conversations (e.g. different word used within varieties of English).

                 Frequency   1   2   3   4

10. Challenges arise that are related to different medical terminology used between colleagues when they speak English.

                 Frequency   1   2   3   4

Section 2: Aspects of Effective Communication in Medical English as a Lingua Franca

Please read the following statements and rate your perspective of their importance during your time working at the hospital.

Importance: 1 = *not important at all* **and 4 =** *very important*

11. Clarity regarding understanding instructions in English in different medical scenarios (e.g. completing medical tasks at work).

                 Importance   1   2   3   4

12. Politeness when communicating with colleagues in English.

                 Importance   1   2   3   4

13. Same expectations of etiquette (e.g. what is considered acceptable in my culture).

                 Importance   1   2   3   4

14. Clarity regarding indirect messages or implied meanings when speaking English.

                 Importance   1   2   3   4

15. A shared acceptable manner of addressing each other in English (e.g. expectations regarding appropriate formality, informality, relationships, power and distance).

          Importance   1   2   3   4

16. Clarity regarding positive and negative answers to "Yes/No" questions in English.

          Importance   1   2   3   4

17. Clear pronunciation from my colleagues when they speak English.

          Importance   1   2   3   4

18. Clear language structure from my colleagues (e.g. word order) when they use English.

          Importance   1   2   3   4

19. Common vocabulary in general conversation when English is used.

          Importance   1   2   3   4

20. Common medical terminology when English is used.

          Importance   1   2   3   4

Section 3: Strategies for Effective Communication in Medical English as a Lingua Franca

Please read the following statements and rate the importance and frequency of each strategy for effective communication when interacting with your colleagues.

Importance: 1 = *not important at all* and **4** = *very important*

Frequency: 1 = *never occurs* and **4** = *occurs all the time*

21. When my colleague's words are unclear, I concentrate on the content of what they are saying, and I reformulate (simplify or modify) the sentence to make it more understandable.

          Importance   1   2   3   4

          Frequency   1   2   3   4

22. When my colleague's words are unclear, I let it pass and ignore any unclear words. I use my common sense, knowing that it will become clearer as the conversation progresses.

Importance	1	2	3	4
Frequency	1	2	3	4

23. When my colleague's words are unclear, I focus on correcting the language errors made by my colleague immediately when they utter them.

Importance	1	2	3	4
Frequency	1	2	3	4

24. When my colleague's words are unclear, I ask direct questions to gain clarification regarding what my colleague is saying.

Importance	1	2	3	4
Frequency	1	2	3	4

25. When my colleague misunderstands me, I correct my language errors to make my language more understandable.

Importance	1	2	3	4
Frequency	1	2	3	4

26. When my colleague misunderstands me, I correct my language structure to make my language more understandable.

Importance	1	2	3	4
Frequency	1	2	3	4

27. When my colleague misunderstands me, I simplify my language to make it more understandable.

Importance	1	2	3	4
Frequency	1	2	3	4

28. When my colleague misunderstands me, I repeat what I'm saying to make my language understandable.

Importance	1	2	3	4
Frequency	1	2	3	4

Section 4. Demographic information

29. Age: 18–29 30–39 40–49 50–59 60–69 70+

30. Gender: Male   Female

31. Nationality:

- Saudi Arabian

- American

- Filipino

- Indian

- Pakistani

- Irish

- British

- Egyptian

- Other (please specify) _____

32. First language (the language you consider to be your mother tongue)

- Arabic

- English

- Urdu

- Hindi

- Chinese

- Tagalog

- Other (please specify) _____

33. **If** you selected Arabic as your first language, which variety of modern standard Arabic do you speak?

- Gulf Arabic

- Egyptian Arabic

- Moroccan Arabic

- Sudanese Arabic

- Other (please specify) _____

237

34. Do you speak any other languages in your daily life, whether at work or at home? Please share some details below (the name of the language(s), the context in which you use them)

35. Which language do you use most often at work with your colleagues, when engaged in medical tasks?

36. Which language do you use most often at work with your colleagues during work breaks (e.g. coffee break, lunch break)?

37. Please describe your English language competence in spoken English:

- Native speaker

- Advanced, near-native speaker

- Intermediate level speaker

- Beginner level speaker

38. Please describe any other challenges that you may have noticed related to using English as a lingua franca in a medical setting.

39. Have you any other comments you would like to share regarding the content of this survey?

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Appendix C- Interview Questions

1. What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

2. What kinds of strategies do you use to prevent misunderstandings with your colleagues?

3. What kinds of communication strategies would you advise medical staff to use in a work setting?

4. What do you think is more important in the healthcare settings: medical English language proficiency or general English language communication skills? Why?

5. What knowledge, skills, attitudes and awareness related to language and communication do you think are important for staff in Saudi hospitals?

Appendix D- Research Ethics Approval Letter

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Application	Academic Year 2021/22
Applicant Code	HT39
Applicant/Supervisor Name	Fatima Mohammed Alhossaini / Prof. Lorna Carson
Title of Research	An Investigation of interactions among interprofessional healthcare staff in a multilingual setting: A Case Study of King Fahad Hospital in Saudi Arabia
Date of this letter	09.03.22

Dear Fatima,

Your submission for ethical approval for the research project above was considered by the Research Ethics Committee, School of Linguistic, Speech and Communication Sciences, Trinity College Dublin on 09.03.22 and has been approved in full.

However, one of the reviewers noted the following points for clarification:

- Ensure you follow all the steps you have proposed to protect any personally identifying data (amend your reference to this data in Section 1, p.5, of your application form).
- While access to Google Drive is provided via TCD MyZone, the use of TCD's Microsoft OneDrive cloud storage is advised for research projects. The Research Ethics Committee therefore require that you store *all* research data on **TCD OneDrive**; your supervisor can create a OneDrive folder and share it with you. For more information on TCD OneDrive see: https://www.tcd.ie/itservices/internet/onedrive.php

Please ensure that you address these issues before you commence your study.

Please note:
(i) On completion of research projects, applicants should complete the *End of Project Report Form* (which can be found at: https://www.tcd.ie/slscs/research/ethics/) and submit one electronic copy (to slscs@tcd.ie)
(ii) The REC requests, in particular, that you attend to your commitments regarding the storage and destruction of data arising from this research, in keeping with REC policy and General Data Protection Regulation (GDPR) guidelines.

We wish you every luck with your research.

Best wishes,

_____
Dr Bronagh Ćatibušić
On behalf of:
Dr Ciarán Kenny
Chair, Research Ethics Committee
School of Linguistic, Speech and Communication Sciences

Appendix E- Hospital Ethics Approval Letter

KINGDOM OF SAUDI ARABIA

MINISTRY OF HEALTH

GENERAL DIRECTORATE OF HEALTH AFFAIRS

AL-QASSEM REGION

المملكة العربية السعودية

وزارة الصحة

المديرية العامة للشئون الصحية بمنطقة القصيم

الرقم : ٧٩٤ - ٢٤ - ٦٢ .... التاريخ : ٦ / ٨ / ١٤٤٢

المشفوعات : .... الموضوع : ....

Wednesday, March 09, 2022

To:	**Fatima Mohammed Alhossaini**, Principal Investigator فاطمة الحصيني Postgraduate PhD Student, Trinity College Dublin, University of Dublin (UD), Ireland
Supervisor:	Prof. Lorna Carson, School of Health Sciences, UD, Ireland
From:	Regional Research Ethics Committee, Registered at National Committee of Bio & Med. Ethics (NCBE) Registration No. H-04-Q-001
Research title:	"An Investigation of interactions among interprofessional healthcare staff in a multilingual setting: A Case Study of King Fahad Hospital in Saudi Arabia"
Study Setting:	King Fahd Specialist Hospital, Buraydah, Qassim, Saudi Arabia
Study design:	A cross-sectional interprofessional communication study
Revision type:	☑ Expedited ☒ Exemption ☒ Full Board

Decision:	**Approval, for:** ☑ Implementation	☒ Publication

Dear P.I,

We are pleased to inform you that the local research ethics committee had approved your research proposal. Your efforts to meet the criteria requested by NCBE are highly appreciated

Upon receiving this approval, you may commence your field work at your convenience.

- You should be responsible for upholding the confidentiality of participants data.
- This approval is for study implementation ONLY. In case of publication, kindly submit a new request specifying the name of the periodical with a copy of the study report.
- Kindly, update us on your project advancement every 6 months. On completion of your project, kindly send us a summary of the project final report.
- Finally, be aware that this approval embraces no financial obligations, or any other responsibility on Saudi Ministry of Health or its health affiliates.

Note: Any correction and/or alteration of this certificate will make it invalid.

For queries, please call Dr. Abdullah M. Al Saigul at telephone No. 00966163693429 ext. 101, and e-mail: irb-qassim@moh.gov.sa or qassim_ethcom@yahoo.com

Best regards,

Dr. Abdullah M. Al Saigul

Chairman, Regional Research
Ethics Committee - Qassim Province

09 - 03 - 2022

Appendix F- Certificate of the Hospital Online Ethics Course

NIDA Clinical Trials Network

Certificate of Completion

is hereby granted to

Fatima Mohammed Alhossaini

to certify your completion of the six-hour required course on:

GOOD CLINICAL PRACTICE

MODULE:	STATUS:
Introduction	N/A
Institutional Review Boards	Passed
Informed Consent	Passed
Confidentiality & Privacy	Passed
Participant Safety & Adverse Events	Passed
Quality Assurance	Passed
The Research Protocol	Passed
Documentation & Record-Keeping	Passed
Research Misconduct	Passed
Roles & Responsibilities	Passed
Recruitment & Retention	Passed
Investigational New Drugs	Passed

Course Completion Date: 8 March 2022

CTN Expiration Date: 8 March 2025

Andel Frazier, Clinical Training Specialist

NIDA Clinical Coordinating Center

Good Clinical Practice, Version 5, effective 03-Mar-2017

This training has been funded in whole or in part with Federal funds from the National Institute on Drug Abuse, National Institutes of Health, Department of Health and Human Services, under Contract No. HHSN27201201000024C.

Appendix G- Scoping Review Initial Codes

1- Communication Strategies Among Healthcare Practitioners

Reference	Findings from the Studies	Initial code	Generated Theme
1	"Nurses and patients both agree that administration of Arabic courses for nurses is essential"	language/cultural competency training	Organisational strategies/ Or Organisational communication strategies
10	there is a necessity for training programs to promote effective communication with the public at both national and local levels, and the necessity for coordinated and planned communication efforts may even increase during and after a public health crisis.		
18	There is a need for a well-structured continuing education program for nurses to increase their cultural competence.		
7	providing language Training programs for healthcare staff in the language of their patients can expose them to the patients' culture.		
15	some hospitals may have dual-role interpreters who often serve as administrative assistants, medical assistants, and clinical staff.	Interpreter Integration & Management	
9	Interpreters must follow the standards of hospital practice such as the maintenance of confidentiality, proper dress, professional demeanour, and refusal of gratuities for services		
9	integrating interpreters into the clinical culture, coordinating their work with other practices within the clinic.		
5	The utilization of interpreter services should be closely monitored, with appropriate responses for both under- and over-utilization. Potential solutions include integrated booking systems or the use of interpreters across center		
15	Health care organizations relying on dual-role staff interpreters should consider assessing staff English and second language skills.		
4	Organizational investment in remote interpreter technologies to increase language access		
4	Training clinicians on how to access and work with interpreters.		
4	An examination of system-level factors that may shape clinicians' perceptions and use of professional interpreters		
4	Supporting the training and certification of bilingual staff to serve as interpreters to expand in-person, on-site, interpreter capacity.		
14	A desirable way to overcome language barriers is to use a professional interpreter		

12	The use of trained interpreters, despite their cost, may lower long-term expenses by reducing diagnostic testing or post-emergency department visits.		
5	Use of trained interpreters improves the quality of care and satisfaction levels for healthcare users with limited English proficiency.		
6	The need for more efficient use of professional interpreting services to minimize unnecessary costs while providing quality healthcare.		
6	Potential solution to the issues of inconvenience and cost by using free translating software programs available on mobile technology.		
4	Organizational investment in readily accessible telephonic interpretation		
10	Use or develop Health literacy organizational assessment tool for health plans that could be used as a benchmark and encourage further work		
10	There should be an evaluation for staff's HL to determine those who has received training in:, Effectively organizing verbal information, Communicating using simple language, Checking for understanding		
10	There is a need for plain language training because of its role in improving national preparedness for risk communication in future public health crises.		
10	There is a high potential of health literacy training for improving healthcare communication skills and community health services. It implements The training program includes introducing health literacy and assessment tools, developing skills to improve written materials, and a follow-up assessment on PHNs' application of the gained skills		
13	To start improving HL workforce literacy, a thorough assessment using a credible tool is beneficial. Post-assessment, organizations can develop a comprehensive plan with targeted interventions.		
8	organizations should implement their own HL assessment tool for healthcare workers. This tool should reflect he particular needs of their stakeholders, as well as their available resources, when determining which practices to promote and to what degree		
10	Healthcare workers should be provided with Health literacy friendly guidelines for verbal communication; Guidelines identifying words/phrases to be avoided or explained in plain language; Guidelines for identifying jargon to be avoided		
13	Having easy-to-understand materials that use plain language is crucial for the population the program serves.		
8	The creation of an assessment tool focusing on health literacy, with the first prioritized item being the consistent avoidance of medical "jargon" in both oral and written communication with patients and defining unavoidable jargon in lay terms.		
10	Healthcare workers should be provided with Health literacy friendly guidelines for regulating use of acronyms/nicknames unique to the healthcare organization system		
3	The health literacy curriculum significantly improved knowledge and attitudes when delivered to nurses and resident and attending physicians.		

12	Use of the AHRQ Health literacy Universal Precautions toolkit can increase understanding and training health literacy, improve transmission of health care information, and increase patient safety.		
3	A brief clear communication curriculum focused on health literacy improved knowledge and attitudes among attending physicians and was deemed valuable by both internal medicine residents and nurses.		
1	Nurses should use simple, everyday words rather than complex words or medical jargon when there's a language barrier.	**Plain language Use**	**Language simplification**
2	Use of simple language and medical terms in both casual and professional conversation can decrease language barriers.		
12	Codeswitching, where speakers switch between two languages in a single sentence or conversation can help in overcoming language barriers	**Multimodal Communication in Healthcare**	**socio-pragmatic and communication skills**
17	Nurses play a central role in patient care communication, interacting with a range of health professionals, patients, and their families. They must be able to use appropriate language registers, elicit information, reassure, instruct, check procedures, and share opinions. Also, Politeness strategies are required to avoid threats to face. In addition, they participate in medical team discussions and provide information, requiring the ability to translate between everyday and medical language registers.		
1	Using nonverbal communication such as hand gestures and facial expressions is suggested.		
18	The senior leaders in the hospital listen to and care about the concerns of the staff. Both physician and nurse leaders in the area listen to and care about the concerns of the staff.	**Empathy in healthcare**	
2	Listening to different English accents over a long period of time has helped healthcare workers develop a better understanding of foreign accents, and asking for word clarificatiion when needed	**Listening skills**	
1	attend in-services my help to understand the culture	**Self- directed linguistic & cultural adjustment**	**Healthcare Linguistic-Cultural Adaptation**
2	Independent and informal study of Saudi culture by healthcare workers to improve their communication skills.		
2	others merely observed the goings-on around them and applied what they see		
2	Some asked colleagues and peers for help adjusting to the new culture		
16	adjusting to working in a new language and culture requires significant effort and self-awareness.		
2	Still others voluntarily helped new co-workers from their home country adjust by explaining the culture to them and teaching them how to get by in English or Arabic.		
16	It's important to question what linguistic, intercultural, and social preparation is needed for nurses whose second language is English to work in a new language and culture.		

Reference	Findings from the Studies	Initial code	Generated Theme
16	The role of language and culture in communication for nurses using English as a second language is crucial.		
16	The transition from the language classroom to the clinical setting involves making complex linguistic, cultural, and social choices, often without support.		
2	doctors often use co-workers to interpret for them	**Peer Interpreting Assistance**	
12	Interpreters do serve as cultural mediators and can pick up on the semantic subtleties and underlying tones of discourse	**Interpreters as Cultural Mediators**	Interpretation Mechanisms in Healthcare
5	Interpreters acting as cultural brokers or mediators, providing a bridge between clinicians and healthcare users.		
14	The interpreter should have linguistic competence and mastery of technical and ethical principles such as impartiality and confidentiality.	**Interpretation Proficiency & Collaboration**	
14	Successful collaboration with the interpreter depends significantly on the health-care worker's knowledge of the interpreter's role.		
6	Potential solution to the issues of inconvenience and cost by using free translating software programs available on mobile technology.	**Digital Interpretation Solutions**	
6	Use of Google Translate, a free online language translation service, on a smartphone for two-way interpretation, enabling communication at any time without having to book a professional interpreter.		
6	With improvement, mobile technology with translating software may be used more widely in clinical settings in the future		

2. Communication Barriers Among Healthcare Practitioners

Reference	Findings from the Studies	Initial code	Generated Theme
2	"Both Saudi and non-Saudi healthcare workers sometimes find it hard to understand Arabic speakers from west Arab countries"	**Accent/Dialect Comprehension**	
2	"Difficulty in understanding accented English by various nurses and physicians of different nationalities"		
2	"Hiring employees with language deficiencies in English or Arabic".	**Language Deficiencies**	**Multicultural Communication Challenges**
2	"Difficulty in understanding handwriting, especially doctors' handwriting, on medical prescriptions, patients' medical files, and medical reports".		
2	"Poor English proficiency of native Arabic speakers, especially those who completed their education or have worked extensively in the Arab world, is a significant obstacle"		
2	"Language barriers with non-Arabic speakers who may only communicate in other common languages or have no language in common"	**Absence of Shared Language**	

12	"A lot of communication difficulties are arising from cultural differences".	**Cultural Differences**	
16	"Nurses are often shocked of require a great efforts of adjusting to work in a new language and culture"		
18	"Working in a multicultural environment is challenging, with each culture having unique characteristics that shape language, lifestyle, beliefs, values, customs, traditions, and behaviour patterns".		
18	"Cultural diversity in the health care environment can potentially affect the quality of care and patient safety".		
6	"Issues with high costs associated with the use of professional interpreters"	**Interpreter Service Limitations**	**Interpreting Barriers in Healthcare**
6	"Difficulty in explaining diagrams over the phone with telephone interpreting services due to limited portable phones with speaker capability"		
9	"Frustration expressed by an interpreter supervisor regarding hospital staff delegating independent medical duties to interpreters, such as giving patients discharge instructions".		
12	"There are many complexities of training already overworked and understaffed nurses to be interpreter"		
14	"The underutilization of interpreters may reflect a policy of discouraging overuse to avoid straining hospital budgets"		
14	"The use of interpreters is not standardized or quality-assured in health care and is often dependent on the health provider's knowledge and initiative".		
5	"Challenges in integrating interpreters into the health system, including unclear job descriptions, absence of performance evaluation standards, and lack of career-pathing"		
6	"Communication difficulties experienced by nursing and support staff who have to attend to patients multiple times a day without an interpreter"	**Interpreter Constraints: Availability and Skill**	
14	"There is an underuse of professional interpreters in health-care settings even though the widespread practice of using non-professionals, family members or friends, as interpreters has been discouraged".		
2	"translators or interpreters are sometimes unavailable"		
4	"The reliance on ad hoc interpreters over professional ones despite the latter's proficiency in the nuances of interpretation".		
15	"Dual-role interpreting Staff who have basic linguistic level was prone to interpretation errors, including omissions and word confusion"		
5	"Feelings of vulnerability among interpreters due to feeling poorly trained for hospital environments, particularly in psychiatry".		

15	"Approximately one in five dual-role staff interpreters had insufficient bilingual skills to serve as interpreters in a medical encounter".		
12	"Junior nurses or student nurses often had acquired a less proficient use of English and are more likely to have errors while interpreting"		
14	"Many physicians and nurses expressed dissatisfaction with the interpreters' competence, their own competence in working with interpreters, and the opportunities to increase their competence in this field".		
5	"interpreters did not undergo the standard induction and orientation program, leading to ongoing training requests".		

Appendix H- Interviews Audio Transcripts

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

5   KFSH1: Okay. So basically, cultural challenges, we do have no cultural differences. Hence, we are from the same region and the same culture. However, if you are talking about foreigners, nurses, and staff, sometimes we have barriers to interacting interaction barriers. For example, we only have a minor engagement in terms of communication outside the medical field life. So, culture and cultural differences, we don't have that differences because we are not exposed to them. KFSH1: Did you get me; did you get my point?

10   Fatima: Yeah, your point is clear. Thanks

KFSH1: We and the nurses, for example, foreign medical staff and those who do not speak our mother tongue, Arabic, do not engage a lot because of the barriers, maybe the language itself. This primary language is English.

Fatima: What about when discussing medical reports and speaking about different scenarios?

KFSH1: Well, that is not the situation when talking to a nurse. You are trying to elicit your research about this hospital, 15   right?

Fatima: Yes, exactly.

KFSH1: Then, from my experience since I worked in this hospital, I have never engaged with a non-Saudi nurse. All the nurses were Saudis. So usually, we do not speak English.

Fatima: Great; any other challenges related to language and culture you encountered?

20   KFSH1: In Saudi culture, when it comes to gender, there are barriers, as I told you. First the language barrier. Second, you know, the stigma of segregation between males and females. So, the exposure or contact between males and females, in general, is very limited. That's what I might say.

Fatima: Interesting. Let us move to the next question, what kinds of strategies do you use to prevent misunderstanding with your colleagues?

25   KFSH1: Okay. So let me give you an example. First, when I came here one year and a half ago, I encountered a weird accident or incident. They told me to do a round-round about one of the topics here in rehabilitation with the medical department. And they gathered most of the staff, and then I started talking about the topic, noticing that no one was literally paying attention, no one was paying attention! Then I just stopped for a while and asked: "guys, what is going on? Are you following me?" And then a guy stood up and said, literally: "Doctor, can you please say that in Arabic? No 30   one knows what you are talking about". However, that, to me, was very, very shocking. I talked for about 10 minutes, and no staff got what I said. Fatima, if you are talking about misunderstanding, this is a misunderstanding, and barriers are there. The English language is very weak here. This made me frustrated in the beginning, so I had to prevent this misunderstanding by speaking my mother tongue,

Fatima: You mean translating what has been said in English?

35   KFSH1: Even not translating. It is like talking to them in Arabic about the medical topic and trying my best to translate the medical terminology into Arabic so they can get it. So yeah, this is one of the strategies that I use.

Fatima: Any other strategies you would like to share?

KFSH1: Another strategy that I use to prevent misunderstanding may be emphasis. When someone is not getting my request, for example, if I ask a therapist to do a specific therapy for my patient, I re-emphasize that the technique I want 40   is this, this, and that. And then I follow it with: Do you get it? Do you get it? Until he/she nods yes.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

KFSH1: A proficient medical language in the medical setting is what I advise. But the problem, unfortunately, here is that they need to look at the English language as a very solid language to be communicated. So, they do not even consider it a primary language to be expressed. And yeah, I mean, inside the hospital walls. So now, for example, go outside the 45   corridor, okay? And just listen to the conversations. No one speaks English, even when we talk about medical scenarios. You know you are following me, right?

And for medical errors. No, I would not say so because our department or medical department is run by doctors first, my colleague and me. And then there comes down the therapists, the physical therapist, the occupational therapy, the speech and language pathologist, and the prosthetist. So usually, when we tell them the instructions, they follow our instructions. 50   So, medical error usually happens from the doctors, not the therapist. We cannot blame the therapist for a medical error that the doctors have caused.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

KFSH1: Well, both are very important. Firstly, medical English language proficiency is fundamental. So, you can get a 55   formal way of talking. This is very important. Secondly, we need the general English language or lay English to communicate very well, even outside the setting of a medical situation. So, medical English language proficiency is as important as general English. Because, as I told you, it makes you strong and stronger in terms of expressing what you need to say, what you need to do to your patient, what to say and what to deliver to your colleagues. If you mastered this, you would master the other things. So, yeah, I would say both are very important.

60   Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

65   KFSH1: So, regarding knowledge, they need to do many courses; this is number one. They need to invest in reading, writing, listening, and basic language skills to develop their ability to express themselves in English. For skills, they need to, and as I told you, they need to listen and speak more, even if they are mistaken. Also, they need to engage more it's also the case for attitude. You must put yourself in a situation where English becomes your first spoken language inside the hospital walls. It is essential. Finally, awareness related to language is not in our hands. As you know, we live in a culture that is not fighting against the English language but does not promote speaking the English language. So, awareness is out of our hands, but if it is not a self-related motivation, we cannot help it.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

KFSH2: Sometimes, we have some challenges regarding the language, especially with non-Arabic speakers and some other nationalities. You have some accents which it is difficult to be picked by some people. Anyhow. For me, my language is very clear. Usually, I use precise sentences so as not to be misunderstood or twisted.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

KFSH2: Of course, you must follow international patient safety goals. First, the patient's full name because here in Saudi Arabia, some names you hear about are repeated. However, to skip this point, you must also mention the complete patient's name—secondly, the file number. In addition, also, I like to confirm with more data. For example, the patient's age, type of specimen, and lesion site. This is to be entirely sure, 100%, that there is no percentage to be left for any mistake. To prevent medical errors because our field is very sophisticated, critical, and sensitive. There is no place for any mistakes.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

KFSH2: Of course, you must communicate with medical staff for the sake of the patient. Getting more medical information and radiological and laboratory investigations are necessary. And again, you must stick to the international patient safety goals. And to be clear, speak only a little, and always be precise by using minimal and clear sentences, mainly when you write a report or comment. You should carefully select words because sometimes the words may be misunderstood or can be understood in another way. And there is no harm if you select, repeat, and cancel some words and put another word to be more explicit.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

KFSH2: When speaking to a doctor, you should use professional language like medical English. Using general English is good if you provide some data to a Nurse; for example, you should expect some of the professional terms she is unaware of, but at least you try to select the most appropriate word. However, it is generally better to speak to the professional doctor and the responsible doctor in a professional way using standard medical terms.

Fatima: May you elaborate more about the standard medical terms?

KFSH2: Yeah, I mean using standard medical terms unless the doctor, he/she cannot understand or are not aware of your field. For example, this is very common, as we have yet to be aware of some of the terms in another field of medicine. And similarly, others are not aware of some terms in our field and in this situation; we can simplify or give the nearest common term to be understood.

Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

KFSH2: Of course, basic knowledge is significant for everybody, and this should be known. Then, according to the level of the person you are speaking with. If you speak to somebody professionally, try to use professional terms. On the other hand, if you are speaking to junior staff, try to simplify your language, and so on. This should be in all hospitals, even Arabic hospitals. Of course, in medicine, we study medicine in English in most countries, including Saudi Arabia; only a few Arabic countries study medicine in Arabic, which is difficult for us. We also try to know the related terms in Arabic. However, I believe English is easier to understand and to convey a message to professional doctors, nurses, or medical committees.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

KFSH3: My dear, there are no challenges. I mean, to that degree. We all speak either English or Arabic. There is nothing of significance in this aspect.

5 Fatima: And you use the Arabic language with Arabic speakers and English with non-Arabic speakers?

KFSH3: Yeah, we use Arabic with those who speak Arabic, and English with English speakers, whether doctors or consultants and during meetings, sometimes we use Arabic, and sometimes English.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

KFSH3: We repeat and discuss if there is a misunderstanding and have meetings. We live as a family in the work
10 environment here, the workplace is group work, but if there are any problems, we discuss them in the group; we are also in constant communication regarding the work between us as doctors. For the other medical staff, for example, the technicians and we speak with them in both languages, and there are no challenges.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

KFSH3: Of course, English is the common language of communication for everyone because we have foreigners who do
15 not know the Arabic language, so I prefer that they always speak English.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

KFSH3: Proficiency in medical English is important, but not to that extent, especially when communicating with technologists; proficiency in medical English is essential with doctors and consultants. Also, while discussing medical
20 terms and diseases, because all reports and documents are in English, but with technicians and other medical staff is not necessarily. However, both should be present for a better result.

Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

KFSH3: They should be given from time-to-time courses and tests to improve the language and language courses for staff
25 who do not know the language, such as technicians and so on.

For the awareness, they are all aware of and use both languages to communicate.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

KFSH4: Of course, we are working here in Saudi Arabia, so many foreigners are coming here. And the significant cultural differences are, yeah, the culture itself and the religion. Some are Muslims, and some are not. Our religion is number one,

5   and our language is number two. We speak one language, English, but some do not speak English. And it is challenging to interact with other colleagues.

Fatima: You mean some of your colleagues do not speak English?

KFSH4: Yeah, some colleagues cannot understand you. And, of course, for the culture itself, our practices are different from their practice whether in the Philippines, Indians and here. The best example for this point is gender segregation

10   when a male doctor comes to a male patient to preserve the culture of Saudi Arabia, where we are working in. So, the language, our ethnicity also some are Asian, some are Arab, some are Americans and so on. It is a diverse cultural setting, one of the challenges we face here in Saudi Arabia.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

KFSH4: One of the strategies is adapting to the working environment and the preferred language spoken here. For

15   example, here in Saudi Arabia, the primary language is Arabic. So as a new Asian here, you have to adapt to what most people are speaking so that you will understand it. And sometimes, if they cannot understand you in any way, you have to act. Like if you ask them and they cannot understand what you are saying, then you have to act and explain through actions.

Fatima: So, you try to act because you do not speak Arabic?

20   KFSH4: Well, we understand Arabic, but they cannot understand us. The best thing we can do is, aside from speaking English, our national and international language, we can act so that they can understand more.

Fatima: And you use this strategy with patients and colleagues?

KFSH4: Yes, I use this strategy with patients and colleagues because language is a barrier for everyone.

Fatima: Do you use any other strategies besides acting?

25   KFSH4: Yeah, sometimes I also use the strategy of visualizing. For Example, since I do not know the Arabic word (milk), so I search for a picture of milk and explain it through visual images to make them understand. I mean, they can understand me in such a simple way.

Fatima: Yeah, that helps a lot. Do you have any other strategies?

KFSH4: Also, one of the best strategies I use is to ask someone else to interpret what I am saying to the patient. For

30   Example, suppose we cannot understand a specific patient. In that case, we call our Saudi colleague to explain our colleague who understands English so they can translate to their local people.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

KFSH4: The best thing is that you have to know the language of the country you are in. You must learn it, not only learn it! Not only learn, but you also have to earn it. Also, as I mentioned, not all people can speak English. Not all people

35   finish college or high school. So, you have to adapt yourself to what is the language that people mostly use, that is for the success of communication.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

KFHS4: In healthcare, medical English language proficiency only applies to healthcare professionals because we can

40   understand each other. However, it is hard to apply to a particular person who does not know anything. For Example, for a medical term like (hyperthermia), which means high fever in medical English, proficiency can be with medical people. But the English language communication skills are for general people. I think it's best to mix both so that when we are speaking, the listener can also understand us so that we can explain well because sometimes some medical terminologies are hard to explain in simple English in a simple way that they can understand. From my perspective, I think both should

45   be equal. Because as I said, it is hard for us to explain all the medical terminology to the patient, but we could with general English skills. So, when it comes to patient care, both should be equal.

Fatima: And what about when it comes to communicating with colleagues?

KFSH4: With my colleague, medical English is applicable as we can understand without misunderstanding because we are in a healthcare setting.

50   Fatima: So, you mean there is no misunderstanding when communicating with your colleagues using medical English?

KFSH4: Yeah, that is my point of view. But for other people, maybe not.

Fatima: Okay, the last question, what knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

KFSH4: For this question, the Saudi staff must study and learn the primary English language for good communication.

55   Because when you know basic English, you will gain the skills, attitude, and knowledge. We should also learn your Arabic language for the other non-Saudi or non-Arabic staff. We also need to know about the culture and religion; for instance, I am a Filipino who must adapt to and respect your culture. And I expect the Saudis also to respect mine for good communication, treatment, and relation with all of us.

Again, for the knowledge, I would recommend to Saudi staff that, for Example, in the Philippines, we study the (KSA)=

60   which means knowledge-skills-attitude for implementation. In other words, the most important thing is knowledge, and then you apply your skills, and then it comes to your attitude because knowledge and skills are nothing without a good attitude. It can be a matter of politeness, but as I said, we have different cultures. We have different ways of living. So

65   sometimes you tend to conflict with one Saudi, and you think he/she is rude, but that is their natural way of communicating. To illustrate my point, other Saudi staff sometimes think I'm shouting when I speak loudly. So, I kept explaining that this was my normal voice, and this is my culture, the way we speak, so it would not create conflicts.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

KFSH5: Sometimes, the problem or embarrassment is if the patient, for example, wants to be alone in the clinic and not be with other people, including other medical staff. Some patients consider it their privacy or a cultural thing they do not want to be exposed to. However, I find it challenging to deliver the message to my colleague in the room; how do I say that the patient does not want you to be present, especially since some patients prefer not to say it verbally.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

KFSH5: Sometimes, if you want to convey a message to your colleague, you may call him for an individual meeting to discuss the misunderstanding to clarify things. It could be earlier in the morning or after you finish your job to have more time. And regarding medical cases, sometimes I use simple videos to clarify more.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

KFSH5: Communication is important; communication is a valuable way to convey the information you have, the advice you give to the medical staff, the tasks you have, and the intersection. However, the skills can be mastered, and others may need to. Therefore, I believe that there should be Arabic courses for communication skills because it is very important in the medical environment and give you the confidence to communicate with other parties,

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

KFSH5: The healthcare structure is for the decision-makers, but there must be proficiency in the two languages and their branches, English and medical English. Mastering both is beneficial and important for all parties in healthcare. Because sometimes your assistant asks you to explain a point where you cannot convey it in Arabic or get it on the spot, it is much wise to discuss it in English, especially if he is a non-Arabic speaker and vice versa. Both Arabic- and non-Arabic speakers should use the English language and the medical language, especially for terms you cannot find their translation into Arabic. So you should be oriented in medical/ English communication skills. As we are in a dental clinic, I found it hard to convey the same material/instrument/ or procedure in Arabic. Plus, in our schools, they teach us medicine in English, so I am sure they have a background in medical English and communication in English.

Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

KFSH5: First, I would like to thank the government of KSA and the Ministry of Health for the notable progress in medical management, medical competence, medical practices, and medical follow-up. Also, the provision of means for the success of activities, practices, and treatment methods in Saudi Arabia, including their capabilities and competencies. These are things to be proud of, but perfection is not for the person; perfection is always for Allah. However, a few matters should be drawn to their attention. They need to hire social workers, and it is imperative to have a social worker first to activate the role of the companion, client, hospital, operator, and all parties. Secondly, it is data for further planning, strategies, and development to avoid miscommunication and errors and build up a solid base structure for future planning because social workers might give you feedback. Social worker presence is so vital. It is also essential to have an interpreter for the non-Arabic speakers to convey their messages more embracing, more beneficial, and more convenient for other medical procedures and the medical staff. And I am sure that the MOH is aware of this issue; it is my opinion.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

KFSH6: For the cultural challenges, just like we are in a professional place and don't encounter many cultural issues. There is a cultural aspect, and people come from different places. We have Indians, Pakistanis, Saudis, and so many other nationalities. However, the biggest hurdle we face here is language. So only some people here are proficient in the English language, and even in the English language, you have some medical terminologies and general English. So, there are discrepancies, which is the thing. But when we talk about cultural differences, it is not a big issue. A factor is involved, but it does not influence much as language obstacles because everything we do here is evidence-based; okay, culture should not influence. Everything is evidence-based, and you must work according to studies and work you already practised. That is the thing.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

KFSH6: Proficiency in English, proficiency in your vocabulary and proficiency in using the correct terminology when communicating with each other regarding patients.

Fatima: So, these are the strategies you use to prevent misunderstanding?

KFSH6: yes, we have electronic methods of electronic communication, and we have in terms of paper-based communication. Also, we have verbal communication. So, since we are using electronics, it becomes easier for us to communicate with each other. However, again, there are loopholes in that. For example, we come from different places and schools, and I am taught differently to write my notes and the abbreviations I use. Someone else will use it differently; I will describe my patient differently, and that person would describe it differently. So, all of this must be standardized. There must be a standardized method while interacting with each other. So that is what we try to do. We keep our language as simple as possible. We try to reduce the number of abbreviations we use. We try to use the complete form of words. It is essential in this in this hospital that you are not supposed to use abbreviations. It helps; it does help. Sometimes verbal communication also helps some people who need to improve in English. Everybody has their pluses and minuses.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

KFSH6: As I told you earlier, we have electronic, paper, and verbal methods. We do not need anything written down, and we don't want to go back and refer to those things again. So electronic is the best.

Fatima: So, you advise your colleagues to use electronic documentation?

KFSH6: yes, electronic is the best use because the filing and everything are adequately documented in the file. They can look it up whenever they like, whatever they want to retrieve or complete the patient's medical history. Paper documentation, no, is not useful. And regarding verbal communication, yes, it is acceptable for simple discussions or consultations. However, still, again, you cannot rely on it.

Fatima: You cannot rely on verbal communication?

KFSH6: No, no.

Fatima: So, you advise them to use electronic documentation?

KFSH6: Electronic methods are always preferable. For example, I'm going on vacation tomorrow, and I will put the order electronically and note that this patient has to be followed up. Then, I have the application on my phone. A patient comes to my clinic, and my juniors see the case and make an entry into the patient's file. Then I can view it on my phone and see what there is; even if I am on vacation, I can still follow up with my patients. So, therefore it is important that the method of communication has to be standardized.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

KFSH6: Both are very important because your general English language proficiency is the basis of how you build your medical language proficiency. Grammar is important for describing the case. For example, if a patient is releasing a tumour or something, you must use proper English, which is understandable. Of course, I am trying to understand what happens when reading this case. They should be able to take a picture of what is going on with the patient using medical terms. Then, you inculcate those medical terms with general English skills to convey the message correctly.

Fatima: Yeah, sometimes medical staff are proficient in medical English.

KFSH6: Yeah, exactly. Using only medical English gets too overwhelming sometimes, where sometimes I am busy and need more time to go through it all, but at least when I glance, I have an idea. So, you should have a balance between the two. It is not that this is very important. It is a balance. You need to learn to balance them.

Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

KFSH6: Knowledge, skills, attitude and awareness are vital because you work with many people. There has to be a standardization goal. In communication, it is not just language that you use. You also use your body language, and all this is important. As I pointed out, some people, you know, in their culture, it is normal to talk in a loud voice and make gestures and everything. I think, you know, it is a grey area there, which has to be worked on. Communication skills are important, and everybody has to keep on pressing on their communication skills over and over again. Communication skills, as I said, include another dimension, such as body language, listening, repeating, and speaking.

Fatima: Anything else you would like to add?

KFSH6: When talking about Saudi hospitals, English is always the language of choice among medical staff because we do not know Arabic. Because of many abbreviations, everything should be electronically based and mentioned clearly and precisely.

Fatima: So, you face a challenge because Arabic is not your first language, and some staff do not speak English?

65 KFSH6: Yes, yes, it is the thing, it is a big challenge. Language is always a challenge because you will not be able to communicate.

Fatima: Do you have any examples you faced related to these challenges you mentioned in this interview?

KFSH6: Once, I had a patient; the orthodontist needed extraction of certain teeth and moved the other teeth to make space. So, he sent me a paper saying that these particular teeth must be removed. Then he calls me again, saying, I sent a patient to you, and there are brackets on the teeth, and you are supposed to remove the tooth which does not have brackets. So, I

70 did not see the written paper and followed his orders via phone and did the procedure. A week later, he returned, saying I did the wrong extraction. So, now I need to get back up to prove what happened. There is a paper with another procedure, and he told me something else. This paper did not go on the file. So, ultimately, what happened? It is my fault; the patient lost the tooth because of miscommunication with the papers. Now that everything is documented in the electronic system. Nobody will, like, back off from what they have written. It's going to be there forever. Also, when I am saying

75 abbreviations, we face many problems with other abbreviations; some people like to write their abbreviations like they write 'IRT' which means ' in relation to'. Okay, I understand that, but some people will not understand. As we have many abbreviations, it is okay to use them. But again, sometimes, it is not nice, not good, I will not understand, also my abbreviation others may not understand them. But for cultural matters, considering the facts from my side, we focus on our patients. Our culture and things like that are secondary, and the primary goal is to provide care for patient

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

KFSH7: Of course, when we talk about communicating with them, it is more in the field of work, most of it is in English, but the accent is a problem. I mean a problem in some nationalities, particularly some Nigerians, their accent is an issue,

5 it is challenging to take endorsement over the phone, I always feel the miscommunication. This is the biggest thing I face. The other thing is culture, we are selective with dealing with colleagues, but within the limits of working in English and very rarely do we encounter cultural issues because the accent is difficult between us, so we limit communication in the field of work.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

10 KFSH7: The biggest problem that causes misunderstanding is that sometimes they explain the words in another way; for example, I use Arabic (local Sudanese), and they do not understand me. So, I simplify and use the dialect that is the easiest thing to understand me, this is when speaking Arabic. For the english language, it is almost the same, but because we are in a medical field we try to simplify more. We also agree on a list of medical terms we use daily to facilitate communication between us. But what I really do to avoid misunderstanding is repeat in another simple way. I simplify and modify, and

15 sometimes I avoid speaking English and speak Arabic because sometimes there are some words and cases it's better to explain in Arabic to avoid misunderstanding. This is because culture plays a role, things are okay with us by communicating, except for matters and details that are outside the scope of work. We try to facilitate them. For Example, when I talk with the Bangladesh workers, I try to make my language as simple as possible. Some have been in Saudi Arabia for a long time, so they have become fluent in Arabic. Some of them are, for example, a hybrid with words they

20 use; I try to introduce them to them, but simplification is the most strategic strategy I use.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

KFSH7: I always advise my colleagues to shorten communication in the field of work. For instance, the endorsement of the patient; I try to shorten my conversation and talk only about work, be direct. I avoid discussing specific topics and cultures to avoid dry communication. I usually talk with them about their hobbies and cultural habits, such as their

25 marriage traditions etc. It is much easier to communicate with Arabs as we discuss common topics in our cultures, history, customs, and religion. Sometimes you discuss certain topics with non-Arabic, but you feel your colleague is not interested. For Example, communicating with Nigerian Muslim doctors is easier than dealing with a non-Muslim Nigerian because his religious and cultural background is similar to ours, unlike other nationalities. You find them almost confined, isolated and confined to work only.

30 Fatima: Any other recommendations ?

Also, the way of communication, body reaction, and facial expressions. I can smile and greet. Simple things that give a good impression and facilitate communication between us. We have to be polite, and the facial impression must be flexible. Another point is that medical staff should try to communicate simply in a simplified manner with different topics. Do not separate the circle, even if it is for the patient care, medical settings, crowdedness etc.; there are subjective topics

35 that could be discussed. We always encourage communication and communicate in meetings after we see the patient, we communicate with doctors, , seniors, juniors etc., It is also essential for recommendations and points of view. Our problem is also confined to the scope of work; even when we meet outside working hours outside the hospital, you will find us also talking about work. The Sudanese, Nigerian, Saudi and other non-Arabic staff meet regularly, and the department invites us for dinner, but our problem is work always drags us.

40 Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

KFSH7: In the healthcare settings, medical English is number one because the medical language allows more space in the development of work, especially communication becomes easier. Non-medical English can go with other matters, such as the behaviour of people and patients and how to communicate with them in non-medical communication, but

45 from my point of view, the medical English language is important in communication with the medical staff.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

KFSH7: I think we should understand Saudi culture, as well as its nature and how it deals with many needs. In other words, here, there is the nature of the region, which I must understand, and the way of dealing, the prevailing need, the

50 method of dealing, which differs from person to person, region to region, according to their capabilities, according to the nature of the hospital. The medical staff must understand the behaviour and nature of here. For Example, some patients are not convinced if I talk to them more and communicate more, they will never be convinced, even if there is a misunderstanding between us, they will come back again and meet another doctor. Therefore, you must understand the culture and communication also from the facial impression and explain to them that you care about your problems and

55 are a good listener to you. This makes a very difference in communication. Here in the hospital, we find that the Arabic-speaking person is fluent and understands the work environment and his patients, unlike the non-Arabic-speaking person. He does not understand and does not know how to communicate. He is always struggling, even in taking a detailed medical history. You find non-native speakers always trying to use the Arabic language to make it easier for them to communicate. Therefore, I advise those coming to work here that they learn the language of the country; they must be

60 aware of and understand the language. I highly advise the Ministry of Health that organizes orientations for non-Arabic

speakers and give them a course to allow them and facilitate them to communicate in Arabic. For instance, the Nigerian nationality, you find them closed in nature and do not know Arabic at all. So, it is very important that they understand the culture and language of the country. We also have problems that occur between the medical staff member and the patient: For Example, I received the patient's history from my non-Arabic speaking colleague. I found many problems and

65   misunderstandings about the patient's condition. Also, the patient is dissatisfied and comes to me and communicates more and asks me to communicate with non-Arabs to understand the situation more and what they mean. There are issues with the patient's history. It is very important that the medical staff learn the local language of the region and take care of body language and try to understand whether the patient is satisfied or not. Many times, you find the patient not convinced that his health is good because of communication and not showing body language that reassures the patient, so you find the

70   patient coming back again because the method or strategies of the therapist was not convincing, and I am completely sure that this therapist is an excellent staff, but he/she lacks some communication skills.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

KFSH8: Regarding language, we have more than one problem. The first problem is that language is the language of communication that connects a Saudi with a non-Saudi, a technician, a patient, a medical staff, or a specialist. If the meanings of the words I do not know, he is forced to speak Arabic, memorize Arabic, and I have to say the word in English.

The medical field is more formal, known, and disciplined than any other field, so there are no cultural challenges it has faced.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

KFSH8: My communication strategies are via email, WhatsApp or verbally. Most of the time, my tiring strategy is interacting orally. I have to confirm with the listener several times and come again after a few hours to confirm it repeatedly.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

KFSH8: I advise my colleagues to communicate via email and WhatsApp for documentation or in any application dedicated to the same hospital.

Fatima: What do you think is more important in the healthcare settings: Medical English language proficiency or General English language communication skills? Why?

KFSH8: Communication skills in English are more necessary because it is essential. It gives and delivers the matter to what I need; everyone is fluent in medical terms, but in terms of communicating in the hospital, general communication skills are essential because medical English is more straightforward. It can be learned by daily practising in the medical field. However, communication skills in English are the most important. It is always an obstacle in communication, and its proficiency reduces miscommunication.

Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

KFSH8: First, confirmation, excellent and effective communication between the team, and repetition until it is confirmed. For example, in such operations, the doctor and nurse must repeat until everything is confirmed. Effective communication includes many things, including having more than one communication channel, direct communication via email or WhatsApp, communication by frequency, and reference.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

KFSH9: One of the challenges regarding some Indian nationalities staff is the pronunciation in English; they always speak faster, their accent is unclear, and they swallow some letters. Also, the English language of some Egyptian staff. These
5   challenges hinder the work, and sometimes, it creates miscommunication. Sometimes, whenever there are Egyptian staff with Filipino or Indian staff, they do not understand each other, and here there are problems. So, I kept hearing: "She told me this, and I did not understand." Alternatively, when, for example, the Indian staff asks her, "May you repeat?" the Egyptian staff becomes sensitive and responds, " Do you mean I do not know how to pronounce it right?" This intelligible becomes present.
10   For the cultural challenges, our "X" staff are usually "I mean; their hygiene" is entirely different. They have certain traditions to the extent that they smell bad at work to the point where you find it difficult to talk to them, and inadequate communication affects the patient and the work. And due to my role, I train the new staff when they come here to the hospital and teach them about our customs and traditions. What is right and what is not? For example, some "X" staff have traditions that ignore personal hygiene; they shower once a month and come to the hospital with an annoying and
15   terrible smell and general appearance.
Concerning the Filipino nationality, I encounter different food related to their cultures, as some bring their food to the hospital. It is heavy and has unpleasant smells and garlic, which is annoying, especially from the first morning; during personal communication, it is difficult to communicate with the presence of annoying odours; I want her not to speak because the smell is irritating. I prefer not to communicate with them because I know what I will smell, and in this case,
20   it will be a defect that will affect patient care, the unit you work in and the facility as a whole, and they become accumulations. To solve these matters, as a "X", I will be direct and explain to them that this is inappropriate. This isn't very pleasant to the entire team. Whenever it is outside working hours in the evening, I explain to them the role of personal hygiene at work. A recent situation happened to me with an "X" nationality. She has a terrible smell that I cannot tolerate it! From my point of view, I have to be very clear about it in a very polite way, and I would rather be clear and polite
25   better than ignore the person and avoid talking with the other staff without being clear about the reasons because they might not know, and you judged them without specifying the reasons.
Here in the hospital, people come from different regions and nationalities and have various rituals, which is normal. We, as Muslims, believe in being good-looking and interested in cleanliness, and we do not forget that we perform ablution five times a day. Showers are essential, and this is the basis of our religion. We also have the basics on Friday: cleaning,
30   perfume and shaving hair, etc., so I must clarify that this is our Islamic religion and culture and that this matter disturbs communication. I believe that I must clarify such issues because I work for patient care, as I am responsible first in front of Allah and front of my job for the sick; I must prevent Anything that hinders communication between my team. I would also like to add something related to the cultural tone of voice. Some nationalities, specifically the Indian nationality, raise their voice when speaking, and I understand that this is their culture; they are used to it. But other staff from other
35   nationalities will come and complain to me: "her voice is loud; she is disturbing me". So they will ask the Indian team to lower their voice, then the Indian nationality will think that she is giving her an order, and here the conflicts begin.
To prevent this from happening, I make it clear in the training that we, as professionals, must pay attention to the tone and intensity of our voice. We must pay attention to how we communicate, even if it is our best friends! Our interactions in the hospital should be professional, and outside the hospital, communicate in the way you like. I always train them to
40   be formal by dealing with: "Hello, how are you? I have this patient, and this is a condition that I need, etc." Pranks and jokes began to take another side for longer time, and they focused on unrelated situations more than patient care. This is one of the issues I encountered, and I experienced most of the time between the Saudi nationality. Hence, the communication topics always become about situations in the hospital, and they mix work with side matters. However, when I explain these points to them, they do not understand me correctly even if I am polite; they always understand that
45   I give them orders and order them because of my position at work; I want to be serious and direct. Unfortunately, the separation between break and work is lacking for us.
I also face conflicts between staff who are from the same nationality, so I needed time to make it clear to them that they should pay attention to deliver the best care to the patient and improve the quality of work. On the other hand, I found it a detraction between cultures, which leads to misunderstanding; for example, I discovered that the "x" nationality detracts
50   from the "y" nationality a lot at work. So, my language must be clear when communicating with everyone, and my style must be straightforward in conveying the idea. I am fine with other nationalities when I explain certain points to them, and I will be frank and direct with them. They want me to clarify the reasons; for example, if there is a conflict between two people of different nationalities, I schedule a meeting and speak clearly to explain such matters because I need proper communication. My goal is patient care. ,
55   One of the situations I encountered regarding personal problems and differences in cultures was when one staff member said that she did not like her colleague nor wanted to work with her. So, I explained that we had come to the hospital to work for the patient's benefit. We did not come because of black and white; we must be grey and neutral people. At work, we cannot determine who our boss, the doctor on duty with us, or the hospital director is. We deal with all shapes,

60   personalities, genders and personalities. All must be dealt with on a neutral level with proper communication for patients' care.

Unfortunately, I am facing difficulties from the staff of the same nationalities as Saudis. I was disturbed that they differentiated from them in determining my role at work. I noticed that if the leader, head or supervisor is non-Saudi, the orders from them are acceptable and dealing with them is flexible, but when the head is Saudi, unfortunately. The matter turns personal as if you were conspiring against them and using the power to deal with them, even though I use the same
65   job role to describe my job and run my duty like a foreigner running theirs. However, there are always sensitivities if the head, supervisor etc., is Saudi. I even used a polite strategy when giving orders; they understood me as if I was ordering or walking them through how? and in the end, I was giving medical orders that needed to be completed. This is the biggest obstacle I face, and unfortunately, I face it to a large extent with both Saudi males and females, my nationality is Saudi, and the high position I hold causes me problems with them.

70   Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

KFSH9: I use proper communication, with polite and clear words and a tone of my voice. I observed all the nationalities using these strategies, and the communication went smoothly without misunderstanding.

But the mentality of the recipient differs significantly in responding to these strategies; the mentality plays the most prominent role. For example, I had a situation in 2018 I used the strategies I mentioned earlier, and there was a
75   misunderstanding. He misunderstood me: "He used to say, you are polite; I know your intentions". He is not used to someone speaking politely and more professionally. I am told by groups who do not understand this matter, for example, I come to you, Fatima, and I say one to two, three, I need you to settle this request for me, may Allah be pleased with you. I hope you finish this task in two hours. Then they say:" I have two hours to complete the request. Why?" Unfortunately, there is no comprehension of the job description, and unfortunately, I face it to a large extent, so your research topic is
80   intense and realistic and needs study. However, I find complaints against me, and when I meet with the director and explain my communication strategies, the director agrees that this is my job.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

KFSH9: First, the English language proficiency with clear, direct words. Also, politeness and avoiding being humorous and using jokes all the time, especially during endorsement; some doctors joke a lot while discussing the medical case.
85   This makes the listener feel lost.

I really insist on English language proficiency from all the staff in the hospital, so all the staff know what is going on. Avoid switching between English and Arabic because this sometimes causes misunderstanding and sensitivity, as sometimes the non-Arabic speakers would understand that we are talking about them. Even with the other non-Arabic speaker, I suggest using English in a healthcare setting and avoiding code-switching.

90   I also advise the other medical staff- my colleagues to be direct and clear and avoid using hidden words- messages where I have to try and think what you mean. I do not have that time to think and feel what you intended to say. Once I faced this with the other Saudi medical staff, she literally said: "I made a hint for you to understand", No, I do not need you to make hints; I want you to be direct.

Another strategy I advise the other medical staff is briefly introducing yourself to the new staff and how you work. This
95   eases communication; this helps to reduce misunderstandings and conflicts. Expressing yourself and your strategies helps a lot. For example, I know that X doesn't like to do three orders together; I knew her abilities she gave me a brief about her strategies at work.

Fatima: What do you think is more important in the healthcare settings: Medical English language proficiency or General English language communication skills? Why?
100   KFSH9: They are both important, the medical English language for the therapist, giving the patient's order, etc. Proficiency in English and its skills are important to communicate within the unit so that all the therapists are fully informed of what is happening in Patient Care. Both are essential for everyone because we have different nationalities, so communication is standard and understandable. To avoid misunderstandings, we must have good communication skills in general English and refrain from using our mother tongue. Even if you suppose that you have mastered medical English,
105   the general English, but you do not have general English proficiency, I am sure that you know basic English because all the medical staff are supposed to learn basic English. Basic English is sufficient, for example: "I want this, do this order, take the blood pressure, do the RPC, send the patient."

You don't need to be at an advanced level of English; basic English will do the job even in written documents, i.e. doctor's notes, nurse's notes etc., should be written in English.

110   Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

KFSH9: They should know English to communicate and learn about our culture and religion. They should know that we pray five times a day and awe fast during Ramadan. They should respect our faith, religion and culture, including; our food, habits and how we dress, i.e. Abaya, hijab etc. Our traditions and knowing our culture in advance will also benefit
115   our patients' treatment. Some patients are religiously closed, and their dress covers everything, so some non-Arab medical

staff would be afraid to deal with some patients. I once faced an Indian medical team who came to me saying that once she saw patients covering everything, she felt scared and thought she would kill her!

So I recommend they read about our culture before planning to work in Saudi Arabia and be aware of the traditions.

120 And our job in this hospital is to explain all these aspects during the orientation and show them some pictures, so they can understand what they might face. Unfortunately, here in the hospital, there is a very brief Orientation about culture for recently joined staff. This is their right, and they should be oriented intensively because only some medical staff would read about Saudi Arabia before coming.

Moreover, emotional intelligence also should orient the staff in this aspect. I mean that they should have these skills once they come here to work. For example, how the Saudi people talk and communicate, what the administration is like in

125 Saudi Arabia, teamwork, how the Saudi female staff act and vice versa, and how to deal with Saudi Patients of different ages. It will let the foreign staff have a background in emotional intelligence and how to deal with Saudi people. Especially in selecting the topics to communicate, for instance, "you don't come to a Saudi staff and speak with them about topics like do you have a boyfriend-girlfriend, etc., This emotional intelligence course will provide and enhance the other staff in communicating with each other with all mentalities. I assume this course will reduce many problems and conflicts if I

130 come to work in a Saudi Hospital. I know what to discuss and not to discuss, what causes issues and sensitivity and how to avoid speaking about specific topics. I met a Filipino nurse yesterday who worked in this hospital for almost 17 years; she told me I like the background of your culture and beliefs. All Saudis are straightforward, direct and clear.

The ministry of health should conduct these orientations to educate the recently joined staff. One reason is that some medical staff hear false assumptions about the Saudi culture and work setting from other medical staff.

135 Again, I insist on mastering the English language because our medical field requires us to master the English language here. Be clear, specific, polite, and precise in your voice. This is effective communication; also, you should read about the language policy and all the available job policies. Unfortunately, we don't have a specific language policy, but the director informed us to speak English all the time. Some Saudi staff who didn't know the basics of English were suffering in inpatient, so they moved their roles to the outpatients. Because the outpatient in the hospital does not require intensive

140 communication in English, it includes a doctor with a nurse and patients who mostly speak Arabic. It also does not require written documents and notes from the nurse.

From the patient's side, I trained the nurses to learn a few used Arabic words and write them down so they could use them when dealing with Arabic patients.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

KFSH10: First and foremost, when I was in the Philippines, I did not wear an Abaya and Scarf or Niqab, you know. So, it was a big challenge for me when I came to Saudi Arabia, where I had to obey the traditions and cultures here, right?

5 'laughing'.. Second is the language barrier. When I came here to Saudi, I only knew the yes and no words in Arabic. So, there were many conflicts between the patients and family during the care. It took time to learn Arabic because we don't use Arabic in the Philippines. We do not hear it anywhere. Although we read the Holly Quran in Arabic. But we do not speak Arabic, which is not very easy.

Fatima: So, speaking Arabic with colleagues and patients was challenging for you?

10 KFSH10: Yes, my patient once told me: "Come, come, come!" Then I told her in Arabic: "TʿĀLY, TʿĀLY" I thought that this word meant 'wait', but it means come! So, the patient got angry hysterically because I told her, "Come here in Arabic instead of wait". It is always a big challenge, but I learned from that. 'laughing'.

Fatima: And now, do you speak Arabic well, or just a few words to communicate?

KFSH10: well, my Arabic proficiency is not advanced, but I could understand it after 16 years.

15 Fatima: Any other cultural challenges?

KFSH10: So far, no other cultural challenges because I am also a Muslim, so I fast during Ramadan and pray and understand the culture and religion. This is because my mother and father are Muslim, so there are no substantial cultural challenges.

Fatima: What about linguistic challenges?

20 KFSH10: Regarding language challenges, here in the hospital, they will not understand you when you speak English very well. You should use simple words like: "You come; you go".

Fatima: So, when communicating, you do not speak an advanced level of English?

KFSH10: No, I simplify my language and use basic English so the other staff can understand me.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

25 KFSH10: So, I'm working on quality, right? So, we always promote this (IPSG) the International Patient Safety Goals for effective communication. So, most of the time, we tend to forget things. For example, if I say something like there is a burn in the Othaim Mall now, it will reach other people, and they will say: "No, it's not in Othaim mall! There's a fire in Nakheel Mall" Stories will change, which is common in communication. So, because we are just human, we are like humans on earth, which is normal. That is why I prefer to have well-written nursing documentation. If I write the

30 document and pass it to you, it will not change.

Fatima: Do you write it electronically on the system or use paper documentation?

KFSH10: In the meantime, 40% of the documentation is now electronic, so I prefer good documentation to communicate well; even when communicating with doctors about their orders, we must clarify before implementing because we are dealing with lives, right?

35 Fatima: Yeah, of course, any other strategies you would like to mention?

KFSH10: No.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

KFSH10: It would be the same communication strategy I use—writing good documentation for better and more effective communication as we are now dealing with illegible handwriting and terrible grammar. At least we should promote legible

40 handwriting and good grammar. So the multidisciplinary team could better understand the treatment and care for the patient.

Fatima: Very interesting. Okay, what do you think is more important in the healthcare settings: Medical English language proficiency or General English language communication skills? Why?

KFSH10: Yes, for this question, I prefer English medical proficiency because we are working in the medical field. We

45 should have the same language. If I say hyperthermia, you should know this term. It's like the patient's family/relatives; they are listening to what we are discussing and the bedside. So, at least there is a little privacy when we speak the medical language, the layman's people will not fully understand, which helps to promote privacy.

Fatima: What about the general English communication skills? do you think it is not that important in healthcare?

KFSH10: If you have learned medical English already, it will be easier for you to learn general English skills. So, medical

50 English comes first and is more important. Because for example, how will you understand the diagnosis, and everything related to medical scenarios if you do not know medical English?

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

KFSH10: Regarding this question, as nurses in Saudi hospitals, we have to be knowledgeable about patient care because

55 this is indeed number one. And, of course, when you work, you should be confident in the skills and procedures that need to be done to our patients. What will happen if we are not confident? Maybe a patient, God forbid, will die just because you are not confident enough? So, of course, it depends on the unit. If I'm in ICU, I should learn what Ventilators are and everything related to the ICU. If I have surgery, I should learn about the operations and how to prepare my patients. If I

60   am medical, I should learn about all the sicknesses, like bronchial, asthma, etc. And, of course, attitude is important; even if someone is knowledgeable and skilful, that will bring us nowhere, right?

Fatima: What do you mean by attitude here?

KFSH10: For example, negligible; I intentionally neglect patients because I have competitors like: "oh, I will not do that. I will not do this thing because it's not my work". You are ignoring the fact that it is very important for patient care. This is selfish because we are nurses; we are bound to care for our patients. Sometimes we forget about our job description

65   just because we want a better patient outcome. Also, when you are very aggressive, with no attitude. How will you deal with your patient's care? It will promote their mental health. Saying words like: "You are a very good Baba- Mama, Salam Alaykum, how are you today etc.." but if you are just shouting with a bad communication attitude, your patient will not heal mentally and will be traumatic. You have to be polite with your patients. That's why I think knowledge, skills, and attitude should go together.

70   Otherwise, without it will not bring you anywhere, and you will not reach the stars if you have a bad attitude. Regarding awareness, although in the Philippines, we already have an orientation program regarding Saudi culture before coming, we are not surprised. When we come to our hospital, we also have our Saudi culture orientation. We even had simple English and Arabic words, like the translation of yes-no. But when it comes to deep Arabic conversation, I would say: "khalas, ma'asalama= means in Arabic, done, by bye' 'laughing', I will call social work to translate", but at least we have

75   someone to help 'laughing. , HELP!'.

Fatima: So, you have a Saudi cultural orientation in the Philippines before coming to Saudi?

KFSH10: Yes, and we also get here another orientation here, and it's needed, even if you are from India, from the Philippines etc.., because we have to prepare to know about the traditional religious clothes that we need to wear, Scarf, Abaya or niqab. But I think nobody comes to work here without knowing those things, so I believe they are already aware.

80   I also hope the Saudi staff nurses and doctors improve their English proficiency. Oh, yeah, what happens if there is an emergency case, and they order something, and they cannot understand? Especially the documentation, the grammar and the handwriting could be more legible. Sometimes they will just copy what is written from the previous shift. This is the scenario we are facing most of the time, and this absolutely will cause medical errors and miscommunication. What happens is: "Oh! did they do all the dressing in the morning?" And I will check and follow up on the documentation. It's

85   like copying and pasting from the night shift; "Well, maybe he did not do" Then I will open it again to check and see that the dressing was already done.

Fatima: Because it wasn't documented well.

KFSH10: Yes, exactly. As a quality advocate, I also want to encourage everyone to practice, promote and apply quality in all aspects of all processes in the Saudi hospital for, of course, patient safety. It makes you feel pleased that you achieved the patient safety goals. That is all I have.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

KFSH11: Yeah, I experienced it while working in the ICU before I was posted here in the nursing office. So, first is, of course, the cultural and linguistic challenges; it is not very easy to deal with them because for us, we are using the English language. And at that time, there were very, very few who were fluent in speaking in English. Fluency is one of the challenges. Another thing is the tone of voice. Another thing also is sensitivity when it comes to using words; maybe sometimes, they will say some words that are acceptable or not acceptable for certain cultures because we are working in a multicultural setting.

Fatima: Do you have any examples?

KFSH11: For example, they will say, I will kill you! That is the most common example, but I will kill you! It's an expression that I later found out is just an expression. However, when I first came and heard it, I felt like, oh my gosh, he will kill me! So, whenever I have orientations, I will do briefings with my new staff and tell them, if you hear the expression, I will kill you! Do not panic, and don't be afraid. So, I will kill you. Why just now? The tone is like they are not. Even if you are used to it, you know they are joking. Yeah, but if you are not used to it, you will panic. Especially if you are very new in the institution and you are not yet adapted to the culture. But later, we were able to adapt. So, I give it for orientation because I have experienced it before, and I do not want them to feel any panic whenever they hear those words. So that is one classic example of the cultural and linguistic challenge.

KFSH11:Another thing, emm, Are we limited in our speaking skills?

Fatima: No, we are not limited to any skill. You may express anything in mind.

KFSH11: Okay, well, another challenge is the writing, for the writing we have many difficulties. I believe up to now that is the biggest challenge because up to now, we are still in paper documentation, and even for our interns, we ask them to do dummy files, so they will get used to writing. So, when they are employed in our hospital, they will be used to it as I did. I did it when I was an intern. So, I will continue doing the same thing. Like it is a practice for them because if you do not give dummy files for them and they are hired here, they will be shocked at the bunch of papers they need to complete. So that is one challenge.

Fatima: I heard they implemented the new system, which records everything electronically.

KFSH11: We are transitioning to recording the documents electronically on the system. Currently, two units are going fully electronic, but it takes time. And I don't know when we can go for the entire electronic. So, we are in between and using both written and electronic. In the past years, it has been a challenge. So, the medical staff prefer E.R. Because of less documentation. That's one challenge because they say: "Ma'am, I can perform the procedures, I can help, I can do bedside". But the reality, the documentation is taking a lot of their time and eating their heads like they don't want to document. And regarding written documents, it is okay if it is a checklist. However, suppose it's narrative-like nurse's notes in the narrative format. In that case, we're using narrative format charting of the patient report, and you will see it copied and pasted from the previous shift without noticing that. Plus, our nursing care plans have to formulate their own, but we tend to see a duplicate of the previously written documents. And I know if you ask them about the medical case report, they have an idea of what it is, but putting their thoughts into writing that's the challenge.

Fatima: Any other linguistic challenges?

KFSH11: Actually, for spoken language and pronunciation, I encounter many fluent Saudis with good pronunciation, good diction, and promising, usually the new generations. Now then, the new female staff from Qassim university, the one we are receiving from the internship. They are excellent in lots of forms. Yes, I can see the difference. Like when I first joined in 2011, as compared to now, it's a massive gap because honestly, before, if I did orientation and my students were Saudis, I struggled like I didn't know how I would give them the information, how to communicate, how to speak with them. Because I know they are eager to learn. Some of them will even record, and some of them will even translate the PowerPoint slides. They have apps for translation just for them to understand. However, it is still different from many understandings it firsthand the first time. So now it is a vast improvement.

