Research Title:

Title: The impact of language communication barriers on non-Arab medical practitioners' healthcare delivery and ways of addressing miscommunication issues: An exploratory-phenomenological study of Bahrain

Thesis submitted in accordance with requirements of the University of Liverpool for the degree of Doctor of Education by Rabab Isa AL Muqahwi

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Abstract

Study Title

The impact of language communication barriers on non-Arab medical practitioners' healthcare delivery and ways of addressing miscommunication issues:
An exploratory phenomenological study of Bahrain

Keywords:

Language communication barrier, language challenges, cultural challenges, coping strategies, qualitative research approach, exploratory and phenomenological study.

This thesis explores and uncovers the language communication barriers faced by non-Arabic speaking medical practitioners from different fields of specializations and different years of experience. These practitioners work in public or private medical institutions/hospitals in Bahrain (i.e., the context of the research is diverse). The study identified and highlighted language communication challenges and the potential accompanied consequences and effects on medical practitioners' professions and/ level of medical services provided. This research further aims to come up with a number of potential coping strategies and future support to solve the issue of language communication barrier encountered by non-Arabic speaking medical practitioners when dealing and diagnosing Arab patients in a diverse Arab medical context in the Bahrain Kingdom.

This research is an exploratory phenomenological study, and it follows a qualitative approach with the use of a semi-structured interview as a method of data collection involving on a number of non-Arab medical practitioners from different medical specialties and various years of professional experience working in three research sites, represented in three medical hospitals and one higher education medical institution. The main analysis method used for analyzing the collected data is the thematic analysis method (Braun & Clarke, 2006) in addition to using the NVivo software for qualitative data analysis to maximize the accuracy of the data collection analysis results.

It is thus expected that the findings of the present study will contribute to first, enhance medical and healthcare services by highlighting both unique and common language communication barriers faced during real- based doctor-patient communication process, resulted consequences of such barriers, learnt coping strategies followed by medical practitioners in their daily clinical practice and recommending practical future coping strategies and solutions. Second, this study further contributes to informing the teaching and learning of Arabic language communication for medical and healthcare purposes as part of the health care studies in higher education and add to higher education context in the field of medical education, for medical and nursing students, academics and for medical practitioners. One further aim,

through this study recommendation is that the aim to convey the study message and findings to the medical and healthcare authorities in this study contexts to facilitate the way of establishing new policies, professional training solutions and future projects.

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Glossary of Terms

B

Barrier

a natural formation of structure that prevents or hinders movement or action **(http://www.merriam-webster.com/)**.

Body Language:

The nonverbal imparting of information by means of conscious or subconscious bodily gestures, posture,… etc.

Reference Link: http://www.yourdictionary.com/miscommunication

C

Communication

1: information communicated. **2:** a verbal or written message. **3:** a process by which information is exchanged between individuals through a common system of symbols, signs, or behavior **(http://www.merriam-webster.com/)**.

Culture

plural **cultures**

Learner's definition of CULTURE

a [noncount]: the beliefs, customs, arts, etc., of a particular society, group, place, or time

- a study of Greek language and *culture*
- today's youth *culture*
- Her art shows the influence of pop/popular *culture*.

b [count]: a particular society that has its own beliefs, ways of life, art, etc.

- an ancient *culture*
- It's important to learn about other *cultures*.

Reference Link: https://learnersdictionary.com/definition/culture

E

Exploratory Study:

"Initial research conducted to clarify and define the nature of a problem". (http://www.personal.psu.edu)

H

Healthcare givers

1) A doctor of medicine or osteopathy who is authorized to practice medicine or surgery (as appropriate) by the State in which the doctor practices; or

(2) Any other person determined by the Secretary to be capable of providing health care services.

Reference Link: https://www.law.cornell.edu/cfr/text/29/825.125

L

Language

the words, their pronunciation, and the methods of combining them used and understood by a community **(http://www.merriam-webster.com/)**.

Learning

1: the act or experience of one that learns. **2:** knowledge or skill acquired by instruction or study. **3:** modification of a behavioural tendency by experience (as exposure to conditioning) **(http://www.merriam-webster.com/)**.

M

Medical Language:

a particular manner or style of verbal expression**(http://www.merriam-webster.com/)**.

Miscommunication:

noun

Miscommunication is a failure to get a message across or lack of clear communication.

When you leave a message for someone and it doesn't get recorded properly, this is an example of a miscommunication.

Noun

(*plural* miscommunications)

An interaction between two parties in which information was not communicated as desired.

Reference Link: http://learningforward.org/who-we-are/professional-learning-definition#.VwIIcfl96Uk

N

Need Analysis in Languages for special purposes:

"Need analysis … is … the process of identifying the language forms that students ultimately will need to use in the target language." (http://www.beck-shop.de)

P

Practitioners

One who practices a profession **(http://www.merriam-webster.com/)**.

Q

Qualitative Approach

Qualitative research involves collecting and analyzing non-numerical data (e.g., text, video, or audio) to understand concepts, opinions, or experiences. It can be used to gather in-depth insights into a problem or generate new ideas for research.

Reference Link: https://www.scribbr.com/methodology/qualitative-research/

S

Semi-Structured

A semi-structured interview is a meeting in which the interviewer does not strictly follow a formalized list of questions. Instead, they will ask more open-ended questions, allowing for a discussion with the interviewee rather than a straightforward question and answer format.

Reference Link: https://www.thebalancecareers.com/what-is-a-semi-structured-interview-2061632

T

Teaching

The act, practice, or profession of a teacher. Engaged in teaching**(http://www.merriam-webster.com/)**.

Teaching hospital: a hospital that is affiliated with a medical school and provides means of medical education. (The Royal College of Surgeons in Ireland- Medical University of Bahrain

(RCSI-Bahrain)) has a Royal affiliated university hospital that trains our medical and nursing students. This hospital has a layer of non-Arab medical practitioners and health care providers in addition to our students).

Chapter one

Introduction

1.1 A Brief Background

This research study addresses an institutional medical language communication barrier issue that exists in diverse medical institutions/hospitals in the Kingdom of Bahrain. This project assesses the situation by eliciting the real picture from the experience of a sample of medical practitioners and searching for suitable learning support tools and assisting techniques.

This research aims to highlight language barriers faced by non-Arabic speaking medical practitioners when dealing and communicating with Arab patients/ patients' next of kin in diverse local medical contexts. This language barrier could be considered as an overwhelming dilemma from my point of view based on my teaching experience with non-Arab medical students at the Royal College of Surgeons in Ireland-Medical University of Bahrain (RCSI-Bahrain). Ulrey and Amason (2001, p.450) claim that "in working with patients from other cultures, health care providers can learn as they go, but this is dangerous when dealing with people's health and can lead to misunderstandings and costly mistakes, including misdiagnosis and violating patients' own ethical beliefs". They emphasize the idea that to be culturally sensitive, medical practitioners need to use culturally appropriate language.

This research is an exploratory phenomenological study and will follow a qualitative research approach. It seeks answers to questions about "what", "how" or "why" of a phenomenon, rather than questions about "how many" or "how much", Green and Thorogood (2014). The qualitative study is mainly conducted to understand more about a phenomenon rather than "measure" the research problem; and it investigates the research problem (i.e. uncovering and highlighting language communication challenges and barriers faced in daily-basis medical & healthcare setting) from the perspectives of a sample of non-Arabic speaking medical practitioners who are from different medical specialties, have various years of experience, in a number of Arab-based health institutions and hospitals, have dealt with different health care and medical systems, and speak different languages.

1.2 The Study Problem

Communication is wide in scope. It is positioned under the umbrella of various types and areas where communication is the key to success. These include social, political, legal, medical, and humanitarian

domains. I consider communication as the oxygenated blood that goes from the heart to the whole human body parts. Thus, without effective communication, there will be no connection between different cultures and there will be no life and we will end up with a dead globe! Personally, among all of these, human beings' life and health and safety are the most important areas, because they deal with life-or-death matters and care about the survival of humankind.

The idea of this study, and the choice of this research topic specifically, have emerged as a result of my daily teaching experience to medical and nursing students in the Royal College of Surgeons in Ireland-Medical University of Bahrain (RCSI-Bahrain) which is located in Bahrain; an Arab GCC country and contains in its campus a large layer of international students from more than 40 different countries around the world. Added to that, with this level of diversity among university learners, students have the opportunity to exchange knowledge and learn from different perspectives concerning medical and healthcare systems and practices.

Our medical students who are non-Arabic speakers and mostly come from different countries with multicultural backgrounds and mother tongues represent the majority of medical students in the School of Medicine. Our non-Arab medical students do not receive Arabic language communication support equivalent to their Arab peers who receive sufficient English language communication support from the university throughout their study in the Medical programmes. It is felt that those non-Arabic speaking students deserve language communication support in Arabic for medicine and healthcare courses provided by their university as an equivalent right to their Arab peers who receive sufficient English language communication support from the university throughout their study in the Medical programmes.

Both this study topic and research questions were derived from my own experience as a language coordinator and lecturer of teaching non-Arabic speaking medical and nursing students in RCSI- Bahrain since 2008. During my teaching to these students who are from different non-Arab countries around the world and who are mostly absolute beginners in Arabic language, I have found that both my students and myself as their lecturer are facing some challenges of different types. From my students' side, besides being beginners or illiterate in the Arabic language, they are also unaware of the Arab culture and not all of them value learning a new language to help them continue communicate in their clinical practice context. In addition to that, students had some concerns about the course itself. These concerns are regarding its content and how complicated that could have been to them as foreign learners to study this foreign language for the first time. Also, students may have other concerns too, such as, how would they achieve learning the language skills; especially speaking and handwriting due to its complexity in Arabic

and also how would they achieve all and learn that in a very short 2.5 credit course and be in a good stage to be assessed. Gradually, students have started to value the time spared to learn the Arabic language to a certain language level. That could enable them to communicate with their Arab patients and for their everyday life matters while studying and practicing in an Arab country when they reach the third year of their medical programme and start their clinical practice and communicate with Arab patients who are not necessarily to be pure Bahraini, but could be Arab from different Arab countries whose English language level is either being low or are in the English language. In both ways, Arab patients' language level does not enable them to communicate or listen to their medical doctors and understand. You can imagine how difficult is to communicate and deal with such patients if you are in the place of these medical students.

On the other hand, there are teaching challenges faced by myself as a language programmes coordinator and instructor, being aware that my non-Arabic speaking medical/ nursing students are facing clinical problems and are struggling every day when communicating with their Arab patients. In addition, my students show concern and feel also stressed about their clinical performance assessment as they need to have an adequate level of Arabic language to communicate with their patients and take the patient history accurately. The knowledge of Arabic language for communication will have then an impact on the medics' assessed professional performance. In other words, for medics to be able to perform and take medical actions, good language communication is needed; language communication is a key success for professional performance in this study setting. As a result, I had then to redesign my teaching curriculum and teaching materials to meet my students' needs and interests. That was not an easy task to me since we have a shortage and of academic Arabic language resources and the absence of Arabic language for specific academic and professional purposes teaching and learning resources. That was somehow challenging, yet very interesting to investigate. I was glad when I received a fax from the Higher Education Council in Bahrain indicating that for Arabic language local module, we have the freedom as a higher education institution to tailor our Arabic language curriculum and teaching materials in a way that meets our academic and professional needs. I then felt that I was born again with a completely clean fresh mind for innovation and creativity in Arabic language teaching and learning.

Above all, this study refers to fundamental language communication aspects which aim to benefit first, the researcher being a linguist instructor to help her improve her language teaching and curriculum. Second, the study target learners and audience, to be named, medical practitioners and medical students in the first place. To achieve these aims, the research addresses the language communication from its various dimensions, such as, level of accuracy and proficiency/ form (e.g., in medical interpretation), meaningfulness (when communicating with others & conveying a message, e.g., in doctor-patient

communication) and language appropriateness/use (e.g., selecting language terms that match with the context culture). The researcher finds that taking the language dimensions mentioned above into the consideration in the language communication process is something essential that cannot be ignored as without making a balance of these dimensions, the researcher feels that the language produced will be very poor, meaningless and nonsense. One further point, the study problem dimensions are discussed in both Chapter two, the Literature Review and in Chapter five, the Conclusion.

My contributions to the study are twofold built on my professional experience in teaching Arabic language to non-Arabic speaking medical students in RCSI-Bahrain. Added to that, being a frequent patient witness when going to my doctor appointment and have then to switch from being a patient waiting for my turn into becoming a translator/ mediator to facilitate the non-Arab doctors- Arab patients communication when is needed.

To sum up, in doctor-patient communication, doctors' medical knowledge must be integrated with clear communication between these two parties. In other words, theory cannot work with no practice; both act as complements to each other.

1.3 The Focus of the Study

The miscommunication in respect of language barriers between Non-Arab medical practitioners and their patients and other health care professionals is a common issue in Bahrain. This study aims to address this issue through uncovering the main language barriers faced by non-Arab medical practitioners from different specialties, the impact of such language barriers on their practice, and possible ways of dealing with this issue.

The main objectives of the study are threefold:

(i) To uncover the impact of possible miscommunication of the Arabic language for non-Arab medical practitioners from different specialties.

(ii) To identify the coping strategies adopted by non-Arab medical practitioners to deal with the language barriers.

(iii) To explore further actions that can be taken to help solve the miscommunication issues between non-Arab medical practitioners and their Arab patients.

To achieve the general objectives, the following questions will be addressed:

a) What kind of training in Arabic language do non-Arab medical practitioners from different

specialties receive to work in Bahrain?

b) What main difficulties have non-Arab medical practitioners experienced when communicating with Arab patients, colleagues, and other healthcare professionals?

c) How has language miscommunication affected the non-Arab medical practitioners' relationship with their Arab patients, colleagues, and other healthcare professionals from the medical practitioners' perspective?

d) What strategies have non-Arab medical practitioners adopted to cope with language miscommunication issues?

e) What types of support are available to non-Arab medical practitioners to deal with the language barriers they face in their practice?

f) What do non-Arab medical practitioners think can be done to help them overcome the language barriers they face in their practice?

1.4 The Study Context

By reviewing the routine tasks assigned to doctors and medical practitioners in their daily clinical practice, we can see that all of the doctor-patient language communication routine tasks require having good level of the communicative language which should be understandable by the two parties involved in the language communication. However, in the Bahrain medical and healthcare context, which is this research context, majority of non-Arab medical practitioners in both public and private medical institutions are either illiterate in speaking Arabic language or have a very low background in Arabic language in a way that they are not competent enough to make a correct phrase or communicate verbally in Arabic. In addition, the main language for communication in Bahrain is Arabic, and English is considered to be a foreign or a second language to Bahrainis, but those are the ones who have good education, but it does not necessarily apply to all Bahraini and Arab patients in Bahrain.

Bahrain is known to be a diverse country and has besides its local Bahrainis other Arab citizens, residents or tourists who are originally from other Arab countries. Not all Arab in Bahrain are competent or literate in English communicative language. Most of them are either illiterate or semi- illiterate in English language and can understand only Arabic. This restriction in knowing other languages for communication than Arabic from Arab patients' side in Bahrain has made the non-Arabic speaking medical practitioners- Arab patients

language communication process difficult and created a language barrier between the two communication process parties.

Since this language communication barrier is common in Bahrain medical and health care context, it then becomes a phenomenon that most of non-Arabic speaking medical practitioners suffer from and it has some negative impacts on their professional performance. The study would investigate the challenges medical practitioner face in their daily clinical practice as a result of language communication barrier.