Fatima: Any other point you would like to add to this question?

KFSH11: No, that's all for this question.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

KFSH11: I guess rephrasing the words or the sentences and asking for clarifications because sometimes if they want to say something or request something, they just go directly to the point without the proper syntax of the sentence like they do not have the subject and the verb. For example, do it or something. It's a different word they are using. So, sometimes you feel that, oh wait! Do I understand it correctly? So, I need to verify, and I need to confirm. This is my understanding. Did I understand you correctly? I confirm, especially not only with nurses but also with doctors. If they order something that is in the medical terms and it is vague, we need to clarify with them. It is always clarification. I mean, I tend to clarify all the time whenever I feel misunderstood.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

KFSH11: I hope that they use medical terms. Plus, the correct English language matches the terms they are using. Because sometimes, for orders, for example, the doctors will still ask nurses: "how do I write the order in English, sister". So, we tend to order them to give the order, to write the order, especially recently joined doctors like the residents.

60   Fatima: So, sometimes they seek your help to write the orders in English?

KFSH11: Yes, yes, in English. So, I am not really sure and do not know the curriculum or the specific qualifying English exams they must take. However, it matters a lot with time management because, especially in the ward now, they are handling 8 to 10 patients, sometimes 12. And I still have a resident with me. I still have other work with me, or I am busy. And up to now, like for other and other disciplines like nutritionists, dieticians, the social workers, they are still writing

65   in the Arabic language, which is a challenge for us because we don't know. But thanks to Google translate that we can sometimes use it.

Fatima: And do you trust the accuracy of Google Translation?

KFSH11: No, even Google Translate causes challenges; sometimes I wonder: "what is that word?" we still need help in breaking down the words. Words are different because Google Translate is not accurate.

70   Fatima: Yeah, because it is still a machine translation. It is not a human translation.

KFSH11: Yeah, so we still seek clarification from those who can read Arabic.

Fatima: So, you seek help from the Saudi and Arabic staff to translate

KFSH11: Yeah, the Saudi doctors and nurses to help me and translate. So, I advise the medical staff should practice more and learn more English to communicate better and be on the same page.

75   Fatima: Great. Any other recommendations?

KFSH11: I think that is it.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

KFSH11: Honestly, for me, both are important because we're in healthcare settings. But I would say the general English

80   language comes first because, like, how would you go further for the medical language if you don't know the general English language? So, we noticed that they know the C.R., the Doris Hall and the English medical terms; but how to say it, and what are the words in English? That is the challenge. So, for me, general English should come first. Because if you're not fluent or don't know general English, you will have a hard time learning the medical language. Yeah, for example, for us as non-Saudi, if we do not know basic English, we will have difficulty discussing with someone not of

85   our nationality. If I only know Tagalog or Filipino, I cannot understand or talk in English. So how can I talk to other people who do not speak my language? So, I think general English should come first.

Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

KFSH11: For Saudi hospitals pertaining to language and communication, more proficiency in the English language,

90   which, honestly, more push. Mm-hmm, because now we are in the stage we are in, it is highly commendable as compared to before. But for the communication, more on the therapeutic communication skills. Um, yeah, more on the therapeutic side. How will they be dealing with and talking to their colleagues and patients? Most significantly, but I've understood since, for patients, it's Arabic to Arabic, and sometimes patients are non-Saudi. So, they have to also be more therapeutic with this type of patient.

95   For attitude, I think they must have self-awareness of their limitations and their skills in communication. Because if you're aware that you are lacking in this part, then maybe you have to improve yourself, but if you're not, how can you improve yourself?

I'll give you a classic example; I have one staff in the outpatient department. He is excellent with work, time management, and skills in the clinic, and he is reliable, responsible and everything. However, he feels he has low self-esteem because

100   of his English language. So, this affects his total work, as he will always be in the corner and just doing what he's asked to do. But when you ask him to talk or share his ideas, he will be shy because he knows he is not that fluent. But he wants to learn, you know, we are doing online webinars now. We started during the pandemic and have adapted it up to now. So, most of the courses are in the webinar for all in-service classes. I record each webinar. I'll give him a copy of it to read and listen to it again and again. Then, he starts asking questions. But if he will be attending live sessions, you cannot

105   expect interaction from him, but it will take time. So, I commend him for his interest, and he wants to excel. So, whenever there are English courses, he is the first to say, I want to attend, he's motivated because he wants to excel, but he knows this skill is pulling him down.

Fatima: So, you mean self-awareness helps to improve language, and medical language?

KFSH11:Yes exactly. For knowledge, the medical English language is also essential, like the standard terms we use in

110   medicine in the medical field. The last time I heard, the English courses they are giving start with A is for an apple, and B is for a banana. That is what I heard the last time. So, it may be because it's about according to the grade or according to their assessment of the audience. So gradually, they must be included in the curriculum, the medical terminology.

Fatima: Yeah, there are courses that they already took in the university, such as English for specific purposes and medical terminologies. Do you think they still need to improve?

115   KFSH11: Yes, in terms of application, yes. It still needs to be improved to apply these medical terminologies. For nurses, for example, they are inserting the cannula. They will say: "right hand?" as if there is no specific term for it, for example, the Metacarpal vein, the Cephalic vein etc. We are medical people; we must not just impress people but use this knowledge so it will not be stopped somewhere in our brains. So, I encourage them whenever I do my documentation courses; I always tell them to use their medical terms when documenting. It creates a good impression and insight and sounds more

120   professional, like if I say: "the cannula is inserted on the right hand". So, where exactly on the right hand?

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

KFSH12: Okay. Here in the ward, we are a multilinguistic staff. We have Indians, we have Filipino, Saudis, and Sudanese also, with many different accents. It is difficult for us if we are not familiar with it. As a Filipino, the accent of some nationalities when uttering words confuses me. So far, we have to clarify and ask them again about what they want to say. We ask them to explain: "What do you want? What do you need? What do you mean by this?".

Regarding cultural challenges, there is a minor challenge, but it is not difficult because before we came here to Saudi, we attended the cultural orientation in the Philippines. This orientation aimed at introducing Saudi Arabia's culture, i.e., what are the cultures here in Qassim, and how we will deal with our patients because here, our patients are not liberated; they are very close. Especially when you go in the patient's room, if the doctor comes, they need to cover their face and body parts. You have to prepare your patients. Religion, belief and gender, for instance, if you are a male, you cannot go immediately to the female room.

Fatima: What about when dealing with your colleagues?

KFSH12: There are no cultural challenges with my colleagues. Our colleagues are open-minded, and cultural challenges sometimes occur only with our patients.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

KFSH12: For example, if I'm talking to them and sometimes you can assess the facial expression like they are confused, they cannot understand what you are trying to say. So, I will explain further sometimes. Also, I will set an example: "do you know this one?" So, I give them examples, really they can understand. Also, the tone of our voice sometimes we have high pitch sounds. But other nationalities think that we are angry. We have to consider this point; if we are dealing with them, we use our normal tone and clarify that we are not angry, which is our normal voice.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

KFSH12: I recommend that staff master the two languages, English and Arabic. Also, regarding the tone of voice, we should lower our tone while speaking and avoid shouting. Because it is sometimes annoying when we are using our language, and we are from end-to-end shouting, patients and doctors will be affected and disturbed.

Fatima: May you elaborate more?

KFSH12: I encourage medical staff to know how to speak Arabic also because we are here for patients. Some patients do not know English; how will we understand our patients and patients' relatives if we do not know Arabic? How will we deliver our nursing care properly if we cannot understand Arabic? How will we communicate with patients and staff when we don't know their language?

Fatima: What do you think is more important in the healthcare settings: Medical English language proficiency or General English language communication skills? Why?

KFSH12: In healthcare settings, medical English is important. Because you see, when dealing with the diagnosis, we have to use medical terms because we have the standard abbreviations.

Nowadays, they are not using medical English because some medical staff have their own abbreviations. Sometimes, also you will see them on orders, especially the doctor's order. There is miscommunication because they have their own abbreviation, and we have our standard medical abbreviation.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

KFSH12: For knowledge, we should be knowledgeable, especially when dealing with our patients. In other words, they will ask you, expecting an answer, so if you do not know how you will answer your patient? And this is also like you are developing rapport; you are developing trust from the patient to the medical staff. We should be knowledgeable, for example, in dealing with our patients with their diagnosis; what are the treatments? As a "X", I must know about my patients and their problems. What is their diagnosis? And that is why we have endorsement every shift. We should know their problems because, you know, patients will ask you, what will happen to me today? What are the procedures? So you have to give them answers.

For the skills, of course, this is the patient's area, and we have many procedures. This is also important because you must be skilful and know about all procedures.

Skills related to language and communication, we have to speak and learn both languages. Because I, myself when I first came to Saudi, I didn't know Arabic at all. And based on my experience, I had difficulties dealing with my patients. I have been here for 12 years now. But before when I first came, my patient wanted to say something I couldn't understand. I used to write and ask somebody available to translate and ask them, "please tell me what she wants?" I became so interested to learn the Arabic language. Because I want to deal with my patients and their needs. What I used to do every time I had a duty, I use my notes and write each word in Arabic and translated it into English. And I encourage my colleagues to do the same; I do not ask them to become fluent in Arabic, but at least they can understand.

For language/ communication attitude, you must respect other people when speaking different languages. For example, sometimes, when staff is speaking their mother language and discussing something seriously, stop laughing at her/him!

You may think this is a joke, but for her/him, it is different. Everyone has to respect them because she may think, why is she laughing? Am I serious?

60   For good communication, I recommended that staff improve their English language and vice versa. As we are trying to learn Arabic, they should try to learn English too. Because for them, this is an advantage. Also, all our doctor's orders and documentations are in English. So for us, for non-Saudis, we use the English language, but we have to learn also Arabic for our patients and relatives so that we can deal with them appropriately. We can address their issues and their concerns. For communication between seniors and colleagues, there has to be good communication to avoid miscommunication,

65   conflict and medical errors.

Mastering medical English is also essential because if we do not use medical terms properly, we will have errors, especially in terminologies and abbreviations. As for me, what I know about specific medical terms is that they are using them differently.

Fatima: Do you have any examples of these abbreviations?

70   KFSH12: One example I faced here is that they use the abbreviation "F-U" to mean follow-up. So I had to seek clarification of any abbreviation because it is not standardised.

Medical staff should use the approved standardised abbreviations here in our hospital. Unfortunately, some staff are using and creating their medical terms. So, I keep asking: "Doctor, what do you mean by this?". If they use the correct standardised medical term, it will become easy for us to communicate. Mastering medical English is also considered to

75   be a private conversation between colleagues. For instance, if we are discussing cases and somebody, not medical staff, is listening, at least are not understanding what we are discussing.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

KFSH13: For the cultural challenges, their faith and religious belief, for example, some patients, when they are here in the hospital, believe that they will heal more using herbal plants (Alternative medicine). So, they will not believe that

5   some medication is good for them, but they will heal better with these herbal blends and the medications we are giving. And this causes a challenge for us as nurses because we cannot understand these herbs and because, for us, healing is through surgery and medicine. Plus, we are still determining how these herbs will be used, drank, cleaned, and applied. This was a challenge for us; we all had to call someone to explain to them and translate. As we cannot understand or explain in Arabic, we know little Arabic. So, we need someone to tell them in their language so that they can understand.

10   Fatima: What about the linguistic challenges?

KFSH13: One linguistic challenge is that some patients, even though we know some Arabic words, have different Arabic dialects, pronunciations and accents that we cannot understand. Even when using Arabic, we still need help understanding them. And another thing related to the cultural challenge. Some patients only want to be treated as if I am a female, they want only female doctors, and male patients want only male doctors. So we need again to explain to them that only this

15   doctor can treat you well and he is the only doctor available at this shift.

Fatima: What about when communicating with your colleagues?

KFSH13: Cultural challenges appear more when communicating with patients; we struggle. But with colleagues, we do not have any cultural challenges because we can understand each other; although we have different cultures, we fully understand each other.

20   Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

KFSH13: Sometimes, if my colleague does not understand English, I explain it in Arabic. But if I cannot explain, I will call other doctors who can understand English to translate it for me. Or I call the social worker or patient to explain to my colleague.

Fatima: Any other strategies?

25   KFSH13: Another strategy I use is speaking to them calmly with respect because even if they do not know English, they can still understand Arabic through writing. Otherwise, we will use Google Translation to translate it from English to Arabic.

Fatima: Do you trust the translation of certain applications?

KFSH13: No, but I will mostly let someone translate my message.

30   Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

KFSH13: When they come here to work, they must know how to speak English and Arabic because these are the two languages we can understand. As a means of communication, we are using here English and Arabic; they must be proficient in speaking both languages.

Fatima: So, you really feel it is important to learn Arabic to be able to communicate with your colleagues?

35   KFSH13: Yes, mostly for communication with patients. Almost 99% of our patients speak Arabic for the sake of our patients.

Fatima: What do you think is more important in the healthcare settings: Medical English language proficiency or General English language communication skills? Why?

KFSH13: In a medical setting, of course, medical English proficiency. Because without medical language, how will you

40   treat your patient? How do you take care of your patient if you don't know the medical language? For example, if there is blood in the nose, what is the medical term for this case? Or you have breathing difficulties. You must know all the terminologies related to the medical language.

Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

45   KFSH13: I don't know how you are taught in Saudi schools. If you are in the medical field, what is the language that you are using in school?

Fatima: For the medical students, it is taught in English.

KFSH13: Medical students should be taught intensively in English, specifically medical English and terminologies, because some staff cannot speak English, so we are struggling with them. So, I suggest that in schools in the medical

50   field, you must master English.

Fatima: You think it is vital to be fluent in English to be able to work in the hospital?

KFSH13: Yes, at least in the medical field, because when you are working in the hospital, English is a multinational language for all staff in the hospital; it is different from communicating in the mall or any other place. In the hospital, our national language must be English.

55   For the skills, I believe in the school. They are practising all the other skills well, but the problem is the language. As colleagues, to some point, we can understand each other and try to communicate. At least they know Arabic, but some staff need to learn Arabic first to handle the language when they are still new. From my experience when I came here, I did not know any Arabic words. All I knew was how to say "salaam Alaykum" as a greeting. So, when the patient talks

to me, I write what he/she is saying in my notebook in my Tagalog language into the Arabic language so that I can learn

60   more Arabic.

Fatima: So, you learnt by yourself?

KFSH13: But again, when the Saudi government recruit medical staff, they should require them to know at least basic Arabic; we must know before we come here so that we will not be discouraged from caring for our patients. Because at first, when we came here, we could not speak to our patients because there was no language. Even when I speak English,

65   not all of them will understand. This created problems because the patients would think that the nurses were not minding/ caring, but the reality is they did not understand. So, as medical staff, I suggest that we must learn Arabic before we come to work in Saudi Arabia.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

KFSH14: The first thing is the difficulty that they understand our language or our dialect or even the words we use even if they are in English because sometimes they speak English using their local accent. It needs to be clarified, as there will
5   be difficulty for them to understand. Also, our colleagues will struggle to understand, too; this is for non-Saudis. Sorry, I mean like Filipino-Indian, etc.

Also, for some Arab nationalities, communication is easier, but there is a difference in some vocabulary, and they do not understand what you are trying to convey. That is why I always try to use plain language/dialect when communicating with my colleagues and doctors because some of the Arabs speakers do not understand our dialect. For example, when I
10   explain the patient's condition and say: " YʿWRHĀ stands for it hurts in Saudi Arabic," he responds to me; What do you mean? However, he understands you more when you explain in a white dialect.

Fatima: Did you face any cultural challenges?

KFSH14: I do not face challenges with "X" staff for culture, but I encounter it with "Y". First, sometimes they are in a hurry and need help understanding what you mean and speak while raising their voices. So I wonder if they are angry or
15   upset, or what is the matter with them exactly. They speak English using their dialect, unlike the "X" medical staff; they communicate more with us and have good English communication skills.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

KFSH14: The first thing I do, whether in English or Arabic, is trying to use a vocabulary that has one meaning to avoid misunderstanding, especially in the question, use white/plain dialect words, and also hear them well. Then I form my
20   questions directly. And if I felt that they did not understand me, I asked them to repeat what I said precisely to make sure that they understood me, and if they did not understand me, I would go back and explain to them.

Fatima: May you elaborate more about ?

KFSH14: For example, if I talk with a nurse about the cleanliness of the patient, I do not speak in general and say: "You did not take care of the patient!" I specify exactly what I mean for her and say: "the patient needs to be cleaned". This
25   point is necessary because if I told her that you did not care about the patient or the patient had not been taken care of, and she would understand other things related to the patient; I prefer to be direct.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

KFSH14: First, they need to hear well, be good listeners, understand the question, and come back to check it, and they speak a dialect different from the colloquial dialect they are used to. They must try to be formal and polite to everyone,
30   speak the formal language and avoid speaking their mother language. Always speak the English language using clear words.

Fatima: What do you think is more important in the healthcare settings: Medical English language proficiency or General English language communication skills? Why?

KFSH14: I think general communication skills in English because they will be able to communicate well and convey
35   information accurately when they have general English skills.

Fatima: So, you mean if I only knew Medical English, I would struggle to communicate?

KFSH14: Yes, you will struggle, and the interlocuters will suffer too. Because they will struggle to explain, even you will not know how to communicate and convey the information correctly. Even if there is a misunderstanding, you cannot solve it correctly. Therefore, communication skills in English are important and reduce the severity of the situation. From
40   my point of view, it is the basis for structuring healthcare.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

KFSH14: The first point is that they need to communicate using plain language. Second, they need to be careful when speaking because their body language and tone of voice may give a different impression from the way they ask. Thirdly,
45   they try to develop their English language. If there is a misunderstanding, they do not rush and try to clarify what they can, whether in writing or body language, for example: "Using their hands to point out; Yes, this is the point I was referring to." Also, it must be ensured that the other party is adequately understood. On the other hand, if the other party is a non-Saudi, for example, from another nationality, they should avoid using their accents when they speak because most of the problems are when they use their accents/pronunciation when speaking in English. They should avoid using your language
50   style when communicating because everyone is involved in the conversation.

I recommend developing English because it is more critical in hospitals than in Arabic. The difficulties are in the English language because even if between our Arabic dialects we differ in words, for example, the Saudi and Egyptian dialects, communication is easier. Unlike the communication between people of non-Arab nationalities, it is difficult to explain in Arabic, and when you explain to them in English. At the same time, they hold on to their accent and pronunciation; even
55   if they explain, you will need help understanding the words and messages they are conveying correctly.

Fatima: And do you advise the non-Arabic speakers to learn our language, Arabic?

KFSH14: Yes, of course. I advise the non-Arab staff to learn Arabic basics, and the ministry of health should implement similar tests like we take the English assessments such as, (IELTS-STEP). There should be similar assessments but for the Arabic language so they can communicate well and clearly.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

KFSH15: There are no cultural or linguistic challenges because we are from the same region; even with medical staff who are not from our region, we have not encountered significant challenges because we communicate in English, which is

5 the language used after Arabic.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

KFSH15: There will be a misunderstanding if there is no English language proficiency, so there must be another party to explain your position through discussions, whether there are meetings or meetings to discuss confusion. Therefore, if I have difficulty communicating in English, I have to seek help from someone better than me to help me solve the

10 misunderstanding.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

KFSH15: I advise them to have discussions, in which there will be a session after work or a meeting, to solve confusion if you have a misunderstanding, which means that they will be resolved when discussing them.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General

15 English language communication skills? Why?

KFSH15: Proficiency and acquisition of general communication skills in the English language. In healthcare, you do not require proficiency in medical English because, in medical work, you need proficiency in general English skills, which is sufficient.

Fatima: If I do not master Medical English, do you think I can communicate well?

20 KFSH15: Yes, you will manage. You do not need medical English.

Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

KFSH15: Being sociable and having communication and social intelligence, they will not suffer in communicating with the medical staff and being proficient in English. I believe these skills are sufficient.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH1: We suffer from the accents of some medical staff. You speak to them with a specific nationality with different accents. It is possible that the accent originally is clear, but there are nationalities whose language is fast or, for example,

5   their letter is pronounced differently. When they pronounce the words, they say them in English, but they pronounce them in their language, so the words are not clear to you at first, but then your ears get used to them.

Fatima: Is there anything else besides the accent?

MCH1: The accent is the main challenge because the nature of their culture and environment makes them speak this way and so fast.

10   Fatima: so, you have challenges with the spoken language, precisely 'accent'? What about other linguistic challenges, for instance, written issues? Or are there any culture matters due to the nature of the work environment, you communicate and interact with multilingual colleagues.

MCH1: Well, there are some matters that my colleagues need help understanding in terms of culture, especially religious matters. For example, when you ask permission from your director/supervisor etc. to break for prayer, she thinks it is very

15   simple for us and could be postponed, but we must perform our prayers on time. We have to pray, and she needs to understand the importance of not being late for prayers. For example, the hour has become 2 pm, so I cannot postpone the Duhur prayer more than that. Because they do not understand the culture and our religion and that we have to pray at the exact time.

Fatima: interesting point; anything else you would like to add?

20   MCH1: No, that's all.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH1: Mostly, one must be patient because sometimes a new employee is hired and has difficulty integrating into the work, such as my situation. I have been in this hospital for almost five months, but I have been in the intensive care department for almost one month and a half. I find it challenging to integrate with work. It requires speed, it needs focus,

25   and it needs many things from you. You will not get used to it, whether you were on vacation before taking the job. Or, for example, you just finished your internship and came here. The work procedures differ here in intensive care, which has more responsibilities. Being a student or trainee is different from being a medical staff. In most cases, a shortcoming or a simple mistake from you may lead to misunderstandings. For example, you are not getting the tasks because you made a simple mistake and sometimes, with excessive focus on people, the simple things are overlooked, but the big

30   things will be controlled, God willing.

Fatima: so you train yourself to be patient enough to prevent misunderstandings with your colleagues?

MCH1: Of course, we all have to be patient. If your colleague misunderstands you, shall I misunderstand them more? Of course not. I have to be patient and tolerate the reaction.

Fatima: Do you explain or clarify?

35   MCH1: Depending on the situation, sometimes, things need to be explained and clarified by me because sometimes it is my fault, and sometimes things need to be clarified.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

MCH1: I feel that if any staff had to do a critical procedure, or for example, you have a new procedure to perform, and you found an available new staff, I mean, you can take advantage and train or show them the new technique of the

40   procedure. Participation and group work are significant in the healthcare field. Once we, as new staff, observe this technique, it will become easier for us to obtain the knowledge.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

MCH1: They are all related, but general English communication skills is essential than Medical English. Because

45   sometimes you do not need things in the department, you need things from outside the department, so you have to use your general English skills. For instance, you will definitely use your general English skills when communicating with the lab or X-ray department.

Fatima: You mean, general English communication skills come first?

MCH1: Of course, it comes before the Medical English proficiency because let us say, I now have a problem with the

50   English language, but in work and the required documents, I usually sit and do the required job. I don't have the basic skills. If I need to communicate with my colleague and ask about related work, I try to use my English, but I need to improve since universities do not teach us English intensively. Sometimes, I have many questions, but I do not ask them because my English is weak. Especially when it comes to explaining and clarifying my points, I suffer a lot. So, we need to master general English skills, which our universities do not teach us well; I mean, we acquire different medical

55   terminologies and diseases, but speaking of general English skills, unfortunately, we do not have them.

Fatima: Okey, the last question, what knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

MCH1: All the medical staff must be aware of the fact that we can communicate. You ask me, and you need me for something. If, for example, I am busy, I'll say, "I am busy". If I am free, you are most than welcome. We miss interacting

60   with each other, and Not everyone is willing to communicate and request; everyone does the work without any means of communication. Because of our department, there may be a shortage in the ICU, and the work is overloaded. So, it is nice that we have excellent communication. We should be considered as one hand and one team. With communication, the work is flexible and easy, and you help me, and I help you. This is a crucial point; even the whole department and your duties will become more flexible with cooperation. Communication is the most important thing. The basis of

65   communication is cooperation; we need proper communication to help each other and deliver patient care.

Fatima: I agree with you, and maybe due to the intensive care department's nature, work must be done effectively and quickly.

MCH1: Yes, exactly.

Fatima: Anything else you would like to add?

70   MCH1: No, thank you very much.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH2: For linguistics, we have an English policy only in our intensive care unit, But sometimes it's being violated. They are unaware that they have to use English, especially during rounds. Physicians tend to discuss the case in the Arabic language. So for us nurses, we understood 80% or 70% plans. However, after that, they will write the order in English, which is very understandable for us.

So another thing is that we are interracial in our department. So we have Indians, Egyptians, Saudis, and Filipinos. So I think that I will tell you that 36% of the nurses and patients in the ICU are Saudi, 80% are Indians, and Filipinos are around 4% and 3% only. So the Indian nurses tend to speak in their language because they are the majority. Usually, if they are endorsing, the endorsement is good because they use English. But sometimes, if they are discussing things like the Indian to India and where we are also included in the discussion, so they will speak in Hindi or their mother language. Also, for Filipinos, when we are together, we will say excuse me: "excuse me, can you speak Filipino please ! because it expresses more". The main issue is understanding; the understanding in the unit is somehow affected, especially since part of Vision International's safety goal is good communication. You improve the safety of communication not only for the labelling but also for the discussions, especially during rounds.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH2: Yeah, we tend to remind ourselves if they speak in their language, we say: "sister, we cannot understand. Can you talk in English?". There was one memorandum from the nursing director that we have to speak English only in the department; regardless if we are talking about personal things, we speak in English. We will remind ourselves to speak in English because this is like a formal discussion between nurses and nurses.

Fatima: Any other strategies you use?

I also validate what is being said: "ah, is it this? For example, when sending the patient to the diagnostic exam, I say: "Do you mean we have to do CT brain without the contrast? If he says yes, then I proceed".

Fatima: so, you validate and ask questions to confirm?

MCH2: Yes, I ask to clarify the task to prevent misunderstanding.

Fatima: interesting; okay second question, what kinds of communication strategies would you advise medical staff to use in a work setting?

MCH2: I advise them to use strategies like validation and confirmation. We have to repeat back the order, and most importantly, from the medical side, we have to read back. For example, there are verbal orders, like telephone orders; whenever the physicians are away from the unit, we will call them to discuss the patient's case, and then they will give their orders; we have to write them down after writing the orders, we have to read it back to them to confirm if that is the case or the order. Yes. Also, for receiving panic values from the lab, we will say: "I inform you that this patient file number and the complete name of the patient, and say this patient is having, for example, vancomycin level 30, which is toxic and high. So as a nurse receiving verbal telephone information, we have to write and read it back because we cannot trust our memory; the information will expire in a few seconds and immediately, we will forget.

Fatima: So, you advise your colleagues always to read back the order to confirm?

MCH2: Yeah. To make it safe, we should write down the instructions and read them back to the sender. We have a policy for that to prevent communication errors.

Fatima: What do you think is more critical in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

MCH2: For me, general English language communication is the easiest way because I will tell you, we have a lot of new staff, especially nurses. So medical English still is challenging for them. So for them to understand, we have to give it in simple language. However, of course, we also have medical terms that cannot be replaced with general English terms.

Fatima: So, which language proficiency do you think is significant in shaping the healthcare sector?

MCH2: Both of them are important and need to be mastered.

Fatima: Great, okay what knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

MCH2: Um, actually, the good thing about these new batches of nurses, especially nurses from Qassim University, have good English skills; I wonder if one of the requirements to attend college is to have a good score IELTS!

Fatima: Oh, no; until now, IELTS is not a requirement to enrol at Qassim university.

MCH2: Aha, well again, let us go back to medical English and knowledge; what I observed is that some nurses, while giving the instruction, they tend to agree that they understand and leave the room immediately to do the task, whereas I'm not done yet giving the instructions. I keep asking them: "Are you sure? Did you understand? Are you sure you understood me?" they say: "Yes. Yes". However, after that, I found out that they did something different than what was given in the instruction.

Fatima: So, you mean that your colleagues must confirm and wait until you have finished giving the orders?

MCH2: Yes, exactly, or maybe they have other factors that affected our communication because I'm their mentor; if I give instructions, they are scared.

Fatima: Any other point you may want to add and share with me?

60   It is always a matter of knowing each other because each person has a different tone of voice, but it does not mean they are angry. For example, our head has a higher tone of voice, but she is not angry. So we have to know each other, so knowing each other means you will understand him or her more. But then again, it's subjective and it depends.
Regarding the language, I have difficulty during the rounds. That is my struggle because sometimes physicians discuss things in Arabic, and like before, they used to speak in English, but since they are all Arabs, they switched to Arabic. One
65   time I told my colleagues I would make a signage image, and I would raise it "English please!" to make staff here keep speaking English "laughing..." I mean, this can be a strategy too, "laughing... ".

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH3: At the beginning of my work, I needed help understanding the accents in English and dealing with medical staff in English. There was a problem in understanding some of the different dialects, especially the Indian and Pakistani

5   dialects, but communication in English became easier when interacting more. With the Saudi and Arab staff, we communicate in Arabic, and I am an Egyptian doctor, so we don't have any communication challenges. For the cultural aspects, there are no challenges at all.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH3: Is this question for non-Arabic staff?

10   Fatima: actually, for both Arabic and non-Arabic staff.

MCH3: It is possible if there is an unclear pronunciation, I try to bring it closer; sometimes, I seek the help of one of my colleagues who will help me in getting a close meaning. Often this rarely happens to me, and there is almost no obstacle. Things are under control, and there are no problems. I also repeat; for example, if there is a problem with my accent, I repeat the sentence more clearly or simplify the meaning in another sentence, but things are going well.

15   Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

MCH3: The medical requests or orders shall be in a written format, a strategy we follow in the hospital. Except in emergency cases, it shall be verbal. We have to repeat it once or twice at least, and they must ask the listener to repeat the order to ensure it is correct. Other than that, we communicate in the ICU through written documentation reviewed by more than one party, for example, dispensing medicine that the doctor prescribed, the nurse receiving it and reviewing it,

20   the pharmacy also reviewing it and so on. This process reduces the presence of errors, secondly, sometimes, the communication between the patient or the patient's family and the medical staff is an obstacle if the doctor or the medical staff needs to speak Arabic and the patient speaks Arabic. This situation here is an obstacle and sometimes needs the presence of an interpreter in the middle. If there is no one to translate, miscommunication occurs. Therefore, the advice is that as much as possible, all the staff should speak Arabic, or at least like what European countries do, there is a

25   language assessment, and this is the patient's right. As far as I know, there is no Arabic language assessment for non-Arabic speakers. Some medical staff of Nigerian nationality need to learn about the Arabic language. Pakistani and Indian nationalities may understand to some extent. However, Nigerians, for example, have a language barrier that requires a translator. They cannot communicate with the patient, which I expect is a problem.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General

30   English language communication skills? Why?

MCH3: In Saudi Arabia, I think Medical English proficiency is essential because this is what we need for communication in the hospital. We communicate with the patient in Arabic. If I am in a European country where they speak English, I must understand the patient and the language of communication. But here, it is purely medical English. There is no communication in general English, whether with nurses or doctors. Of course, we sometimes need English communication

35   skills to formulate sentences. From my point of view, in Saudi hospitals, it is necessary to have a good command of medical English.

Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

The speaker preferred not to answer this question.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH4: Relationships at work are superficial and not deep, so a working relationship is more than a friendship one. Therefore there are no challenges in terms of culture from my point of view. For linguistics in terms of speech, sometimes some of the nursing staff can pronounce words in the language that is not clear, but we understand it from our coexistence with them, and we rephrase and repeat the words if we do not understand. At work, we have a target, and our goal is to deliver healthcare. So, there are specific medical needs that we understand, and there is nothing personal. We do not exchange conversations or exchange distinct linguistic words. We regularly have a target of repeated words for giving orders that we usually implement, and there are no issues with that. There are no personal relationships, but we consider them as colleagues. There is no side conversation; we only discuss work and different medical scenarios.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH4: I use the repetition strategy to prevent misunderstanding. I repeat the request in a way, but it is not a lot. From my side, I almost ninety-nine point nine do not see a misunderstanding with orders. However, it does happen if we engage with non-medical topics. It can happen with daily conversations about different topics, and we must be polite when communicating with our colleagues. But for medical scenarios, if I feel a misunderstanding is about to occur, I ask for a repetition. Sometimes the tone of voice is unclear, so I ask them to raise their tone to be more explicit. I also ask them to speak slowly, especially if the topic is essential.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

MCH4: I advise them to speak more clearly. A little slowly, slow at times, especially when talking about a topic in terms of work. I mean a topic that concerns the patient and such needs. It is necessary to speak; clearly. These are international recommendations, and we speak clearly and slowly so that anyone can understand them.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

MCH4: Medical English is more important because most people master English, but when they are in the medical field, they do not understand many things medically. The medical field requires many skills, including knowing all the medical terminologies. Fluency in the English language is needed when people talk about different topics. I know a person who studied abroad and whose English language is good, but when engaging in the medical field, he suffers, especially in some terminologies. We, as doctors, are primarily interested in medical terminology and medical English. As for the slang English and general English communication skills, this concerns us in two things if there is a personal relationship or questions and problems that require a deep discussion, because sometimes it requires fluency in English communication skills, especially when you sit with medical staff and discuss non-medical topics, explaining will be complicated.