It is shown in literature that more understanding of doctor-patient conversation can be achieved if there is an active interaction between both communication process parties, "mutual understanding between doctors and patients can be enhanced when both parties actively engage in a dialogue and exchange of information during consultations (Charles et.al., 1999).

1.5 My Epistemological Positioning as a Researcher

My choice of qualitative exploratory approach to my study has come to draw from the suitability of such an approach to serve my research purposes and answer my research questions, as well as my epistemological and ontological positioning as a researcher. To justify my research approach choice, I will link it first to my epistemological positioning being a constructivist. Constructivism is "an approach to learning that holds that people actively construct or make their own knowledge and that reality is determined by the experiences of the learner" (Elliott et al., 2000, p. 256). Since the study problem has not been addressed clearly in my context although some evidence show that it is common and exists, then I entitled my study as an exploratory phenomenological study and categorized it under the qualitative research approach. Having a phenomenological study entails that this phenomenon is common but requires many details and evidence data to prove its existence in the research context and qualitative approach has the feature of providing detailed data if being followed. This justifies the choice of qualitative method and its link and suitability to phenomenological study. Besides, the study is mainly approaching medical practitioners and aims to elicit the study evidence-based data from their real clinical experience in facing language miscommunication issues when dealing with their patients or patients' next of kin. From this perspective, the problem knowledge and description will be built based on the collected data or real-life experience and the research role comes after by analyzing and interpreting the data collected and be able to describe the study problem clearly and highlight the language communication barrier challenges faced by medical doctors in the study setting.

My philosophical perspective in doing this research is categorized under critical research (Myers, 1997) or Constructivism. As a Doctoral researcher, I believe in the ability to make possible positive changes in my targeted community, which I assume will contribute to organizational development processes in the three research medical institutions or hospitals.

Being a constructivist researcher, I must ensure including the following principles in the whole process of my doctorate study and thesis writing. First, I can construct the meaning of the study phenomenon by exploring it. Second, being a constructive researcher will enable me to learn and widen my learning scope of this study problem. Third, constructing the meaning of the study phenomenon details will strengthen my mental thinking. Fourth, to be a constructive researcher, my chosen words and language in expressing and interpreting my study findings. Fifth, constructivism involves researchers to be social and to have a connection with human beings. Communicating and interviewing medical practitioners when conducting this study provides this social connection. Sixth, constructivism requires learning to be contextual and relevant to real-life situations and that is also applicable in this study. The collected data are elicited from medical doctors' real duty life scenarios. Seventh, transferable knowledge by referring to previous similar knowledge and experience and using that as a basis to build up new ideas. This could make our new knowledge more valid and reliable. Eighth, constructivist learning takes time to learn and to think, analyse ideas, and blend them to come up with strong ideas. Ninth, the most important thing in being a constructivist is the motivation to help researchers fulfil the study objectives and answer the research questions.

1.6 Contributions of My Study- What I expect to achieve with My Findings

There are a number of benefits that are expected to be gained from this research at institutional and personal level, both practical and theoretical gains. On the one hand, the study is expected to accomplish some practical goals and benefits. To begin with, at the personal level, I hope that the findings of this study have an impact on my current professional practice as Arabic language tutor and programme coordinator in medical higher education contexts by legitimating my own practice and revealing areas for improvement and innovation of both my teaching and the Arabic language curriculum (i.e. new clinical language communication teaching methods & curricula) to suit the needs of non-Arab medical learners attending the Arabic courses for medical and healthcare purposes.

In addition, the chief practical benefit that is aimed to be achieved through this study is to enhance the level of medical and healthcare doctor-patient communication (i.e. healthcare language communication), emphasize the importance of making a balance between the three main language dimensions (form, meaningfulness & use- appropriateness for the context/ culture/ intercultural language communication) for

medical practitioners in their communication with their patients/ patients' relatives. The study also aims to raise the quality of medical and health care services by being able to describe the study phenomenon of language communication barrier clearly, identifying the challenges faced as a result of a language communication barriers and coming up with practical recommended coping strategies. These aims will not be fulfilled without the attempt to communicate these the research findings and communication with the authority bodies who are responsible of managing medical and healthcare services in the country. Achieving the aim of upgrading the quality of medical and healthcare services in the area of doctor-patient/ patient's next of kin clinical language communication as a result of this research study findings is expected to contribute to mankind's health and life in this particular part of the world (i.e., the Bahrain Kingdom) if the communication problem is being resolved.

On the other hand, through conducting this study, the researcher has the aspiration to achieve some theoretical benefits which would add to the previous knowledge and studies conducted in the area of language barrier in medical clinical settings but more focus about Arabic language communication barrier in diverse Arabic clinical context such as Bahrain. First, to contribute to some relevant literature fields to this study, for instance, clinical and healthcare communication, clinical language communication teaching and intercultural communication aspects, copying strategies used in other countries to deal with language communication barrier in clinical settings highlighted in the literature review chapter of this study. Added to that, the study data analysis, findings, and discussion will help the researcher to identify the gaps in literature in term of language communication in the local and regional clinical context and recommended future areas for further research studies in the area of clinical and healthcare language and cultural communication.

1.7 Thesis Structure

The thesis study consists of six main chapters. The first one is the Introduction chapter which gives a brief overview of the study and the anticipated outcomes.

Chapter two brings forth the research literature on some main subheadings supported with evidence from the literature. Chapter two highlights the following topics: the importance of language communication in various cultures and the Arab world; the importance of language communication in different professional contexts. The third topic of the chapter talks about language communication challenges faced in healthcare contexts and consequences. Chapter two concludes by presenting some examples from different sources of literature about some implemented coping strategies to resolve the miscommunication barriers in medical and healthcare settings.

Chapter three articulates the theoretical perspective and methodology choices made for this study. This chapter justifies the application of the qualitative approach to the study.

Chapter four, 'Data Analysis, Findings & Discussion' presents and analyses the study's qualitative data collected and provides comprehensive study findings. The 'Discussion' part begins with a summary of the findings and makes sense of the findings by discussing them in articulation with the literature and given the implications they may have.

Chapter five presents the conclusion of the study. This chapter also considers the limitations of the study and draws recommendations for practice and future research.

Chapter 2

Lit review

Chapter Two: Literature Review

2.1 Introduction

This chapter forms the theoretical basis of this study. The chapter particularly highlights some important gaps in literature derived from the researcher's critical review of the literature related to language communication barriers in different international languages in general (e.g., English language, Spanish language communication…etc.) and Arabic language communication barriers in particular. The Arabic language is the major key communicative language utilized in patient-medical practitioners' routine cases in a diverse medical context in Bahrain. Some of the selected literature resources focus on describing the language communication barriers in some medical contexts irrespective of the type of language used in communication or the country of the medical context. Other elements highlight potential risks, costs, and challenges resulting from language communication barriers on both intended research parties (i.e., patients & medical practitioners) towards recommending some practical academic and professional solutions, strategies, and techniques designed to cope or resolve the research problem.

2.2.0 The Importance of Language Communication in Different Cultures and the Arab World

Although communication is important in all aspects of human life and all the areas of activity, it plays a critical role in the healthcare professions. Gregg and Shah (2007) consider that the idea of a language barrier does not only mean the verbal language used, but it carries cultural aspects too. Language comes side-by-side with culture. In response to this language and culture issue, special attention, and integration between language and culture should be given when talking about language communication. However, in communication, language takes the first place in the ranking. When learning and understanding a language, cultural aspects will be clarified and at the same time language learners will understand how to choose the type of verbal and non-verbal language that could fit in certain conversations for different communication purposes.

Sakamoto and Miyatani (2017) refer to what Yep (2014) discusses as an important issue in terms of languages and their relevance to cultures. Most research on intercultural communicative competence tends to equate culture with nationality Yep (2014). In Bahrain, there is a huge number of citizens from different

origins who carry the Bahraini nationality but come from different countries of origin, some are Arab, and others are non-Arab. Thus**,** they represent their country of origin's culture and mother tongue. Although some of them know some Arabic or Bahraini dialect, their cultural values are not representing the original Bahraini culture, but their own original cultures. Therefore, I assume that this cultural fact opposes Yep's (2014) previous idea that culture does not always equate with nationality and also nationalities do not always reflect the type of cultures these people belong to. Having a recent increase of multi-cultures in Bahrain has resulted in the emergence of this country's status where no clear citizenship identities occur, "but boundaries of culture and language have become blurred, and new identities are arising that defy neat categorization and labeling" (Sakamoto & Miyatani, 2017, P: 298). Recently, there is an issue of having a confusing mixture of different cultures in most of the diverse countries worldwide, such as Bahrain while multi-cultural generations will grow up together on the same land. As a result, we are influenced by what I will call "the missing identity of pure cultures". This title means that my pure Bahraini culture nowadays is affected and influenced by the high rate of diversity in the country. The diversity caused by the door opening for residents from different countries around the world to have the right to gain citizenship and benefit from real civil rights. In return, multicultural generations will grow up together as Bahrainis, but with a mixture of beliefs, multi-languages, and different forms that are far away from the original local culture. Therefore, we conclude that not all Bahrainis speak Arabic or have sufficient educational background to enable them to speak and understand a sufficient amount of the English language for communication. Although this is the reality: the vast majority of Bahrainis are Arab, but some Arab citizens originate from different Arab countries. They carry the Bahraini nationality and their level of English or English backgrounds can be less than the original local Bahrainis. This issue has been raised here to link it with the real communication barrier faced by non-Arabic speaking medical practitioners when communicating with Arab patients. These non-Arab medical practitioners sometimes are confused and think that all patients who are "Bahraini" by title and carry the Bahraini nationality can speak English to some extent. They also think that all Bahrainis are pure Bahrainis and Arabs. Added to that, they may make an overgeneralization that all Bahrainis are English-illiterate or some Bahrainis who are East- Asian in origin might not speak or are weak at both Arabic and English language. This too could be added as description features of pure Bahraini's communication level claimed by medical practitioners.

The Aichi Prefectural University (n.d.) Project for the Promotion of Human Resources Development suggests eight abilities necessary for global careers. For instance, advanced language ability, international outlook, presentation skills, information literacy, communication skills, adaptability to other cultures, problem-finding and problem-solving skills, and management abilities. From these nine identified abilities, I find three of them are more relevant to my study. If the following two main skills, a.

communication skills which include language abilities as the main part of communication and b. adaptability to other cultures are available and acquired by non-Arab medical practitioners; then I assume they will be able to communicate properly and understand their Arab patients well and of course be able to diagnose them better and provide them with the required medical treatment needed for their health problems. I find communication skills are the broader scope which has the language abilities come as a part of it and when talking about languages, then we will find ourselves talking about cultural adaptability. It seems to be that each of these skills leads to the other and makes a unique inclusion.

Albougami (2015) concentrates on three main key elements, cultural, language, and communication barriers and the effect of all of that on the healthcare services' quality provided to Arab Saudi patients in Saudi Arabia by expat foreign medical practitioners who work in Saudi clinical areas and hospitals. All the key elements; language, communication, and culture should be included in effective communication regardless of the type of communication context. Yosef (2008) states about his research that Arab people perceive "treating Arab clients without addressing Arab culture is an indication of culturally insensitive care". Therefore, language-communication must come hand in hand with cultural aspects and it is important from my point of view to understand the culture of the work environment to select suitable correct terms matching with the communication context and to reach an effective communication level.

For some cultural-based challenges, such as dealing with non-verbal cultural communication matters, cultural awareness educational programs have been recommended to cope with these barriers. Albougami (2015) has addressed several culture-related issues relevant to language and communication barriers between nurses and patients in the Kingdom of Saudi Arabia (KSA) which are partially linked with my study culture (i.e., Bahrain). One of these issues is the use of touch and shaking hands between males and females, which is unwelcome, and that the nurses who work in KSA as reported in this paper, noted stress behind being denied certain aspects of non-verbal communication, particularly touch, spatial limits, eye contact, and intimacy.

I find that non-Arabic speaking medical practitioners in Arabic clinical areas require some cultural awareness depending on what country they are working in and the language and cultural backgrounds of their patients. Albougami (2015) further stresses that expatriate nurses should be made aware of a dominant Arabic practice, that Saudi patients (and similar cases applied to most of the GCC and other Arab Muslim countries) will have a family member or "sitter" with them for most of their duration of stay in a clinical setting. On the other hand, careful attention must also be given to those patients who have no educated relatives or friends to accompany them and help them communicate with their medical practitioners. The

author further emphasizes the importance of raising cultural awareness of healthcare givers by stating that "assisting nurses to develop their awareness of cultural diversity would build acceptance, appreciation, and commitment to the care of culturally and linguistically diverse (CLD) patients and their families" Albougami (2015, p. 168). As a framework model for this doctorate study and personally as an EdD researcher I concur with the idea of Albougami (2015) that raising professional context-related language and cultural awareness is the key to gaining acceptance**;** convincing others should come gradually, step by step.

Achieving quality medical and healthcare services in a diverse context is an outcome of the cooperation of different sources, both hospital-relevant human and non-human resources, "Disparities in Healthcare, a consistent body of research indicates a lack of culturally competent care directly contributes to poor patient outcomes, reduced patient compliance, and increased health disparities, regardless of the quality of services and systems available" (Mather Lifeways, 2015, p. 2). The information stated in the previous quote indicates and emphasizes that healthcare service in any medical/ clinical area will not be able to show its level of quality and efficiency without having competency in medical practitioners' level of acquiring patients' language and culture. These two major elements, language, and culture are the keys to efficient patient-medical practitioners' communication.

A study by Kawi and Xu (2009) claims that the professional induction orientation done for newly recruited nurses in practice does not deal with cultural needs. As a result, I assume a review of the induction process and integration of language communication and cultural aspects of the spoken language community would assist in improving the communication process to suit the diverse international nurses.

Since language and culture are interlinked, language cultural aspects cannot be neglected and should be treated seriously to avoid any negative consequences. The language barrier that communication carries is the main message this research would like to convey to the targeted community in general and the medical institution's senior management (RCSI- Bahrain) in particular. Most of RCSI-Bahrain Non-Arab medical students/ practitioners come fresh to the country to study medicine or to supervise medical students without a language or cultural background in the host country (i.e., Bahrain). Singer and Lakha (2003) state that healthcare practitioners should acquire and understand modes of appropriate communication beyond language. The phrase "beyond language" by Singer and Lakha (2003) indicates that language communication is not a simple process as I believe; language carries in its content and meaning: cultures, norms, beliefs, religions, traditions, and moods; and thus, it should not be taught separately to the intended medical practitioners.

2.2.1. Intercultural Communication in the Context of Medicine and Health Care

Medicine and anthropology share a similar focus which is the focus on a human being. However, each could study the human being from different aspects and angles, Weidman (1979) claims that "the transcultural posture applies to professional approaches: anthropology and medicine: also, to the knowledge of the cultural context of both the patient and the health professional involved" (p.85). Medical and healthcare authorities should ensure raising awareness of both medical practitioners' and patients' cultures and this cultural education need to be reflected in doctors or health caregivers' and patients' communication, "transcultural view is a prerequisite to interethnic (intercultural) communication in medicine. Raised health levels might be expected as a consequence of improved interdisciplinary/ intercultural communication" (Weidman, 1979, p. 85). Medical practitioners' and healthcare providers' attitude towards more professional learning, such as patients' language and culture education should be changed to be positive by raising their awareness of this learning importance and consequences if being absence or by providing them with some motivating incentives to encourage more learning, "health professionals have to some extent been "absolved" from having to learn very much about the patient's world view and health cultural tradition" (Weidman, 1979, p. 85).