However, as an Arabic society, most of our patients are Arabs. For us, there is no problem in communication because they are Arabs who speak Arabic, but the problem is if the patients are Arabs and the medical staff speaks a foreign language other than Arabic, meaning they are in contact with the patient in the first place. The patient needs more explicit information because here lies the miscommunication.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

MCH4: In Saudi Arabia, there is currently nothing compulsory in employment like in some other Arab countries. I mean, for example, in other Arab countries, they are required to have TOEFL and IELTS. Therefore the requirements of these assessments mean that medical staff language improves significantly regarding speech and how to use different English rules. Sometimes, we misuse the verb in the past, present and progressive, continuous forms, and knowing these rules is essential to master the language. These assessments enhance our skills, especially in a work setting. In Saudi Arabia, of course, there is nothing mandatory, that is, even in terms of work or even in taking some exams, such as the Saudi Board. Some countries require such assessments as IELTS or (OTA) tests to improve the English language. And it does help in communication between staff, but the communication between us here in the healthcare setting is a brief business-to-business communication. We give medical orders or discuss orders while communicating with others. I understand her/him, and she/he understands me, and we are forced to discuss medical topics related to the patients only. If we talk about non-medical matters and form relationships at work, people can improve their language by taking internationally recognized courses Such as TOEFL and IELTS.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH5: To be honest, until now, with different nationalities, languages and dialects, the problem I faced is that some vocabulary they use among themselves, it has another meaning, for example (easy-going) I assume it should not be used

5 as a medical term instead it appears in a general slang English conversation, and here I struggle understanding what my colleague means when using (easy-going) as a medical term. Also, how some of my colleagues use verbs and tenses, for example: "sample sent!" - "is it sent already? or sent to be sent?". These are the most problems I face.

Fatima: Do you face any cultural challenges?

MCH5: From my side, until now, there have been no cultural challenges.

10 Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH5: I repeat the question. I keep asking questions for clarification; I repeat to them and make sure whether this is their intention or not. In this way, communication is more straightforward.

Fatima: What about when you feel your colleagues misunderstood you? What would you do in this case?

MCH5: I keep asking them: "Did you understand me?" I always use repetition to clarify things more.

15 Fatima: Any other strategies you use?

MCH5: Not really. Most of the time, I ask questions and repeat.

Fatima: Interesting, okay; what kinds of communication strategies would you advise medical staff to use in a work setting?

MCH5: Clarity of their tone and repetition.

Fatima: May you elaborate more?

20 MCH5: I advise them to watch their tone; their tone should be clear so everyone can hear and understand what they are trying to say. Also, when we communicate, it is crucial to repeat. Here in our department, everything is in a written format on the system, but when receiving an oral request, their voice must be clear, and they must repeat the request to ensure that all parties understand it.

Fatima: Anything else you wish to add?

25 MCH5: No, may Allah bless you.

Fatima: Okay, question four, what do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

MCH5: I feel that when you master General English skills, you will be able to understand and master Medical English, so it is imperative to start with the proficiency of general English skills. Because it is like the example I mentioned earlier:

30 (easy-going), I can ask and discuss what she means, and she can explain it to me clearly. But when she speaks only medical English, I will struggle to understand because it is only a medical language. Thus, I believe that mastering English communication skills is a path to learning Medical English.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

35 MCH5: Language standardisation, the language must be English for communication in the Saudi hospital. I think it depends on the person to improve skills and awareness in terms of communication and language. But the medical community should unify the language because you can notice that we are now used to giving requests/ orders in both English and Arabic, and I believe this is not acceptable in a healthcare environment.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH6: No cultural challenges, all religions are here, Muslims, Hindu, Christian etc. So, we are here like colleagues who deliver care to patients we do not discuss cultural and religious matters.

5 Regarding linguistics, we commonly speak English, and other languages are spoken between the same nationalities; we use our mother language.

We do not have any challenges regarding language our culture between colleagues. But sometimes, with (Murafeq) the patient's relative and the person who accompanies the patient, we have issues because most of them don't know English, so we call the Saudi staff to translate.

10 Fatima: what about if there is no Saudi staff available during your duty?

MCH6: Arabic doctors will be here; we will call them.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH6: There is no misunderstanding between colleagues. Actually, we do not have that much time to speak, and we are mostly busy in the ICU.

15 Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

MCH6: I advise them to use English all the time.

Fatima: you mentioned in question no 1, that you speak your mother tongue with your colleague who shares your nationality. May you elaborate more?

MCH6: yeah, if any Saudi staff is with us, we will explain to her in English.

20 Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

MCH6: We commonly use the general English language in the hospital; if the recently joined staff need to learn the English medical terminologies, we use simple English to explain.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more

25 important for staff in Saudi Hospitals?

MCH6: Here in the ICU, sometimes we have patients without (Murafeq), i.e. a relative accompanying the patient; we do not have issues with that. But in some wards speaking Arabic is compulsory to deal with patients and their parents/relatives. So, all medical staff should know Arabic. I can understand Arabic but cannot speak the language.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH7: With my colleagues, the cultural belief is different between India and Saudi Arabia, so we are just adjusting to these cultural and beliefs differences, and because we work in the ICU, we do not have that miscommunication with

5 colleagues. So, we are not bothering about culture.

Fatima: You mean in the ICU, you do not communicate much?

MCH7: Yes, the challenges are with the patient's relatives and (Murafeq), i.e. patient's relatives and parents. Some know English, and others do not, so Arabic staff will help us communicate with them.

Fatima: Do you have any other challenges regarding language?

10 MCH7: No, nothing from that side. Everything is okay.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH7: I do not use any strategies because we are doing fine. We do not have misunderstandings.

Fatima: So, you do not use any strategies such as repetition, clarification, explaining and so on?

MCH7: No, no, we do not have to repeat, confirm or write. Everything is clear.

15 Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

MCH7: Sometimes the language is okay, but the pronunciation is the problem. So, I keep asking my colleague to repeat and clear the problems.

Fatima: So this is a strategy you use to prevent misunderstanding!

MCH7: 'laughing', yah, yah.

20 Fatima: Any other strategies besides repetition?

MCH7: Yeah, my colleagues would repeat, and things are cleared.

Fatima: So, you ask questions and ask for repetition?

MCH7: Yes, but this only happens sometimes.

Fatima: Great, what do you think is more important in the healthcare setting: Medical English language proficiency or

25 General English language communication skills? Why?

MCH7: Both of them, because sometimes we speak general English, and when speaking with doctors, we use medical English, but with other staff, we use general English, so we need both for good communication.

Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

30 MCH7: Outside the hospital, there is no need to speak English because everybody speaks Arabic. Yeah, but inside the hospital, we are educated. So, we speak English, and there are Indians and Filipinos. However, most of them are Indians, so we speak our mother language, but sometimes we want to communicate with others, and then we use English with them. We came here with an aim; we want to improve the English language. All staff should improve their English skills.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH8: Here, at Prince Sultan Centre, we have different nationalities from Pakistan, India, Sudan, and Egypt. However, we all speak one language, English, but for the linguistic challenges, there is nothing. If we reach a point where we need
5   help understanding, some medical staff try to explain and speak Arabic, especially if they have been in Saudi Arabia for a while, then they have few words. For example, we have a Pakistani consultant named Dr 'x' who asks me to explain to the patient's family in perfect Arabic. During my first year in the cardiology department, when I was a trained doctor was my first year in; I did not know how to explain to the family in Arabic. I was surprised that he used to explain to the patient's family in Arabic; with broken Arabic, I mean not fluent, but the family understands it. Therefore, as challenges
10   in the Prince Sultan Centre, there are no challenges. Hence some of the doctors and nurses know little Arabic.

For the cultural aspect, we never had any challenges; even once, we went out for a break. We asked everyone to wear their traditional clothes and bring us food from their country, and we enjoyed it a lot as every member showed us their traditional dance. There are no cultural challenges. We are here as a family and have known each other for a long time. Every staff knows the situation of the other colleague at work; for example, this Muslim colleague takes a prayer break,
15   the other does not take a break during this time, and so on.

Fatima: That is amazing. Let us now move to the second question, what kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH8: We use repetition and translation and follow a communication strategy. For example, each of us has a (senior); I mean, now I have a Cath List of patients every Tuesday; I do not discuss it with the consultant before discussing it with
20   the specialist, so we repeat the topic several times. Cath patients list means patients who enter on Tuesday for catheterization; we review it with the specialist, and then we return to the consultant, like a scale. This is also the scenario if we visit a group of patients during shifts in the clinic. If a patient comes to us in with a severe condition, the first thing I call the specialist, and the specialist discusses with the consultant. Then, the consultant comes to the clinic and discusses the case with the family. In this process, we upgrade step by step, starting with the junior doctor, the specialist, and then
25   the consultant. Even when discussing other matters, For example, in the morning shift, we do not discuss issues and medical misunderstandings in front of everyone. If, for instance, the surgeon is present, we do not discuss such matters in front of the surgeon; we wait for the surgeon to come out or arrange a private meeting to solve the problems. This is because they are not from our Department of Internal Medicine and the Prince Sultan Centre. The second reason is that consultants prefer to discuss these matters without the presence of any other parties to avoid conflicts and embarrassment.
30   We would not discuss issues in front of other colleagues, which is perfect. As for the errors, we have to repeat our discussion/orders many times, meaning we review the case and papers more than once with the specialist and then discuss them with the consultant.

Fatima: Very interesting; okay what kinds of communication strategies would you advise medical staff to use in a work setting?
35   MCH8: I advise them that communication is the most important thing. For example, today, I am asked to cover clinic number one. I am surprised my colleague at clinic number two is away on vacation. This ruins the schedule. Anyone who takes leave needs permission, and the whole team must be informed because we are all one team. For example, my colleague today has an absent envelope that she cannot cover inpatients. I am already being told, so I know I can cover her shift in advance because everyone has their circumstances. This is the first thing in communication. Anyone who gets
40   a permit or something shall give us a notice.

The second thing is regarding the non-Arab nurses. They are part of the work and help us as a colleague. I imagine, for example, that I have a family, and then I discuss with them the treatment plan in Arabic. Okay, the nurse has a note; she has to record the discussion! How will she write while I am speaking Arabic? So I must explain the treatment plan to the nurse in English and then explain it to the family in Arabic. We always need to remember the nurses who record everything
45   per minute. We shall not ignore our colleagues who do not speak Arabic. It is necessary to speak with them in English.

Fatima: I agree, okay, what do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

MCH8: General English communication skills are fundamental. The medical language and terminology are between the doctor and us, and even nurses sometimes do not have advanced proficiency in Medical English. Medical English is
50   typically discussed within five minutes, but general English skills are what we encounter continuously. Many families come from outside Saudi Arabia and do not speak Arabic and English, so if I know Medical English and I am not fluent in English, how will I communicate with them? Even when writing medical reports, for example, patients from Hail city come from the north, He wants the medical report in English. Sometimes the father asks to explain certain situations in the report. For example, He says," may Allah bless us, our financial condition is below the average, and I have a child
55   with special needs; his mother cannot leave him" This is not (Medical English); he needs it written in English to take it to the medical coordination; the medical coordination requires it to be written in English. Do you imagine we have advised the family to go to any translation centre to translate the report and pay the translation fees? Another issue is that even here in the hospital, there are no interpreters, and some patients want it translated into Arabic and others into English.

60 Sometimes we know the disease in English, but we do not know it in Arabic, so we keep asking them to translate it to a translation centre and translate it from English to Arabic and vice versa.
I suffer greatly from converting diseases and other medical terms into Arabic. Sometimes I cannot discuss the patient's medical condition with their families.
Fatima: Do you think this is from the college foundation?
MCH8: Yes, I think so. For example, we learn all the medical terms in English, but we should know them in Arabic too.

65 Maybe it comes with experience and practice. But it is challenging, and sometimes I go through embarrassing situations; I used Google to translate the term "pneumoperitoneum', and in most cases, Google is inaccurate. In the medical work environment, we need proficiency in Medical English and Medical Arabic for reports and communication, as well as English language skills for communication and writing reports. This is a critical point. In many cases, I need to describe the patient's condition, and my writing needs to be in clear English, especially if the report is sent to a formal party. We,

70 as medical staff, must have all communication skills in English and Arabic.
Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?
MCH8: Some colleagues have this misassumption that it is inappropriate to communicate through WhatsApp in Saudi Arabia, especially between males and females. But this is not true. For example, I took a fellowship and have been here

75 for six years. We communicate freely at any time with no limitations. The situation is changing significantly, and I think the new generation is open to these matters. Previously, I was suffering from this issue of the lack of contact and communication, it is forbidden to communicate through a mobile number, and there is a strict rejection of this matter. Many urgent situations cannot wait for a response via email. Earlier, to meet the consultant, I must meet the secretary to refer me to him, and the process needed to be shorter. They think this communication method is professional, but the fact

80 is that you are delaying critical matters related to your patients. It is essential to have flexibility and easy access to the consultants. We are here for the patients and must improve our communication skills to deliver healthcare.
Fatima: Yes, I agree with you. Any other point you wish to add?
MCH8: No, many thanks, Fatima. Interesting topic.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH9: Well, linguistically, there are a few challenges. However, we recently encountered problems with the new staff, particularly the Nigerian staff, in communication in terms of language. Some staff's language is not clearly understood,

5 even their reaction and facial expression. Sometimes their tone of voice is loud, and you also cannot understand their facial expressions and body gestures. As you experience when speaking to someone, facial reaction shows a hint if the listener is getting what you are trying to say, but with them, I do not see it happening. I keep wondering: "Did they understand me?" When they respond to me loudly, I question if I said something wrong that upset them. Also, the pronunciation and accent are unclear, so we always need to ask about the exact message they received.

10 Fatima: What about accent and pronunciation, may you elaborate more?

MCH9: Yeah, some staff, their accent is unclear, so I have to go back and confirm what they understood to make sure we are on the same page.

Fatima: Did you face any situation you would like to share with me today?

MCH9: Yes, I encountered a misunderstanding with the African nationality. We discussed medical orders, and they

15 responded with something unclear; from the pressure of work, I let the matter pass, and then, by following up with the medical case, I realized that they did not understand the point I was making.

Communication between Saudi and Arab nationalities is manageable because sometimes we speak Arabic. The nationalities we have in the department: are Saudis, Arabs, Indians, and Filipinos. Communication with Filipinos and Indians is easier because they have been in the hospital for years and understand our culture and language. Nigerians,

20 because they are new, we face problems with them. This is what I am facing personally.

Fatima: Would you like to add anything else?

MCH9: Yes, a recent situation happened with my Nigerian colleague when there was a severe medical condition, and I needed help with the patient's case. I explained to him that the case was critical. His reactions and body language always made it clear to me that he did not understand, and his loud voice worsened the issue.

25 Fatima: yeah, and they do not mean to raise their voice; it is part of their culture.

MCH9: Yeah, because when we discuss such matters, they respond that they are not upset, and it is the way they speak. Also, when we have a shortage of medical staff and receive a sensitive case when making orders, we realize that the orders and requests take time to reach my colleague, and then we wait for them to finish the request. Later, we discovered they did not understand us in the first place, which is why the order took so long, so we had to ask the nurse in charge to

30 explain again.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH9: We ask, what is the problem? For example, with some of the Nigerian staff, whenever I hear them speak loudly, I ask: "what is the problem? What did you understand from my words?". I discussed the situation and why did they react like this. We must try to solve the issue.

35 Fatima: Interesting. Do you use any other strategies to prevent such misunderstandings?

MCH9: To be honest with you, we rarely encounter a misunderstanding with the expert staff in the hospital for a long time. Such as the Filipinos and Indians have been working here for years, so we do not need to go back and confirm the matter with them. If the order is given, we trust that it will be completed.

But the re-confirmation strategy we always use with the new staff, whether Saudis or Nigerians. We need to understand

40 precisely the message that was delivered. We ask them to repeat and confirm to avoid misunderstandings, problems and errors. I do not oppress our Saudi staff; they are very hardworking but fresh graduates who need guidance, time and experience to understand the medical work environment.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

MCH9: First, we need to communicate in clear English, I do not care if they have a common language, but when

45 communicating with me as a doctor, I need the language to be clear, direct English. The second point is that we face extensive pressure in our medical settings, but medical staff need patience and understanding. Capacity in our hospital is very loaded, and the turnover and patients are overloaded. We, as medical staff, must learn patience to communicate well, whether between us or with the patient's family. We need to understand and appreciate the situation, give excuses for miscommunicating with the patient's family, and consider that they have a sick child. We must understand even if the

50 situation does not make sense, and we must understand the circumstances.

Also, we must ensure that our language is clear, meet regularly and discuss things that are not clear instead of blaming ourselves. Especially when taking an order, we must keep asking, understand the entire request, and deal with the misunderstanding on time. Being patient, we need to be patient.

Fatima: What do you think is more important in the healthcare settings: Medical English language proficiency or General

55 English language communication skills? Why?

MCH9: Both are important, but good English communication skills are critical. Especially writing skills because all medical cases and documents are written in English, so if the staff cannot read or write, there will be defects and

weaknesses in the medical facility. We must be fluent in the language to avoid errors in writing or reading the report because it is our responsibility as medical practitioners to deliver healthcare to patients. We do not neglect the importance of the medical English language; I mean, it is also imperative. We must be familiar with medical terminology because our medical field is full of medical terms and concepts we need to know. One medical terminology shortens much time and diagnosis. Also, we must master them to read a full report; sometimes, the report contains one terminology that shortens an entire case or symptoms for us. But general language proficiency comes first, but both are important.

Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

MCH9: Since we work in Saudi hospitals, we must be aware of the Saudi culture, not just our culture as an individual, but the culture in general of the city and surroundings around us, because I have a particular culture in medicine that is different from that of another doctor. Especially in terms of (Alternative medicine and traditional medicine), every person, region in Saudi Arabia, and family has a different culture and awareness of alternative medicine. If we go to other cities, we will find that they have a different awareness of alternative medicine.

Regardless of the alternative medicine they practice, is it right or wrong, this is another issue, but we must be aware of this matter. Sometimes, as doctors, we face patients who deal with alternative medicine but are unaware of what alternative medicine they used or the medical intervention or advice.

Alternatively, sometimes medical concepts, for example, this disease is caused by this matter or this herb, so we find it difficult to discuss it with patients to convince them of something they are accustomed to and resort to more than resorting to us as doctors. What is required of us as doctors is that we have an awareness of our culture and the terminologies of alternative medicine and that we understand these terms. As an example I encountered recently, the term "fatigue-FASDقسط" is prevalent in alternative medicine. Recently, I learned the meaning of this term (they shed blood on specific areas and make it bleed to extract the rotten blood). Also, the term 'SʿWṬ - سعوط', is well-known to them so far, but I do not know its meaning.

Another recent example I encountered yesterday was because the Maternity and Children's Hospital is large and equipped to receive all cases. An uneducated mother came in with her first child from a remote area far away from Al Qassim. I discussed her child's case to take the medical history, and I asked: "What did you do to your sick child?" She said: "I gave him SAAOT," I asked her: "what do you mean by SAAOT?", she did not answer me. I told her to explain its ingredients and how she used them. She told me that she did not know. Until now, the meaning of these herbs has not been clear to me, even though we are both Saudis. The idea of mentioning this example is that until now, I do not know what "Saaot" is, not just this term. Other terms and procedures we need to learn in alternative medicine we find difficult to understand; sometimes, we know some of them, and I always refer to my aunt and ask her to clarify if she has a background and is sometimes ignorant of these things. Therefore, as doctors, we must gain awareness and knowledge of these matters surrounding our culture.

Also, we shall remember that the Kingdom of Saudi Arabia is large and different in regions, customs and traditions. It is difficult to know everything that surrounds us, but at least we try to spread it between us as the medical staff. I mentioned the situation I faced yesterday in our department WhatsApp group, where there are 14 male and female medical staff, to discuss the meaning of the term. Until now, my colleagues and I have been searching for the meaning. In the following hours, we may find an explanation of the alternative procedure used to heal the child. We are trying to spread among ourselves as doctors and pass our knowledge of these terminologies to learn. It is difficult for the non-Saudi staff. I faced such issues with the medical staff from the intensive care department because non-Saudis always needed clarification. The issue is significant, so we need to spread awareness in the region and among us as doctors, and we need it. I am not from the Qassim region, but I see many villages with different cultures here.

I reiterated that we must be aware because remote villages often have low education and use alternative medicine more. Alternative medicine is diverse and has various procedures. To succeed in communication and understand the patient's condition to avoid medical errors, for example, some medicines and herbs in alternative medicine cause conflict with some prescribed medicines.

I do not know who is responsible, but we must be educated and aware of such matters to explain to the non-Saudi medical staff.

Another example is patients from the south of Saudi Arabia who visit us in the hospital. We had to call a doctor who was originally from the south on her shift to explain to us because we did not understand the patient's language and accent. The south borders are the borders near Yemen, and their language is complex. Many patients from the south of Saudi Arabia come to us, especially the haematology department. There are many blood-related diseases, and our hospital is excellent at treating blood-related diseases, so follow-ups are periodic. Sometimes the patient comes with her mother without the father or brother, so linguistic communication is challenging. The difference in dialects between us as Saudis, whether from the south, the Hijaz or the Badia, i.e. desert areas, leads to ineffective communication, and it is not easy to comprehend such dialects. Sometimes we can understand them, but we find it challenging to communicate and explain the disease to them or diagnose them. Therefore, we must have the skills of how to pass information; how will you, as a

115   doctor, explain "Bronchitis" in simple terms in Arabic, such as inflammation that are difficult to understand and challenging to explain to them, the patient or the patient's family need simplified language. We need simplification skills to reach the audience's education level. If we have to imitate their dialect to facilitate communication, why not?. We must also, as medical staff, use the method of confirmation and constantly ask whether he/she understands the diagnosis. Sometimes, we reach a stage where diseases are simple; however, due to ineffective communication of the patient, he/she

120   does not follow up with the doctor and does not complete the treatment plan, and the issue is straightforward. We did not effectively communicate; if we could reach the recipient's language, I would not see the patient come again, and you would obtain the patient's satisfaction. It is a requirement to have communication skills and intelligence, and medical language should be avoided with the patient or the patient's family. We shall use them only with the medical staff.
       In many cases in the hospital because the medical staff loses the strategy of communication and communication skills. I

125   found the patient's mother calling me in the hospital aisles and asking about her child's condition. I was not the doctor responsible for his case, so she told me: "the doctor explained to me, but I did not understand what he said, even though he was an Arabic speaker". We have many departments in the hospital; one has 85 patients, and each doctor specializes in certain cases. We have a paediatric department, a surgery department, cardiology and haematology. Various reasons and factors could hinder communication. It may be a mistake by the doctor in communicating the information, or it may

130   seem that he needed to reach the level of the patients. Alternatively, maybe the blame is on the patient's family; they were not listening, which is another mistake.
       Another situation we face as doctors, especially new doctors, is (needle biopsy). For a moment, when you hear about this medical procedure, you will think that the issue is severe and frightening. Indeed, the subject is not easy, but it becomes straightforward when you, as a doctor, simplify it with simple language and simple explanations. Sometimes we have to

135   explain to the mother by pointing to the area on her child's back that this does not cause problems or pain. Sometimes the mother asks whether it causes paralysis. Because the idea was certainly not clear to her, it is normal for her to fear and refuse the treatment, but our role as doctors is to clarify the matter efficiently, its harms, its advantages, and so on.
       Body language is essential; you explain simply by pointing at the patient's body. Some junior doctors recently joined the hospital, and one of their duties is to inform the family of these procedures. Sometimes we send them to take a biopsy,

140   and they return to us saying the mother or the patient refused. I asked her/him why they refused. She/he says, "I do not know."
       For example, we have a "X" doctor here in the department, her communication skills need to be enhanced. When she goes to the patient to take a biopsy from them, we find the patients are afraid because her way of communicating with them caused this dispute. I mean, she tells them that the patient must be alone and the place is sterile, and the area is

145   sterile; we find patients think that it is surgery. This is due to poor communication.
       We also have a medical procedure called conscious sedation. The "X" doctor tells them that it is sedation without a simple explanation of the mechanism of this examination.
       Although we took a course on the Saudi Board called "Communication Skills", we were required to pass this course. I believe these skills come with time and are not taught. So we need to have the awareness to develop these skills.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH10: There are many challenges, but most of the challenges I face daily are linguistic ones. Since our environment has many different nationalities, the accent could be better or clearer in some specific nationalities. When you
5   communicate with them, you make a great effort to understand what they are trying to say. The second challenge or problem we also face linguistically is that some nationalities speak with their colleagues from the same nationality in their mother tongue during work. Sometimes, when engaging in a conversation, the non-Arabic speaker switches to their language, which causes a massive challenge for me. This makes me think they are talking about me, and I feel some projection.

10   Fatima: would you like to add anything else?

MCH10: Oh, no, that is it.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH10: Since our environment has different nationalities, so there is always a misunderstanding, or it happens to some extent, but I try as much as possible to avoid any misunderstanding when I talk to the medical staff or any staff, I try as
15   much as I can to have my tone clear. So that the language is clear to them, and I always try to explain the information using my body language when I deliver it. I use my hands a lot, and I feel that the information is given faster and more precise, and always; at the end of any conversation, I keep asking: "Do you understand me?" and I repeat, then I ask them whether it is clear, I mean, I have to confirm with them whether I have delivered the accurate information or not.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

20   MCH10: Excellent question. We have some doctors, more specifically, Egyptian doctors, whose words are fast when they speak to us. I only understand a term of two words. So, I try to memorize and know what they say. Since we are in a work environment with different nationalities, the best strategy is to speak clearly and calmly. Otherwise, we may need more communication and understanding. We must simplify the sentences to be more precise and restructure our language to avoid language errors. Some Egyptian medical staff have language errors because their mix their accent with the Egyptian
25   dialects when speaking English. We should be clear so that others understand us and we can communicate well with our colleagues.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

MCH10: Both are important, but I assume that the medical English language is essential in the medical environment. As
30   I said, half of our job will be using the correct form of grammar, writing, speaking and listening. But we should know medical English very well. We are talking about patients, about a medical situation. It would be better if we had an advanced level of medical English to understand the condition and help the patient. We are all there to help patients. Proficiency in medical English is more critical and required than General English skills.

Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more
35   important for staff in Saudi Hospitals?

MCH10: Regarding awareness, it is vital for anyone in a workplace with different nationalities or individuals from other places to be familiar with or have a simple background about the culture and traditions of the country. Especially for staff coming from abroad must have a background in Saudi culture to avoid conflicts and misunderstandings with Saudi staff. The other thing is communication skills. Communication must be excellent, and listening to other colleagues is necessary.
40   The critical point I mentioned before is that the language must be simplified and straightforward. Staff should avoid speaking their mother tongue during medical discussions.

Fatima: May you elaborate more? Any example you would like to share with me today?

MCH10: For instance, I encounter much recent staff of different nationalities, especially some Filipinos; they usually do not have red lines due to the nature of their culture, and their culture is more open and free. I understand that they may
45   discuss specific topics with us unintentionally and innocently. But they must avoid speaking or asking very personal questions to any Saudi staff, especially Saudi females. For example, I mean some taboo topics in Islam and Saudi cultures, such as personal questions and sexual topics. I know my colleague does not mean to embarrass me. They are unfamiliar with the culture and our Islamic religion, but I cannot accept it. So they should be aware of our culture and religion to avoid discussing such topics.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH11: Okay, cultures vary from one nationality to another, sometimes, a high tone of voice is acceptable in certain nationalities, but for me, I cannot accept it; I see it as a loud voice. This is one of the challenges that I face here. Secondly, If there is tension and pressure at work, some medical staff do not respond to me. I feel discharged from the conversation, and there is no quick response. You must insist on them so that they finish the orders.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH11: I often rephrase the sentence and ask them to see their reaction, meaning: "I understood". If I see their reaction, it becomes more apparent if they understand me; if not, I repeat and explain to them more simply.

Fatima: How do you evaluate that they understood what you are trying to convey?

MCH11: I measure it by facial expressions and their reaction, and if they provide me with the answer that I expect, if not, I ask them again for mutual understanding, in order to reach the same request that I need, especially with the patient.

Fatima: And do you use the same strategy with your colleagues?

MCH11: Yes, I use the same strategy.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

MCH11: I advise them if something is not clear, they come back to clarify it. Also, listening skills are essential; they should listen well, with clarity in words and tone of voice. These are the strategies that I always want my colleagues to treat me with.

Moreover, I advise them as you just observed the situation before we started the interview. I will summarise what happened just now to clarify my point; the "x" needed me, and she called me on the phone. She did not explain what she wanted. I had to go to the department to meet her face-to-face and assess the situation. Investigate what does she need? What does the patient need? There needs to be complete clarity of the situation she wants me to solve for her or the patient's needs.

Fatima: So, what do you advise her?

MCH11: I advise her to have an arrangement of thoughts. The first thing is to arrange her thoughts on what exactly she wants from me. Also, to put it in the system. Speaking of the system, I advise my colleagues seeking advice in the system; some of them write (low weight) or simple words without explaining the details of the medical case, writing words without a full consultation. What is the medical condition? What the lab results indicate etc. They jot down low weight without mentioning the patient's condition, laboratory analysis, and essential details that should be mentioned, and their written documentation is very brief on the system. Then I'm required to go and ask them again face-to-face about the patient's current condition. Such matters must be evident through the system or by phone. I do not need to go to all the consultants and doctors every day to take a complete patient history and to clarify some things that are supposed to be well explained by the system to save time.

Fatima: What do you think is more critical in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

MCH11: They are all like what I told you. If you lose the general skills in general communication, if there are unclear words or terminology on the system, how will you seek clarification if you do not master general English communication skills? You will not understand if you are not familiar with the complete skills of writing, reading, listening, and speaking. It is not enough that the health practitioner writes the disease to me in medical English without not mentioning the details of the case in details. So, we should have English communication skills and medical English. Both are important.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

MCH11: Of course, non-Saudi medical staff must be familiar with our Saudi culture. We should have good listening skills. We must be available if a patient or colleague needs to clarify some matters. That is all that I have.

291

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH12: Of course, the environment is Arabic, so I do not expect to have particular problems with my Arabic colleagues. Even with non-Arabic speakers, we communicate in English and do not have any linguistic or cultural challenges.

5   Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH12: We have specific ways of communication here in the hospital, and we depend on the British Ethical Dilemma. We must follow the hospital rules. And if any misunderstanding occurs, praise and thank my colleague first, and explain the point at which the misunderstanding occurred with respect. This mostly depends on the matter in which the misunderstanding occurred and the situation if it needs to be reported or ignored.

10   Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

MCH12: I advise my colleagues to improve their communication skills. We lack communication skills, and this is what has been observed. We do not value communication skills; we plan to gain knowledge in medical skills, but the communication skills are missing, need more practice, and are overlooked. I suggest that my colleagues deal with communication skills as a priority and take such courses to improve these skills. The healthcare system should provide

15   these courses to enhance communication in this aspect. My colleagues need to prioritise communication skills. These skills and strategies could be improved by reading certain books.

Fatima: May you elaborate more?

MCH12: Recently, I read a book called (Rapicut). However, there are many other books and resources that medical staff can rely on to improve communication skills. This aspect is missing in the hospital and medical work environment, rooted

20   in our eastern culture.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

MCH12: Of course, proficiency in both is essential. I cannot say more for this question.

Fatima: Okay, what knowledge, skills, attitude and awareness related to language and communication do you think are

25   more important for staff in Saudi Hospitals?

MCH12: Communication involves many other parts, including using suitable vocabulary or body language and acquiring other skills. The skills include a linguistic part in which they choose specific phrases a certain way, and a narration style, for example (breaking the bad news). The medical staff must have a specific method, a suitable place, appropriate words, and preparation, especially if there is the presence of family members. They need to master these skills and provide

30   support when they receive bad news. We need to possess the art of communication and provide a suitable place for communication. The listener feels about what you are trying to convey, so we must train ourselves to choose simple phrases and our body language.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH13: Cultural and linguistic challenges only encountered a little because of our specialization: therapeutic nutrition. The way we talk and the messages we want to convey to foreign medical staff are within the limits of a narrow scope. We do not need to go further or talk in-depth with them. We have three to four lines, which are repeated daily. As a result, we have manageable challenges. There are, for example, some minor challenges that I face, such as the accent, which may be different and difficult to hear. This is primarily the only problem that I need help with.

Fatima: Regarding culture, did you encounter any situation or challenge with your colleagues?

MCH13: Frankly, One situation I faced related to the culture of my colleague from India. Finger snapping to them is an insult. While the purpose was to draw attention. We had a misunderstanding regarding this matter. Because finger snapping in their culture refers to the dancer, in Saudi culture, finger snapping means asking the listener to get the task done as soon as possible and to point out the importance of something. So:" she looked at me with the look that you are underestimating me and referring to me as a dancer and not your colleague at work" However, in Saudi culture, finger clicking means asking the listener to get the task done as soon as possible and to point out of the importance of something.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH13: Of course, when I speak English, first, I show the speaker my level and tell them about my capabilities in the English language. I explained that my English proficiency, skills and vocabulary were low. I am still at the beginner level, and I explain this to the listener or the speaker to save time, convey the information, and simplify it more easily. Suppose we did not reach a result, sometimes the speaker's level is also beginner, or sometimes they memorize certain words and repeat them daily. So, I seek help from one of my colleagues whose language is good or excellent to facilitate or deliver the order in an understandable English structure.

Fatima: How do you seek help from your colleagues? Do you call them, or do you use a specific application?

MCH13: Sometimes, I ask them by WhatsApp, and I wait because they may be busy. There must be mutual respect between us. It is impossible to ask them to come immediately; maybe my friend is busy with something else.

Fatima: How do you deal with such situations if they are not available?