2.2.2. Intercultural Communication in the Field of Medical Professional Education

Hamilton and Woodward-Kron (2010, p.560) provide a case study paper that talks about developing a multi-media tool as a trigger for the teacher to assist learners to explore, understand, and take into account the interrelationship between language, culture, and communication in healthcare settings. Lately, there is a lot of emphasis on the integration of language and culture. Having this combination of language and culture together has opened doors for more professional training, education, and a new approach for language teaching that has culture as its complement that cannot be separated from, "In intercultural communication, language and culture can negatively impact on the success of the interaction. When this occurs in professional settings such as healthcare, misunderstandings, and communication breakdowns can have serious implications for health outcomes and patient safety. While the interrelationship between culture, language, and communication has been theorized and has informed education and training sessions" (Scollon & Scollon, 2001, p.560).

2.2.3. Intercultural Communication in the Field of Language Teaching

Hamilton and Woodward-Kron (2010), refer to the challenging task faced by Language teachers when

constructing language curriculum aiming to engage language for specific purposes learners in learning a language for special purposes and they present English language as a language example, but this could be appliable to other language teaching and learning too, such as Arabic language.

The target language's teaching and learning culture should be considered when teaching languages for specific purposes, "For English for Specific Purposes teachers, the relationship between language, communication, and culture is constantly brought into question as we engage with the task of teaching language from within a specific content domain that has its own 'culture' such as the 'hospital culture'." (Hamilton **&** Woodward-Kron, 2010:561). For instance, western medicine and health care language should be evidence-based following the western healthcare system and the language should match with the realistic professional context, like when teaching English for medical and healthcare purposes to Arab students, the language used should apply to their nursing/medicine professional clinical context. Whereas teaching the same language and its professional use in some of the East Asian countries, such as India, may differ a little bit considering using English for medicine language in a purely Indian medical and health care context.

Integrating language and culture in a foreign language classroom must be a very challenging task for language teachers to explain to language learners, "For ESP teachers, a major challenge is to raise awareness amongst learners of how these multi-layered cultural domains inform language choices in professional communication" (Hamilton & Woodward-Kron, 2010, p. 561). From my language teaching experience, good teachers must know how to select the best teaching and learning techniques that can enable them to integrate both language and culture to teach the learners how to choose the appropriate language to match with their professional culture by applying it in a semi-realistic context if not being 100% realistic. This challenging task could show the teaching art of teachers by transferring the language use knowledge to their learners successfully and by making a connection to their mother tongue and everyday life.

Selecting the best suitable language to be used in a professional multicultural context, such as the medical and health care setting is another challenge that may encounter foreign language learners when applying the language learnt in a real social/professional context. The more learners use the learnt language in a realistic language context, the better they will be, and they will gradually become more fluent and more confident in speaking the foreign language spontaneously.

Northedge (2003) recognised the potential danger of this link and argued that for English as additional language speakers to participate effectively in their professional fields, they need to learn to be able to recognize any differences in their own and others' cultural identities as well as move back and forth between these cultural and language identities without feeling a sense of loss or guilt. Byram (2000) described this ability as intercultural competence. He also recognised the need for additional language users to critically analyse their own and other cultures and to have an understanding that their thinking is "culturally determined rather than believing that their understanding and perspective is natural" (Byram, 2000, p.2). Based on that, language teachers should take into their account that through their language teaching they need to bring language learners up to certain levels of language intercultural competence; perhaps this depends on the learners' language level and their professional need of the language learnt; for instance, the language intercultural competency needed to non-Arabic speaking medical practitioners to communicate in Arabic with their Arab patients in a daily-basis medical practice.

2.2.4. Intercultural Communication Competence of Medical Practitioners in Healthcare Settings and Language Communication for Specific Purposes Curriculum

Ulrey and Amason (2001) discovered that medical providers unable to communicate effectively across cultures were more anxious on the job, "Communicative misunderstandings between patient and provider can lead to simple dissatisfaction, misdiagnosis, lack of any medical care, or even death. Ineffective intercultural communication can also lead to stress for health care providers, causing anxiety and job dissatisfaction" (Gibson & Zhong, 2005, p.622). To alleviate these potential problems, healthcare providers must become competent intercultural communicators. What these authors stated about the communication intercultural competency and its link to the language used and selected to be used in a professional context shows how important is this factor in both the theory (i.e., learning a language) and practice (i.e., using the language in a realistic professional context). For example, multicultural medical and healthcare contexts where medical practitioners are in direct contact with humans their patients in the first place and/or their patients' next of kin.

There is a door to bridge the gap in the literature for future research in investigating and exploring the intercultural communication competence in diverse medical and health care contexts like Bahrain, "Research has investigated the phenomena of healthcare communication and competence in other settings, yet there has been little research concerning characteristics of intercultural communication competence in healthcare settings" (Gardenswartz & Rowe, 1998).

To ensure having medical practitioners reaching a certain level of intercultural communication competency required from them to deal and communicate with their multi-cultural patients, researching a sample of diverse medical practitioners or health care providers to be able to identify the major factors that could make a well- interculturally competent medical practitioners would be useful to meet language and cultural needs for medical and healthcare delivery in a diverse setting. Gardenswartz and Rowe (1998) and Thomas (1981) research are inconclusive in demonstrating appropriateness and effectiveness, which are the key measurements of communication competence, are sufficient variables to determine the intercultural competence of a medical provider in a healthcare setting. There are other potential variables such as empathy, previous intercultural experience, and the ability to speak a second language.

2.3 Main Implications of Miscommunication in Medical and Health Care Context

The term miscommunication could carry some implications and this section will highlight the main possible common ones. To begin with, one example of these miscommunication implications would be empowering both medical and non- medical hospital staff to take part in medical interpretation with patients/ patients' next of kin when needed for clear medical communication and for making accurate medical decisions. For that Bischoff and Hudelson (2009) posit that in many contexts, health professionals continue to rely on ad hoc interpreters, for example, bilingual employees or patients' relatives for providing linguistic assistance. This is worrisome because these strategies have been shown to be associated with a number of problems related to poor quality communication and care and breaches of confidentiality. Besides, medical practitioners must be aware of how important it is to bridge any intercultural gap in their communication with their patients/ patients' relatives to create an effective comfortable communication environment. Kreps and Kunimoto (1994) report that there are many barriers to intercultural communication in Health care. Patients are often too scared and sick to focus on communication, whereas providers are pressed for time or too focused on technology. Furthermore, Meuter, Gallois, Segalowitz, Ryder, and Hocking (2015, p.1) argue that "Language discrepancies may result in increased psychological stress and medically significant communication errors for already anxious patients, something to which patients in language-congruent encounters are less vulnerable". The issue of intercultural awareness as a fundamental part of effective patient-doctor communication should be stressed in real medical practice not only in the medical code of conduct. Moreover, Ribeiro (2007) argues that scientists who belong to different cultures and communities are seen to be responding to different worlds. If there is no attempt to find a solution to bridge the language barrier in clinical areas, then many negative consequences are expected to take place and human beings are the main victim in this scene. Also, Hossain, Shamim, Shahana, Habib, and Rahman (2010) talk about similar research problems faced by medical students in

Bangladesh; especially when it comes to communication between medical students and patients. The importance of ensuring effective intercultural communication should be conveyed to both medical practitioners in practice and medical students too who are also treating and communicating with patients in their study clinical practice.

All in all, language miscommunication issues affect both health care professionals and patients. Medical practitioners will find it difficult to communicate diagnoses clearly and make management recommendations to their patients. Patients, in return, will fail to understand their healthcare providers' instructions and care plans. As a result**,** patients will have worse access to and receive poorer quality healthcare (Gregg & Saha, 2007), which will, therefore, affect their satisfaction with the quality of the healthcare and medical services provided and they may lose trust in their doctors' professional performance.

2.3.1 Main Study Focus and Themes

2.3.1.a. Verbal and Non-verbal Language

An understanding of how language functions in context is central to comprehend the relationship between what is said and what is understood in spoken and written discourse. The context of the situation of what someone says is, therefore, crucial to interpret and decode the meaning that is being conveyed (Halliday 2006). The context of the situation includes the physical context, the social context, and the roles of people involved in the interaction. As Thomas (1995, p. 22) puts it: meaning is not inherent in the words alone, nor is it produced by the speaker alone or the hearer alone. Making meaning is a dynamic process, involving the negotiation of meaning between speaker and hearer, the context of utterance (physical, social, & linguistic), and the meaning potential of an utterance. In here, we can notice that language communication is a complex process that can be either verbal or non- verbal and within the language interaction, the parties involved (i.e., speakers & hearers) are expected not to be just language receivers, but also meaning negotiators. That of course will require enough bank of communicative language; either verbal or non-verbal.

According to Hyland (2009, p. 20), "discourse analysis is a way of studying the language in action, looking at spoken and written interactions in relation to the social context in which they are used". (Mention/ Include this quote and comment on the type of language that should be used when medical

practitioners communicate with their patients who speak different languages than what medical practitioners speak or use as their means of communication.

Following this approach, medical language cannot simply be defined as the medium through which physicians, nurses, and doctors communicate among themselves within the specialized medical community. Therefore, you can understand that meaning is produced during interactions. However, in this research study, the focus of language interaction is between the speaker and the hearer and we exclude from that the written language (i.e., between writers/ readers) as it is not our focus in this study and considered to be one of this study limitations.

2.3.1.b. Understanding the Nature of Doctor-patient Interaction and its Link to Language Communication

One cannot deny how fundamental is the interaction between patients and medical doctors in medical and healthcare contexts. Some important examples of the common situations and purposes where doctor-patient interaction takes place could be medical care, diagnosis, and assessment, the healing process, educating patients on their health status, and how to take care of their health or use certain medical devices or take medication. Therefore, to make all of these essential doctor-patient scenarios run successfully, we need to think of how to ensure having a good level of language communication shared by the two communication parties (i.e. doctors & patients/ patients' next of kin) **, "**The doctor-patient relationship is a socially sanctioned, institutionalized encounter governed by mini-rituals of opening and closing, by a logic of information exchange, by time, place, and task constraints, and by setting specific diagnostic aims**"** (Manning 1987, p. 20).

Another interesting quote by Sadegh-Zadeh (2012) shows that doctor-patient relationship is beyond physical diagnosis as it is expanded to deal with a patient as a whole human being who is a body, mentality, feelings, emotions and even dreams: "A widespread misconception about medicine is that medicine is just concerned with illness and disease. However, the subject of medicine is the patient, and all the activities have to be directed towards the prevention and relief of human suffering**"** (Sadegh-Zadeh, 2012, p. 110). This could bring the complexity of the sort of communication used in such a doctor-patient relationship. Here, we can see the fundamental role of language communication to facilitate the communication process. A clear level of language clarity could help in meeting patients' medical and health care needs, raise their trust in their doctors and patients' satisfaction and at the same time, this may impact on the doctors' self-confidence in their level of professional performance which is relying on the first place on language communication.

Added to that, second evidence that verbal language is the fundamental mean of communication in the process of doctor-patient education, and it is considered to be the mean of communication in the medical context is shared by Sadegh-Zadeh (2012) that the patient history-taking process or what could be called as the clinical interview of the patients requires the verbal component of language communication. This verbal part can be seen when a physician elicits information when noting down patient history-taking while diagnosing patients using the taken history. Good patient history, according to Sadegh-Zadeh (2012) is having effective doctor-patient communication and this verbal element is the building block of physician's relationship with patients. In all cases, one should keep in mind that doctor-patient communication consists of both the verbal and non-verbal processes through which doctors obtain and share information with patients, Sadegh-Zadeh (2012).

Understanding the main routine role of medical doctors could allow us to evaluate how much language needed, how frequently it is used for communication purposes and how important is the language element is in clinical communication and life/ death decisions. To start with, physicians generate and test diagnostic hypotheses. In some cases, patients' data, such as the main reason or problem for coming to the hospital, gender, age, voice, and appearance just gives doctors an initial idea of what health problem the patient may have. However, these few patient personal data may not be enough for physicians to make decisions on patients' treatment plans and health. As a result, doctors may have to ask other specific questions to acquire more data which would be important to evaluate and test their initial hypothesis and diagnosis. During doctor-patient conversation, patients or their next of kin would normally ask questions that are considered relevant to get a clear overview or details about patients' health status, treatment plan and its effectiveness in solving certain health problems. It is obvious from this description the amount of conversation involvement patients'/ their next of kin may have and that requires good use of a certain level of language to carry out doctor-patients conversation.

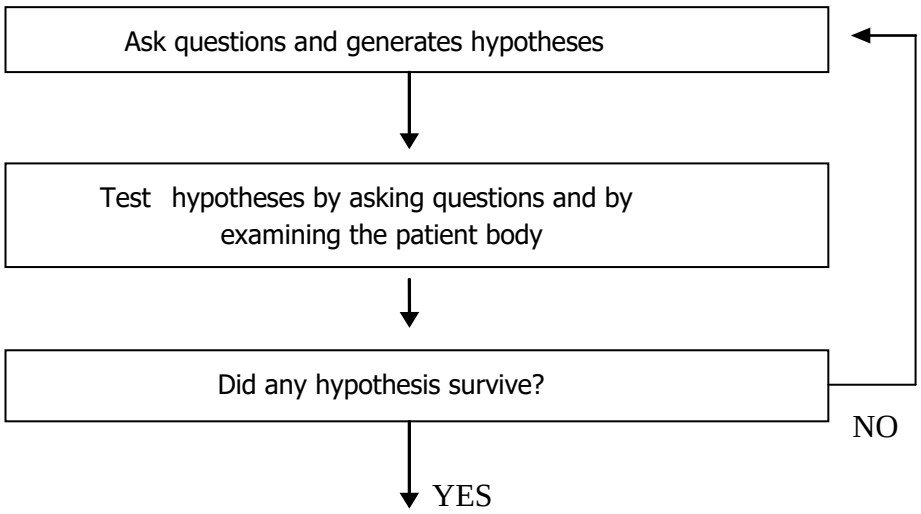

Figure 2.1: Selection of a course of action/ treatment decided by physicians

When interpreting the diagram in Figure 2.1., which reflects a selection of a course of action or treatment decided by physicians to their patients, we can see that physicians' job is not as direct and easy as we may imagine; it is a quite hard job. We may think that doctors are only having to build up a positive relationship with patients, organize and run conversations, make hypotheses their patients' diseases and health problems, and decide on suitable treatment care plans, but the fact is different. The real physicians' routine duty requires them to listen carefully to their patients, give them all the required care and attention to enable them to address patients' health concerns and to interpret all the collected information from patients whether being useful or not. Physicians have to further ask more questions to elicit more details from their patients to help doctors evaluate and comment on patients' health status, identify causes of patients' health problems and suggest the best treatment and prescribe effective medications, (Mishler 1984, p.5).

Figure 2.2 Physicians' activities during medical encounters. (Welsby 2003, p.3).

By commenting on the above figure 2.2, Nelson in Bakić (2008:75) reports that there are seven identified fundamental components to be found in doctor-patient communication. These components are the following, building the relationship, opening the discussion, gathering the information, understanding the patient's perspectives, sharing information, reaching agreement on problems and plans, and providing closure.

2.3.1.c. Why Language Communication is Essential in the Medical and Healthcare Context?

One may wonder why we are focusing here on language communication. Is it so important in a way that we are making it the core topic of this study? We can say yes by referring to what comes by de Laurea (2012-2013), "Clinical practice is centered on the patient[1]; its main active agent is the physician or the therapeutic team; their main activities deal with patient history, diagnosis, prognosis, therapy, and

prevention". Based on this latest quote, it is clear that within the physician-patient language communication a number of important human life-related tasks and activities are involved from both doctors and their patients, for instance, patient history-taking, diagnosis, treatment and therapy, health prevention and I will add patient medical and healthcare education which is conducted by physicians in the first place and other health caregivers.

By asking ourselves what medium of communication is used to allow doctor-patient conversation, our answers may mostly be similar or could vary as ideas are coming from different perspectives. Possible similar answers would be like language, both verbal and non-verbal (e.g. could be cultural aspects, drawing medical/ anatomy pictures….).

2.4. Challenges of Language Miscommunication in Clinical Contexts

Language-communication barriers in clinical contexts have logically led to many challenges faced by medical practitioners when dealing with their patients who speak different languages than what they do. Potential consequences are expected to happen because of such miscommunication challenges if these problems are not resolved. Simpson et al. (1991, p.1385) claim most complaints about physicians do not deal with clinical competency problems, but with communication problems; and most of malpractice allegations arise from communication errors.

According to Simpson et. al. (1991), patients' dissatisfaction is mainly related to uncertainty and lack of information, explanation, and feedback from the doctor. Doctors are often blamed for not listening to their patients' concerns and they are often criticized for not having enough time for their patients. As a result, many patients leave the consultation without asking questions concerning doubts that are troubling them and feel unsatisfied with the health service provided.

Kawi et.al. (2009) highlighted some communication barriers faced by International nurses (Ins), such as language and communication difficulties, the difference in culture-based lifeways, lack of support, inadequate orientation, differences in nursing practice, and inequality were registered as barriers. These nurses who work in a healthcare environment are from Australia, Canada, Iceland, and the USA. Based on this information stated by Kawi et.al. (2009), I assume that these types of language communication challenges could lead to some legal risks and consequences because of the potential for having many medical errors.

Albougami (2015) indicated the sort of medical care -based challenges faced in hospitals in the Kingdom of Saudi Arabia (KSA). These can be highly related to the communication and language barriers that exist

between non-Arabic speaking healthcare givers and Arab patients in Bahrain healthcare settings since both of them take place in the GCC which mostly share similar features in many fields. One of the most common problems of communication barriers is *medication errors* which registered an error. Consequently, it registered an error rate of 56 per 100 orders. This is a highly dangerous percentage rate which could have a huge threat to patients' life. Added to that, Albougami (2015, p.168) clarifies that learning a few words of Arabic by the non-Arabic speaking nurses is inadequate to communicate effectively in another language. "Knowing a smattering of a foreign language only allows one to make a fluent fool of oneself if the implicit meanings behind highly subtle linguistic symbols are not understood".

To conclude, this research paper (Albougami, 2015) presents a study that explores the lived experienced foreign nurses working at hospitals in Iceland. From the study's findings, five main themes describe the overall theme of "Growing through experiencing strangeness and communication barriers" (Magnusdottir, 2005, P. 263). The first theme is entitled "tackling the initial, multiple challenges", and under that, there is a sub-theme called "Feeling distressed", and an example given of an experienced married nurse from a western country who expressed his feeling toward working abroad in Iceland: "I was crying all the time. …. I don't know why I'm even trying – the language and everything. Others did not feel so overwhelmed", and that shows the level of suffering that the nurse had encountered while working in that foreign country due to many challenges faced and one of them is the language and cultural differences. Magnusdottir (2005, P. 26) points out to what Buchan et.al. (2003) states that "nurse managers in the UK have reported that language problems are a major obstacle with international recruitment" and that stresses the importance of language communication in medical and healthcare settings and its major role in affecting both the performance of the medical practitioners and the level of the health care services provided.

Another language miscommunication challenge presented in the article by Gregg and Saha (2007) which refers to the idea that if the healthcare providers and their patients speak different languages, some expected consequences will occur. For instance, patients will have worse access to health care, receive poorer quality care, they will not understand their healthcare providers' instructions or care plans and their satisfaction will be less on the quality of the healthcare and medical services provided. Not only the patients' side will be negatively affected, but also medical practitioners on the other hand will not be able to communicate diagnosis and recommendations to their patients effectively.

A study by Davision (1993), USA summarizes the type of negative consequences, resulted in language communication barriers. As real examples, nurses did not speak up and had quiet, passive, or submissive personalities, experienced discrimination (e.g., fewer wages, undesirable shifts, and perceived disrespect

from patients). Other consequences addressed in this study about Konno (2006), Australia. International Nurses (INs) felt like strangers, with a lack of support seen in the workplace, not trusted, and endured rudeness, and negative attitudes or behaviours, assisted minimally with nursing registration. I can imagine similar feelings non-Arabic speaking medical practitioners in Bahrain context would have due to the absence or lack of language communication competency they need to deal with Arab patients, and this is one fundamental element of this study.

From my point of view, if health caregivers stress about their level of communication and inability to communicate with their patients and their families, negative consequences will be impacted on their professional performance and the medical decisions made by these medical practitioners. Added to that, there is a possibility of them having potentially more medical errors which could presumably threaten patients' health and life and lead the practitioners to go through legal cases and lose their future. Also, Davidson (2004, p.609) emphasizes the idea that "poor communication is a major source of stress for staff. One study showed that nursing stress increases when nurses do not have enough information about a case to answer questions from the family and also when communication is poor between the physician and the family".

To sum up, there is a different expecting challenge that may face my study participants which is the fact that their Arabic language level is either being elementary which does not enable them to communicate properly using the language or being zero beginners of the language who have no background in learning the Arabic language.

2.5 Ways in Which Miscommunication has been Addressed

Some techniques to solve the problem of miscommunication in the Healthcare context have been discussed in the literature. To begin with, an example from a real medical context shows how medical practitioners sometimes must be innovative and create some coping strategies to deal with language communication barriers faced with patients. "Doctors on the late shift in the emergency room have often had no way of taking a patient's medical history …. I asked one doctor what he did in such cases. He said, "Practice veterinary medicine." (http://novella.mhhe.com**,** P. 368). Bischoff and Hudelson (2010) refer to the type of communication support that was provided in Geneva in 1999 by the Geneva Red Cross (GRC). The GRC created an interpreter bank available to Geneva-based social service and healthcare organizations. GRC interpreters receive minimal training (usually four 2-hour workshops in which professional standards are communicated) and participate in several supervisory sessions per year. There are other steps the GRC

has taken to assist hospitals with interpreter support. First, the Geneva University Hospitals established a convention with the GRC in 1999, making the GRC interpreters available to all hospital staff needing linguistic assistance. Second, the GRC provides the hospital with a regularly updated list of interpreters, which is accessible to staff via the hospital intranet system.

Harzing et.al. (2009) state that there is a need for practical solutions to language barriers, and this could be achieved by conducting real-practice research. There are some sources of literature that talk about addressing the language communication problem, especially in the medical and healthcare context. Bischoff and Hudelosn (2010, p.18) suggest that "language services need to be integrated into organizational routines", which shows the necessity of language communication services in medical contexts no matter what language they are speaking or the nature of their culture.

Although this has been accomplished in some hospitals in the USA, several studies point to the challenges involved in implementing such institutional changes. To begin with, Bischoff and Hudelosn (2010) describe another strategy that has been implemented in some settings to identify bilingual healthcare staff who can officially (rather than informally) have double job roles and work as interpreters. However, the quality of interpreting should be assured in this regard. Therefore, it is important to train and assess bilingual staff to be professional interpreters.

Furthermore, hospital administrations have suggested having alternative language translation solutions in medical contexts. This action can be done by asking for the assistance of some patients' family members and bilingual staff to meet the language communication needs and solve the cost problem if hiring some professional interpreters. What has been claimed by Bischoff and Hudelson (2010, p.19) is similar to the medical context in the Kingdom of Bahrain, "As populations become increasingly diverse, priority needs to be given to developing procedures for systematically identifying patients needing linguistic assistance, linguistic assistance strategies that respond to provider and institutional contexts and constraints, interpreters for all medically important communication with patients who do speak the local language…. for all patients".

2.5.1 Implemented Coping Strategies to resolve the Miscommunication Barriers in Medical and Healthcare Setting

This section is presenting some successfully implemented ideas and coping strategies designed to resolve the miscommunication barriers faced in different global healthcare settings.

2.5.1.a Solving the Cultural Part of Language Communication Barrier in the Healthcare Context

Gregg and Saha (2007) suggest a solution to reduce language barriers between patients and healthcare providers is by increasing the linguistic and cultural diversity of the health care workforce and to give patients greater choice in selecting providers when they can understand who can understand them. I think the latter solution, which gives patients the choice and the freedom to choose their healthcare providers by themselves could not apply to my country setting as I do doubt that this could be possible in my research context due to the increase in patients' numbers and the shortage of healthcare providers. Public hospitals in my country Bahrain do not give the options to patients to select their health care providers. This choice option is only available in private hospitals and clinics in my country in which patients will select their doctors and will pay money for their appointments and treatment. On the contrary, the vast majority of citizens cannot afford to go to specialists in private hospitals due to their low financial status.

2.5.1.b Communication with Professional Nurses act as Culturally Interpreting Volunteers

Through learning a language for communication, learners become more aware of the learned language culture and its use in real communication contexts, such as the communication between health caregivers and their patients who speak different languages than the spoken languages of practitioners. This idea is supported by what Albougami (2015, p.168) added, "The study found that interpreters and bilingual health workers were effectively used to facilitate communication with culturally and linguistically diverse (CLD) patients, and some nurses showed empathy, respected willingness to make an effort in the communication process, while others showed an ethnocentric orientation." However, I could see that it is difficult for nurses/ medical staff to play a dual role (i.e., two or more, being nurses & interpreters at the same time). In the Bahraini context, professional interpreters are not provided in the medical setting to facilitate the communication process between medical practitioners and Arab patients. However, Arab medical staff members are asked sometimes to assist in the interpretation process, but not all the time staff members could volunteer to provide translation help due to their job commitments. Besides, medical practitioners who volunteer to assist as interpreters are not necessarily accurate in translation as they are not professional interpreters and not specialized in this field, and this issue itself could act as a potential risk and lead to inaccuracy in the translated data as well as having some medical errors.

2.5.1.c Hiring Professional Interpreters as a Solution to Language Communication Barriers in Different Countries

In reference to what Albougami (2015, p.168) claims that learning few words of Arabic by non-Arabic speaking nurses is not enough to communicate effectively with confidence in another language, a solution by Albougami (2015) is suggested in this regard. This solution states that professional interpreters must be hired to facilitate communication between English-speaking staff and Arabic-speaking patients. I concur with what Albougami (2015, p. 168) added (i.e. an example that illustrates the cultural dimension, especially within the context of Islamic countries) that when hiring interpreters to work in Arab-based clinical areas, we should select interpreters of the patient's gender (A male interpreter for male patients & a female for the females), and that will likely to result in having a more comfortable and efficient interpretation process on consideration of religion and culture in the Arab region. However, the idea of hiring interpreters to assist medical practitioners and patients who speak different languages would not be a preference in my Bahraini medical context. The reason behind this is that the government nowadays is moving towards cutting off money, expenses and establishing more taxes to make a financial balance to the cost of living and going for the decision of hiring professional interpreters is expected to add unaffordable costs to the government.

In addition to these tools, there is a recommendation to have in each health setting (i.e., hospitals, clinics, and health centers**)** some well-trained interpreters and translators to mitigate any potential language and cultural barriers that may occur in daily life. However, hiring interpreters costs a lot, and maybe not all medical institutions could provide this service. It is also possible to benefit from the experience of Grace Plaza of the Great Neck Comprehensive Care Center's language bank program. This programme uses staff members to act as voluntary summer interpreters to communicate with patients and family members who do not speak English. A similar language programme can be implemented in Bahrain to guarantee to have a good number of high school and university students. The selected students are on their summer vacation, good at the English language and could work as voluntary interpreters in medical areas and mediators between non-Arabic speaking medical practitioners and Arab patients. However, the medical translation would require much more specialized people in the field of translation and interpretation to avoid any medical errors or inaccurate translation which may lead to many negative consequences and legal issues afterward. The translation process of the proposed voluntary translation programme could be more systematic by making a schedule offered to the patients, patients' relatives, or visitors of the available interpreters with required details of names, times, and places. The "Language Bank Programme" as being described by Central Coast Children's Foundation (n.d) has proved its effectiveness in enabling and facilitating patients to communicate their questions and needs or concerns to physicians and healthcare

providers. It is also mentioned that trained interpreters' role can include conveying messages regarding patients' diagnoses, treatments, and payment options to avoid communication errors and misunderstanding. I assume that such strategies can be implemented for pharmacists too when prescribing and explaining medicine-taking instructions to patients who speak different languages from what they speak.

As a coping strategy for the language communication problem, it is suggested by Central Coast Children's Foundation (n.d) that first, trained interpreters and translators, either hired or volunteers can be utilized to resolve the language and cultural communication barriers. Second, another alternative that has been used if no professional well-trained interpreters are available as being described by the Central Coast Children's Foundation (n.d) are language boards with pictures and symbols to communicate with patients. Third, to guarantee to have available interpreters at any time needed, Central Coast Children's Foundation (n.d) has implemented a technique that uses a schedule showing when staff members who speak some foreign languages are available to assist in interpreting. Medical interpretation in a clinical context as being referred to may include conveying messages regarding diagnosis, treatments, and payment options to patients and their relatives or friends who may accompany them and all of this effort aims to avoid communication errors and misunderstandings in the medical clinical workplace.

Bischoff et.al. (2003) main issue of discussion is about the difficulty to hire interpreters- high cost. Bischoff et.al. (2003) pointed out an important coping strategy which I believe could solve the issue of the expensive cost of hiring professional interpreters to work in medical clinical settings. To solve this problem, Bischoff et.al. (2003, p.541) thought of "improving communication between allophones patients and physicians by training the physicians of a primary care clinic in the use of interpreters". This means that physicians in medical and healthcare contexts are encouraged to be trained in dealing with allophones patients and working with interpreters. The study conducted by Bischoff et.al. (2003) has added some ideas to the literature, for instance, the need for raising physicians' awareness of communication with allophone patients which has resulted according to this study in decreasing the practitioners' reliance upon non-qualified proxy interpreters.

2.5.1.d Using a Picture Board and Low-tech Tools to facilitate Communication in all Medical Settings

Central Coast Children Foundation Central Coast Children's Foundation (n.d) talks about language communication barriers in general in medical and healthcare settings. There are many benefits according to Central Coast Children's Foundation (n.d) for including language access and support services in health

care settings, for instance: more preventive health activities, higher quality care, increased patient satisfaction and ensuring appropriate resource utilization.

We can benefit from what this paper Central Coast Children's Foundation (n.d) refers to using a picture board and low-tech tools which help in facilitating communication in all medical settings (i.e., this strategy could also be expanded to more hospital settings or areas, such as ambulances, hospitals, emergency rooms, and health clinics). Most of the patients in public Bahraini hospitals and health centers speak in Arabic and are either semi- or fully English language illiterates, and such suggested tools that were previously discussed in this study from the literature of other regions' similar experiences could bridge the language communication gap between the two intended parties (i.e., patients & medical practitioners).

2.5.1.e Implementing the Language Access Services (LAS) in Medical Healthcare Workplaces

The need for Language Access Services (LAS) has become increasingly pertinent given the continued growth in language diversity within the United States, explained by Pacheco (2005). The author further adds that the number of individuals who speak a language other than English at home rose from 31.8 million in 1990 to 47 million in 2000. In addition, the number of individuals who speak English less than "very well" increased from 14 million in 1990 to 21.4 million in 2000, reflecting a 53 percent rise in the number of LEP individuals in the United States over the 10-year period.