MCH13: If they are busy, we postpone this case to a convenient time for the doctor and me.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

MCH13: Of course, I advise the medical staff and my colleagues whose language, Masha Allah, is good or excellent that they must understand the level of English of the listener/speaker from one word or two and evaluate their level in English. For example, if they are not at your level in the language, respect them and shorten your speech and simplify or reform. The conversation and orders, in this case, must be simple, direct and precise. Also, they must try as much as possible to reach the recipient's language level to facilitate communication.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

MCH13: I recommend general English communication skills, and the medical staff should develop them further. From my perspective, these skills are number one in structuring healthcare. The reason is if the medical staff has an excellent general English language, the medical terms or the medical English language will become easier for them to learn. If they master the general English skills, the medical terminologies or medical English language can be searched for in references and using different resources. Also, general English skills allow you to simplify the Medical English language to the other medical staff to improve communication.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

MCH13: Well, if you are a health worker and you have the opportunity to work in a country, you must be well aware of their culture, customs and religious traditions. Indeed, from state to state, it differs from city to city; customs, traditions and culture differ. You must know the culture of the place you plan to work in.

Also, I advise any health worker to practice the language daily and rely on it for a large part of their daily work; practising will develop their language, and their outcome will increase. I advise all health practitioners to unify the language of communication and use English, even if, in the beginning, they need help or realize that, for example, their linguistic level is below average. With experience and through time, skills will improve and develop. These skills need practice; only with practice will it become more manageable.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH14: With colleagues, more or less nothing ! because we both know English, We understand each other in English. It is the most difficult for others whose second language is not English. Okay, because for us, I'm Filipino, so my second
5   language is English. So I can speak well with doctors, the nurses who speak and understand English. I have a little knowledge of Arabic, which I learnt from my colleague; I learnt from the patient and the daily routine, but most likely much less; we differ in pronunciation. Let us say, You have the Irish diction, and I have the Filipin diction, yeah. They have their diction, So if I mispronounce and they need help understanding, they should ask me. Sometimes misunderstanding occurs. They did not understand my pronunciation because their pronunciation or diction was different.
10   However, I can deal with them and the patients. By the way, I used to work with patients before moving to quality control. So I deal with the patient and with my colleagues typically. For the cultural challenges for me, I can adjust. Because in the Philippines and before coming here, they oriented us to what we will expect in this country. In our country, we are hired through the government. So our government, before we fly to Saudi Arabia, we have the PDOS, we have the 'Pre-Departure Orientation Seminars', which gave us some ideas on the culture, so we know what to expect. Yeah, although
15   that is very brief and because what we see in reality is different from what they tell us and what we expect. Reality is always different, but at least we know what we will do and should do. So we attend the PDOS before coming here, whether hired by companies or the government.

Fatima: It is always good to have a background before moving to the country; okay, what kinds of strategies do you use to prevent misunderstanding with your colleagues?

20   MCH14: It has been 20 years since I started working here. I used to carry a notebook with me, and I wrote everything in Arabic. I will write what they said and ask them: "what is this?" And I will write the meaning in English. I like to translate. That's how I learn; otherwise, we also use actions and body language. Somehow I survived with body language with some actions and some practice. We must adapt to their culture and language if we live in one place. So practice makes it okay. And then, like when I was new here, I tried to communicate and to learn the language by talking with them. I will ask
25   them to tell me the exact word and repeat it until my pronunciation is correct; that is how I adapted. For the culture, since recently only we are allowed to go out alone. Yeah, but up to 2014, I adapted to staying in the villas only or with only females. We can go to the grocery store and the park with limited movement. Lately, that has changed, and it was fine with me.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

30   MCH14: Now, since we have much new technology, an influential leader can take advantage of it and learn to communicate with patients. So our priority is the patient. Well and good if the patient can understand English, but if not, we should be the ones to adjust for the patient, not the patient adjusting for us. So for us, as non-Saudis, it is a challenge; we need to improve for the patient, and our work, not the patient or the work, adjust for us. My advice, since we have a list of technologies, is to take advantage of the technologies online. Okay, we can learn online. We have translation
35   applications and voice translators, and you can take advantage of them. And for us as a Filipino, I usually get in touch with the Philippines to know the online courses; our government offers free online language courses, now I'm taking a Spanish course. So, they can take advantage of similar courses if they have access to them. You know, we have free online schooling about language. So you will select and fix your schedule; it's all with technology. It is crucial and beneficial. Nobody will open a single book if I tell them to learn from books. Learning languages is an essential skill because not
40   only here in Saudi Arabia but anywhere for us, I have expanded my experience. When I visited my cousin in Finland, I could not communicate using their language, but my cousin, who learnt their language, is communicating with them. Yeah, so it's easier. Though I speak English, every place I visit or work. Everyone has to learn the language and the culture of the place they decide to work for.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General
45   English language communication skills? Why?

MCH14: Both. In general, we must speak with the patient in layman's terms. Yeah, because if we are both nurses and doctors, we can understand this language. Suppose I say these vital signs! What are vital signs? The new patient who came from a remote area might need help understanding what's this medical terminology. So we must learn the general language, not only the medical jargon or the medical term, but in general. Both are important and would improve our
50   professional and patient; we are discussing patient care. Both are very necessary for hospital settings. We will not limit ourselves to the hospital setting in the work area. We go out, and we use general English. Communication is not only in the hospital and workplace but when we go out grocery and visit some places.

As I said, medical English will benefit all medical staff. Still, patients with no idea about medical English are disadvantageous because they will ask more questions. We have to explain to them using general English communication
55   skills.

Fatima: Fascinating points, question five what knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

MCH14: I think maybe, and this is my suggestion because in other countries, for instance, if we go to Japan or Korea, like for us as nurses, I'm mainly speaking English. They ask us to take their language; in Japan, their language is
60   "Nihongo". If we pass their language assessment, we can apply for a job. As I said, most people need to speak more

English in the place they are working in. So, we have to consider that when going to the hospital, some professionals may speak English, and others do not speak English. They may be able to understand and read, but their speaking skills are complex.

65 So, first, the knowledge of the language of Saudi Arabia. So what we are suggesting is that I was talking about this last week with my friends, and we were wondering why they do not require us to at least study the Arabic language. So when we work here, it is easier to communicate with the patient, especially the patient. When they tell us, we ask them, What is your name? They will say to us: "Haa Haa", which means; what in Arabic. They will keep asking again and again. And then another question you will ask the patient: "what is your problem? Of course, the patient will speak in Arabic. Well and good if they know English, they would give us some answers in English. But we still have to adapt or learn the

70 language of Saudi Arabia.

Even with the other medical staff, we still need to learn Arabic. Okay, I'm working with professionals, and my "x" has a PhD from the UK. But when we talk about work, they are still struggling with translation. I do my best to take notes and search for them. See, I take advantage of that technology. I will use translation applications.

But, sometimes, the translation is different even when using translation applications. Because I translate two parts, I solve

75 one part, but I need to translate the whole text to understand, and machine translation is only sometimes correct.

Fatima: Yeah, machine translation is not always accurate.

MCH14: Yes, exactly. For the attitude, I believe in acceptance, challenge yourself and accept! You are already in Saudi Arabia. So challenge yourself to learn. For the betterment of yourself and your profession, learning is non-stoppable; whether you are old, you are young. It will always benefit us if we keep learning. That is a challenge because some of

80 their attitudes are that I'm here already and working, so why should I learn?" Yeah. Okay. When they hired me, they did not tell me to learn Arabic; why shall I learn Arabic? I see this attitude. It is challenging, but if they are willing to make some changes and improvements, it will benefit both the workplace and the person, and everybody will benefit, patients and colleagues.

Regarding awareness, we should know what is happening in reality and in the hospital's community. So, you keep learning

85 because it is connected with your attitude; everyone should continue learning. And for the skills, It can always go together with your awareness and attitude. Your attitude depends on you; we cannot force one person if they do not want to learn. Attitude is the most challenging part for me. It depends on how they were brought up and how they feel toward it. Yes, it depends on so many different factors.

Fatima: Do you have anything else to add?

90 MCH14: well, now I can see we are all aware of our business environment. But yeah, my comment about knowledge, it is still okay. I hope that Saudi Arabia will implement like other countries, especially regarding language. Not by force, but to implement at least because they are hiring Nigerians right now. For example, the Egyptians know English and Arabic, which is fine. But Nigerians, Filipinos, Indians, and non-Arab speakers should learn Arabic. This is what we need, and it will be easier with them when dealing with paperwork when you have to process your papers to human

95 resources and people working in the human resource department are older. Okay, although they try their best to speak in English when they go to the system, it's Arabic. So it is challenging for them and us because they try their best to communicate with us in English. But when they go to the system, it's Arabic. Yes. So for me, this is only my suggestion, maybe with time inshallah.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH15: Of course, there are some effects, but in the medical field, you can say there is not that effect in terms of culture. We have Indians, Filipinos, and other nationalities. We face some difficulties with the accents; sometimes, it is unclear to them or us. Yes, we face these issues. But regarding culture in the medical field, I mean it is normal. There are no situations that reflect the culture they come from. We have language challenges, especially since we all speak English as a second language. So, I noticed issues with language and dialect, especially with some nationalities, those who joined us recently from Africa. It is challenging to deal with and communicate with them. For one of our nurses here from Africa, I speak with her in English and try to explain, but she does not understand. She does not understand me well when I try to clarify things. We reached a point where I told her: "well, just read the order; maybe you will get what I am trying to say". I mean, it is not easy to interact with some of them. Other nationalities, such as Filipinos or Indians, have been in contact with us for a while. Even at college, many lecturers were from India and the Philippines. However, as I said, we do not face cultural issues, there are limitations in communication, and we only discuss the patients and orders. So, nothing makes them have to express their culture or mine.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH15: As for the misunderstanding, it happens even between us as Saudis. It is usual with other doctors, seniors, juniors, and residents. Sometimes the request is misunderstood. For example, if I say the order fast, he gets confused, and you see some mistakes. It happens because we speak a second language—one of the things we do to avoid confusion, forgetfulness, or misunderstanding is emphasising. For example, during rounds, we say the order: "do the CT brain, all right, Doctor?" It is necessary to hear the confirmation after the repetition of orders. We confirm orders verbally or in the WhatsApp group. Our department settles WhatsApp groups, and we use WhatsApp to confirm orders and cases with other doctors. Sometimes, we ask for orders from a specific doctor. The second doctor says: "yes, it is straightforward and easy" the first party understands that the second party will settle the order, and on the next day, there will be a misunderstanding: "you said it is easy, so I expected you to finish the order!". So, we try to avoid these misunderstandings through direct communication, repetition and confirmation. Especially some abbreviations when we pronounce them quickly, for example (ECG, CPR, ACG, CRB) I mean, such abbreviations, when uttered quickly, could be misunderstood, so we need to check and confirm.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

MCH15: As I told you, what is compelling is following up. When you write or request an order, you must follow it up. We, as medical staff, should not depend on our words and others. We must follow up on all the orders and cases because sometimes your colleague misinterprets or is busy doing another urgent matter. Unfortunately, orders are frankly incomplete in this hospital. The requests are written, but nothing is executed from them. You came the other day and observed that the work still needs to be completed. Even the nurses are busy. When you write any request, you must follow it, confirm with your colleagues and ensure everything is complete, or being sent, and so on, so that the patient's parents/relatives do not complain. The essential strategy in the medical field to avoid errors and miscommunication is to review and follow up.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

MCH15: Okay, I believe the general language skills are more effective because even if we know medical English, still without general English skills, we will suffer. I know all the abbreviations and terminologies, but for example, the general English language helps me communicate with non-Saudi or Non-Arab staff. Sometimes I miss the medical term, or they may miss the specific word for the illness; we communicate quickly, so it is possible. If I have general English language skills, I can explain and describe without using medical English, and my colleague will understand. I face this with the "x" medical staff, who do not know medical English, so we use general English to explain and simplify.

Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

MCH15: Anyone who plans to work in Saudi hospitals must have a background in our culture. I mean, we are Saudis and Muslims. There are limits and boundaries. In our hospitals, we have male nurses and female nurses. The foreign staff must know their limitations when dealing with Saudi people, and females know their limitations within the work; I mean, you know that they can go beyond limits and do not know the culture. These are essential things that they should be aware of, our culture in particular. You must know your limits and morals even when communicating. They should be formal and polite and know there are some limitations when communicating with Saudi males and females, and specific topics and actions are considered taboo in our culture.

Another essential strategy we should have is a sense of clarity in speech, style, and formality in the message we are trying to convey. Especially as this is something that has to do with culture, of course, so it affects. In the sense that I am clear and my words are forward/direct, for example, when I speak about a specific case or critical plan, we should be clear and straightforward. When I speak, it is necessary to have clarity of style and professionalism, especially when speaking with males. I encounter this in the ER, especially when I speak with a male patient and try to use a sense of humour to make

60 the patient feel comfortable, but misunderstandings occur with their wives. Indeed, you need to speak clearly in a clear tone and avoid side comments and humour as much as possible. All these led to misunderstandings between patients and staff, especially those from different cultures. I did not encounter this issue with the Saudi staff; I do not mean to say that we are not professionals, but I see them more than I see my family. There is some communication outside of work matters. We have side interactions, for instance: "how are you today? How is your family etc.?". It is possible that the nature of our work culture, and as Saudi colleagues, we understand each other's intentions. However, sometimes, for example,

65 when dealing with another culture, to be more specific, another Arabic culture. I did face this kind of misunderstanding, especially when having these side conversations; whenever I say: "how are you, doctor today?" he misunderstood my intention; he started thinking that I cared about him and took it personally, which caused some sensitivity. Thus, I believe our talk should be clear and more professional to make communication more accessible and straightforward. We should be direct and choose our words formally because sometimes our intention is misunderstood.

70 It is worth mentioning that even patients and their families face these issues and complain about the non-politeness and informality of specific nationalities when communicating with them. Your style differs, and the way you speak makes much difference, even if you are from another culture and speak another language because your style indicates what you say.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH16: Okay, we are from India and working in Saudi Arabia. The language was difficult to understand when we came here because the HR staff knew only Arabic. So, when we first came here, we found it very difficult to communicate with them. However, we learnt Arabic later, so it is okay now. The HR staff in this department should know English to communicate with the other medical staff because English is a worldwide language, so it is better to comply with it. I have been working here for 13 years, so I have a little background in the Arabic language. It was uneasy considering the Arabic staff nurses who recently joined. However, nowadays, the recently joined Saudi staff who graduated from Qassim University are good in English, but before, it took much work to communicate with them. For the patients, there is no problem, but in any norms, the recently joined staff from India, Pakistani etc., it is complicated to communicate with them in English, as they need to learn the language. So, when we give them training or orientation, they do not understand. The teaching methods in English and language assessments may give them a better chance to study and practice the language. Concerning culture, it will be different for everyone, with different religions and different cultures. I am from India, and we have Muslims, Hindus, and Christians. However, there is no difference between us. There are no challenges; we work together, and everybody has their religion. Although I am Christian, okay, but when I go outside, we should follow the cultural rules of Saudi Arabia, wearing hijab etc. I have been here for 13 years. So when I'm going outside, I cover my hair and wear a scarf, but when I go to Riyadh, I do not because people there are more open-minded, and even Saudis do not wear Abaya/ scarf.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH16: We speak English, but with the Saudi staff, we try to speak Arabic, and sometimes they do not understand. Maybe because our Arabic is not good, or because we do not speak like the native speakers of Arabic, if, for example, nurse "X", is available, we ask her to explain to them in Arabic. If she is not available, we call other Arabic staff to interpret. Now Google Translate is available; they record and translate that into English or Arabic. Yeah, so then they will ask us to gain feedback, and we will manage to understand each other.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

MCH16: We should document everything in written forms and then speak to the patient and the responsible staff to gain more details. Another point to consider is that our department provides courses such as IVY therapy, CPR, and advanced life support course for the recently joined staff, which is good. But I assume that they should audio record the lectures. All these courses we offer should be repeated and practised daily in our nursing life. Moreover, for teaching language, our training centre teaches Arabic and English speakers separately. For example, this week for Arabic speakers, next week for English speakers and so on. So they can understand the material quickly. However, it is better to take these English courses only if they plan for higher studies abroad, for example, in Australia, New Zealand or America. So it is better to learn in English.

Fatima: What do you think is more critical in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

MCH16: Medical English language proficiency. If we are telling that the patients have hypothermia, they can understand that as an increase in temperature. It is better to learn medical English first, then general. Other things will be acquired if we study first the medical language and terminology. So, we are all human beings; we can learn by listening and social media and all recent applications like Twitter, for example. So if they are interested, they can learn. However, because the medical field is in English, they can read and practice nursing or this doctor's profession, physiotherapy etc. The medical field requires high proficiency in Medical English; if they wish, the general English skills can be learnt by practice.

Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

MCH16: Nowadays, it is better to upgrade our education frequently because I studied nursing and completed my Bachelor's degree; the previous Saudi staff had just a diploma. However, I advise them to update their degree. Day by day, we should upgrade our knowledge to be one of the better sources for the OR so we can share our knowledge. We can also share our knowledge with the recently joined staff and teach them; experience counts, and if our degree is high, we can teach them better. Okay, they may think you have a diploma; why do you want to teach me? So we should be more knowledgeable. We should study better to improve our degree and improve our knowledge very much. For skills we can only gain by practising. Here I observe all the trainers and staff; they just come and sit. So better, they should show an attitude of learning. Because if we are improving ourselves and learning for a better future, on the other hand, they should be willing to learn and improve. I am not Saudi; I will go to my home country after 10-15 years of service. This is your country; Saudi staff will remain here, so they should be learning from our experience before we leave. Bearing in mind that the 2030 Saudi vision aims to implement the Saudization system, which means by 2030, all the healthcare workers will be Saudi. So it is better to be motivated to learn and improve.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH17: Okay, I'm from India, so I'm dealing with multinationalities; Saudis, Indonesians, Filipinos and Nigerians. But we are dealing with the patients also, and the patient's language is Arabic. I don't know anything about Arabic. The first time I came here, it was my first time hearing the Arabic language. So because of this language problem, I cannot communicate well with the patient. So there is a miscommunication happening, and some problems are created. And speaking English is better for us, but some staff need to learn English. So it can be challenging for us to interact with them. I'm acting as a "X", which means I teach some courses to the staff as a part of the training orientations. And I found that some Saudi staff cannot understand English. So it became more difficult for me to communicate and teach them. For example, if I am teaching some policies and procedures to my staff, sometimes they say they understand, but the truth is they don't know what I'm saying because every time I ask them a question, they need help understanding.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH17: If I cannot talk to them, I mean, if they do not understand what I am saying, and if there is any Saudi staff who knows English and Arabic fluently. I will ask them to translate. When there is no one to translate, I use my simple Arabic words to explain. I know some medical terminologies in Arabic, but I cannot speak Arabic with them in emergencies.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

MCH17: I prefer closed-loop communication. This means what I am telling them, and they need to reply. For example, they need to answer me if I ask anything about a topic. This is the only way we know whether they understand or not. We also communicate through messages in WhatsApp or the department group. So we send all the urgent messages, including medical tasks. We send everything in the WhatsApp group, so any staff on vacation can read the message and acknowledge it in the group whether they read it or not.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

MCH17: I will say both are needed. But, general English proficiency is more important because we are not always talking about the patient's condition. We talk about other things happening in the hospital. So then we must master medical and general English language, but more importantly, the general English language skills. And if you have general English skills and need medical English, you'll learn it automatically when practising in the clinic and medical setting. But general English proficiency is difficult to obtain because you need to speak more.

Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

MCH17: Non-Saudi staff must learn Arabic to communicate with patients and relatives. I need to know the Arabic language to understand my patients and talk to them—also the Saudi staff who do not speak English fluently. For example, the HR Saudi staff in our department don't know English, so we try to talk to them in Arabic. From the Saudi staff side, I think they need to improve their English language so we can communicate better.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH18: I have been working here for about four years, and I have already adapted to the culture of patients and staff. We are here to deliver care to patients. However, the problem is that we face communication barriers because we need to speak Arabic, and some nurses cannot. When we talk about new staff, they must also learn Arabic and communicate with patients. We speak English with my colleagues, but my Saudi colleagues know Arabic much better than English. They cannot understand English very well. Sometimes, they ask me how: "I say this word in English". Yeah, and I learn Arabic from them; it is a lovely experience. We exchange, I'm glad to teach them English, and then they teach me Arabic. Sometimes I struggle with written consent in Arabic, and I will ask them: "please can you do it for me?" She writes the consent for me and explains everything to me.

Fatima: You are in a hospital setting, and as far as I know, you are asked to speak English all the time. Do you have any challenges regarding this matter?

MCH18: We are asked to use English in the hospital, So we know more about the diseases and illness conditions if it is in English. So, the main challenge is fluency in Arabic; I face difficulties when medical procedures are written in Arabic. I mean, we can face every challenge if we speak English.

Fatima: Interesting, what about culture, do you have any challenges?

MCH18: Regarding culture, Arabian culture is entirely different from Indian culture. There were some challenges, but we adapted to the culture, and we could manage.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH18: One day, I needed to send something to another place, and the driver was Saudi. The driver does not know a single word of English. I tried to tell him some Arabic phrases to explain the place, but I did not convey the place in Arabic, so I needed to figure out what to do. Then I searched for some Arabic speakers around me. There was my Saudi colleague and I asked her: "Please, can you explain to the brother about this place?" she explained to him, and he took the stuff to the correct place. So, I seek translation, and sometimes I search on Google Translate, like what is that particular word in Arabic, some doctors help me and translate. Once I did not know what to say to the patients when I needed blood tests. So, I searched on google and showed the patient some pictures so she could understand. Also, if I do not understand the patients, they will type on google Translate and show me, "please nurse, bring me some water", so we can communicate this way.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

MCH18: For non-Arabic speakers, like doctors or nurses, can seek help from translators, I mean the other medical staff fluent in Arabic. Using this strategy can prevent some errors and misunderstandings which will occur due to a lack of communication. Moreover, sometimes I will do the same and use Google Translate, and I will show if I cannot; I will call help from some other staff to translate.

Fatima: So you advise them to seek help from translators?

MCH18: Yes, and sometimes I do the same. I type on Google Translation, and if I struggle to explain what I mean, I search for someone available to help me.

Fatima: Any other strategies you recommend to your colleagues?

MCH18: Sometimes, when teaching health education, some papers are written in Arabic. I used to write the Arabic words and their translation in English on the back of the paper, and then I read it. I recommend my colleagues use such strategies.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

MCH18: Medical English language is very tough because of the medical terms; almost all staff do not know them, also patients. So, general English comes first. You can quickly pick up the medical terms and language when you know general English, making it more understandable. It would be complicated if we insisted on them learning Medical English without knowing general English. So, we should first start with basic English and upgrade our knowledge to the medical language. In my opinion, only if you know general English skills can you learn medical English.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

MCH18: Knowledge means they should be knowledgeable in all areas, like our nursing profession. We should be knowledgeable in all aspects and learn the Arabic language. Because for better communication, Arabic is essential because it is important when providing care. We cannot expect all patients will know English, but we should learn some Arabic. In brief, I will say medical staff should know Arabic because some non-Arabic doctors do not know Arabic. Once a patient came to the doctor and asked something about her condition. Then he will not know how to speak Arabic. Then he started raising his hands to the staff: "What is this?" So he has to try at least learn some Arabic words so that only he can be able to care for patients.

For the skills, the best skill all staff should have is taking good care of patients. Well, we selected nursing as a career to care for our patients. So what is our primary goal in our profession? We should treat the patient very well; you should treat your patients as if you are treating yourself to deliver excellent care.

For attitudes, we should be kind-hearted and affordable. Like if a patient asks for something, we should be affordable. It is our responsibility to give care to the patient.

Also, all medical staff should be updated with any recent research in their field. Not only in our medical field, but we should also improve our languages and learn Arabic to balance. Lastly, my suggestion for Arabic speakers is to improve their English because English and Arabic are essential for good communication and caregiving.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH19: One of the challenges at the beginning of my journey as a doctor was the multiculturalism of many people from outside the Al-Qassim region, mixed races and different cultures. It was a challenge for me to adapt to this diversity.

The second challenge was communication with my female colleagues. You do not know how you will be misunderstood, whether in an office or a station. So, I avoid talking with females to prevent conflicts. Also, dialect is a challenge. There are many people; for example, dialect differs between Bedouins from villages/remote areas or other social classes. So, dialects sometimes cause misunderstandings. But after one year of exposure to the work environment, you will know and go along with the differences and get used to them.

Another challenge was that all the fact that most of the nursing staff are foreign, so communication problems occur. Speaking from my own experience, I was weak in English; I did not reach the advanced stage in the language yet, but there was a difference in the language, and it was challenging to convey my message. Sometimes it takes time, and I prefer to avoid doing my job, so I do not confront the language. I avoid communicating with colleagues due to their professional language, especially in Medical English. I suffer a lot to reach their professional medical language level.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH19: In medical settings, it is always better when giving orders or requests to the patient; it is preferable to repeat all the requests. Even when taking the medical history from mothers/ relatives or the patients themselves, it is helpful to summarise the case and ensure you understand it accurately. This strategy helped me a lot from the first day I started working here, so I like it, especially when discussing and giving orders. I also ask the speaker to repeat; I even summarise the case, provide them with an idea, and ensure we reach a point of clarity.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

MCH19: First, the repetition strategy is advantageous. The second thing is if they feel there has been a misunderstanding and the doctor dispenses medication. It is preferable if the patient says: "I disbursed the medicine from the pharmacy." You must follow up, ask the patient to bring the medicine, and verify the name and whether it is the same prescribed medicine. You must investigate: "Did the prescription arrive at the pharmacy, and is the handwriting clear?" Sometimes the system does not work, so we have to prescribe the medicine in a handwritten form. It is better to use Google and show them a picture of the medication or to ensure that the treatment is accurate. Also, it is preferable to develop our English language before starting work. The medical work setting is based on proficiency in the English language, whether the primary language is Arabic, they will undoubtedly become familiar with English, or if their first language is English, If the English language is excellent between staff members, communication will be clear.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

MCH19: General English proficiency is essential. What can we gain if the medical staff can master medical English and know the terminology or the name of the medicine? The most important thing is that I know what I want and how it is made and that there is mutual respect in the dialogue, politeness in speaking, the method of making the request, and the method of receiving the request. So I prefer to have excellent English communication skills. We need to understand each other and understand how to communicate. Our field consists of a lot of discussions and conflicts, so we must master general English skills to ease communication and speak in a humorous way to improve the work atmosphere. The relationship between the medical staff, whether nurses, doctors, consultants or technicians, is more like a family. The results will be much better, meaning that each one likes to give more of what they have, but if they all knew the medical language, okay, assuming they may understand each other. However, the order may go wrong, or the communication process may fail in some parts. You can understand the medical language through a sentence if you have general English and its skills. It is possible to explain the name of the disease in a sentence. I do not need to master medical English.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

MCH19: Non-Arabic staff must be fluent in the Arabic language well, or even the least basic. Many doctors come here who do not know Arabic. Although they speak English very well, their Arabic is weak. Indeed communication with the patients leads to misunderstanding. All the doctors who come from Abroad; do not speak Arabic, so they need a translator. The translation may have a lack of words or a misunderstanding. The misunderstandings increase when so many people get involved in the translation process. Therefore, it is essential to know the Arabic language.

Secondly, it is necessary to be familiar with the culture and traditions because our culture differs from the culture abroad. If the doctor used to joke with the patients or the female gender inappropriately, this is considered impolite in Saudi culture. Some actions might be acceptable in other countries, but it is not permitted here. Cultural awareness must be present in any medical staff working in Saudi Arabia, specifically the Qassim region.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH20: I face difficulties with positions and power. If my colleague is higher in position, they do not accept some of my suggestions when discussing a medical case. I must try as much as possible to rephrase my suggestion and act as a learner, not a colleague. I rephrase my suggestions and form them as a question phrase because they do not accept that someone less than them in position provides a suggestion or advice. I keep trying to find the easiest way, so I do not show that I am more knowledgeable than them or impose my opinion. The opposite situation happens too; for example, if my colleague is below me in the position, I feel he/she is afraid to advise me on a particular matter. In our work settings, we have this stereotyping when communicating with our colleagues with a higher power. Whenever I face this matter, I explain to my colleague that we are all close to each other in the position and are all working for the patient's safety. Sometimes those less than me in a position hesitate to give suggestions for cases. This causes a hindrance in communication and makes us produce mistakes. For example, if the patient becomes in a critical condition and we discuss and make recommendations with other consultants, they consider it as a primitive way. They will say: "Why did you talk to me about it?". This causes some obstacles, so we know we cannot communicate with this health practitioner.

Secondly, the difference between the gender at work causes an obstacle for us because in cases like shifts, the females are present in their breakroom, so communication does not take place until they are outside the breakroom. Especially during immediate requests, we had to call them, wait for them to respond, and inform them of the problem. There is no speed in communication, which is another obstacle.

Regarding language, I have issues with vocabulary, and I find it challenging to choose the appropriate vocabulary, especially when communicating with foreign staff. Also, with listening, sometimes my non-Arabic colleague has different pronunciations of some letters. A little while ago, there was a critical condition, and my colleague was trying to discuss the case with me. I told him: " Repeat, I do not get you" he repeated the words five times, and I did not understand. So, I had to meet another colleague to understand the scenario of the critical situation and the request. Language differs in some nationalities, and the pronunciation of some letters and terminologies causes some misunderstandings.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH20: I try to improve my communication strategies, especially if I am talking to someone on the phone; even if I am speaking clearly, some of my colleagues may have difficulty understanding some of the words. So, I tell my colleague that there is no connection on the phone, I cannot hear you so we can communicate via WhatsApp, and I try to use all the synonyms of my words with a little effort of simplification. So, I try to avoid verbal communication. Sometimes I use the simultaneous translation in my brain and put it in Arabic. I try as much as possible to use different strategies until my colleague understands. Also, to prevent misunderstanding, I try not to use direct command words; I use the suggestion strategy instead, such as the form:" " What if...". I have experienced that some of my colleagues are sensitive on this matter. I get sensitive with some of my colleagues at the same job level, using inappropriate words/phrases of dialogue and a sense of power. They expect you to follow their suggestions. I try as much as possible to reform the sentences, especially if he is higher than me in the position, to avoid conflicts and touch.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

MCH20: Our means of communication should not follow a single method. For example, I wrote a request for a specific case to my colleague for medical advice. I verbally discussed it with my colleague and formally requested that it be written on the system and the WhatsApp group. I do not prefer to deliver my message in one single method. I try to avoid using a single line of communication as much as possible. Because many times the methods of communication are distributed, my colleague may rely on one method of communication. For example, he waits for the request via WhatsApp or face-to-face, and it has already been registered on the system, so there is no interest, so I use more than one method of communication. I advise my colleagues to ensure that all the information is well-read and understood.

Also, the language is supposed to be straightforward because we often hear vague vocabulary and see abbreviations of things we have not come through, especially in writing abbreviations. I frequently open my mobile and search for some abbreviations and find that they mean more than one meaning. They are used in more than one case, especially in the cardiology department, because there are various cases, and the words are long. They often use different abbreviations that need to be discovered in my field, and this causes me some problems.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

MCH20: Both of them are important, but English communication skills are more vital because their language level is almost average or slightly below average here. Because in our work environment, we gather with different nationalities, and some nationalities are satisfied only with the medical English language; if I sail with them in a

conversation, there will be a misunderstanding, and they will not understand my point. Therefore, the quality of communication skills in General English is more important than the quality of communication in Medical English

60   because Medical English and its vocabulary are equivalent to general English. Therefore, if communication skills are absent in the medical language, an explanation in the general language is accessible.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

MCH20: First, we must accept all different dialects. For example, I am originally from Qassim, and I have a

65   particular way of pronouncing specific words that are not well-known. This surprised my colleague, so they must accept this. Sometimes they see this matter as an insult, and they see that I spoke my colloquial dialect and did not appreciate the existence of different dialects in the work environment.

The second thing is to understand that this is a high-pressure environment. As much as possible, they should consider the tone of voice and the choice of words because sometimes unintended transgressions occur no matter

70   what pressure and work. For example, when working under pressure, we speak loudly but do not mean it. This is a mistake. Formal communication always saves; on the other hand, communication in a humoured manner sometimes makes our work loses its importance. So, we must hold ourselves as much as possible because the entire environment is stressful. The work pressure is normal, which generates sensitivity or may cause misunderstanding.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH1: According to culture, I'm from India, but I adapted to this culture, and we don't have any cultural problems. For example, here, we wear Abaya, but in other places, we do not wear Abaya. We are open like in Ireland.

5   Although we wear Abaya, we are okay with it; we are comfortable with this dress.

Regarding language communication, as I mentioned, we are adjusting to everyone in the hospital, not only the Saudi but also Filipinos and non-Saudi colleagues. We have no differences between Saudis and non-Saudis. We are like friends.

Fatima: You do not face any linguistics challenges?

10   BCH1: First of all, it was difficult for us to communicate at the first time, It was difficult to understand the Arabic language. But after one month, we coped with the situation.

Fatima: Was it difficult in the English or Arabic language?

BCH1: No, the Arabic, It was difficult to understand, but within a month, we coped with it.

Fatima: Did you learn Arabic? And how long have you been?

15   BCH1: Yes, I did learn; I am four years of experience

Fatima: When communicating in English, do you face any challenges?

BCH1: Yes, I faced challenges because some of the staff here do not speak English, there is no proper communication, and maybe because they need to learn how to pronounce in English and have some grammar difficulties, some communication barrier was there. Anyway, they are also trying to cope and improve their

20   language.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH1: Nowadays, we record every detail related to the patient's condition on the computer. In my 8 hours shift, I record everything on the system in case any misunderstanding occurs; we can go through the previous notes, whatever the staff has written. This includes what care was given to the patients? what has not been done, and

25   what medicine was given by the doctor. I follow up on the system to avoid any misunderstandings.

Fatima: Other strategies you use?

BCH1: We use WhatsApp and can communicate with all the hospital's related departments to know what is going on. That is the better way of communication, I think.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

30   BCH1: They have to improve their language skills, then only they can communicate efficiently, and we can do teamwork. This way, the ward and ICU or any department in the hospital will run smoothly.