Added to that, Pacheco (2005) elaborate that Language access services (LAS) are also commonly referred to as language assistance services and linguistically appropriate services. LAS are services that are designed to ensure effective communication between limited English proficient individuals and English speakers. Primary LAS include interpretation (oral) and translation (written) services. LAS can also involve provisions that enhance communication, such as signage and symbols for wayfinding.

Pacheco (2005) illustrates some benefits which could be gained through implementing the Language Access Services (LAS) in medical healthcare workplaces. Those benefits are related to healthcare qualities, level of patient satisfaction…etc. The number of benefits gained proves that the implementation of (LAS) had achieved successful outcomes. All these language communication services in medical and healthcare organizations are entitled "Language Access Services", (LAS). This database used for accessing language services could be proposed and implemented in my work medical institution (RCSI- Bahrain).

2.5.1.f The Importance of Treating Patients as a Whole Human

Some literature resources emphasize the importance of proper language communication between medical professionals and patients. Various suggestions to help medical practitioners cope with daily-basis language communication challenges have been made to overcome this fundamental human-based problem. First, Emily (2007) indicates an important aspect of the medical practice when dealing with patients that medical practitioners should treat their patients as a whole human; not only physically, but also emotionally and psychologically. Second, it has been referred to by the Joint Commission (2018) that one of the fundamental bands of the legal or medical code of conduct for medical professions is that the level of language communication between medical practitioners and their patients should be high. Therefore, a good level of language communication and clarity are required between patients and medical practitioners when communicating together.

2.5.1.g Conducting Communication Skills Workshops for Medical and Healthcare Practitioners

Baile et.al. (1999) have come up with some solutions and coping strategies that could match my country medical context's needs and be under the last research question of this study. First, medical practitioners could discuss their difficult cases with their colleagues to share some recommended new learning approaches which may suit solving common patient problems, the majority of them encountered in their everyday work in medical and healthcare settings. This research paper concludes by suggesting that communication skills workshops would be useful copying tools that can provide training to oncologists in stressful aspects of the physician-patient relationship. These communication skills workshops could also serve the language communication needs of other medical specialists and not only restricted to oncologists.

2.5.1.h The Idea of Reforming more Community-Oriented Training Curricula by the World Health Organization Eastern Mediterranean Region (WHO EMRO)

It is reported by Kronfol (2012, p.1158) that "training in public health and the management of health services is singled out by the World Health Organization (WHO) as a pressing need for the future development of health services". I find it interesting to explore and investigate what sorts of professional development training are available in public health and the management of health services. This investigation could be conducted to check whether or not there is a language communication training within the professional training programme for healthcare providers or being absent, then I could think of raising awareness and sharing a world-wide organization of how important is to implement and include

such a training programme in its professional development training agenda.

Based on the vision and mission of the World Health Organization Eastern Mediterranean Region (WHO EMRO) as indicated by Kronfol (2012) who was a pioneer in the international movement and was for the idea of reforming the training curricula. The reason for that reform was to become more community-oriented and thus more relevant to people's needs. It also supported several institutions in the region in this regard. As an Arabic language programme coordinator, I would enthusiastically follow the WHO's mission in designing and developing my Arabic language curriculum for medical and healthcare purposes in the coming future.

2.6 Chapter Two Summary

In conclusion, this research study aims to highlight language barriers in diverse local medical contexts. This language barrier could be considered an overwhelming dilemma from my point of view based on my teaching experience to non-Arab medical students at RCSI-Bahrain.

The first section of this chapter, "The importance of language communication in different cultures and the Arab world" shows how broader and wider the communication field is rather than being a term that focuses on language only.

The second section of this chapter focuses on "the importance of language communication in different professional contexts including the medical and healthcare context, and in part, it is obvious that communication is an important mandatory skill in multi-professional careers. However, medical and healthcare professions seem to be on the top of other careers to have the priority of ensuring good effective communication skills among its staff members due to its link to human being life and safety.

The third section highlights the challenges in addition to the potential consequences that resulted from miscommunication in medical and healthcare contexts.

Last but not least, the final section ended up in presenting some coping strategies for facing miscommunication barriers in both different professional contexts in general and in the medical context in particular which are successfully implemented and could be adopted in Bahrain's medical and health care setting in the coming future. The coming chapters will provide detailed data and will draw a real picture of the miscommunication barrier impact on non-Arabic speaking medical practitioners when dealing with

Arab patients in Bahraini medical and healthcare settings.

All in all, communication is built up of a number of components and there are different means of communication, both verbal and non-verbal. Although all of these components are important and could have either direct or indirect or both impact on the communication process; however, I find that language ability plays an essential role in the medical practitioners' daily-life conversation with their patients in the medical and health care context where human beings are the most important clients.

Chapter Three

The Study Methodology

3.1 Introduction

The objective of my research is to address the issue of language miscommunication between non-Arab medical practitioners and their Arab patients. A qualitative approach was selected to gather data that would bring altogether a clearer picture of what is meant here by communication barriers in general and language communication barriers in particular. According to the role of a qualitative study in giving a clear image to a new phenomenon explored, my thesis study would fit first in terms of research design under Exploratory Phenomenological Study.

The research brought together patterns and themes. Besides, the qualitative collected data served to understand further rich details of the communication barriers. These barriers are faced by non-Arabic speaking medical practitioners in their daily clinical practice when dealing with Arab patients through a more in-depth approach. The resulting data provided a more personal account of the type of possible communication challenges faced, their risks and consequences, a good database to study their problem in-depth, and be able to design or adapt suitable coping strategies and solutions. In the remainder of this chapter, the aim of the research is presented in conjunction with the epistemology, theoretical perspective, methods, and a general summary of the research process. This chapter includes data collection, data analysis, participant selection, and ethical considerations.

3.2 Research aims and Guiding Questions

The teaching experience and continuous voluntary language support to many non-Arabic speaking medical students have informed both the research paradigm and methodology. In this chapter, I will elaborate on my epistemic choices and their methodological consequences, share with you the process I have used to design the project, and finally give a full description of the tools I employed to ethically enter the field, collect and analyse the qualitative data using a couple of data analysis methods, thematic analysis method (Braun & Clark, 2006) and the NVivo qualitative data analysis application.

3.2.1 Main Aim and Objectives

Miscommunication in result of language barriers between Non-Arab medical practitioners and their

patients and other healthcare professionals is a common issue in Bahrain with some negative consequences. This study aims to address this issue through uncovering the main language barriers faced by non-Arab medical practitioners from different specialties, the impact of such language barriers on their practice, and possible ways of dealing with this issue.

The main objectives of the study are threefold:

(i) To examine the impact of miscommunication in the Arabic language on non-Arab medical practitioners from different specialties.

(ii) To identify the coping strategies adopted by non-Arab medical practitioners to deal with language barriers.

(iii) To explore further actions that can be taken to help solve the miscommunication issues between non-Arab medical practitioners and their patients.

3.2.2 Research Questions

To achieve the general objectives, the following questions will be addressed:

a) What kinds of training in the Arabic language do non-Arab medical practitioners from different specialties receive to work in Bahrain?

b) What main difficulties have non-Arab medical practitioners experienced when communicating with Arab patients, colleagues, and other healthcare professionals?

c) How has language miscommunication affected non-Arab medical practitioners' relationships with their Arab patients, colleagues, and other healthcare professionals from medical practitioners' perspectives?

d) What strategies have non-Arab medical practitioners adopted to cope with language miscommunication issues?

e) What types of support are available to non-Arab medical practitioners to deal with the language barriers they face in their practice?

f) What do non-Arab clinical practitioners think can be done to help them overcome the language barriers they face in their practice?

3.3 Study Methodology and Type of Study

This research is an exploratory phenomenological study using the qualitative research approach and is expected to provide rich data input to this particular professional medical education area.

To start with, qualitative research is defined as "the systematic inquiry into social phenomena in natural settings. These phenomena can include, but are not limited to, how people experience aspects of their lives, how individuals and/or groups behave, how organizations function, and how interactions shape relationships" (Teherani, A, Martimianakis T, Hayes TS, Wadhwa A. & Varpio L, 2015, P. 669).

In this qualitative research, the researcher is the main data collection instrument, Teherani et.al. (2015). It is single-researcher research and not collaborative, because it is conducted to again a doctoral academic degree. This study matches with the qualitative research approach since the researcher examines why events occur, what happens, and what those events mean to the participants studied. My role in this study is a constructivist researcher who believes that there is no single reality about my research problem under investigation, but I aim through this study to elicits my participants' views of reality relevant to language barrier during their daily-basis doctor-patient communication process. What strengthen my constructivist role is following a qualitative research approach which generally draws on constructivist beliefs (Teherani et.al., 2015). Besides, there are different qualitative research approaches commonly used in medical education and phenomenology is one of them which reflects the type of this study. This selected study qualitative approach acts as a frame that shapes my research questions, the method of data collection and data analysis.

Making the choice of a qualitative approach before starting to conduct the study, consider how my views as a doctoral researcher about what is possible to study will affect my approach. Furthermore, being a researcher, I put in mind selecting an appropriate approach that align with my research aims and questions. Qualitative research focuses on the events that transpire and on outcomes of those events from the perspectives of those involved (Teherani et.al., 2015). In this case, qualitative research fits to help in understanding the impact of language communication barrier on medical practitioners' clinical performance.

The study type is exploratory-phenomenological and the term phenomenology according to (Teherani et.al., 2015) describes the essence of a phenomenon by exploring it from the perspective of those medical practitioners who experienced it. The researcher expect that the research results would contribute to her understanding of the phenomenon of language communication barrier challenges faced in diverse clinical

and healthcare setting in this research in Bahrain Kingdom. Interviews would be used to understand how non- Arabic speaking medical practitioners deal with the daily clinical challenges experienced when communicating with Arab patients and / their next of kin.

To justify the choice of qualitative research approach for this study, first, a qualitative research approach provides the researcher with rich informative data of an underexplored phenomenon; especially in the Arab medical context where Arabic is the main communication language among Arab patients who are not only Bahraini but come from different Arab countries around the world. Besides, the qualitative approach uses words or narratives to add meanings to the data and can potentially present a more in-depth conclusion through greater insights.

3.3.1 Methods

Methodology is concerned with the process and the method by which the researcher acquires knowledge about the world (Creswell, 2007; Edwards & Skinners, 2009 & Punch, 1998). The research method selected for this study is the qualitative research approach. In addition, research methodology helps the researcher to get data through selected research data collection tool (s). It is argued that methodology plays a vital role in achieving research objectives. If the research objective is problem solving or exploring the phenomenon under study like what this study is exploring, then it would recommend interpretivism (qualitative methods) (Creswell, 2007). This could justify the choice of qualitative method to explore the study phenomenon.

The following sections of this chapter will focus on the main components that have been selected for the present research. These sections also provide some detailed justifications of the selection of these components for this thesis study.

3.3.2 Type of Study

The study type is exploratory-phenomenological and the term phenomenology according to Teherani et.al. (2015) describes the essence of a phenomenon by exploring it from the perspective of those medical practitioners who experienced it. The researcher expect that the research results would contribute to her understanding of the phenomenon of language communication barrier challenges faced in diverse clinical and healthcare setting in this research in Bahrain Kingdom. Interviews would be used to understand how non- Arabic speaking medical practitioners deal with the daily clinical challenges experienced when communicating with Arab patients and / their next of kin.

A research design is a plan for conducting the study (Creswell, 2013). Suitable study design for this research topic is the qualitative research design. There are some reasons for selecting this research

approach instead of other approaches, such as quantitative and mixed method.

To justify the selection of the qualitative approach in this study, the researcher decided to use the qualitative research design to explore and investigate this study problem and be able to describe it in depth. The research problem then would need to be widely explored. The qualitative approach uses words or narratives to add meanings to the data and can potentially present a more in-depth conclusion through greater insights.

Qualitative approach from the view of Creswell (2013) will help researchers to study a specific group or population closely, identify variables that cannot be easily measured, or hear silenced voices regarding certain research issues. Besides, we also conduct qualitative research to reach the complexity and detailed understanding of the research issue. Another reason for conducting qualitative research is that when aiming to empower individuals to share their stories, hear their voices, and minimize the power relationships that often occur between the researcher and the participants in a study. To further strengthen a power relationship, I may collaborate directly with participants by asking them to review the research questions. For example, the pilot test I conducted and elicited feedback and views from some medical practitioners and educators who work for improving the qualitative tool. Also, participants may be required to collaborate with the researcher during the data analysis and interpretation phases of research. As well as the choice of qualitative research would allow the researcher to present the informal voice of the research participants through a simple language presented in their shared personal incidents or stories. One further point, qualitative research is followed to develop new theories if the existing theories are not enough to analyse the complexity of the research problem being investigated.

Qualitative research approaches have the quality of providing both unique and valuable insights. Phenomenological- qualitative research approach is well-fit in health-care related research studies (Barnard, McCosker & Gerber, 1999) which makes it a perfect choice for this doctorate study that is categorized under professional medical and healthcare education and focuses on daily-basis clinical doctor- patient communication scenarios. What make this qualitative phenomenological approach suitable for this study is that this approach helps in eliciting answers for the research questions from the experience of the participants. In this thesis study, the main source for collecting data are the medical practitioners and their shared professional experience. Barnard (1999) described phenomenology to be first, a division that is claimed between pre-reflective experience and conceptual thought. The phenomenon can be seen in this research through the experience of non-Arabic speaking medical doctors when communicating with their Arab patients who speak a language that their doctors do not speak and the expected challenges that may occur as a result of this language barrier between these two parties.

3.4 Research Participants

3.4.1 Selection Criteria for the Research Participants

A sample of volunteered participants from different medical institutions/ hospitals (Minimum three practitioners and maximum five from each research site) were selected from each institution based on their professional experience and specialty. For this selection, I accessed a list of practitioners in the three medical institutions/ hospitals. Thesis selection criteria are expected to provide a rich dataset not only regarding the practitioners' language communication challenges but also the ways they have tried to overcome such difficulties and the identification of possible ways to address the problem.

For the participants' sampling, I followed a *Maximum Variation* as a sampling strategy (Hardon, Hodgkin, & Fresle, 2004) to include practitioners of the diverse specialties and elicit different perspectives from participants who have different years of work experience as medical practitioners in Arab-based clinical contexts. The *Maximum Variation* is a type of qualitative sampling and it is a popular approach in qualitative studies, Creswell (2013).

Maximum Variation is a purposeful sampling strategy. The aim is to sample heterogeneity. This method is used by researchers to enable them to understand how a phenomenon is seen and understood among different people in different settings and at different times. Added to that, when using a maximum variation sampling method, researchers select a small number of units or cases that maximize the diversity relevant to the research.

Table No. 3.1 The Characterization of the Research Sample

KHUH= King Hamad University Hospital, **RBH=** Royal Bahrain Hospital, **RCSI – Bahrain part-time medical practitioners:** The Royal College of Surgeons in Ireland- Medical University of Bahrain, **P=** Participant (e.g., P1, P2…etc.), **Dr.=** Medical Doctor & **R=** Researcher / Rabab.

MS1P=Medical Site 1- Public, **MS2Pr**= Medical Site 2- Private, **MS3Pr**= Medical Site 3- Private

Notice: Medical Practitioner participants are referred to by their either first or first and second initial letter/ letters and they are eleven medical practitioners participated from three different medical institutions / hospitals.