They also have to improve their speaking skills, which I believe is essential in healthcare settings. First, when we came from India, we didn't know how to speak correctly in Arabic and English, but day by day, we communicated with them and can improve our language. Writing, listening and reading are essential skills and must be improved.

35   Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

BCH1: Both are important. Considering the medical English, not everyone in the hospital will cope. However, with good skills in general English, we can link with everything related to patient care. Also, we can use Medical English if we are talking with doctors. So, in my opinion, proficiency in general English skills comes first. Then

40   you will automatically pick Medical English. That is why general English comes first for communication.

Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

BCH1: 'Laughing', I'm telling you frankly and not blaming anyone, but they must improve their language skills and practise what they are doing in the hospitals. We observe all the procedures daily, so they must improve their

45   language. They are talking only in Arabic, but they have to learn English and communicate with the staff, specifically with the non-Saudi

They have skills but are not performing on time.

Fatima: What do you mean by time?

BCH1: I mean, If any patient has an emergency request, and belongs to this specific staff, sometimes they are not

50   bothered about that. The person doing other orders has to come and do the duties there. But it should not be like that. All the medical staff, Saudi and non-Saudi, have an equal distribution of patient care and equality is essential. So they have to improve that. They have good attitudes and knowledge of communication skills, but they must improve their English.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH2: This is a multinational work setting, so we have a language problem here. People come from different cultures. In the beginning, it is difficult for us to understand and for them to understand us. Yeah. So we must use

5   a few common words to improve communication.

Fatima: Common words in Arabic or English?

BCH2: No, I mean in English because, during endorsement for nurses especially, we do not do it in Arabic.

Fatima: Interesting, and what common words do you usually use? may you give us an example?

BCH2: Sorry, not common words I mean the basic English language.

10   Fatima: Did you face any challenges during your endorsements?

BCH2: Yes, I did, though most of us are from India. In India itself, we have many languages. So it is difficult for us to understand each other. Although we are from the same country, India has many languages, which is one of the problems.

For communication in Arabic, I used to call the Arabic staff to come with me to help me communicate and

15   translate. And later on, we try to learn from them the Arabic language.

Fatima: Have long have you been here?

BCH2: Almost three years now. So, I do have the basics of Arabic.

Fatima: Would you like to add anything else?

BCH2: So far, nothing more I can say.

20   Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH2: Oh yeah. As I said, standard English language. The basic language that everyone can understand. If I notice that they do not know what I'm trying to say, I will try to make them understand. For instance, I explain using my mother language if they are from India. But if we do not share the mother language, I use a simple language. Also, I use the google Translate app to translate for my patients. Even my patient uses it. But with my

25   colleagues, we manage through using simple English.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

BCH2: I advise them to make their language as simple as they can. Make sure your language is simple, not complicated.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or

30   General English language communication skills? Why?

I think general English is essential. Because of medical English, we know most of them, and I believe it is unnecessary. Even if I tell you some terminology, you will be able to understand it because you are also a nurse. Even if my colleague does not know medical English, it is unnecessary in healthcare. We can use simple English, which everyone can understand, whether the recent or expert staff, we all could manage using general English

35   only.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

BCH2: I have observed that most Saudi patients do not understand much English, So when we deal with patients, we have to make them understand, use body language, and use Google to translate, or you can draw pictures. We

40   must use anything accessible to convey our message to them. As a nurse, if you are planning to work in Saudi, you have to learn Arabic, at least basic Arabic. Without Arabic, it is not easy.

Fatima: Would you like to add anything else?

BCH2: No, that's it.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH3: We have so many challenges regarding language, and maybe because at work, we mix with native speakers of English and non-native speakers. We have Filipinos, Nigerians, and Indonesians working in the same
5 department. We have challenges with their pronunciation, and we do not understand what they are saying. This is all I have regarding this question.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH3: I use some strategies to prevent misunderstandings, like photos to illustrate simple English language and to try to repeat and change or simplify the words until the listener understands.

10 Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

BCH3: I advise them to simplify their English language, and I recommend my colleagues to memorise the daily terms and phrases we use.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

15 BCH3: Of course, general English language, let me give you an example of the Latin medical word ENT; we can explain it by saying 'ear-nose and throat'. All the medical staff are familiar with medical English; we experience it daily, and before we are hired in the hospital, we must take the exam from the Saudi Council. This exam is given to each medical staff according to their specialised field and includes all the medical terminologies. You can explain and learn even if you do not know medical English with general English.

20 Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

BCH3: It is essential to be aware of the culture of Saudi staff and other nationalities working in the hospital. For example, once a non-Saudi patient who had to do a CT was afraid and refused to take the CT. So, I had to explain to her using simple language and show her some pictures to convince her that this was necessary. Every day we
25 face similar cases from both patients and colleagues. So, we must be aware that people are different and accept the differences. Of course, we have to simplify the language in various methods, such as showing videos and pictures. We also have to have an advanced level of English, and I remember when I started working in the hospital, I struggled a lot. Because I graduated from college and my English was weak, all the lecturers were Egyptian and Arabic speakers, and we were taught in Arabic. So, when I came here, I had a culture shock and did
30 not communicate with my colleagues efficiently. Then I took English courses to try and enhance my language. We have to work on ourselves and keep learning. It is worth noting that this is a challenge for healthcare workers because we use English only at work, but Arabic is the dominant language in our daily life.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH4: We have a "X" staff, and It isn't easy to understand her language. Even when she speaks English, some words are difficult to pronounce, so it is challenging to communicate with her.

5 For the cultural challenges, some Nigerian staff, when they want to say "yes", move their head, but in the Philippines, it means to say 'no', and when we want to say "yes," we nod. So, different preferences cause challenges. Also, when I first came here to Saudi Arabia, I could not understand Arabic, So I had to learn the language.

Fatima: Interesting, and how long have you been working here?

10 BCH4: Maybe five years.

Fatima: Did you learn Arabic?

BCH4: 'Laughing', Not too much, but I understand that sometimes we can thoroughly communicate with the patient.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

15 BCH4: Usually, I complete my statements; if I feel that my colleague does not understand, I restate, read back then ask questions to see if they understood.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

BCH4: We should use English as our primary language during a general endorsement because we have other Arabic, Saudi, Nigerian, Indian and Filipino staff. So it will be better to complete sentences using the English

20 language. If staff do not understand, they can refer to the system and read the written reports. Doctors and we write these reports during our shifts.

Fatima: Do you sometimes face challenges while reading or understanding these reports?

BCH4: Because we are using abbreviations, it is better to use the standardised abbreviation list. I use the medically accepted abbreviations, and I advise my colleagues only to use the hospital's set of accepted medical abbreviations.

25 So it will be easier for us to understand during endorsement or on the nurse's notes.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or general English language communication skills? Why?

BCH4: Since we work in the hospital setting, it is better to use the medical English language. Because when pointing to any part of the body, it will be easier and safer for us to understand. Outside the hospital settings, we

30 could use general English skills.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

BCH4: The willingness to learn and to understand the other speaker is essential because other speakers do not know the English language well; even though English is our second language, we tend to learn languages.

35 However, if you are willing to learn, you will expand your knowledge. Trying to understand the other person; If they have difficulty expressing themselves in English, give them some time to formulate their sentence and express their thoughts. I assume we must master writing and reading skills for better communication. These skills are important.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH5: Most of the staff here are Indians and Filipinos. So, for example, during endorsement, specific nationalities like Indians use their mother language to endorse with other Indian staff. So that time, I could not understand
5 some endorsements because they spoke their language. It is challenging for me.

Fatima: And what do you do in this situation?

BCH5: I keep reminding them, can we speak English? I guess they sometimes forget because they are of the same nationality and feel comfortable communicating in their first language. They tend to forget that other nationalities are attending the endorsement.

10 Fatima: Any other challenges you faced while working here in the hospital?

BCH5: From my side, I did not face any challenges related to culture. I am Muslim, and we share the same belief. So, so far, nothing. My only point regarding the language is that we should avoid using our first language when discussing medical cases. I often use my Tagalog with my colleague at work, and I do not realise that I should not do so. We must constantly remind ourselves that we should use English only.

15 Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH5: Some things happen where, as I said, sometimes they use their first language. So, I would always remind them to use only English. If, in any case, I encountered some misunderstandings related to the endorsements, I would listen to them first, ask them to explain clearly, listen actively, respect their opinions and finally accept their mistakes.

20 I prefer clarification and repetition. Using these strategies would always prevent misunderstanding.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

BCH5: I recommend my colleagues use English only. In my previous work experience in a hospital in Jeddah, there was a policy always to use English. There were warning tags on the walls that if we used languages other than English, we would get a warning. But here, in Buraidah's Central hospital, we do not have a language policy.

25 We all shall speak English so that everyone can understand and communicate better.

I also advise my colleagues to have acceptance.

Fatima: What do you mean by acceptance?

BCH5: Because some nationalities are not fluent in English, I mean, like recent nationalities, Indian and Indonesian, do not know English. As a "X" staff, we shall accept, understand and give them some time to learn
30 because each of us has different abilities. We are not the same.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

BCH5: Since we are working in hospitals, I prefer mastering medical English because we handle patients. We usually use medical English to discuss the anatomy of the patient's body, so we should use medical terms. Medical
35 English is very different from general English; I think it is more critical when discussing cases with doctors and nurses.

Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

BCH5: For me, the essential skills are interpersonal skills and communication. Because it includes empathy and
40 understanding, emotional intelligence, and being an active listener to everyone surrounding you, the way you deliver your words to others should be clear. With these skills, we can prevent any mistakes or at least misunderstandings between colleagues and patients.

Additionally, this is an Arabic country, so it is better to learn the language, like the other countries such as Japan and UK. If you work in their country, you must know their language. Finally, we as medical staff should possess
45 the self-awareness to know right and wrong. Because with self-awareness, you can understand other people and know how you talk with others. We shall know and think of our words before delivering them to others.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH6: Initially, I had some difficulty with communication, especially with Saudi people; they have a tone and a way of speaking that is entirely different from ours, which is difficult for me. But now, I can understand their

5   languages, talks, and tones. Everything, everything I can understand. However, I suggest using some terminologies and trying to learn more English, mainly if they communicate, so they should have some language proficiency.

Fatima: So, you struggled at the beginning to communicate?

BCH6: Yes, I have too many difficulties communicating, especially in Arabic, but I do not know Arabic. Then with the help of my head nurse, I used to try, and now I speak Arabic. But even though some people, especially

10   Egyptians and doctors and some people from Korea and Nigerians, we have difficulty communicating with them because they do not know how to speak and do not know English properly.

Fatima: Do you have an example you would like to share with me?

BCH6: For example, when I came here, we had a patient who collapsed there, so the Syrian doctor came here, and it was challenging to communicate with him. Although he spoke English, I could not understand him because

15   of his pronunciation.

Fatima: What about the cultural challenges?

BCH6: One of our main cultural challenges as non-Saudis is wearing Abaya. And when people ask us if we are Muslims, even patients, ask if we are Muslim or Saudi. They are conversing and separating us from their culture. That is too difficult for us because we are from different places. Okay, we understand that you have some particular

20   cultural rules and regulations, but it is difficult for us. But, we are managing okay.

Fatima: And do you still wear Abaya and Hijab?

BCH6: Nowadays, we try to wear Abaya less and cover our face, but sometimes if we go outdoors, it is too difficult for some people. They will get angry and say, where is your Abaya? Inside the hospital environment, we do not have any problems. My challenges are with the language; for the cultural side, we are managing well, and I accept

25   the culture here.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH6: If they cannot understand my language, I will try to translate using Google or show some pictures. And sometimes, my colleagues cannot understand me because of my tone and pronunciation when I speak; in this case, I write and show them.

30   Fatima: Any other communication strategies?

BCH6: No, nothing more.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

BCH6: I advise them to express their feelings to others and communicate with each other for their knowledge. We can improve our language and try to learn whenever we get a chance, and also, they should use English in all the

35   hospital wards. And they should improve their writing in written orders and notes. I found many spelling mistakes on some doctors' and nurses' notes; spelling is complicated for us. Once I read on the doctor's note that instead of writing the surgery that removes gallbladder "lap chole", he wrote "lab calling", which means something else. This is a big mistake that could harm patients and create medical errors. I suggest that my colleagues improve their English whenever they get the chance, whether they listen to music, read books, or even use Google Translate

40   to learn how to spell and pronounce words.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

BCH6: From my point of view, English language communication is much more important than medical because some people are from outside the medical field. They cannot understand our medical language and terms. From

45   my point of view, English language communication skills are more critical.

Fatima: Let us assume that my medical English is below the level. Will I manage to communicate in healthcare settings?

BCH6: Even if you do not know the medical language and some terminologies, with simple English words, we can explain them to you.

50   Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

BCH6: They should improve their English language skills, especially the recently joined Saudi nurses and doctors. They say that we are used to speaking Arabic even in our medical school. We also learn it in our language, but whenever we get the chance, we try to use English and forget our language. I understand that we have the mother

55   language we respect, and I'm not asking that we should ignore our first language and speak English. However, we should all learn English to communicate and make good relationships in a multinational medical environment. Some staff from other departments come and communicate with us using only Arabic, and they refuse to speak English. I think they refuse because they do not know the basics of English. So, I advise them to take any available courses to improve their English for healthcare delivery.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH7: Okay. I was at the bedside for 13 years as a bedside nurse. As I mentioned earlier, my colleagues, especially the physicians, cannot express their treatment or feelings in English. Still, now Alhamdulillah, they are improving

5   somehow. However, there is still a gap, especially when they are giving orders. Some can give orders in English, but others can do it in Arabic. They even explain the procedure in Arabic to the nurse and the patient. Yeah, the patient, no problem. Because they are Arabic, and they should be in Arabic. But the problem is that they will not translate to the nurses who are non-Saudi what they are explaining to the patient. Most of the nurses here are non-Saudi; only a few Saudi nurses. The Saudi nurses primarily work the morning shift and non-Saudi nurses in the

10   evening. Yeah, so during that time, all were non-Saudi and could not communicate very well with a physician.

Fatima: And that is because the physicians used Arabic to explain the procedure.

BCH7: Yeah.

Fatima: And what is the situation from the nurse's side?

BCH7: So, the nurses ask some doctors again, the doctors who are accompanying the main physician. Yeah, so

15   they will ask for an explanation; it is either the resident or the specialist. Some will explain and repeat, and colleagues can translate into English.

Understanding the discussion in English is essential to nurses. After all, the nurses will write in the nurse's notes because everything that happened or was discussed with the patient should be seen in the nurse's progress notes.

Fatima: Great, what about the cultural challenges?

20   BCH7: For the cultural challenges, some staff face cultural shock to some nationalities. My voice is so loud, and some patients do not want it like that; some physicians also get irritated. So I modulate my voice. However, when the other parties increase their voice, it is not the problem. But, It is a problem for my side. If they are the ones who were shouting or raising their voices, there will be non-judgments.

And then at the same time, some nationalities are not wearing Abayas; we have different religions. But since we

25   came here to Saudi, we should. Specifically, in Qassim, you should wear your Niqab to cover your face, but now we do not wear it anymore. It has become more open than it used to be. However, 13 years back, it was a challenge because I needed to cover my face despite being a Muslim. But back in my country, I do not wear Niqab; I am just wearing a scarf. And it's no problem for me because I am used to it, but I do not like wearing a Niqab. So, I started to not wear Niqab, since COVID because I wear a mask- (participant laughing).

30   Fatima: Oh, so instead of wearing Niqab, you wear a face mask?

BCH7: Yes, I replaced it with a surgical face mask. But I am still covering my face.

Fatima: Any other challenges?

BCH7: I do not have any cultural challenges. Not for me because I have a background and have been here for years. So from the other point of view, my colleagues are shocked. For example, when they hear the call for

35   prayers, ' Athan', they wonder, what? What is the noise? Thus, I tell them to keep silent because that is the call for prayer. Then I explain to them what Athan is and that this is the call for prayers; they will pray. However, somehow the new staff were okay with the culture and adapted. I, myself, adapted for 13 years. But I love this place; I love it. This is my second home after the Philippines.

Fatima: And you live here with your family?

40   BCH7: Before, they were with me, but when the pandemic started, they returned to the Philippines. Because I am financially broke, they request the non-Saudis pay taxes. This was implemented after COVID, but earlier, back in 2015, we did not have to pay taxes so I could bring my family and children here. Also, there was an increment of around 1% to 5%. Now the situation has changed, and we face challenges financially and emotionally because we are already stressed from work and being alone here. Much previous staff left because they could not support

45   themselves or their family.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH7: Sign language (participant laughing): When I was at the bedside, some doctors could not communicate very well, but because I could communicate, I could translate to the medical staff. At the same time, sometimes, because I am always the shadow of the doctor, I will go inside along with the doctor to the patient's bedside. Then,

50   the staff handling the patient cannot understand what they are saying. So after the rounds, that is the time I will get to explain to the staff. This is the case; this is the order.

Some staff can speak in English, but others cannot, such as some Indonesians and Indians who cannot speak fluently in English. So, I use sign language and Google Translate.

Fatima: And what about the accuracy of Google Translation?

55   BCH7: Even Google Translate is not accurate when you write in Arabic and translate it into English or verse and vice. Recently around two weeks ago, I spoke to a Saudi colleague to investigate a matter that happened in the department. I wrote my inquiry in Google Translate from English into Arabic, I do not know what's written in Arabic, but I am sure about what's written in English. I said: "if you are directing your patient here, you are automatically giving them an appointment". But in the Arabic translation, it was different.

60   Fatima: What does the translation mention in Arabic?

BCH7: Later, my colleague came with his director to clarify things. According to him, the Arabic translation mentioned names whom I do not know, so the director told me: "you are telling him to speak to those people?", and then I said: "No sir, I told him if you are directing patients to us, you are automatically giving them an appointment, and that not acceptable on the system". The translation of Google caused a misunderstanding,

65   although I asked my colleague during that time: "did you understand me ? he said yes, and then appeared with his director. I do not even know that person who is written in Google Translation. That's strange.

Fatima: Yeah, sometimes the translation is not accurate.

BCH7: Yeah.

Fatima: So, you used sign language and Google Translation.

70   BCH7: The strategies I use are Google Translation, sign language, and asking direct questions: "did you understand?" Even in Arabic, I say: "Anta Tafham? = means do you understand in Arabic" then he said: "Aywa, khalas, okay?".

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

BCH7: Enhance speaking and writing skills. Because some physicians cannot talk but can write, I recommend

75   using both skills—otherwise, sign language and bringing the specific medication they use because some physicians do not say.

Fatima: So, do you mean prescribing medication using English and enhancing speaking skills?

BCH7: Yes, to learn and speak English. I always tell them to bring a small notebook because when I started learning Arabic, I used to bring a small note and write the Arabic words and their meaning in English. My non-

80   Arabic colleagues should learn Arabic too.

Fatima: So, you advise them to carry a notebook that could help them learn Arabic?

BCH7: Yes, because I told them how they would learn and communicate with the patients if they were not interested in learning their language. That is the only way to communicate and gain the patients' trust.

Fatima: So you advise them to learn the Arabic language?

85   BCH7: Yes, at least when they communicate with colleagues and patients.

Because we are already here in Saudi Arabia, we are responsible for learning the mother language here. I learned how to speak Arabic over six months when I started my work. Because of what I did, I always talked with the patients and watchers. So, even if I did not understand, I wrote in my notebook. Some relatives of the patients guided me and corrected the meanings of some words so I could record them in my notebook. Then I improved

90   gradually.

Fatima: So, you advise learning both languages, Arabic and English?

BCH7: Yeah. I advise my colleagues to learn the two languages; some of my colleagues tell me they need to know how to learn English; I always tell them to use YouTube and learn step by step. Some of them use their phones to learn instead of carrying a notebook, and others use YouTube or watch movies to learn how to communicate.

95   Learning cannot be immediate; we all learn gradually.

Indeed I advise my colleagues to learn the two languages and to love their work. Because if we do not love our work, we will not be motivated to learn.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or general English language communication skills? Why?

100   BCH7: General English communication skills are essential. Because only some patients and staff know the medical language, including its terms, if you, for example, are in OPD, so all of the optical medical terms, there is a high probability. Still, if you go to the other speciality, you will not know. So better, actually. If I need to improve my medical English, I can extract it from the daily discussions in my department. I want to say that the general English language comes first, and you will gradually learn medical English. To put it more precisely, with

105   the help of general English, we can learn the medical language in any department we work in. Because we will be communicating with the other medical staff using all the medical diagnoses, discussions and medical terms.

Fatima: So you mean General English comes first?

BCH7: Yes, it comes first. Because if you only knew the medical English language and its terminologies, how could it help you to communicate? So the general English language and little proficiency in medical English are

110   applicable.

Fatima: So, you mean if I know general English communication skills, I will be able to master the medical language?

BCH7: Yes, primarily related to your field. Because the physicians will use the medical language, terminologies and diagnoses in the medical notes, so, first general English, then extract some from the medical English.

115   Fatima: What knowledge, skills, attitude, and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

BCH7: I could not say, be like me (participant laughing). I mean speaking of before, even though I cannot understand Arabic, somehow, I used only to understand the holly book 'Quran', because I learnt it back home. I

120   can use other communication strategies, like smiling, facial gestures and reactions. Even if we do not understand the other party, for example, patients, when feeling pain, it is necessary to have the intelligence to understand what they are trying to convey. Body language and visualization explain that sometimes, let us say they are holding their abdomen, and you will call the physicians to see the patient. This is communication! It is our responsibility to adjust and understand the matter.

125   We have to have the ability to communicate, interest, understand, interact and internalize what they are trying to convey to us.

Also, I think it is essential to be patient when communicating because if you have a short temper, a volcano will explode from the other party, which means there will be no peace. It is a significant matter if you can understand and communicate with everyone around you.

Audio interview 8, BCH8
Date: 29th August 2022
Duration: 20:38

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH8: Actually, you know, coming from an African background like Nigeria in West Africa and one of the West African countries. And then I came here, and before I arrived, I was already made to understand that when you come here that the culture is going to be very different. And in Saudi Arabia, you know, the Islamic religion is the predominant religion, although they respect other people's religions. And then you have to adapt to that because that also determines how people live and behave in this place. So there is something we say respect other people's culture; even if you are not a Muslim, you have to respect that culture. And that is what I have come to realize. Back home, we don't cover our heads, and we do not cover our faces, except maybe they are going to the judge, and you are going to the mosque. Then coming here, we have to adapt to the culture so that we don't have any problems and you work well and work on. So I don't really have a problem with that.

I've already adapted to the culture because back home in Nigeria, we have both Muslims and non-Muslims. So we already know some of the cultures, the Islamic culture. So coming here, knowing that it is fully practised here, back there, we mixed up, but here, you know, that is the most predominant religion and the culture. You have to adapt and go back.

I don't have any challenge, you know, because nobody forces you. Because one beautiful thing about this place is that; it is the headquarters of the Islamic religion. However, nobody forces anybody, you know, to become a Muslim. So this is the respect they have for everybody. And that is one of the most beautiful things. When I returned home for my last holiday, everybody was like, How did you do this? I had to do this. This is what they do! I said: "You don't do anything. Don't talk about what you do not know. I came from Saudi Arabia and observed what they do".

Back home, in Nigeria, they have false assumptions because of gossip. See? Even before I came, maybe I had that too. But when I came here and discovered it is a lovely and peaceful place and I went back home, I told all the stories we used to hear were not true. One day I'll invite some of them to come here. But after all, the culture is beautiful. Peaceful.

Fatima: We are happy too to have you in Saudi Arabia. Do you have any linguistic challenges?

BCH8: Of course, oh yes, that is the primary problem. Before we came here, we had pamphlets where somebody tried to bring out some Arabic medical language words we could use. Frankly, if you even have a scale of 1 to 10, I would still say minus one with the language. But the beautiful thing is that the people can speak English and some people can interpret, you know, so you speak that you get some people to translate the language for you. And gradually, we are picking up, but I have been here for almost six months or around a year, and I can communicate more fluently with the Arabic language. I'm also trying to watch Arabic YouTube.

Fatima: Do you have any examples you want to share with me?

BCH8: Yeah, the first time I came and, you know, coming here trying to get people to do things for you, most people did not really understand English. And then they said, the way I speak is very fast, you know? So I said when I complained that they didn't do this for me, somebody would say, your English is too technical. That is, you speak very fast, and then you have to come down to the level of the people. So I had to break down. For now, if I want to say good morning to people, I would just say goooood mornnnnning. Also, the very first thing I learned from here was: "Bokra, = means tomorrow in Arabic". When I speak to my colleagues and ask them to do things for me, I do not know what they used to understand, but what I used to hear from them, only one word; they tell me that Bokra, bokra, and every bokra comes with nothing. At that point, I had to cry. I cried so much one day when I needed something. And they told me Bokra, and it has come more than five bokras, and this time around I just broke down and cried. So everybody just ran around and did what I wanted that day. And so I said, okay. So whenever I needed something here, I had to cry. I must always cry for them to do something. Gradually I got used to it, and everything was fine. So, okay, I'm integrating, and I've made friends. I've met so many people, and we now understand each other. And everything is fine.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH8: Yeah. You know, as I said, one thing, I speak very fast, so I try to calm down because sometimes you talk with somebody and a person may not understand. And each person has peculiarities. And maybe instead of somebody telling you, could you repeat or something? But I was trying to form and, you know, my gestures. Suppose I noticed that this person did not understand. So I will try to come back as I told you, then I realised I was speaking very fast. I come back and speak slowly. I repeat what I said before. And then, eventually, you discover that it is actually they did not understand you. That is why they behaved like that. So when you speak at their level, they tend to interact more with you. Then sometimes, when you have a misunderstanding with somebody, you try to listen to both sides and let the person express more of where he had a problem understanding. So both of you sit down and see how you can come to terms and solve the problem.

I'm very grateful that I do not have many problems because the Lord has given me these communication skills and how to deal with people. As I said, I am very humorous; I talk and make you happy. And if anyone wants to be angry, I calm them down. So I have a strategy of making people smile first.

314

60   Fatima: So, you have a high sense of humour.
      BCH8: Yes, a very high sense of humour. Thus, that also helps in communication and prevents misunderstandings.
      Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?
      BCH8: The basic thing, communication technique is to speak, repeat and give feedback. When you are talking to somebody, do not just assume the person understands. What I do and I advise people when you are communicating,

65   and the person is listening, get feedback, ask: "Do you understand what I said?" Yes, I do. "What did I say?" And as the kind of speak-repeat, and the person speaks and repeats what you say, so fine, that means you got it right. In the process of repeating, you notice the person missed something and try to fill in the gap. So, speaking, repeating and then giving feedback is one way. I advise that before you do not just go and assume people understand.

70   Another thing is illustration also comes to mind when you speak to somebody about something, and I learned that the person understands 10 to 20% of what you speak. I finish speaking, and we only understand about 10 to 20%. However, if you have associative illustrations, visuals of something, posters, you know, written a pamphlet for those that can read, they will understand. I also tell my colleague that when talking to a patient, talk to their relatives. As you advise a patient, a physician who comes on the stand also talks to somebody. So that if you forget

75   something at home, somebody will say what the doctor said etc.., you know, it is always good to have one or two people around, except it is very confidential. You only want to speak with your patients even if it is confidential, and the patient will also have somebody they trust and will be with whom you are communicating. So, when speaking to somebody, try to get their feedback and ensure the person understands.
      Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or

80   General English language communication skills? Why?
      BCH8: The general English, you know, because if we want to go to proficiency, fluency, you may not get it in so many people, especially where we are. But you tend to have people that understand when we say literacy in English does not mean fluency. Even if the person speaks and the tenses are not correct. However, I understand what you mean, and knowing at the back of my mind this person is not really into the English language, I wouldn't

85   expect that level of fluency. But that understanding, the general English understanding, like let me say somebody can tell you: "I will came tomorrow" That's bad English, that's not good English, but I understand what the person means. Especially the person that is not so fluent in English and is trying to understand. So, I know what you are saying, which is the literate part of that communication with the person. So it only generates a little fluency.
      Fatima: What about medical English proficiency?

90   BCH8: So, the general English language is important when communicating with patients or any other party. But, medical English proficiency is essential; when interacting as a doctor, I want to document something. I'm talking as a doctor now, and I want to document, but if I'm generally talking with patients and interacting with people in communication, general English is okay, but proficient in knowing the actual medical English to write. Medical language, terminologies, and other words to use as a doctor. We are talking about doctors, and you should master

95   it. Because number one, the documents you are writing may be used internationally and not only localized here. Supposing I'm referring this patient to the United States, I want them to understand what proficiency is. When we are documenting for a doctor, you should be proficient in medical English. You should also be able to document, but when interacting with other people, knowing that people may have a lower level of proficiency. General English is okay for communication, but a doctor or medical staff should be professional in both.

100   Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?
      BCH8: As we have already said, when we say to staff, remember it's not just medical staff. We have what we call the co-staff, the doctors, the nurses, and the supportive staff, the supporting areas. Moreover, we have another additional group: dietary units, social units, physiotherapy, and many others. Okay. In Saudi Arabia, we already

105   know that the primary language is Arabic, so that is like the step language; we would not take that away. However, since we have international staff but bearing in mind that most of this international staff also have the languages coming, the general English, you know, is there. With time, with communication interaction, international staff get to understand Arabic. So the two languages are equally imperative. They are equally essential.
      Bearing in mind that more than 80% of people coming to the hospital, the patient themselves, speak Arabic. We

110   come here, and we should try and understand Arabic so that we can interact with them as much as English; also crucial because all documentation is supposed to be in both languages. Unfortunately, those who do not understand Arabic will do them in only English. So most of the documentation is in English. But the two languages are important for us to be able to practice and work and work in Saudi hospitals.
      As I said, in both the speaking and written visuals, we have visuals, we have them and boards; we have signboards

115   where we post something written and then if we can use sign language is also in our communication. Because I know how often I've used sign language for people, the acts for this seem to me. I will; I'll now direct.
      Once, I was going out, and on my way, somebody asked me for directions. I know from something that the person was in the basement and wanted the first floor. So he mentioned something that I knew meant the first floor.

120 However, how do I direct from here? I just had to go out of my way to take him to the first floor. So sometimes, actions help with communication and interaction with staff and patients.

Attitude is also for patience when somebody speaks to you; even if you do not understand, do not just stop the speaker and say, "Mafe Ma3loom= means I do not know in Arabic". I have seen people like somebody start speaking. I mean, just allow the person to finish speaking. What do I do? I just nicely sit and say, I'm sorry," Mafe Ma3loom," but I must connect the person to somebody that understands Arabic. At that time, I would not say in

125 Arabic; I do not know, that is not nice. I would not feel good if somebody told me I did not understand. No, I do not understand. You try and do something. At that point, the person needs help. You know, you connect to somebody immediately. Get them help. I try to do that. I encourage other people to do that. Don't just leave people hanging because you don't understand.

Fatima: Anything else you would like to add?

130 BCH8: Oh, talking about Saudi Arabia, I don't know whether that is part of this interview, but I want to say that coming here, as I said, I came with false assumptions in mind. I was afraid. I hope they will not cut my neck in Saudi Arabia. I know they will not do this, but I came here and discovered it was different from what I knew. Because of what you hear on the news, do not read, come here to see; I've been to England and many other places. Saudi Arabia is one of the most peaceful places I have been to. The people are friendly. They are very lovely. And

135 one beautiful thing is, like I told you, it is the Islamic capital. But nobody forces anybody here. Nobody comes and tells you why you are not Muslim. Everybody respects every person's religion, and it was beautiful. You must respect the religion of where you are and the culture and follow the rules and regulations. You must possess good interaction, smile at people, and, as I said, speak politely even if you do not understand. (Participant laughing), that is what I usually do; I smile and say: "Shway Arabic= means very little Arabic", then they will tell me: "Oh

140 mafy Ma3loon English=, which means I do not know English".

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH9: First, when I came here, I was shocked by the food because, in our culture, we are used to having a heavy meal from the start of the day. But here in Saudi Arabia, they only have bread and cheese, like a light meal.

5 The second challenge is the dress, you know, we have to wear, we have the cover, and during work, I struggle because I must take care of the patients, clean, touch them and things like that, and while wearing this dress, I get messy too.

Thirdly, I am not degrading some nationalities, but they smell, I mean heavy smell and sometimes while working you will get annoyed, and have a headache and cannot concentrate. Also, religion is a challenge.

10 Fatima: Why is religion a challenge? What about it?

BCH9: In our country, we all take a break for prayers, but here it is different. Only Muslims can take a break to pray, which is a valid reason.

Fatima: May you elaborate more?

BCH9: For example, at work, your colleague went to pray, and something happened with her patient, and you do

15 not know anything about her patient's case because you are taking care of your patient. Suddenly you observe that something has happened to her patient; the doctor comes and asks you, but you still do not know anything. This matter needs to be clarified sometimes. However, they take 15 minutes for their prayer break, which sometimes goes beyond this period.

Also, during Ramadan, the working hours are 6, and some already come late. But for us, it is 8 hours, I understand

20 that it is a valid reason, but it is a challenge.

Another point is the tone of voice; we are used to speaking loudly in the Philippines; it is part of our culture. So, when I came here, many of my colleagues and patients misunderstood me and thought that I was mad; when I was only discussing and speaking with them, I felt that my tone was normal. But they complained that I was always angry and shouting.

25 Also, the segregation of males and females is a challenge. As a nurse, I was shocked that I was not allowed to touch men when I came here because, in the Philippines, it is allowed. Even males refuse to be touched and cared for by a female nurse. Not only the segregation of males and females, but also I was shocked that we are not allowed to mention sex and bring jokes regarding this topic. It was a shameful and taboo topic; sometimes, I joked about it and felt they took it seriously. I noticed that in Saudi culture, it is prohibited, especially if you are single.