No.	Name of the interviewed doctor/ medical practitioner	Gender	Hospital/ medical institution he/she works in	Nationality/ Knowledge of Arabic Language if any	Specialties	Total Years of professional experience	Years of professional practice in Bahrain & Other Arab Countries if any
1	P1- Dr. K.	Female	KHUH MS1P	Indian No Arabic	Ophthalmologist	6 years	3+ 2 years in KHUH & 1 and a half year in a private sector
2	P2-Dr. N.	Male	KHUH MS1P	Indian No formal learning of Arabic **Informal learning:** just by listening to some frequent Arabic words or phrases from patients or some Arab medical staff who sometimes help doctors in translation.	IC- Intensive Care- Critical Care & Anesthesia	11 years	1 & a half years
3	P3-Dr. D.	Male	KHUH MS1P But also worked in Salmaniya Medical Complex in Bahrain before working in KHUH and both are public hospitals	Indian No formal learning of Arabic **Informal learning:** Knows some Arabic words/ phrases related to dialysis ward.	Nephrology – Internal medicine- Dialysis, different types of dialysis- Kidney transplantation- Not a surgeon but a physician	Started practicing medicine since 1983 ,35 years of medical practice, practicing Nephrology around 32 years in total	In 1991, started working in Oman Sultanate & then moved to work in Bahrain – A total of 28 years of medical practice in the Gulf (Oman & Bahrain) In Bahrain have spent 15 years till now.
4	P4-Dr.Ro.	Male	KHUH MS1P	Indian Know few slang words and phrases, but unable to communicate and open a dialogue	Critical Care Medicine- IC Intensive Care	6 years in total in India	One month only in Bahrain

5	P5-Dr. Va.	Male	KHUH MS1P	Indian No formal Arabic Learning **Informal Arabic Learning:** Learnt few social Arabic informally through some Arab patients & their relatives, national Arab staff & Arab consultants.	Critical care medicine	A total of 9 & a half years in the medical professional practice	2 & a half years of practice
6	P6- Dr. Vi.	Male	KHUH MS1P full timer-RCSI-Bahrain Part-timer	Indian Cannot speak Arabic at all	Intensive Care	21 years a total of professional practice	6 & a half years in Bahrain
7	P7-Dr. Ra.	Female	American Mission Hospital (Amh) MS2Pr full-timer-RCSI-Bahrain part-timer	Pakistani Informally learn to speak few broken basic Arabic just to convey her message. She has not got the chance to practice informal Arabic outside work.	Obstetrics & Gynecology	23 years in total	5 years in the Gulf, Saudi, Dubai & Bahrain Lived in Oman but didn't work there. All of the Gulf countries share similar cultural aspects, but have different dialects if not speaking in standard classic Arabic which we call it " Fuss-ha'a"
8	P8-Dr. J.	Female	American Mission Hospital (Amh) MS2Pr full-timer-RCSI-Bahrain part-timer	English She took an elective course up to Intermediate Arabic Language level in Kent University in London.	Obstetrics	18 years	8 years in Bahrain, 10 years in London & 8 years of professional practice in Bahrain

9	P9-Dr. B	Female	RBH MS3Pr	Indian Does not speak Arabic, only few words and broken phrases learnt informally.	Pediatrics	25 years in total	20 years in Bahrain
10	P10-Dr. Sh.	Male	RBH MS3Pr	Indian Only little broken Arabic	Urology	A total of 15 years of Urology	Only 2 years of medical practice in Bahrain.
11	P11-Dr.Sa.	Male	RBH MS3Pr	Pakistani Can just speak some broken Arabic for the patient history	Medicine: Internal Medicine &Critical Care Medicine Work in both ICU & Outpatient Department (Opd)	Over 38 years of medical practice	25 years of medical practice in Dammam Central Hospital + 9 years of medical practice

3.4.2 Selection Criteria for the Research Participants

A sample of volunteered participants from different medical institutions/ hospitals (Minimum three practitioners and maximum five from each research site) were selected from each institution based on their professional experience and specialty. For this selection, I accessed a list of practitioners in the three medical institutions/ hospitals. Thesis selection criteria are expected to provide a rich dataset not only regarding the practitioners' language communication challenges but also the ways they have tried to overcome such difficulties and the identification of possible ways to address the problem.

For the participants' sampling, I followed a *Maximum Variation* as a sampling strategy (Hardon, Hodgkin, & Fresle, 2004) to include practitioners of the diverse specialties and elicit different perspectives from participants who have different years of work experience as medical practitioners in Arab-based clinical contexts. The *Maximum Variation* is a type of qualitative sampling and it is a popular approach in qualitative studies, Creswell (2013).

Maximum Variation is a purposeful sampling strategy. The aim is to sample heterogeneity. This method is used by researchers to enable them to understand how a phenomenon is seen and understood among different people in different settings and at different times. Added to that, when using a maximum variation

sampling method, researchers select a small number of units or cases that maximize the diversity relevant to the research.

3.4.3 Methods of Data Collection

The method of data collection that will be utilized in this study is the in-depth semi-structured interview, "the semi-structured interview, therefore, not only gives interviewers some choice in the wording to each question but also in the use of probes," (Hutchinson & SkodolWilson, 1992, p. 117-119). The reasons for selecting this type of interview to meet the needs of the qualitative study stage are first, to have an overview about the research problem elicited from a variety of intended medical practitioners' real practice. Secondly, to study the problem from three dimensions by asking medical practitioners from different medical career stages and practical experiences to contribute to the study with their real insights. Thirdly, to create a sufficiently rich database, this will assist in designing a variety of data collection tools for future research and could think of some practical solutions to solve the miscommunication issues faced in their everyday professional clinical practice.

3.4.4. The Interview Protocol

The semi-structured interview protocol consists of six categories. The first one is about the general questions category and it includes five social demographic questions. Some of the question elements are considered to be study variables. The mother tongue question is important to have an overview of the common nationalities of non- Arab medical practitioners who work in Bahrain's public and private hospitals or medical institutions and who face language communication barriers in their medical professions and daily clinical practice.

The second general question asks about the number of other languages excluding the mother tongue that each participant could speak. This feature of whether or not each practitioner can speak other languages besides his/ her language can be used to compare with support of relevant literature to investigate that if being able to speak more languages, would that be an advantage to learn a new foreign language for communication such as the Arabic language in a short time?

The third question in the first category asks each medical practitioner about his/ her field of specialization in the medical setting. Through this question, the researcher could take this opportunity to check whether or not medical practitioners of similar or different areas of specialization share similar or unique themes of the language communication challenges faced in the clinical medical contexts when dealing with Arab

patients. A similar measure could be used to check if these practitioners have used or come up with common or different coping strategies. These strategies aim to help them solve the language communication barriers encountered in their daily routine medical practice in a diverse Arab country's medical setting like Bahrain.

Both the fourth and the fifth questions ask about the years of experience in practicing medicine, the full experience, including their home country and other countries of professional practice plus the years of professional experience of practicing medicine in Bahrain as an Arab country. Some of the study participants practiced medicine in other Arab GCC countries before, such as the Kingdom of Saudi Arabia (KSA), Oman Sultanate, and the United Arab Emirates (UAE) in addition to their current professional clinical experience in Bahrain kingdom. Therefore, for those of them who have multi-experience in different countries with similar or different health care systems, there is an advantage of carrying the benefit of transferrable knowledge and experience. Added to that, some of the study practitioners refer to some successful coping strategies which they used in the past or what their previous workplaces in other countries followed and found effective. While others share some advantages and means of support found in their current work systems.

Any development coping strategy or professional development training solutions to cope with the language communication challenges faced by medical practitioners. The mother tongue question is not used for other variables investigation in this study.

The other five interview protocol categories include all the research questions in sequence. Each category is given the main theme elicited from the keywords of each research question. Added to that, some relevant questions have been constructed to facilitate the interview process. Several unconstructed probing questions had been asked by the study researcher herself to the participants to facilitate the interview process, provide further clarification and explanation to the participants and to enrich the study with deep relevant collected data.

(See Appendix 3.1, P.: A Sample of the final approved Semi-Structured Interview used for Collecting the Study Qualitative Data).

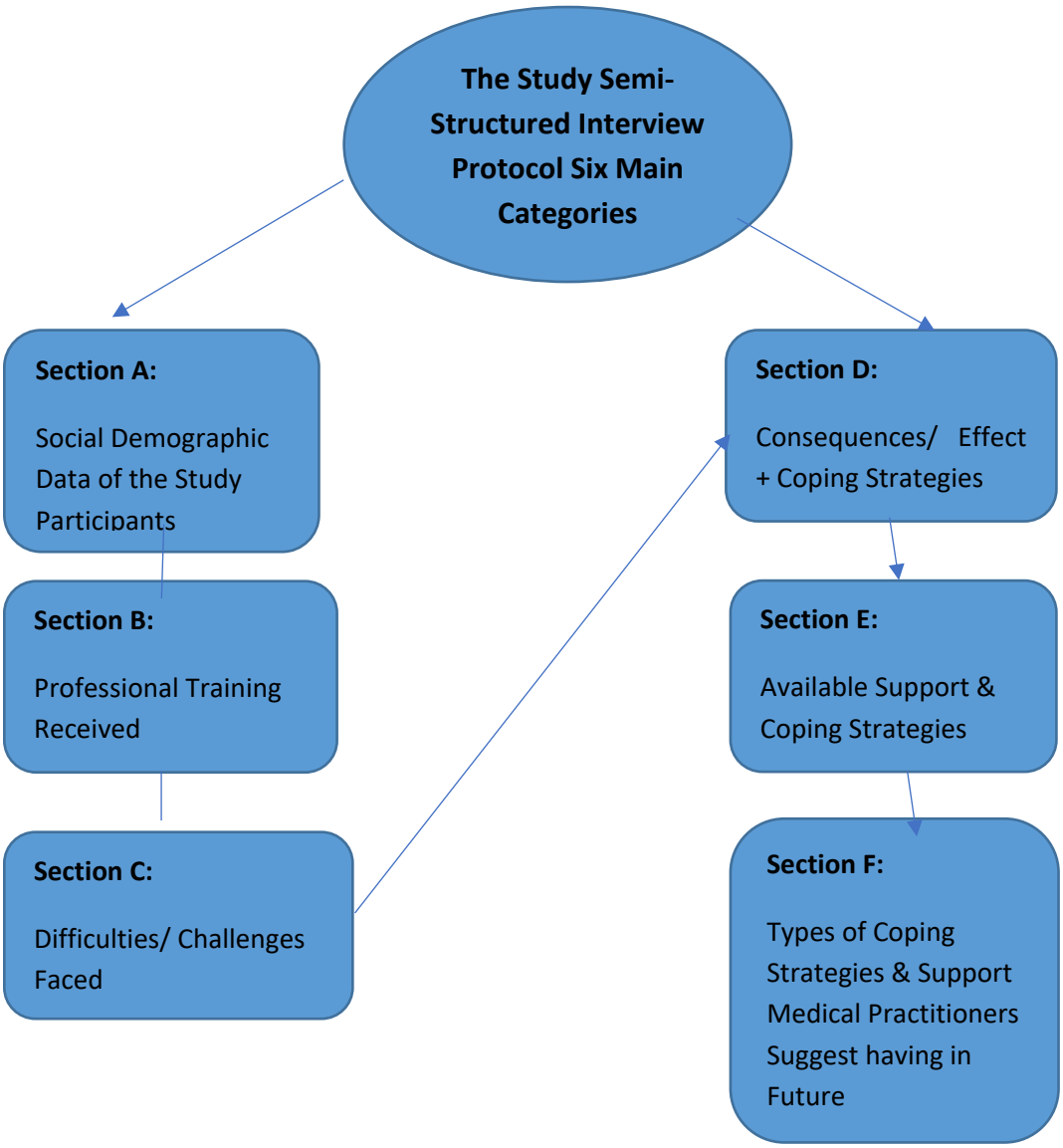

Diagram 3.1: Shows the six categories of the semi-structured interview protocol used to collect the study data from the medical practitioners- Section A includes social demographic data questions and the rest sections from B-F represent the actual research questions

3.4.5 How the qualitative data collection tool was validated

The quality and credibility of qualitative research have been often questioned. Generally speaking, quality refers to the transparency of the whole research process; credibility pertains to the validation of findings and results. For a long time, these issues have also been associated with discussions of the reliability (of methods) and *validity* (of data). In this research study, several techniques were followed by the researcher to validate the data collection tool and ensure its accuracy and relevance to the research topic and objectives.

Some procedures were followed to validate the qualitative data collection tool which is a semi-structured interview protocol designed for a duration of 45 minutes to 1 hour long. To begin with, a draft of the interview protocol and a copy of the Participant Information Sheet (PIS) were sent to six senior faculty members in a medical institution. These educators have long, rich experience in research and medical professional education in a way that can contribute to the modification and improvement of the qualitative tool. Out of six faculty members, only four responded with their insightful feedback and comments for further improvement of the final tool. The researcher, then, made the final changes to the interview protocol and conducted a pilot study to further, test, validate, and improve the tool before the actual study starts. The pilot study was then conducted with three medical practitioners who had different specialties and had different years of professional experience.

3.4.6 Interview Data Collection Process

Eleven medical practitioners participated in the study and were interviewed using a semi-structured interview. These participants are all medical practitioners from different medical areas of specialization and work under one of the three research sites (i.e. one public university hospital, one private hospital, and the 3rd is a higher education medical institution). All of these research sites are located in the Bahrain Kingdom, which is a diverse Arab GCC country.

The interviews took around 45 to 60 minutes of time duration each. The eleven participants work in various medical institutions/hospitals in similar or different wards and departments, such as ICU, pediatrics, gynaecology, renal unit, Oncology, Obstetrics…etc.

The qualitative data were collected through a semi-structured interview protocol. The protocol consists of six categories, each category consists of a set of relevant questions. Only the first category asks social demographic data questions. The purpose of asking such questions in the first interview category is to use some of the data as study variables (e.g., years of experience spent in practicing medicine in Bahrain

&/ other Arab countries and spoken languages) to compare and contrast between the study participants' responses and to link ideas together and come up with new ones when writing the thesis discussion and the conclusion.

Through the qualitative data collection, semi-structured interviews would be conducted on a sample of non-Arabic speaking medical practitioners in three research sites which are all medical institutions/ hospitals, both public and private sectors. The research brought together patterns and themes to reflect the real experience of facing communication barriers in realistic clinical practice, the impact of these barriers on the medical practitioners' professional performance and the healthcare services offered, the consequences, how they are dealing with such challenges, if or not any available coping strategies or techniques and their suggestions for continuous future professional support.

This qualitative data served to understand further rich details of the communications barriers non-Arab speaking medical practitioners usually face in daily clinical practice when dealing with Arab patients through a more in-depth approach. The resulting data provided a more personal account of the type of possible communication challenges faced, their risk and consequences, a good database to study their problem in-depth, and be able to design or adapt suitable coping strategies and cures. One of the variables is the years of experience of practicing medicine and the work experience in Bahrain or similar diverse Arab countries.

All research questions start from the second category. Around six research questions are distributed among five interview categories. Starting from the 2nd category till the sixth one, there are subtitles to be included to provide more clarification to the research participants to understand what the questions require from them to help them provide relevant rich answers.

Moreover, each interview category's set of questions includes some extra probing questions that were not being previously or formally structured in the interview protocol but were formed by the researcher at the time of the interview for several reasons. For instance, to ask for more clarification from the participants or to enrich and add to the answers provided by the participants which may not be clear or enough or probably irrelevant to the questions and the main focus of the study.

Following the phenomenological research approach will not result in forming or testing a hypothesis but provides rich insights into the research participants' professional reality. That was achieved by asking the study practitioners more professional-based questions like, "Have those communication difficulties affected your professional practice?"

The qualitative data was used to bring together the concept of language communication barriers to analyse and interpret emerging themes that address the main research questions. The data were collected through a semi-structured interview protocol.

3.4.7 Methods of Data Analysis

For the qualitative data analysis, the thematic analysis method (Clarke & Braun, 2006) will be utilized to analyse the data collected through one-to-one in-depth semi-structured interviews. Relevant themes will be identified. Given the exploratory nature of this phenomenological study, this method of analysis allowed for a detailed description (Creswell, 2013) and interpretation of the data. Besides, the study benefited from the use of the NVivo Qualitative analysis software to help to integrate both mind and technology to come up with as many valid relevant themes from the data collected.

3.4.7.a Justifying the Choice of both Thematic Analysis Method and NVivo in Analyzing the Study Collected Data

Qualitative interviews were the main method in this study. This research tool helps the researcher to obtain various perspectives on the research questions. Qualitative interviews give a new insight into a social phenomenon as they allow the respondents to reflect on a variety of subjects in a different way (Folkestad, 2008, p.1).

The method of analysis chosen for my study was a qualitative approach to thematic analysis. Generally speaking, thematic analysis is considered to be one of the most widely used qualitative data analysis methods followed for analysing interviews. Based on what Braun and Clarke (2006) mention that thematic analysis is a method used for identifying, analysing and reporting patterns (themes) within the data (2006, p.79). My justification for following this method is based on what comes by Braun and Clarke (2006) that rigorous thematic approach can produce an insightful analysis that answers particular research questions.

Added to that, this approach investigates the interview data from two major perspectives; first, from both a data-driven perspective and a coding perspective which is presented inductively. The second perspective here is the research question itself used to check whether or not the data were consistent with research questions and providing relevant sufficient information.

The next essential step in my qualitative data analysis was highlighting and identifying themes within my interview scripts after transcribing them. According to Braun and Clarke (2006, p. 82), what is entitled as a theme is that if it is something that captures the key idea about the data in relevance to the research question and which represents some level of patterned response or meaning within the data set. I think it

is important when analysing qualitative data is to be consistent throughout the process of determining themes in a way to avoid confusion by the research readers and audience.

Bazeley (2009, p.6) made a claim which is based on the idea that themes only become important when they are linked to form a coordinated picture or explanatory model in a simple three-step formula when reporting the results: “Describe, compare, relate”. On the one hand, Braun and Clarke (2006) state that themes or patterns within data can be identified either in an inductive “bottom-up” way (citing Erith & Gleeson, 2004). On the other hand, Braun and Clarke (2006) mention that themes or patterns within the qualitative collected data can be identified through theoretical, deductive “top-down” way (citing Boyatzi, 1998 & Hayes, 1997). Thomas (2003, p.2) expresses that the primary purpose of the inductive approach is to allow research findings to emerge from the sort of themes inherent in raw data, such as the frequent, dominant, or significant themes inherent in raw data; without the restraints imposed by structured methodologies.

By referring to Thomas (2003), there are three main purposes for using an inductive approach. Firstly, to condense extensive and varied raw text data into a brief, summary format. Secondly, to establish clear links between the research objectives and the summary findings derived from the raw data. Thirdly, to develop a model or theory about the underlying structure of experiences or processes which are evident in the raw data.

The data collected through the semi-structured interviews were analysed similarly based on a three-stage procedure advised by (Creswell, 2007, Miles & Huberman, 1984), 1) preparing the data for analysis by transcribing them and 2) narrowing down the data into themes through a process of coding and representing the data. I find it important to refer to what Clarke and Braun (2006) point out that patterns are identified through a rigorous process of data familiarisation, data coding, then development and revision. Besides Braun and Clarke (2006) thematic analysis method, I used the NVivo software for the first time to analyse my interviews as they contained a large amount of data which was difficult to manage by an individual busy researcher. From my experience in using the NVivo software, I found the data analysis process through utilizing this software, accurate and timesaving. However, I consider myself a novice user of this software as it is my first time using it and I think I require more training on the use of NVivo advanced qualitative research analysis features. Therefore, I relied on myself as a doctorate researcher in following the thematic analysis method as it comes in Braun and Clarke (2006) and I just used the basic qualitative analysis features of NVivo, but relay more on my human researcher's input.

The audio recording of the interviews of eleven medical practitioners was listened to several times to ensure accurate transcription. In a second step, the transcripts and the audio recording were imported into the NVivo. The transcripts were coded both manually and through the NVivo while listening to recordings

as and when necessary. But, by using the NVivo, my interview data analysis was created in two ways to start generating codes. The purpose was to look at transcripts from two main perspectives those were previously described and probably to reduce the bias when the decision comes on the most common important frequent themes in the audio scripts from one source who is me, the student researcher. Sometimes, it is good either to put more emphasis that such a repeated theme is important as it is mentioned by two sources or another theme could be unique and could change our perspectives and open our mind to think out of the box for new innovative ideas. I am not against the use of technology in research or other areas of study, but I consider the human being's mind as the most valuable reliable source of information and any other sources will come in the next stages.

Within the third stage was the theme development. During this stage, code nodes on NVivo were read and reread to identify more significant broader patterns of meaning (i.e., any potentially relevant themes). The preliminary analysis came up with subcategories such as challenges faced by medical practitioners, language miscommunication barriers faced by medical practitioners, consequences medical practitioners encountered as a result of language communication barriers, absence or lack of professional training received in term of language communication with the local patients and recommended coping strategies to deal with language miscommunication barriers faced in Arab-based clinical settings by non-Arabic speaking medical practitioners when dealing with Arab patients.

3.5 Ethical Issues

The study poses no serious ethical problems. Ethical issues need to be anticipated if being occurred. Ethical issues may arise throughout any study, such as doctorate thesis work with different amounts and levels of seriousness even in the data analysis process. It was said by Erasmus (n.d.) that prevention is better than cure (De Bracton, d.1268 & De Legibus, c.1240). Ethical considerations could vary from one country to another; depending on the cultural aspects and beliefs as stated by Pitta et.al. (1999) that different cultures have different rules of conduct. Ethical issues in research studies are major factors that can shape the quality of the study; speed up or slow down or maybe delay or stop the research from being accomplished.

According to Robson (2013), people should always be asked in advance whether they are prepared to take part in studies or by giving them an overview of any study they will be involved in and asking them to sign a consent form if they are interested in contributing to the study.

For this qualitative research in which one-to-one in-depth interviews were conducted, some ethical considerations had been taken into account. First, a list of employed medical practitioners was obtained from each of the three study medical institutions. Second, research ethics committees' approval letters and a reference letter issued by the University of Liverpool (UOL) were presented to the research communities

to seek their permission for conducting the research. Third, both a UOL standard consent form and a participant information letter were sent to the intended participants asking for their acceptance to volunteer and participate in the study. Third, giving anonymity to research participants when reporting on research is viewed as good practice by ethical research boards and committees and had given the research much more weight and acceptance as stated by Robson (2013). Based on this, participants' names and identities had not been mentioned when transcribing the interviews; only codes were used (e.g., Participant 1 = P1, Participant 2 = P2…etc.). Fourth, participants in this phase had been asked in the consent form for their permission to have their interviews audio recorded by the researcher for purposes of the study only. Fifth, the collected interview data have been stored securely for some time for the study purposed only and then will be destroyed. One additional point, participation in my research must be voluntary without coercion or manipulation and this had been included within the participant consent form.

Research qualitative phase volunteers were contacted to arrange a suitable time and place for the interview. Interview questions and protocols had been constructed after receiving approval from the University of Liverpool's research ethics committee (UOL REC).

At the end of the study, a "Thank You Letter" will be sent to all participants who took part in the research and also those who participated in the pilot test for validating the research data collection tool.

3.6 Conclusion

To sum up, this chapter discusses some major research components, such as the epistemology or the researcher position, theoretical perspectives, research approaches followed for this exploratory study which uses a qualitative data collected tool.

The chapter focuses on the qualitative approach and provides some justifications from the literature and also based on the researcher's insights. The qualitative approach best fits the aim of the research as this is an exploratory phenomenological study that requires rich data to draw the final discussion gives a bonus and benefits to the study and will add to it much more weight. The coming chapters will discuss the study findings and the discussion of the results relevant to the implications for the practitioners and provide some recommendations for future research studies to be conducted.

Chapter Four

Data Analysis, Findings & Discussion

4.1 Introduction

This chapter is fulfilling the main research aim which is to uncover the main challenges non-Arabic speaking medical practitioners from different specialties face, showcase the impact of this barrier on medical practitioners' professional performance and stating some coping strategies recommended by the research participants to deal with the encountered language challenges. In addition, the data presented ensure achieving the previously stated research specific objectives, first, examining the impact of miscommunication in the Arabic language on non-Arab medical practitioners from different specialties. Second, the analysed data achieved identifying some coping strategies to deal with the language miscommunication challenges faced elicited from the real professional experience of the study participants. Third, the research findings come up with some possible further actions that can be taken to solve the language miscommunication issues occur in the research medical and healthcare context. Furthermore, each section of the interview protocol represents one of the six research questions and that has helped in ensuring providing answers to all these questions through the collected and analysed data.

This chapter commences with a focus on the main elements and themes being addressed in the study data collection tool presented in a semi-structured interview. Both data analysis and findings will be presented in sequence in each interview protocol category, starting with section B, professional training received category and ending by the last category that focuses on types of coping strategies and support, medical practitioners suggest having in the future.

4.2 Qualitative Data Analysis, Findings and Discussion

Analysis and Findings of the Semi-Structured Interviews Data (i.e., The Research Questions Categories)

Themes identified in the 1st Research Question:

Research Question 1: What kinds of training in the Arabic language do non-Arab medical practitioners from different specialties receive to work in Bahrain?

4.2.1 Main Theme: Professional Training Received Relevant to the Arabic Language

The first research question focuses on the main theme for investigation and discussion. The theme of the first question is about formal professional training in the area of language communication. The types of professional training this research question looks for are the one provided to medical practitioners by their workplace or the Ministry of health or any other formal bodies in charge of medicine and healthcare in Bahrain if any.

From the first research question collected data, we can notice that all the participants who medical doctors admit that they have no formal professional development training in Arabic language and communication provided by their workplace or the Ministry of Health. Therefore, I believe that this could support my choice of this study type and method which is an exploratory phenomenological study. An interpretation of the lack or absence of language communication training provided to medical practitioners in this study medical and healthcare context is included in the conclusion chapter of this doctoral thesis.

All the study participants admitted that there is no formal training for language communication provided to non-Arab medical practitioners to meet the need of language communication and resolve the language miscommunication issue faced, “no formal training in learning the Arabic language received” (P2 Dr. N), and “there has been never formal training in the Arabic language received”. Language miscommunication and the consequences faced in healthcare settings are creating a phenomenon and this is proved by the medical practitioners.

Summary of the first research question data analysis and findings

To sum up, we can notice that all the participants who are medical doctors admitted having no formal professional development training provided by their workplace or the Ministry of Health. it is obvious that language communication is either being unknown or not given good care by those in authority of local medical and healthcare services as a major barrier that non-Arabic speaking medical practitioners encounter in their daily medical practice and when communicating with Arab patients. All the study participants admitted that there is no formal training for language communication provided to non-Arab medical practitioners to meet the need of language communication and resolve the language miscommunication issue. Language miscommunication in a healthcare setting is a phenomenon that exists in various medical contexts. However, to cope with this phenomenon, awareness should be raised in the

community of the research context. Besides, more explanation of the problem should be reported to and shared with the people in authority of medical and health care services in the country.

4.2.1.1 First Main Discussion Theme: Professional Training in the Arabic Language Communication

4.2.1.1.a Sub-theme: Absence of Doctor-Patient/ Patient's Relatives Language Communication Professional Training in Hospitals and Medical Institutions in Bahrain

What concerns the researcher is that all the study participants admit that there is no sort of formal professional development training offered to non-Arabic speaking medical practitioners in Bahrain to help them cope with the language communication challenges they encounter daily in their clinical practice routine. In fact, Bahrain is an Arab country and there are other GCC countries such as Saudi Arabia, UAE and Oman that have a similar phenomenon as being shared by some of the participants, "There has been never formal training in the Arabic language received" (P3-Dr. D), "no formal training in Arabic language received in all the Gulf countries I worked in including Bahrain" (P7-Dr. Ra.).

Meuter, Gallois, S. Segalowitz, G. Ryder and Hocking (2015) state that their language barriers in health care study's data analysis will inform policy and practical solutions for communication training, provide an agenda for future research, and extend theory in health communication. The same thing with this thesis study based on the research data analysis, language communication training solutions for the clinical context is included in Chapter Five: Conclusion and Recommendations.

The absence of professional training in the area that I have mentioned above is a serious issue I believe that must be shared with those people in the authority of medical and health care services and also medical education in this part of the world. The new non-Arab medical practitioners are the target group to benefit from this initiative support when referring to this study outcome and recommendations of language communication coping strategies and training solutions. This sort of initiatives could create a reliable source and a base for implementing and building up any professional training relevant to daily-basis doctor-patient communication. In addition to this research outcome based on a sample of medical practitioners' realistic experiences, I witnessed the existence of language communication barriers in the clinical context in Bahrain, both public and private. Those parties who encounter language communication barriers are my non-Arab medical student, and medical students' clinical supervisors (clinical supervisors are also working as medical practitioners and medical faculty in my work institution). Another source of relevant research-topic information was a medical translation workshop designed for nurses from different private and public medical institutions and hospitals in Bahrain which had been conducted annually in my work institution. I assist in organizing this workshop and act as a facilitator in the area of Arabic-English

and English -Arabic translation. This research outcomes and findings would support me as a reliable source of information when sharing and passing my personal experience to those people in authority and decision-makers in both areas of medical education and medical and healthcare services. Aljuaid, Mannan, Chaudhry, Rawaf and Majeed (2015) in their research paper come up with the idea that the establishment of continuing training programmes in communication and interaction skills is needed for physicians and nurses, to make them aware of the problems impeding optimum quality of care. This idea is highlighted in Chapter Five, the Conclusion and Recommendations.

4.2.1.1.b. Sub-theme: Possible Reasons for having No Professional Medical Interpreters hired in Our Public and Private Hospitals

Participants in this study rely in the first place on both available medical and non- medical staff on duty who act as medical interpreters and assist non-Arab medical doctors when communicating with Arab patients/ patients' relatives who do not know good English or maybe are totally illiterate in English. All participants confirmed that there are no permanent or temporary professional medical practitioners hired to assist them in daily doctor-patient communication. I believe this is a critical matter especially where a language communication gap occurs with the increase of hired non-Arabic speaking medical practitioners in Bahrain without receiving proper communication training. In both Bahrain and other Arab GCC countries as being shared by the research participants (e.g., the UAE, Saudi Arabia & Oman where more expats come to work and live in these countries), there are some possible reasons for not recruiting permanent or part-time or per hour medical interpreters in both private and public hospitals. First, hiring professional interpreters will cost the country an extra huge budget to employ them in public hospitals and medical institutions. To make them available in all shifts, that is another impossible service to be provided by the ministry to everybody; especially with the current financial and economic crisis that most of the countries in this region have been facing. Second, it is very difficult to find professional interpreters who are medically trained; most of them focus on general languages when translating rather than pure specialized medical language. Third, from the study findings and the fact that the language communication barrier exists in our public and private hospitals and medical institutions, it is obvious that this phenomenon has not been clearly expressed or given the proper care to be investigated for the lack of language communication support provided to medical practitioners by local medical and healthcare bodies. Last but not least, both professional interpreters and medical staff in hospitals who act as medical interpreters lack the proper professional training and certification as professional medical interpreters and have this role as a unique permeant job under the list of major professions required to be hired within medical hospitals and institutions in a multi-cultural country like Bahrain. Brandl, Schreiter and Schouler-Ocak (2019) elaborate that the treatment of migrants with limited language proficiency poses major challenges to health care

professionals. The use of professional interpreters in medical settings is still limited, which is, among other reasons, due to cost concerns.