30 For linguistics, pronunciation is difficult; you know pronunciation is different among cultures, nationalities and languages. Also, Saudi Arabia mainly uses British English, accents and words. However, in the Philippines, we use American English. For instance, once my head nurse told me that I would be on an evening shift today. To me, evening shifts start from 9 pm; for them, following the British system, the evening shift starts from 3 pm. So, I did not appear at three o clock. Then my head nurse called me asking why I did not come on my shift, and I told

35 her you said to go on the evening shift at nine. So, sometimes the choice of words causes a misunderstanding because of British and American English.

Fatima: Would you like to add anything else?

BCH9: Oh, yes, of course; another point, here in the hospital, they mostly use Arabic, especially for the written document. Even the consent forms are written in Arabic, and you do not have a choice but to sign only! Nobody

40 will translate, and even if you ask them, they will explain in Arabic. Still, you will not understand.

Fatima: And you sign forms that you are not familiar with?

BCH9: Yes, of course, I do not have a choice.

Fatima: And do you try to translate it on your own?

BCH9: No. Nothing, I was new at that time, I don't know. They just told me to sign. Even they will explain. Still,

45 I did not understand because of the language.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH9: The first one was a demonstration. As I said, I would instead do the task myself because they will not understand, and sometimes it is difficult to explain; no matter how you explain in layman's terms or another basic English language, they will still not understand. So, I would do the medical task myself to prevent

50 miscommunication and medical errors. And sometimes, it will be a fuss for the work; even if you use Google Translation, it is different and leads to another translation.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

BCH9: Language literacy, to study English and for non-Arabic speakers to study Arabic, not just the Arabic language, but also written Arabic. For example, when I came here for the first time, they taught us how to write

55 simple words and numbers in Arabic. That's all.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

60   BCH9: Both are very important because we are in a healthcare setting, and there are not just doctors and nurses but other medical professionals in the healthcare setting. We also have ITs who do not know the medical language. Also, we are dealing with patients, you know, we have to explain what they can understand in layman's terms. Thus, they would not understand if you used mainly medical English. We should use medical language for documentation when dealing with tasks, so both are important.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

65   BCH9: For me, I believe language literacy is very important for both Saudis and non-Saudis, both knowledge of Arabic and English. Because we are dealing here with the people in Saudi, patients are primarily Saudi. So how will we explain to them how we will discuss with them and confirm the medical report with the patient? So we need to have both literacies.

Another thing is that attitude. Sometimes we are talking, and here we are explaining something important. And

70   then suddenly, they will interrupt, "Salam Alaykum, hi etc." So we are talking about something important, we will be distracted, and when they are left, we need to figure out where we stopped.

I highly recommend the knowledge of both languages for skills and awareness because it will start from there. If they are literate enough, everything will follow.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH10: Linguistic and cultural challenges, especially now that we have a multinational staff and nurses are Saudi, Filipino, Indian, and Pakistani. So it is difficult with different nationalities, cultural languages, and dialects. So we must maintain one common language to understand each other—for example, we are receiving Indonesian staff. I am not downgrading them, but their English is very weak.

So as you know, we are in the nursing field, so we had to communicate well with the patients. So it is hard for me to teach them English and Arabic simultaneously. So they have to be flexible and learn as fast as possible. So these are the problems that I am facing right now.

Fatima: What about cultural challenges?

BCH10: With the Saudi Arabian staff, now, their language is well. I mean culturally, by language, they are little by little improving. They try their best to learn, taking this English assessment to be in the medical profession when they take the specialisation licences. So I do not have that many problems with them because they already have college English language proficiency.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH10: For me, what I usually do, for instance, recently because, as I have said, like for the Indonesians, I am searching for one who knows more knowledge in the English language, and I am using the translation, or else I will speak to them in English. Then they will reply to me by translating in the Google App. So this is one of the strategies. And another one is giving them a little time to study, to know at least the minimum basic English. Also, for the Arabic language, I have a problem with this because, like for us Filipinos, especially for the new beginners, the new staff coming here first thing was Indians. There are a few issues with the language; some speak Malayalam, even though they are in India, but they have different native languages. So some of them do not understand English. So, one basic language should be given to all staff.

Fatima: You mean simple English?

BCH10: Yes, basic and simple English should be given to all the staff in at least one primary language.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

BCH10: At least the best thing is that they have to communicate clearly, and slowly, and then if they cannot understand, use translation, either from another staff or through Google. Because now, Google also they have this English translation or any language translation Apps they can use to help them.

I also advise them to ask someone to have an open relationship with the staff and good communication skills. And for the language, at least now in our education and training, we provide the primary educational tools. We give them - basic English, Arabic, and then Malayalam Filipino for new staff.

Fatima: Is it an online course that you provide?

BCH10: Yeah, they have the lectures in the orientation; one booklet is already given to them, followed up in the sections by those senior staff and the head nurses.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

BCH10: I prefer general English language communication skills because like this is the foundation. You can, if everyone or the medical staff knows or have the knowledge of the general English language skills, so at least they can communicate it and not as deep as it is. Still, at least they can already give the communication with them. There will be no mistakes, and there will be no errors. Because if one staff cannot understand one common language in the instruction, it will be complicated. Having a multinational team here, really it, is also a challenge for us in the administration.

Fatima: If my general English language skills are weak, but my medical English is excellent, will I manage in the healthcare setting?

BCH10: You can manage if you know the abbreviations and medical terms. Because, like for the nurses and the medical professions, we are already taught about these. If they also have the knowledge taught in their schools and universities, it can be a good foundation for anything.

Fatima: Is mastering the medical language without general English enough?

BCH10: No, no, no, it is difficult because confusion occurs even with the medical abbreviations and terminology. So, you have to have general English proficiency.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

BCH10: This is a big challenge for all Saudis, I mean all the Saudi settings, especially in the Qassim province area. In cities, I'm sure they are fluent in English because they are exposed to the language, and their universities are excellent. As I said, I'm not downgrading, but preferably the foundation only starts in the schools. So, the Ministry of Education and the Ministry of Health need to collaborate to include the English language foundation in the curriculum. Because as we know now, Saudi Arabia is already open for international scholarships like you and at least the Saudis already have good English communication skills wherever they go. The hospital settings

60   are critical, as the practice modules we use are more UK and United States based. So we are following their site's practice, although we also have unique methods in Saudi Arabia. However, 80% is from the western side. So the primary language for English proficiency is fundamental in all settings. Not only for the non-Saudis, specifically the Saudis and even the patient, because some patients are already fluent. So if the nurses or the medical staff cannot communicate fluently, they challenge the nurses and the medical staff. So the English language should be
65   preferred and in the curriculum of each university.

Fatima: When you mentioned some patients are fluent, do you mean fluent in English or Arabic?

BCH10: I mean in English. Even though they are Saudis, they communicate with us in English. And I am happy for some patients who are also trying to use English. Indeed, language is number one in treatment. If the doctor or nurse cannot understand the patient for any symptoms they might complain about, there will be misdiagnosed
70   and mismanagement of the patient's disease.

Fatima: What about communication with colleagues?

BCH10: As of now, nurses' and doctors' communication could be better, and I cannot say it is perfect or excellent. However, at least it is on average because most of them are also our doctors from Nigeria. And the Saudis, residents and doctors, are fluent in English because they study at other universities like Riyadh and others from the UK. So,
75   they are bringing all the practises here. Even during meetings and rounds, they are not talking to their Saudi colleagues in Arabic and only explain in English. So it is a must for everyone to learn this language.

Fatima: Would you like to add more?

BCH10: Nothing more. Thank you for choosing me; I wish you luck.

Audio interview 11, BCH11
Date: 31ST August 2022
Duration: 10:06

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH11: The cultural challenge I experience with my colleagues is how they talk about their religion. Because they have their language or their own words regarding their religion. For me, nothing except religion.

5 Fatima: What do you mean? Can you explain more?

BCH11: I mean the prayers and phrases they use. I struggle to understand and need to hear more because everything here is based on the Islamic religion. Many people live in Saudi and have different beliefs. But, all the Saudi people are Muslims, and I have issues understanding their language when they use some Islamic prayers. Regarding the culture, I have been living here for 20 years, and I am adapted to the Saudi culture more than the

10 Philippines culture; I do not have challenges related to culture.

Fatima: Any linguistic challenges?

BCH11: For the language, I struggle to understand Arabic because they speak deep Arabic in the Qassimy dialect. So, I cannot express my thoughts or explain, but I can understand how they speak to me; I tell them: Sorry, I cannot explain, but I understand what you mean".

15 Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH11: Keep asking, explain harder by the elaboration, or I will ask somebody to explain the meaning; I mean, call my Arabic colleague to translate for me. But I understand them through the way they are speaking with me, including body language, actions and simple Arabic Alhamdullah I can understand.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

20 BCH11: I advise them to make simple, clear language or words that everybody can understand with clear instructions and simple instructions. But, with doctors, I will ask them to explain well or the simple thing we can understand.

I encourage them to avoid using their mother language, and we should use simple English. Because some cannot speak English, they use their mother language to explain. So, during our duty, we avoid using different languages,

25 so that is why we have a meeting, and during meetings, we use English as a medium of language. Even Saudi staff, we encourage them to use English all the time so we can understand each other. However, with patients/relatives, if we cannot understand, we ask them to translate for us. My dear, nowadays, we have a language barrier in the hospital, and many of the recently joined staff are Indonesian and do not speak English nor write in English. This is the main challenge.

30 Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

BCH11: We need both so we can understand. We need medical language in medical scenarios, but when discussing other non-medical discussions, we need to use basic English to interact. Some staff, especially Saudis, find it hard to understand medical terminologies, so we need general English to explain them. These are very important in

35 hospital settings.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

BCH11: We should use English as a medium language for communication in all settings and hospital wards. We should communicate using English, and avoid using our mother tongue. Using our mother tongue for simple

40 conversations is acceptable, but it should be avoidable. Even doctors sometimes use Arabic when explaining the diagnosis to the patient and medicines. As nurses, we cannot understand what they are saying, so I ask the doctor every time to speak English.

Also, we shall motivate them to study more and use English because they struggle to speak and express their thoughts in English. They struggle with speaking skills, and writing is also weak. There are many errors and

45 mistakes in the written documentation. I am not blaming them, but they should teach them English. Some of my Saudi colleagues are willing to learn, asking me: "Can you write this for me in English" I help them a lot. But other colleagues refuse to learn English; they stick only with the Arabic language. But, in the future, my dear, how will they overcome the language barrier? They need to be encouraged to learn and speak English.

Fatima: Would you like to add anything else?

50 BCH11: Emm, schools should implement more English classes from an early age, like in the Philippines, we learn English from the nursery, that's why we are fluent in English. We are not grammatically correct, but at least we are communicating.

The same happens with some of the Indonesian staff, who are coming here, whose English is ZERO. In the meantime, with the written documentation, I check, ask my colleague to edit it, and then I recheck to make sure

55 it is clear without any mistakes. Especially for the diagnosis and medical terms; some are inaccurate, and the grammar is wrong. My dear, this is the situation now in the hospital, which may cause medical errors. So, as I mentioned earlier, medical English is not enough; general English should be improved and studied efficiently in their schools. But inshallah, with time.

Audio interview 12, BCH12
Date: 31st August 2022
Duration: 13:56

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH12: First, the culture and the language are different; for example, for some actions, the meaning of me is good for them in their culture is different. So during communication, I had to clarify and specify to them that If you do not understand, stop me and clarify these things; likewise, if I did not understand them, I would ask them to clarify.

Fatima: Do you have examples of these actions that you've mentioned?

BCH12: For example, rolling your eyes, for some cultures, this is an insult, but for other cultures, it means maybe. Also, if you speak and your hand is in your pocket in some cultures, you do not respect me, but they do not mind in other cultures. So these different actions and body language cause some challenges, as our cultures differ significantly.

Fatima: What about the linguistic challenges?

BCH12: Regarding the linguistic challenges, you know the learning process is step-by-step, right? So, here in Saudi Arabia, as somebody told me, I have to learn five words every day, so by the second day, you should have learnt ten words and so on. Then you have to connect these words; although we exchange messages, it is understandable to them, especially for the old ones and patients who did not go to school. But, with few words, how will you interact with them? We also understand by thoughts, so this is a two-way understanding. If we do not understand, we must seek help from somebody to clarify things. Even if there is nobody, we still have to clarify things.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH12: We have to clarify that if they do not understand, just say; I do not understand; we have to stop for clarification before each colleague goes away. Otherwise, she will go home wondering what you are talking about, and vice versa. So, clarification is crucial.

Also, I elaborate on things even though it will take a couple of minutes. As long as you are satisfied with the explanations, you must clarify everything because sometimes we differ in our accents. Like for some Nigerians, although they speak English, maybe my English and accent are different from theirs. We vary a lot; some words come from the nose, the mouth etc. So, we always have to clarify, ask and repeat.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

BCH12: In our medical setting, we encourage each other, especially the new staff, to be always positive, although some sentences might be rude to some of our colleagues. However, there is respect, but we need to reconstruct the sentences and speak with them to clarify. For example, for some nationalities, you must speak clearly, slowly and without eating the letters. And again, we have to clarify because things will get worse without clarification.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

BCH12: General English communication skills are critical. For the medical language, some staff speak Arabic with few medical terms. Even when discussing medical cases, they still switch to Arabic. Thus, general English skills are vital because they will need to clarify to their colleagues in English, especially when they use medical terms in Arabic. Otherwise, you would carry out an incomplete doctor's order, and create medical errors. So, clarifications with general English are essential, especially with multi-nationalities.

Fatima: Let us say that my Medical English is excellent, but I struggle with general English skills. What are your thoughts about it?

BCH12: If your general English skills are weak and your medical English language is advanced. You will still need to demonstrate to convey your message; demonstrating is an interesting strategy that helps you to understand the basics. Even with a few words of Arabic, you will reach a point when demonstrating. But the medical English language cannot stand alone, and you will still need general English skills for clarification, demonstration and explaining the Arabic terms you've used.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

BCH12: In Saudi hospitals, we will meet many nationalities; some know English but differ in their accent. Some healthcare professionals cannot speak English fluently, but later on, you will observe that their language improves significantly through frequent communication with colleagues. Here, the acceptable languages are Arabic and English, especially for the staff who have been in Saudi they speak Arabic very well. However, you will have to speak English if you cannot speak Arabic. Here in the hospital, even during endorsement, you are allowed to use English and Arabic; there is no way around it. So, in English, first, if you see that they do not understand, use Arabic, and if they still do not understand, you will need to clarify. I am sure with time and frequent conversation, they will know somehow.

Secondly, skills related to language can be improved by additional efforts like watching movies and using translation methods for the spellings and meanings. There are many learning methods, and it just needs time for improvement. Nowadays, Saudi Arabia welcomes many nationalities, so learning English is important. I have

60   been here for 15 years, and learning English was not essential when I first came here. However, education has improved a lot, and we have staff with master's degrees and higher studies; they know a lot and can write and speak English fluently. It is improving a lot which is good.

Everything can be learnt only if the person is interested and by force. We are in the medical field, so we must learn by force. Otherwise, we will not properly deliver healthcare. This will be acquired and learnt over time and with

65   the help of their colleagues. Also, there is the internet, and we have many applications supporting it, such as translation. So it is much more accessible for them to learn. There is no doubt or excuse because learning is accessible now, so it is a must to learn the language.

To finish my points, Saudis are now improving in English language proficiency, and they travel abroad during holidays. You will notice that even the old patient, 'baba', 80 years old, can communicate with the medical staff

70   using English. Others take some business, and you can see the improvements in their language. It is mandatory in their school nowadays to take English. So the situation during my 15 years in Saudi Arabia has changed a lot, and I am happy about this change and improvements.

Fatima: Interesting points. Would you like to add anything else?

BCH12: No, I want to say that I am very happy about these improvements.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH13: For me, behaviour, attitude and religion because we are of different religions.

Fatima: May you explain more?

5   BCH13: Some of my colleagues' behaviour is superior. For example, If I engage with them in a discussion or suggest some advice, they do not listen to me. I encountered this situation with some Saudi colleagues; they say that we are Saudi, so do not speak or argue with me like that. So I stopped talking because I knew I was a foreigner. Even if they are not telling it to me frankly, some tell me directly. And I feel they treat me with power because I'm a non-Saudi.

10   Fatima: And what about linguistic challenges?

BCH13: Some do not understand or speak English; most speak Arabic, some are good at English, and some understand me while I am talking. So we manage to understand one way or another.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH13: I explain more to make the listener understand what I am telling or discussing. I'm just the type of person

15   who describes well, and it is up to you if you do not understand. However, my English is not good but clear. I explain very clearly. I will just hand this example to one patient or during lectures; I can explain it properly and with all the details.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

BCH13: It is better to communicate in one language, English, as the formal language in the hospital. Even if you

20   have yet to finish your study or graduate from your course, all the books and classes are in English, so we should learn English. I mean, use simple English, a simple way of communication.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

BCH13: In the hospital setting, both are important. But general English is number one.

25   Fatima: Why do you think that?

BCH13: Because with general English, You can express and explain to a doctor, your staff, colleagues, or the patient and patient's relative. Also, you can discuss with the patients what kind of medicine they take, what time and the diagnosis. Also, with medical English, you can also use it to discuss different medical cases with patients/medical staff using different terminologies. How will you discuss medical cases without using medical

30   English? of course, you will need general English to explain. So, both general English skills and medical English are needed.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

BCH13: First is the language; they just have to speak English. Secondly, as I mentioned earlier, the attitude and

35   character of most of the Saudis that I encounter want to learn. However, their deeper side is that they think they are superior and refuse to learn. I guess because they think that if I teach them or share my knowledge, they will underestimate me and estimate the quality of learning from me. After all, they think they are more knowledgeable than me. But this is my duty, and I came here to work and share my experience and knowledge. In a recent situation, there was a new machine, and I was given an orientation on how to use it to explain it to my colleagues.

40   During the orientation I gave, one of the staff were Saudi, they refused to learn and said: "we know how to use this machine". I mean, it is not a matter of being superior; it is one way or another. If you have the knowledge, you will share, and if I know, I will share. Indeed, we are here in the hospital for the patients. So if we know the patient's problem, we will solve it according to the patient's case. Even the doctor wants your knowledge of what you will share regarding the patient's case because this matters to the patient, not who you are or what power you

45   hold. I observed this issue while working in the Saudi hospital, not only in this hospital but in general.

Fatima: How long have you been working here?

BCH13: I have been working in Central hospital for almost 12 years and worked in a hospital in Taif city for ten years. Nearly 22 years living in Saudi Arabia, and this is what I encountered. I mean, some were interested to learn, and some were not. However, we cannot blame them because this is an inner feeling.

50   Fatima: Anything else you would like to add for question 5?

BCH13: There is a communication barrier in the health setting because some are not fluent in English. They keep saying: 'Arabic, learn Arabic'. However, for me, I cannot speak well in Arabic. So, we all must use the general English language and improve it. My additional point to conclude this interview is that all Saudi or non-Saudi staff should show acceptable behaviour and respect. Behaviour is a challenge for me. Even if you are

55   Saudi, there is no need to remind us that you are Saudi and this is your country.

Audio interview 14, BCH14
Date: 1ˢᵗ September 2022
Duration: 32:23

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH14: I believe cultural and linguistic challenges in healthcare, like other fields, are possible in hospitals due to the multinationals working in the Gulf countries. All professionals, whether medical or non-medical, are also of

5   different nationalities. The challenges are that the language we use, even if we use the same English in some nationalities, they have different pronunciations, the way we speak English is different, or we find it difficult to translate or even hear. The use of English language verbs, even verbs to be, I mean, some colleagues need to use the correct grammar in speech, then you do not know what is meant by whom they are speaking. It could be the past, present, or an action we do. The correct grammar structure must be used accurately (laughs). Indeed, I need

10   help with the verb to be.

Fatima: Can you provide us with an example doctor?

BCH14: When I discuss or speak, for example: "the patient is going to have or will have", which means we still did not start the procedure. But some non-medical and medical staff understand that the procedure has been done already.

15   You start the discussion, and they misunderstand, so the discussion begins, and the objection is that the process was completed and ended without discussion and consultation. This is causing me problems; I find myself attacked and arguing. However, I am just giving an opinion about a procedure that still needs to happen. Or the opposite happens, and I am the one who misunderstands them from the way they speak and their improper use of verbs. Sometimes they do not use the verb to be. For example, they are discussing the patient's situation, and I wonder

20   if this is his current or future situation. I can't even estimate or speculate, so I need to repeat the question more than once and go deeper to understand the details, and this sometimes annoys them; the speaker gets annoyed. Also, the speed in some words with Indian nationality has a different pronunciation in the English language, or they babble, which makes some words incomprehensible. I do not know, but they must take extra courses, or we take communication courses. So I always prefer to see written documents better to communicate well.

25   Fatima: Regarding culture, did you face any challenges?

BCH14: I have been working here in the kingdom since 2007. Mashallah, the kingdom is in tremendous development, and at all levels, it contains all nationalities and religions. This is the truth. There is more than one culture here because there are different religions. There are Christians, male and female colleagues and others who do not worship and have no beliefs. I faced this problem when I spoke about the medical field, there may not

30   be many problems to a certain extent, but sometimes they may issue comments about patients. You, as a Muslim, see certain situations from a religious point of view; I mean, you find denial from a spiritual point of view, meaning that they are not seeking to win Allah's pleasure. Their expression of certain matters implies such misunderstandings. However, the truth is that the kingdom here accommodates everyone. This freedom increases the extent of acceptance of others, and the issue becomes not what it was before. I used to face a problem in the

35   past; for example, society is conservative. Some people, like my non-Muslim colleagues, lost contact with me because I covered my face. And she wants to see my expressions or see me face-to-face, or some existing cultures are bothered about my outfit and take it for granted that my clothes are long, so there are sensitivities. Also, because she does not see my facial reaction, I may be smiling and happy in communicating, but my colleague may think I am holding a face mask against her. And there was a problem with my colleagues when recent

40   colleagues came in, who did not understand our customs and religion and why I covered my face! However, now the awareness has become more significant, and they understand that these are choices and freedoms and that they are not compelled to do anything, so they are comfortable dealing with us. So there are never cultural problems; I worked with colleagues who had no religion, and they told me that, but I did not feel any issues or differences. Just the simple things that happened between us as women were long ago. Now the situation has completely

45   changed. The issues are only linguistics.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH14: I always like to set an example, even if it is a simple example from our daily life. Maybe they will understand me; I mean non-Arabic speakers. I always try to set an example from a question, remind them of a previous patient's case, or write in documents. I always feel better when I speak and there is a written document.

50   Because what is written is that they can see it, reflect on it, review and understand more than they hear. While I am speaking, it is possible that I do not describe them correctly, or words fall out of me, but they will become more focused and understandable when I write them. For example, before the meeting starts, I like to plan and draft my ideas on paper to know what I will say and what to avoid saying so that they understand me; I mean, choose the appropriate words. So far, I am using this strategy to learn how to communicate. This method facilitates

55   communication so that even if I look at my diary, I find a point I forgot to discuss. Writing and arranging ideas in a better way is an essential strategy.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

BCH14: The first thing to deal with is the correct general English language we all use. Language unification is essential so that the language is clear and understandable to everyone. Secondly, my colleagues who speak

60 languages other than Arabic are not supposed to speak their mother language in the medical work environment. Some colleagues if other colleagues begin to speak a language we do not know their mother tongue, it falls in your heart that they object or talk about something against you. Communication loses a significant link, and there becomes sensitivity, which is the biggest reason for misunderstandings between colleagues. Sorry, I forgot to mention this in the previous question about language challenges.

65 Maybe I am discussing a medical matter or issue, and then my other colleague starts speaking in their mother tongue, so I stand confused; I mean, because it is, first of all, embarrassment. Secondly, if the discussions were appropriate, they would not have spoken in their language that we do not understand, their discussion may be anything against you, or they are objecting. This is where the loss of communication and significant defect occurs. Because I will keep asking them, for example, did you misunderstand me? Do you understand me? Did something

70 happen? Things are complicated. It is better that all employees in the hospital, even if they are of different nationalities, speak the same language, which is English. The side conversations in their language do not occur in the field or medical environment. It is possible to speak your mother tongue during break times or any other place, especially since I have seen this with patients. I may be the patient or one of my relatives or friends on a visit. When the patient waits for the nurse to feel reassured and confident about their condition, if a question is asked,

75 the nursing staff begin to discuss in their language, and the patient starts to feel dissatisfied. For example, I encountered a situation when I was visiting a patient, and there were nurses of Indian nationality. So the patient inquired about his blood pressure, so I got up to check on him and asked in English about the patient's blood pressure status. Then the nurses started talking in their language, and I did not understand. However, the patient thought something was wrong with his condition, and I did not want him to know. This is what I have always

80 seen.

Also, handing over the patient's case to the nurses in the following shift; the handover and discussions in the patient's room are in their mother tongue. This is difficult and causes sensitivity; the patient may think his condition is critical. Medical discussions are supposed to be as far as possible from the patient because they are in a state of loss of communication and do not understand what is happening around them. That is why it is

85 essential to standardize the language into English, and choosing the right places for medical discussions is very important.

Some colleagues discuss the work environment in front of others, so the matter only concerns my colleague and me. If we discuss this issue in front of everyone, it may lead to everyone's intervention. It may cause embarrassment, for example, to explain to my colleague his shortcomings in a particular medical matter or a

90 specific defect that occurred. It is better to have rooms or suitable places for discussions in the hospital so the speaker knows when to speak in the appropriate place. It is imperative that the discussion is not for the public and choose the right place and time because the discussion in front of everyone needs more communication and is a significant cause of problems in all departments, and this is what I have seen through my experience.

I advise my colleagues to make the language accessible and clear and use examples to support their opinions. On

95 the Arab side, I recommend they avoid using expressions that may differ from one Arab region to another. This also causes communication problems.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

BCH14: I think it is important to master communication skills in English first because, in the medical environment,

100 there is a non-medical staff; we have engineers, workers, administrators and operators. What is the benefit I have a medical English language, but I miss handling proper communication in the English language? And always if I talk, I lose communication with others, and others understand me wrong, and a problem arises. Medical English has its place and, as I mentioned, has its use in handing over cases, but communication requires linguistic and social skills, and we need to study this matter. I hope we will have communication courses that enhance our

105 communication skills. We need these courses. I suggest they add to the medical orientation courses in communication, which are very important.

Some doctors may not mean this, but they talk to the patient in purely medical language and explain their condition using complex medical language and terms the patient may not understand. And some patients, when you speak with them in medical English or Arabic, would feel that their medical case is severe. If I speak medical English

110 even with my colleagues, they will not understand me correctly.

Fatima: So, if I only spoke medical English without general English skills, would it be a big issue in communication?

BCH14: In that case, you will not be able to deal with anyone in the hospital environment, which is what we see in reality. For this reason, I think that medical English should be used in universities during teaching medicine.

115 We graduate and work using it for medical cases only, but to communicate, we need general English language skills; how will I explain different cases without these skills? There are ways to describe different cases with specific words that should be used.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

120   BCH14: First, education about the environment and awareness of culture are the prevailing things here in the environment anywhere in the world. It is necessary for a person to get acquainted with the background first, to get acquainted with the beliefs and to get to know the customs and traditions right, which is the first step. The person understands the people around him to know how to attract them in speech and what are the things that repel them from speaking. For example, some people do not understand speech and do not speak but understand sign

125   language. Therefore, people must know and understand their nature and environment to be able to communicate with them, i.e. know the secrets of people, meaning the secrets of souls that make them respond, red lines and points of attraction. So that you do not attack my religion and respect my culture; our religion is different, we shall speak about work issues and avoid these matters. For example, some countries may use religious vocabulary between themselves and each other, as Arabs may use some religious vocabulary in front of the patient that it is

130   not correct to use or say. For example, some Arabs who are non-Muslims or foreigners use some vocabulary and phrases they should not use in the Muslim work environment; for example, saying: "Jesus", Muslim people, whether patients or medical staff, will not accept such expressions. Therefore, they should not give the people around them any impression that they are different from them.

There is a situation I faced. I was working with doctors of different religions, and they did not have beliefs. I was

135   in a meeting, and we were talking, and I said: Allah is willing, we will strive and persevere, and Allah will reward us. We want Allah's wages even if our work is hard. The important thing is Allah's satisfaction and the patient's satisfaction. Then, my colleague suddenly said: "There is no Allah!" This caused me harm in communication. We had big problems because he always objected to religious matters in our culture. So I could not deal with him at any point.

140   Now I am pleased because there are Filipinos and other nationalities who are not Muslims. However, when communicating, I find them saying some of the phrases we use, such as "Praise be to Allah, Alhamdulillah, Inshallah". This gives me the impression that she respects me very much, communicates well with me, and loves the environment in which she works.

Also, I think it is essential to make a simple culture orientation for new employees to be aware of our culture and

145   what is acceptable and unacceptable. I emphasize that the hospital should have an orientation on communication skills and culture.

Another point is writing skills and their importance, and everyone needs to learn how to write a document in English in a very clear language. We shall have a list of words and use a language policy dedicated to each discussion. For example, for meetings, there will be language policy and specific words that facilitate

150   communication or unify the forms. The forms must be unified so that each doctor does not write a different and ambiguous form because it may need clarification. Unfortunately, we do not have a language policy, and this is the cause of problems and poor communication between non-Arabic staff and the Arabs themselves. All governmental hospitals here are rising and progressing, but specific issues are still pending and must be developed. In addition, there should be different language policies for communication to exchange congratulations and social

155   posts. For example, some sites allow you to congratulate a colleague, but the policy must be unified. Phrases of congratulations, condolences, and so on must be applied to everyone; I mean choosing what we should see and read about in the media and what we should not. To make the idea more precise, a colleague who obtained a specific certificate or a colleague who had a baby is a beautiful matter. However, important matters that must be shared do not appear in the media in the hospital. Like my colleague wrote an important article and gave it to the

160   head of the department to decide whether to publish it. And there should be a platform where everyone publishes their articles and research. It does not fall within specific criteria and choices because what I consider important may not be necessary to you. A specific specialist should publish such matters for the benefit of the hospital's media platform and be available to everyone, taking into account what is published and what is not published. I may have an important paper that I would like to publish, so I present it to my director, who will reject it because

165   he does not find it helpful. A specialist and supervisor should manage a unified communication platform to revise what is published to improve communication. For example, a distinguished succeeded medical surgery in another department that I did not see because the director did not see it as worthy of publication. The employee should be free to see all that is published.

In conclusion, I would like to note a point that often happens in the hospital and hinders communication: it is

170   necessary to take into account the appropriate time when discussing certain matters. For example, suppose I have a message or deliver it to a colleague in another department or office. In that case, entering him during work and crowds is inappropriate because this causes him to misunderstand his colleagues. If we were discussing some things and another colleague came at an inopportune time, he would think I broke in, and that happens a lot here in hospitals.

175   And this may happen with the opposite gender, and you may be misunderstood because we, as females, are kind by nature; it is possible in some cases to be misunderstood or camouflage your style to another curve. I

encountered this a lot with men where when I talk or discuss my point of view, he understands it as a challenge, but it is nice that this topic began to shrink with the new generations.

180 Sometimes communication in the Arabic language leads to misunderstanding because we, as Arabs, have very different cultures and methods. For example, saying greetings in a certain way that the listener may not accept because his culture differs, so you must be aware and understand the different cultures around you to communicate correctly. We, too, may need to communicate appropriately with the new generations because their communication is different, which is what the old ages face with the new ones. There is an apparent miscommunication and problems. Therefore, there must be orientations on communicating with the new generations because there is a

185 real gap.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH15: The challenges we face are the knowledge of the language in terms of speaking, terminologies and the understanding of foreign doctors. Our language of communication is English, so understanding is complex
5   between a foreign doctor and a Saudi doctor and health practitioner, especially in medical terminologies. I think terminology is the most challenging because our language is superficial and straightforward, and we do not engage in deep conversations in English. Therefore, sometimes when we encounter a doctor who is advanced in the language, we find it difficult to understand. As for the cultural challenges, there is none, and only language proficiency is a challenge.
10   Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH15: Keep learning and increasing knowledge with all aspects of the language, primarily related to conversations in our field.

Sometimes I have to include some terms in simplified Arabic or speak in broken Arabic so my colleague can be understood.
15   Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

BCH15: Proficiency in medical terminology in which they work in their fields and knowledge as well as education. The language must be simplified to facilitate the process of understanding between colleagues. Because sometimes, there is a difference in understanding between a doctor and a doctor or between a practitioner and a doctor, so simplifying the language is important.
20   Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

BCH15: They are all important, and they all have their uses. It usually differs if communication is general or with the patient; proficiency in the English language is required, but proficiency in medical English is essential when communicating with the medical staff.
25   Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

BCH15: First, it is necessary to be proficient in the English language, especially the terminology, because, among most practitioners, it is vernacular, not the primary language. Also, those proficient in their field of work must be familiar with the terminology. I encountered a practitioner who is very good at conversation in English, but his
30   terminology is weak, so the understanding is reflected between him and the recipient.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH16: Cultural and linguistic challenges, every region differs from one place to another, the meanings differ, and the pronunciation and the language of patients differ from one age to another. I always have problems with
5 the elderly, in some words. They did not understand my words, while they understood the words of my Saudi colleagues who were with me in the place, and I had to seek help from them to help me communicate with the elderly in particular. I suffer from understanding some of the cultural words in different dialects. I mean, what is required of their questions or what is meant by their answers? I swear to Allah that a simple term like (ĀLĀ= a Qassimi dialect meaning yes) constantly confronts me; I still do not understand whether it means yes or no. When
10 I ask them whether they take medicine, He tells me " ĀLĀ". For example, I ask him: Did you do the job? He says to me: " MBṬY" a Qassimi word, meaning I did it for a long time, and I keep wondering, did it from last week or a year ago? , I do not understand. These are examples that need to be checked. Another linguistic Challenge here is that most people are used to cultural, medical terms. Old people learn medical terms in Arabic, such as "الشقيقة", a classical, traditional Arabic term which means migraine headaches. It needs an effort from me to understand the
15 speaker even when speaking the same language 'Arabic'.

Once, I remember that a patient spoke to me about a disease she had. She was telling me in Arabic I did not understand the disease, so I had to ask her to tell me more. In this case, I cannot give an anaesthetized patient to such people in my work. Indeed, because of this misunderstanding, it is necessary to change the medical plan when working with different patients completely.

20 Fatima: What about the challenges that you encounter with your colleagues?

BCH16: With colleagues, there are relatively few Saudis with different medical schools working in other nationalities, different customs and traditions, in different languages. Among the doctors in the department, we have the Egyptian, the Algerian, the Syrian, the Sudanese and the Palestinian. They all studied medical language from different schools, which teach medicine using different languages and methods. We in Egypt learn medicine
25 in English or Latin; in Syria, for example, they study it in Arabic; and in Algeria, they learn it in French. All the terms differ, and there is an overlap of terminologies in the medical field. Not only when speaking of medical scenarios, but it was also a challenge to communicate mainly with my colleagues at the beginning. It was complicated to understand the intended meaning, "do you mean this or that?" I need to understand more. However, we solved this matter by reaching a common language to understand the desired meanings.

30 Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH16: Often, with colleagues, we have had to unify the common language in medicine. We always try to speak clearly and using only English. We appreciate my other colleagues, the Syrian and Algerian, are tired because they are learning medicine from scratch and the medical terminology in English. I understand their tiredness, but communication became more manageable. We suffered at the beginning, but now it is more convenient, and we
35 can understand each other.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

BCH16: As I mentioned before, language standardization is essential, so when there are lectures on a scientific/medical topic, the topic is more straightforward. Everyone understands it, so we do not need to understand the synonyms of this medical terminology in French or Arabic. When we explain, we say the
40 concept/term from A to Z, and we are confident that all the medical staff understands the discussion. I believe that attending a lecture or discussing medical cases helps us reach common ground in the conversation. Attending different medical lectures or discussions would allow us to unify the main terms and discussions, so even if my colleague knows the medical term in French only, he will be able to understand the unified English language that we will use to discuss different medical cases. We will reach a point of understanding. Therefore, I advise
45 strengthening these discussions in various scientific and medical topics so that everyone can benefit from the scientific and linguistic points of view.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

BCH16: It is crucial to be fluent in medical English. We all may speak excellent English, which is not essential.
50 You must know the medical term we meant by what? When I talk with my colleague who studied medicine in French, it may be that I do not speak French, but with these medical terms, we communicate efficiently. We reach each other faster. Maybe we do not care about grammar or perfect English structure so far. For example, in our medical field, when we go to England, they request a language assessment, concentrating on whether our English words are unambiguous. It is not essential to be proficient in the structure of English.

55 However, when I speak in the general English language, I know I am talking about the past or the present. I understand that the action has happened or will happen; this is more important. It is not necessary to master English language skills. Medical English comes first, then the language, taking into account the importance of knowing the tenses of verbs in our medical field.

60 Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

BCH16: Ok, in principle, there is the culture shock that comes to us relatively first. In Egypt, most of our dealings are with Egyptian staff, and we all speak Arabic, the same dialect. But here, at first, I was shocked that we had to change our words from purely Arabic to purely English. Because in Saudi hospitals, we have other medical staff and technicians with different cultures. Even our Arabic language varies from dialect to dialect, so communication

65 is not easy. For example, when communicating with my Sudanese colleagues, I understand them more when they speak English, not Arabic, and I think it is necessary to have the basic English language before coming to work here; indeed, it is imperative. If you have the basics of English, it will become more manageable with time and more observations.

Moreover, it is necessary to be aware of Saudi culture and know that I came to work here; I must know what

70 people think and how they deal with the Saudi environment. I do not want to offend them. We must know what vocabularies and language are acceptable in their culture, and I have the right to be excused when I create a misunderstanding, especially when using specific terms. Of course, some words may be considered taboo in the Gulf countries, but in my Egyptian culture, they are acceptable to say. So, we must excuse some of both sides and communicate common ground with some words so that it is clear to both parties.

75 Fatima: Is it possible, doctor, to give an example of some of these terms that caused you a misunderstanding?

BCH16: I mean here, when communicating about other topics, For instance, the term (MKWH, meaning - gluteus maximus) this term you have in the Gulf is a defect, and you are not allowed to say it out loud, whereas in Egypt it is a common term. I still do not understand what is wrong with it? We are Egyptian Arabs, and we do not consider it a defect. I still do not understand what is wrong with it! The culture of the Gulf countries is very

80 different from the culture of the Arab world; for example, we are Arabs, and we do not consider it a defect.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH17: Some colleagues are from Algeria; their first language is French, and they have few words in Arabic. Communicating with them is a challenge. Also, some staff from South Asia speak English but with different accents.

Fatima: Can you elaborate more, doctor?

BCH17: There is no specific point; I mean, in general. When speaking with them, we had to clarify, repeat and confirm.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH17: I repeat the question twice and ask whether the information has reached them. I always use the confirmation strategy.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

BCH17: The language must be unified so that English is the language of communication for all staff, which is imposed in all Saudi hospitals.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

BCH17: Proficiency in medical English is more important because this is a matter on which all people agree. Proficiency in the general English language sometimes leads to misunderstanding; for instance, some words have a second meaning. In other words, the medical language is fixed.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

BCH17: There is an experiment implemented at King Fahd Specialist Hospital; if they notice a problem with some staff communicating with others, they give them a training course in the hospital to train them in the English language and the medical language to improve communication. I think this experiment will succeed if implemented in our hospital here, Central Hospital. This is all I have and good luck.

Audio interview 18, BCH18
Date: 5th September 2022
Duration: 3:02

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH18: I expect to face language challenges when new medical staff join us; I mean, the tone and accents are challenging. I suffered a lot with some of the Indian nationality when they recently joined us, but communication
5   has become easier with time.

Fatima: Are there any cultural challenges?

BCH18: There are no cultural challenges; it is only the language of our new colleagues.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH18: I try to explain and clarify to the colleague. I repeat what I said until we reach an agreement of
10 understanding. Moreover, of course, simplifying the language is essential.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

BCH18: I advise them to be calm when communicating between the doctor and the medical staff, especially with nurses. Respect and being calm are always vital, and the tone of voice should not be raised.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or
15 General English language communication skills? Why?

BCH18: They are all important, but the general English language is more critical. Because if you engage in a discussion or dialogue with anyone, you should know the language skills. If you only know medical English, you will not get involved in any discussion with your colleagues. Of course, the priority for general English; when you master it, it will become easy for you to learn medical terms.

20 Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

BCH18: I believe they should be a good listener, listen more, understand more, and learn more. The listener/receiver of the message must be a good listener to understand the message without misunderstanding.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH19: For me, there are no cultural challenges; why! Because Arabic is the basis of my education, and my mother language was French, not English. This is because of where I lived. But when I came here, it was necessary to raise my English slightly. Why? Because here, I work with nurses and doctors who do not know Arabic or another language, either English or their mother tongue. I faced many situations while working and discussing medical cases with my colleagues. I subconsciously found myself using words in French, and they were not fluent in them. I noticed they did not understand me, so I reviewed my words and used only English.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH19: In order to avoid misunderstanding, I explain a lot. Sometimes I explain to them using other methods. For example, I use translation applications and pictures when I want a specific device or procedure that I know in French but do not know in English. So, I use such strategies to deliver the correct information. Some challenges had to be improved, so I needed clarification, and things were manageable.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

BCH19: It is necessary for the medical environment to unify and use the universal names for any tool or medicine related to our field, whether in French, English, or any language. For example, I use the scientific name, not the trade name for drugs and medicine. Because it will lead to the exact meaning whether I studied in the Philippines or any other language. To illustrate this point, (Amoxcilciline) is the scientific name, but sometimes they use Omexil or another trade name that is an entirely different name. And Paracetamol is the scientific name, but it could be Perfalgan or, for example, we use Efferalgan in Algeria and so on. So we should use only scientific terminologies because they are common nouns, on the one hand, no matter what the language is. As for communication, if communication fails through using the common language in the hospital, it is possible to communicate through sign language. I can deliver information through sign language because words may not convey information but may be delivered by body language.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

BCH19: Both are important. General English is to a certain extent, but medical English must be at the highest level. You must master it. Because sometimes, you need the speed to finish some medical tasks and speed in taking/passing out the medical tools, you do not need to take time to think about. At the same time, the general English language is needed at a certain acceptable level to fulfil a purpose and give its information.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

BCH19: I mean, a person must sometimes improve his educational level. He/she must read and study. Improving themselves and not being satisfied with their current level. Especially that we will occasionally encounter doctors of different nationalities with a high level of English; for example, if they come from America or Europe, this is an opportunity for you to raise your level, and this is the goal. Sometimes the level is, for example, they come from Sri Lanka, and their language is English. However, their dialect and pronunciation become difficult for you to hear, and you need to familiarize yourself with your listening skills to understand these English words in different accents. And this happened to me recently when I was with an Egyptian doctor who knows English but does not understand the nurse while she speaks to him in English. Because there are more than one dialect in English, I am talking about the dialect, not the language itself. The language will not change, but rather in the way of pronunciation. So they need to improve their knowledge. And this happens in a hospital environment with practice. The practice developed me a lot. I am very fluent in French, but I have problems with some words in English, and with practice and mixing with dialects, I got used to them and raised my level.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH20: There are no challenges because I do not see challenges in my department, and our culture is close to each other.

5   Fatima: What department do you work for?

BCH20: I work for two departments, the Anaesthesia technician and community health.

Fatima: Ok, regarding linguistics, did you encounter anything you would like to share with me today?

BCH20: At the beginning, of course, but with learning and with time, it became easy. I do not see any challenge. Maybe when I first came here, I graduated from a University where we were taught in Arabic and only had the

10   terminologies in English. So, I enrolled in a private English institution and completed my BA in community health in English. I was forced to develop and improve my studies and my English language.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH20: If my colleague does not understand me, I simplify, then repeat. I try to replace the term with another term until my message is conveyed.

15   Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

BCH20: I advise them to be calm and understanding. Also, do not get upset when communicating with colleagues at the beginner or advanced level. Calm down because we are all colleagues, and all do one job: to deliver the best healthcare for patients.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or

20   General English language communication skills? Why?

BCH20: Medical English is more important because of the terms you become familiar with and communicate correctly. You can mention medical terms you previously used at work that do not apply to general English because it is difficult to find their equivalent in General English.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are

25   more important for staff in Saudi Hospitals?

BCH20: I will summarize it in one sentence; You must be proficient in English and work on developing it to communicate with the team and the hospital staff.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH21: For language challenges, some people at work their English is weak. We cannot communicate with them. If I want to ask them for a specific request, it will be challenging to explain to them the health requests. Especially

5   here in the Operations Department, we need orders to be executed quickly. I think these are the linguistic challenges we face. Cultures and religions differ from person to person, and their method of dealing with some colleagues. However, some colleagues need some recommendations.

Fatima: Do you have an example you would like to share with us?

BCH21: The recently joined staff need more time to adapt and communicate. In a situation that happened to me

10   recently, I was trying to explain to my non-Arabic colleague about the anaesthesia machine, in which there is a setting that should not be changed from case to case. He did not understand me, so he changed the setting of the device, and it would have caused a medical error. We dealt with the matter and spoke to him; my colleague was new to the situation. Later he learned how to manage the settings of the device.

Fatima: Did you communicate with him in English?

15   BCH21: At first, he did not understand English, and one of his colleagues spoke in his language, so we asked him to explain the matter.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH21: The most important point is that I try to reach the level of the speaker's language. For example, I am talking to an Indian or a Filipino of the nationalities that we have in abundance. First, it is necessary to be patient

20   while communicating with them, and I try to understand them and talk to someone of their nationality and ask about the easy words I can pick up to communicate with them. , then I advise them to read and try to understand and acquire Saudi or Egyptian Arabic to understand us.

Fatima: Do you mean doctor, that you try to search for words of the same nationality to understand or reach their level?

25   BCH21:Yes, exactly, for example, most Indians call each other (Biya), which means; my colleague, or my friend. So I use this word to call them because if I call them in Egyptian Arabic or Saudi Arabic, they'll not understand. After all, he is a foreigner, but we are Arabs; we understand each other because we speak one language. I need to acquire and memorize certain words in their language to communicate with them.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

30   BCH21: We try to talk to each other and acquire some languages and words so as not to be surprised and bump into words that we do not understand and are transmitted to us when we do not understand them. So, learning a few words from the Filipino, Hindi and Bengali languages or any other language will make your job easier. I am an anaesthetist. I treat the patients while they are not conscious. If I say to him (my friend) in English, he will not understand or understand Arabic, so you need a few words from different languages to be able to speak

35   and communicate, which is not wrong. On the contrary, it makes it easier for us to work and saves time and effort. I always advise my colleagues to learn the dialects of others. Sometimes our Sudanese and Syrian colleagues have words that are difficult to understand, despite the fact that we are all Arabs. With effective communication, do not become close to yourself because it is challenging to communicate with time.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or

40   General English language communication skills? Why?

BCH21: Good question, both are very important, but if we give priority, proficiency in general communication skills will be more critical because not all staff who work with us can speak medical English. They might not be doctors, coordinators, engineers, or workers.

We must have the general skills to communicate with staff and deal with patients. For example, the patient comes

45   to me and says: "Where is the pharmacy? How can I reach the outpatient clinic?". I should not talk to them using medical English. Then how do I explain the way to him or describe it to him? I think general skills are the most important.

Fatima: Ok, Doctor, if I am a doctor, for example, a surgeon, I do not master Medical English and miss out on some terminologies or diseases. But I have mastered general English communication skills. Will I manage in the

50   healthcare setting?

BCH21: See, I will give you an example; we have some nationalities here taking medicine or being educated in Arabic, for example, our Jordanian and Syrian colleagues. They have been awarded a medical degree and studied the medical language, but not in English. So, just using general English to explain will make them understand without needing good medical English. This is my personal opinion. It may be true or false, but my opinion is that

55   the general language is the most important. However, it does not preclude the importance of the medical English language.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

60 BCH21: Social communication skills, i.e. it is necessary to have skills that can mingle with the person who meets you and avoid collisions with each other. In misunderstandings or a clash between colleagues, each one should not turn his back on the other. There must be an understanding and a solution, for example: "You did not understand me and did not understand what I meant?" Find someone who speaks their language to resolve this discussion between you. But the problem is, in the first place, when there is a misunderstanding or a request, and you do not implement it because you did not understand me, say it! Because I might think that you are refusing

65 to communicate with me or refuse to make the request, but in fact, you did not understand from the first point.
I always say that it is necessary to have the ability to explain the situation, for instance: " you did not understand what I said?". That's fine, and I will look for someone who speaks your language to resolve this misunderstanding.
Fatima: Doctor, you mentioned a while ago that I need to have a background on all the departments in the hospital. Please explain more.

70 BCH21: Exactly, a medical staff should know a brief background on every department in the hospital. For example, I have some cases next week in the emergency department. I must begin to know essential terms in the emergency department; for example, if I hear (code blue) or (RTA), I know that there is an emergency case which requires immediate action and cannot wait. I believe that in such cases, there is no time to search for what RTA means.

75 Likewise, if you work on yourself using a dictionary for a week, you will learn words that make medical communication easy.

Audio interview 22, BCH22

Audio interview 22, BCH22
Date: 6th September 2022
Duration: 12:37

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH22: See, I'm from a country which is in Southeast Asia, like India and Pakistan. We have significant cultural differences here because the Arab culture is very different. Our society is mixing males and females and relations
5   with each other, but here I see many differences. In Saudi culture, the male population is separated from the female population. They cannot live with each other, especially cousins and relatives. Even if I'm not here in Saudi, and a family member visits us from my home country, we cannot welcome him to stay at my home without any fear. Secondly, culture is a problem, and you can say now it's almost changing. But when I came here ten years ago, it was very strict. Previously, females were not allowed to come out of their homes.
10   Nowadays, you know, there has been much difference. Now you can see that females are driving cars, which is the change we want.
       Another point is that previously, the females were so much heavier and overweight. Obesity was very much more than 52% of this obese population. Surprisingly, people liked the obese people, you know, males like obese females, not The smart/thin ladies; they were rejected.
15   Nevertheless, the culture is very different, So I foresee that maybe Saudi Arabia will become more liberal after ten years. Those are my points of view.
       Fatima: Any linguistic challenges?
       BCH22: Regarding linguistics challenges, the situation here is complicated for us as staff from India and Pakistan. People do not understand other than Arabic, which is also not the standard Arabic; maybe ancient tough Arabic,
20   especially if you go outside Buraidah, like to rural areas. For instance, I used to work in Hafar Albatin city and suffered from understanding their Arabic language. Arabic was difficult, and people did not want to learn English. There were exceptions, like in cities such as Jeddah, Riyadh and Damama, where they spoke and learnt English. But the situation here is different; people rejected learning and speaking English. And even if they know English, they do not want to talk.
25   Fatima: And what about your colleagues in the medical setting?
       BCH22: There is a problem when communicating with my colleagues when they are all Arabic, such as the Egyptians, Sudanese and Algerian, speak Arabic. When sitting with them, I feel I'm just nowhere because I do not know they are what they are discussing.
       So it is very difficult, even with my colleagues, that this is a very different scenario here. Okay. Well, they will
30   talk in English if something concerns me. Otherwise, they will speak Arabic everywhere.
       Also, the problem is not speaking Arabic; the problem is that when they speak Arabic, they do not speak basic Arabic like the beginners level like us. They speak at very different levels, with different dialects that are difficult to catch. Sometimes, it mixed with English and sometimes not.
       Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?
35   BCH22: I prefer to always speak in English and clarify things in written English. If there are some problems, I write it in English. Let us say some investigation; we do not want to write anything which is not what we do not know. So I write my answer in English and go to a translator, and they convert it into Arabic.
       Fatima: So this is the strategy you use, you write it in English and translate?
       BCH22: Yes, this is my strategy to prevent misunderstandings.
40   Fatima: Do you translate it yourself using Apps like Google Translate or let someone translate for you?
       BCH22: No. Usually, my colleagues or translation services, you know, near the court areas, some translation offices take the money and translate for you.
       Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?
       BCH22: I recommend that our colleagues should speak English all the time. During break time, they can speak
45   Arabic, but in official meetings and when discussing medical scenarios, they should use English only. Unfortunately, this is not the case; even in Riyadh and other hospitals, they speak mainly in Arabic. However, if the topic requires my response, they switch to English. So I feel I'm not part of this meeting and this is the problem.
       Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?
50   BCH22: As technical, medical workers, we use mostly the medical language. We do not care about literal and general English, and we do not use general English. Unfortunately, they are also not using general Arabic. Also, most people do not know the common language. Speaking common languages is very different from the actual Arabic - English. Nevertheless, When I attempted to learn some Arabic, it was literal. So, when communicating, it did not work at all.
55   Fatima: what do you mean by literal Arabic- English? Do you mean the slang language?
       BCH22: Yes, I mean the slang language; they all talk in slang Arabic. However, we should use medical English in a hospital setting because everyone has the right to understand what is being said. So, if they are speaking in Arabic and I am sitting here, I will feel that might be something wrong with me or something against me. I cannot understand that, and this is a problem. So, medical English is more critical.

338

60   Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?
      BCH22: In Saudi hospitals, it is very difficult for young staff, and other than doctors and nurses, I don't think they will speak much proficient English. So it will be a mixture between Arabic, some Arabic and some English. So that can work. But for the medical staff, we should use the medical English language and English language.

65   For awareness, I should be aware of this; suppose I am coming to work in a Saudi hospital. In that case, I should know English because most of the medical staff here; for example, do you see the doctor sitting with a beard (pointing at his colleague)? I do not want to mention his name in the interview. He believes everyone should learn Arabic and then come to the Saudi hospital. So any person who is not an Arabic speaker should not come to work in Saudi hospitals, and this is his point of view. However, I believe that there should be a universal language in

70   the hospital and medical English. So everyone should learn it, and it should be compulsorily implemented.
      Fatima: Very interesting. Anything else you would like to add?
      BCH22: No, thank you.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

MCH23: Saudi Arabia is a multicultural, multilingual country. The only thing considered easy, of course, is communicating in Arabic. We know the Arabic language; we communicate with the Saudis and sometimes with
5   people who are foreigners and have been in Saudi Arabia for a long time and have understood the language. For foreigners whose culture is different from ours, if a person joins us recently, we find it challenging to deal with them, so we communicate by sign language/ body language, then in Arabic and English. As for the staff who has been working in KSA for a long time, they acquired Arabic, and we acquired their language by communicating with them. For example, our colleague, the Algerian doctor (pointing at him), we began to speak some of his
10   words, i.e., such as (فهمتش عليا ، والا مافهمتش) in the Algerian dialect, meaning= Did you get me or not?. In the beginning, we told him how you communicated and asked questions sharply, and we felt that you were always angry. However, with time, we acquired some phrases to speak with him, and things became simple for us when we understood the words.

Of course, English is our dominant language with Filipinos and other nationalities who do not speak Arabic. As
15   for culture, of course, we are in Qassim, their culture tends to be more religious, and if it is lovely, it helps us as Muslims. At the same time, communication with them is easy, even the social life, and may extend to visiting families of any social relationships, such as, marriage ceremonies.

But I see the solution to communication in an Arab country is to unify the language. For example, for comprehensible communication between colleagues in the operating room, we will speak with them in Arabic if
20   all those present speak Arabic. If they are from different nationalities and do not speak Arabic, then we speak English, the language that people understand.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

MCH23: First, I believe attending the first orientation done in the hospital for the new staff is crucial as it explains the administration process, for example, tasks within the departments, this is for (infection control, and this is
25   etc.). It helps a lot to know what you must do and how.

Secondly, body language is very important. The smile gives the impression that you are social and willing to make relationships and communicate. Hand gestures, for example, by pointing with your hand: " stop please, stop please do not continue, sorry, I DO NOT LIKE THIS TOPIC". You showed signs of nervousness in expressing your point and communicating with others. Number three, it is necessary to learn the culture of the country where
30   you work. I mean the Qassim region, retrieve the history of Qassim, search for the language in which it is used, the history, when it began, and the most important thing is the tourist areas in it, etc. This will enrich my background to help me develop my language abilities and, at the same time, learn about the culture/region. These are the strategies I use when communicating with my colleagues.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?
35   MCH23: In the hospital and at work, of course, the English language is what we are supposed to speak. Communication between colleagues is social communication, which means, for example, inviting your colleagues to share breakfast or any meal, it could be a cup of tea or juice. This calls for emotional warmth between colleagues, which helps the team to love the work setting and encourages them to mix more inside work; therefore, they will adapt to the work environment and then I would not think of leaving it. So, an investment in relationships
40   is needed, as well as the stability of the place. Social communication creates a love continuum between the feeling of brotherhood and the feeling that we are one team. We help each other and support each other so that there is no obstacle between us, and of course, we do not forget that our religion encourages these strategies. Communication is vital, whether over the phone, during holidays every year, Eid Mubarak, happy Ramadan etc. ", or even by WhatsApp or social media applications.
45   If I get upset with my colleagues or misunderstand them, it is also essential that I speak to them and explain the reason for my anger: such and such. Transparency is important, and I do not conceal a matter in myself. Because after that, concealing the anger leads to misunderstanding/ conflicts, and the person begins to empty his rage on colleagues in an unworthy manner.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or
50   General English language communication skills? Why?

MCH23: Of course, general English skills because medical English as a language will not help me, but other skills such as listening and speaking are necessary. What do I do with an artery, a bone, a tongue, an eye, Hepatitis A and so on in communicating with colleagues? But when I invite you to dinner tonight, or say that I am so happy with your work today, how do I express and explain it without general English?
55   Also, when discussing different medical conditions, we often do not use medical English only. However, it is mixed between body language and different expressions in general English and its skills. Therefore, from my point of view, proficiency in English communication skills comes first, followed by medical English.

Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

60   MCH23: As I said in the first place, I look at the history of the place and the dominant language in the area. This research, along with the orientation, brings me closer to the environment. Also, watch your skills; are they closed and not open in nature? You have social intelligence, and your personality is likeable and not introverted. It mixes with all members of the group. It becomes easy to deal with and communicate with, and any task will be manageable for you, so if you find any work related to management or any technical need, it becomes easy.

65   Accepting everything without complaints, for example: "I work in many cases, I cannot complete this report, and so on". Instead, you will love the medical setting and mix with different teams. With time, you will find yourself integrated into the middle of the group, and there will be no spacing or dissonance.

Fatima: Would you like to add anything else, doctor?

MCH23: Thank you for the topic, which is important and deserves to be raised. And I hope that the Arabic
70   language will prevail in communication and become the dominant language.

Fatima: What cultural and linguistic challenges do you tend to experience with your colleagues? Can you give an example?

BCH24: The most important challenge is defining the meaning of the desired term, whether in English or Arabic; English is often more complicated. The variation determines the specific term and makes the listener not
5   understand what you are saying, which depends on the speaker's level. Communicating with a physician-consultant is different from communicating with junior or medical staff.

For example, in the Emergency Department, they understand what you mean other than what the nurses understand, which is a challenge to me. This problem is from the centre you work in; when you are with a specific department that is more specialized in terminology, the variation of the terminologies decreases. When I worked
10   in the National Guard hospital in Riyadh, the challenge of selecting the medical term or terms in general English was rare.

Fatima: Doctor, do you mean the medical terminologies or the language in general?

BCH24: The language in general, and often the challenge I encounter most, is medical terminology. When you utter a word to the consultant, he understands. But when you utter the same term to a senior consultant, he does
15   not understand even if he is higher in level.

The same idea to ER physicians; for example, the phrase (do not have the patients' stability), is different from orthopaedic stability. If you notice, the word stability is general. So who defines the terms? It is your task to ask him: "what do you mean, doctor?" then you expect him to ask you a direct question, or he expects you to understand the term directly. Your understanding of the meaning is entirely different, so the issue of responsibility
20   goes back to the department where you work. The language was more explicit when I was in the National Guard than at the Central Hospital.

Fatima: Was there a language policy in the national Guard Hospital?

BCH24: I do not remember if there was a language policy to follow, but we have not been having this confusion of terminology.

25   Fatima: Are there any cultural challenges you faced while working in the medical field?

BCH24: Among the medical staff, there is not much, but among patients, there are many. Frankly, according to the ruling of the Ministry of Health, we receive patients from everywhere, and there are some barriers.

Fatima: Is this a barrier with Saudi/ Arabic or non-Arabic patients?

BCH24: With Saudis and non-Saudis, the reason is that the region differs, and the region's education differs. For
30   example, I worked in the Easter Province in Dammam, and the patients were more educated, many of them from Aramco and oil factories, especially the Khobar region. Likewise, the language was clear and specific when I was in Riyadh. However, in the Qassim region, there is a struggle. So I often face cultural issues with patients and staff who do not speak English, specifically Saudi staff.

Fatima: Do you mean when communicating with them in Arabic?

35   BCH24: I mean, sometimes, you must learn to answer the term in Arabic. In Arabic, you must be very descriptive to explain a term. Unlike English, one term or a sentence can describe your whole message. Here, we have a problem with many people who need to learn English. Unlike while I was in the National Guard, their English is good. In four months, all Saudi staff knows English, whether administrative or any staff working in the hospital has English. However, the challenges are clear here, even in the training centre. One is related to the language,
40   and the second is determining the medical staff's responsibility as the challenges. There needs to be a greater understanding that responsibility does not define the tasks.

Fatima: What kinds of strategies do you use to prevent misunderstanding with your colleagues?

BCH24: I am a descriptive person. I explain the exact point I want in detail: "low stability patient, stability means..., call the general surgeon and the neurosurgeon, do the investigation, then call me again". As for me, I do
45   these steps that are boring for my colleague and boring for me. I know it takes time, but it prevents misunderstanding and future medical complications.

Fatima: Are there other strategies you use besides the description?

BCH24: In some cases, I write, especially with some of my colleagues of different accents of Indian nationality. We have many accents that tire us frankly, while in the Guard Hospital, most Filipino nationalities' language is
50   clear and excellent, better than here in Central Hospital. Sometimes I ask them to write on paper so I can understand more, and sometimes I write to them on a piece of paper. In a few cases, a translator is often called when speaking with the workers in the cafeteria, non-Arabic patients, and the reporter; I can call someone to translate, but there are few cases.

Fatima: What kinds of communication strategies would you advise medical staff to use in a work setting?

55   BCH24: Specifying the term, clear language and accent, especially the Egyptian nationality, for example, with the letters pronounced (z.f. h) It was a problem that they were unaware of, for example: 'that' is pronounced > zaht. I advise them to be aware that their pronunciation and accents are unclear and the listener does not understand what they mean. Also, determining the tasks for each medical staff is one of the problems I face here. Sometimes I

60 complete a task that I thought was my responsibility, and then I encounter that my colleague has finished it. Determining obligations is essential. Sometimes the tasks can be understood differently; here, the responsibility varies. This is the problem that I deal with when the tasks and duties are not straightforward. This is one of the matters that the Ministry of Health should focus on. The tasks and responsibilities must be clearly explained to each medical staff in the hospital.

65 Moreover, the lack of clarity of terms, so you understand the term in another situation. For instance, once I was ordered to 'send the sample to the lab', I thought it meant putting the order on the system, which is what I did. After 4 hours, the lab called saying they did not receive the order; when I checked the system, it appeared on the system; how come they are saying they did not receive it? Of course, 4 hours delayed to the patient, the surgery preparation was delayed, and the last operation in our department was at 2 pm. So we had to postpone the surgery until the next day; why? Because they said in our department, 'send the sample to the lab means you have to bring

70 it yourself to the lab, not record it on the system. I never thought that this was one of my tasks. So, these misunderstandings occur daily.

Fatima: What do you think is more important in the healthcare setting: Medical English language proficiency or General English language communication skills? Why?

BCH24: General English skills are more important because it is possible for anyone who speaks any language in

75 the end, even sign language, to understand you. However, the question is whether you understand it correctly. This is the idea of the language in general that you understand the meaning of the speaker's messages. So I think general English communication skills are more critical.

Fatima: Doctor, what if I master medical English but do not know how to communicate in English? Will I manage?

BCH24: No, you won't manage in the hospital setting. As I mentioned, defining the term varies from patient to

80 patient, specialist to specialist, and level to level. When I was a resident was different from when I became a consultant, and when communicating with internal medicine was not like communicating with other medical staff, for instance, the radiant and so on. The term is different, and it is essential to know what I'm trying to convey, and it is necessary to know what they mean. There are many skills you should master, but knowing only the language will not help.

85 Fatima: Ok, Doctor. Suppose I am a surgeon but do not master Medical English, and my English proficiency is advanced. Can I deliver the medical terms and scenarios when explaining in general English?

BCH24: With good communication, you can. If you can describe the situation in English, you can manage. The problem, I, is that are you aware that with your lowest term level, can you convey the information or not? You are not from my department, and you communicate with me about another medical field that I do not know,

90 but you are a descriptive person, and your English language is excellent. I will understand your message without the need for medical language.

I face some doctors who write the report, small paragraphs full of terminologies that are not from my field or might not be apparent to me. Even in Riyadh, I used to call my colleague who wrote the unclear report about the patient, the transfer etc. So, until now, I had to call back to ask the doctor in charge to explain more.

95 Fatima: What knowledge, skills, attitude and awareness related to language and communication do you think are more important for staff in Saudi Hospitals?

BCH24: The first thing is the standard of English. I mean it; this is what we need to fix. The communication between Saudis and non-Saudis, and I believe it is the MOH job to enhance this point.

Secondly, the tasks and terminology should be clear, as the meaning of the language should be direct, and the

100 variation of the terminology should be less.

Also, we need direct communication. Whenever I need you, I can reach you. Here in the hospital, when we say direct communication, they think you will disturb them with your calls. When I was in Riyadh, there was a direct call, and I mean a direct phone is in the department so that even if the doctor in charge is not there, the doctor on duty receives it, and so on. So if any defect you can call and reach someone. It is necessary to have a hotspot that

105 is available all the time. I record my notes in Buraidah's central hospital, but no one knows who I am. No one knows how to communicate with me; my name is written only. Who am I? What is my level, and how can they reach me?

I mean, in Riyadh, my contact information is recorded, for example:

My name .. - He is an "ROLE". His pager number ..,

110 When my contact information appears to the doctor, it will become easier to reach me through direct calls in case of urgency. Even at home, I would check my pager and keep updated.

Here we have a similar process, but it takes a long time. First, you search and see who is the doctor in charge is and what the department in which you take his name, then ask the department which he is. They tell you, for instance, that he is a senior registrar or consultant; how can I reach him? You have to search for his papers and go

115 to the department and so on.

Fatima: Anything else you would like to add, doctor?

BCH24: No, that's all.

Fatima: Doctor, you mentioned the variation many times. May you elaborate more?

BCH24: Defining the term and avoiding variation is needed. Let me give you an example when I ask: "Fatima, from your perspective, what is the meaning of stabilization? What do you say? For example: Are you stable in your life? For example, I view divorced women are unstable. This is a general meaning for me, and the married woman for more than three years has not given birth to a child and wants to have children; they are unstable. A wife who is far from her husband for reasons, for example, a job, they are not stable. This is my understanding of the term 'stable'. But it is possible that you, Fatima, have different understandings and assumptions of the term. Maybe your opinion is that stability means that 'I am comfortable, my husband is comfortable, and life goes on without any problems'. The concepts are very different, and the term is clear once you and I discuss it with a family consultant or specialists who understand it and may explain it explicitly. My point is that for some English terms with more than one meaning, we need to be precise in choosing the term. And this depends on the strength of language and communication; as long as the language and the tasks in the centre are unclear, we will not reach successful communication.