Themes identified in the 2nd Research Question:

Research Question 2: What main difficulties have non-Arab medical practitioners experienced when communicating with Arab patients, colleagues, and other healthcare professionals?

4.2.2 Main Theme: Difficulties/ Challenges faced

In this section, the questions are constructed to enable the research participants to talk about and discuss the main communication job-related difficulties and challenges; some are general challenges and others particularly address the language miscommunication issues in the local clinical research context. The sub-themes in this section are labeled as either being minor or major sub-themes depending on their level of relevance to language communication barrier in the study medical context.

Sub-themes:

Sub-theme 4.2.2.a: Differences in Healthcare Systems between Bahrain and Some Participants' Home Country Health System (e.g., India, Pakistan & the UK (Evidence-based Medicine System))

Some medical practitioners mention that one of the challenges they have faced when coming from their home country to practice medicine in Bahrain is that the differences in healthcare systems in both countries. The study participants compared the two systems in terms of whether these hospitals are well-equipped or not and if they are well-organized in calling the patients or not. Some medical practitioners consider the differences in healthcare systems in both Bahrain and their home countries a challenge and others find it as a benefit and a good opportunity to learn new skills and technology to improve them professionally. Changes in medical systems may not be acceptable or may be difficult to cope with to some medical practitioners and this could affect both the quality of their professional performance and the language communication with their patients. For example, adding more computer-based work to doctors to do during the doctor-patient visit could minimize the time that should be spent to diagnose and communicate with patients.

It is normal to have differences in healthcare systems depending on certain factors. First, India has more population, and it is considered to be a developing country; lots of poverty and lack of health awareness whereas Bahrain is a GCC civilized country, "In the public sector, it is too crowded and disorganized. While in the same country in India in private hospitals, it's well-organized and the service provided there is "A" class" (P1-Dr. K).

Participants' answers to this question indicate that regardless of a country is developing or civilized, there is a significant difference in the medical system quality in public hospitals versus private hospitals. Paying money to get medical services will lead to receiving "A" class services and gaining more patients' satisfaction than what patients get of available services in public hospitals which serve the whole community with various social and educational status.

Public hospitals versus private hospitals is another issue the research participants included in their answers to this interview section questions. In public hospitals, they are open for public, for all. So, it is normal to be disorganized in comparison to the private, "In the public sector hospitals, it depends on the patients' social status" (P1-Dr. K).

The collected data shows that from one doctor to another, the experience of the doctors differs although they are from the same country sometimes. It depends on their previous work hospital whether being private or public, "due to the similarity between health care systems both in Bahrain and the one in India, I have not faced any serious challenges yet" (P2-Dr. N).

Sub-theme 4.2.2.b: Language Barrier: The Need for the Arabic Language When Communicating with Arab Patients and Patients' Next of kin

Some practitioners express that in different Arab countries in general and in Bahrain in particular; medical practitioners may encounter various challenges in their workplace. But what challenges them more is that the language communication when dealing with Arab patients and their next of kin. Several participants shared that it is important to speak the patients' local language and that communication with Arab patients would be better if they know how to speak using the patients' mother tongues, "Sometimes, we feel the language barriers come. Because we can communicate with the patients more if we know Arabic, but due to this we feel more restricted" (P2-Dr. N).

Language-communication is on the top of the list of the clinical challenges faced by the medical practitioners, "From my one-month experience, there are three challenges, one of them is the language of course" (P4-Dr. Ro). A number of medical practitioners talked about the language communication barrier as a challenging issue. Medical practitioners added that if one member knows English, at least one member of the patient family, then the doctor-patient communication will be facilitated.

Doctors are not satisfied with their performance, because of the language barrier they have and their concerns of not conveying the doctor's messages and instructions to their patients, "I find it difficult to

communicate with them. And this is where I worry. The challenges I would say I am not very sure if I conveyed the message or not" (P7-Dr. Ra).

There are serious life or death matters some medical practitioners talked about which cannot be ignored I believe. Quick urgent solutions should be implemented to resolve these matters resulted from the language barrier, "there are two scenarios, what I will say: **1)** If the patient as an ectopic pregnancy or **2)** the patient has a small baby because they are two life-threatening things. One for the baby and one for the mother" (P7-Dr. Ra). These risky matters could leave a negative impact on medical doctors if their patients leave their clinic without understanding even half of the doctor's message and the explanation plus the instructions are given. The doctors prefer to speak to the patient directly without a mediator to translate, but this is not possible to most of the practitioners as they are illiterate in Arabic, "I want to ensure that they understand my message. They go with a little of half a message. It makes me feel a bit scared of how to communicate with such a scenario, I have used nurses also, but nurses or nursing assistants. But again, I feel I can do better if I can speak directly to them" (P7-Dr. Ra). **Example No. 1** of Risk: One of the potential risks that could occur as a result of the language communication barrier. It is really a scary matter! **Example No. 2:** One interpreter for all is not enough. Only nursing and receptionists are used for medical interpretation. No professional interpreters or trained medical doctors on translation are used, "I'll tell you from my experience in Bahrain, Saudi, and Dubai. The only place where it was formally available was in Saudi in government hospitals, we have a woman who sits there for translation. If three or more doctors need her, then it becomes more difficult. But, here in hospitals, I rely on the nursing girls who speak Arabic and a little time from them to come from their work or duty. And if they are busy, we cannot ask them to come. So, we use anybody from the nursing girls to the receptionists" (P7-Dr. Ra).

Using the verbal broken Arabic by the medical practitioners if they know some and then mixing it with English and non-verbal language techniques just to continue performing their work without the need to call for their colleagues to assist them with translation, "as I said that most of the time, I don't need it, with my broken Arabic I do communicate. But I do sometimes" (P7-Dr. Ra).

Most of the patients' and their next of kin feel more comfortable when speaking in their mother tongue "Arabic" (This is frequently mentioned by a number of the research participants), "I face some challenges, especially when…most patients understand English although some of them are comfortable when speaking in Arabic" (P9-Dr. B).

Arabic dialects are confusing to non-Arab medical practitioners. Therefore, sticking to standard Arabic when they learn Arabic as it is the mean of communication with all Arab, "Now, Bahraini Arabic is what I am mostly used to. Egyptian Arabic is sometimes difficult to understand because the terms they use are slightly different terms than what the Bahraini use" (P9-Dr. B). Although Gulf Countries share many

features in common, they speak Arabic in different dialects, “those who are coming from Kuwait and Saudi Arabia, their dialect slightly different than what Bahrainis speak” (P9-Dr. B).

Sub-theme 4.2.2.c: The Need to know the Main Medical keywords Required for Giving Medical Instructions or Counseling while Diagnosing a Patient

The majority of medical practitioners who took part in this study recommended that medical doctors should at least learn the main basic medical terms in their patients’ mother tongue, such as Arabic in this research context, and that is to be able to communicate with their Arab patients up to a certain language level.

To begin with, patients’ demands for receiving detailed feedback in Arabic may put more stress and cause more challenges, “Patients are looking for details, even they have lots of questions. If the patient is diagnosed with diabetes and if I have to treat them by giving them injections in the eye or I have to give them laser…” (P1-Dr. K.).

According to the participants, the first doctor visit, patient communication is more challenging as still, they do not know enough about their health status. This could indicate that the more doctor visits patients have, the better communication they will have with their doctors, “If it is a follow-up patient who knows what the 8th situations is, then it is easier because they know what’s wrong with them, what they should undergo” (P1-Dr. K). Added to that, language communication is required for calming down patients and counseling them, “it is difficult with patients who are very anxious about it and if I have to calm them down or counsel them, then it gets very difficult” (P1-Dr. K). Lack of the language needed to communicate with patients to tell them about their critical health cases, such as having kidney failure patients is one of the main language communication challenges encountered by doctors, “I know that sometimes patients are very sensitive. In our field, with kidney failure cases, it is very difficult, like breaking bad news. I say to my patient you require daily dialysis; I use the Arabic terms for that “Andak Qaseel Khellah/ You have kidney dialysis, Kella Mafee Tarteeb, Mafee Shuqul/ Your kidney is not functioning well/ Kidney failure” (P3-Dr. D). One further point, valuing the importance of learning a new language is important from the medical practitioners’ side to take the initiative to learn to perform their job, “language is very important, especially for us Indian. We know the value of a language as India has lots of languages. If I know one language I can speak, then I can speak to 1-100 million people who speak this particular language” (P3-Dr. D). Also, learning some of the patient’s language always makes a difference “So, to know something is better than to know nothing” (P3-Dr. D), “the language is very important, especially with local. It makes a difference if you know how to speak some languages” (P3-Dr. D) and “You will build trust and satisfaction, especially we are dealing with a human being” (P3-Dr. D). One final point, some participants show how serious was the impact of the language communication problem on them as medical doctors in

a way that they lost their confidence in performing their job without having the country language of communication which is Arabic, “Initially, it was… a’ah …communication was very difficult in Saudi Arabia because I don’t know any Arabic and there, they speak only Arabic. So, it was really a problem and I was frightened to go to the office. And I don’t know what I will face sometime if I am called. I don’t know what they will give me” (P11-Dr. Sa). Others show how language communication is highly important in the work environment especially in a setting like the medical context where they deal with human beings and care about their health and life, “initially, it may be very challenging, not only in medical practice but in day-to-day life also. In day-to-day life ok especially when we face someone who only speaks pure Arabic” (P11-Dr. Sa).

Sub-theme 4.2.2.d: Need for Professional Interpreters in Medical and Healthcare Context

The majority of the participants shared the challenges of having no hired professional interpreters and the preference is to have medical doctors acting as medical interpreters to help them communicate with Arab patients and their relatives, “we need interpreters for the families who do not know any English. Even if they know some English, I prefer to use interpreters because there is some technical stuff to be translated. It’s better to have interpreters which I prefer to be medical doctors as they know all the medical terms, even the nurses and healthcare staff will not be able to express certain medical issues” (P6-Dr. Vi). Added to that, participants explained techniques used by some patients to help themselves cope with language communication with doctors, “even now, they get information from Google and they want to verify and this and that” (P6-Dr. Vi). However, there is a need for the doctor’s verbal explanation which still exists besides the use of technology. Moreover, the research participants claimed that there is a lack or absence of professional interpreters in clinical areas not only in Bahrain but also in other countries’ health care systems like India. On the other flip of the coin, there is a possibility that interpreters are available in private hospitals since many people from many countries around the world come for medical treatment and of course they will need accurate medical interpretation from Hindi to other languages, “The main challenge in here is the language; otherwise, if you can communicate with them through an interpreter issue are the same as in India the same everywhere” (P6-Dr. Vi). Most of the medical practitioners agreed that language communication is the main challenge in their daily-basis clinical practice, “No, we don’t have interpreters. I mean if you have interpreters here, so people can communicate well, then it’s ok. That’s the main challenge” (P6-Dr. Vi). This absence is due to some reasons that will be discussed in chapter five “Discussion”. The study doctors all agreed that spoken language is very essential in clinical practice, “If you are one of three family members and one of them can speak English, then it’s a bonus. But otherwise, it’s a problem” (P6-Dr. Vi). One interpreter for all is not enough; only nursing and receptionists are used for the medical interpretation. No professional interpreters or trained medical doctors on translation are

used. Using the verbal broken Arabic by the medical practitioners if they know some and then mixing it with English and non-verbal language techniques just to continue performing their work without the need to call for their colleagues to assist them with translation, "as I said that most of the time, I don't need it, with my broken Arabic I do communicate. But, I do sometimes" (P7-Dr. Ra). The girls are not with a medical background and they have to leave their job and assist doctors with the translation. By doing that, they may be blamed for not completing their duties. Some of the new practitioners have no Arabic to use to communicate with others. One important further point is that doctors' preference to have professional medical interpreters who are medical doctors too and not any other medical or non- medical professionals, like nurses, pharmacists, lab technicians…etc. This issue and future project for empowering these medical practitioners to tackle a dual job; being both medical doctors and professional medical interpreters is being discussed in chapter five "Discussion" of this doctorate thesis work.

All in all, there is a strong emphasis on the need for professional medical interpreters to be hired and available in all work shifts-24 hours to help in the patient-doctor communication process and minimize the number of negative consequences which are expected to take place as a result of language miscommunication.

Sub-theme 4.2.2.e: Communicating with New Difficult Patients

To start with, communication with patients for the first time is more complicated than if the patients have frequent doctor visits and could understand even if partially some of the related terms and instructions, "But if it's some complicated cases, if the patient being diagnosed for the very first time, they do not know what is wrong with them" (P1-Dr. K), "But if they are new patients, then I have to tell them ok" (P1-Dr. K). Also, what makes the communication more difficult between the non-Arab doctors and their Arab patients is the number of medical cases details they request to have from their doctors. More load and stress would be added on the doctors' shoulders, "patients are looking for details, even they have lots of questions" (P1-Dr. K). Added to that, "communication gets difficult if the patient is not cooperative with the doctor and has lots of stress and fears as for that the doctor requires a good bank of terms and phrases in Arabic to enable him/her to handle such hard situations" (P1-Dr. K). This is another example shared by a research participant where lack or absence of the patients' or their next of kin's language could make the patient-doctor communication difficult or sometimes impossible, "I know that sometimes patients are very sensitive. In our field, with kidney failure cases, it is very difficult, like breaking bad news" (P3-Dr. D).

Sub-theme 4.2.2.f: The Cultural Differences in Healthcare Contexts (Eastern or Western Healthcare Culture)

In different Arab countries or Bahrain, medical practitioners may encounter different challenges. But what challenges them more is that language communication and culture when dealing with Arab patients and patients' next of kin. One of the participants is a Pakistani doctor, and he expressed his experience practicing medicine in some Arab countries' hospitals. He found Saudi Arabia following a different health system; especially that the main communication language between medical practitioners and their patients is "Arabic Language" which was a big challenge to him. Also, when he worked in the UK, the western health care system was a new thing to him and the culture was different from his home Asian culture too, "I was thinking of them, the way they consult people, their behaviours when talking, their majors…. etc. Not a surprise, but sometimes upsetting, sometimes compromising and sometimes Ok. But it was a good experience. I don't have any problems or major problems with these two countries that affected my work and my life or something like that. It's also because no two persons are the same. Every place is different. People, cultures are different. Not two persons are the like in the world. You have to respect these differences in other cultures" (P10-Dr. Sh).

Getting familiar and accepting other cultures differs from one person to another. Settling down is important to medical practitioners who come to work in another country to show better professional performance. Added to that, the language came repeatedly with culture in many scenarios and situations. They seem to be like a compliment, "Challenges have two types, the language and the most important one is the cultural challenge" (P6-Dr. Vi).

Sub-theme 4.2.2.g: The Challenge of being Unable to make Important Medical Decisions as a Result of the Language for Communication

Most of the medical practitioners feel so bad about themselves because they are unable to communicate with their Arab patients and convey the doctor-patient message accurately, "If you know the original language is far better. You can speak to them up to their level" (P2-Dr. N).

Some of the research participants expressed that there are more restrictions in communication if the doctor does not speak the patient's language, "but sometimes we feel the language barriers come because we can communicate with the patients more if we know Arabic, but due to this we feel more restricted" (P2-Dr. N). Besides, some doctors feel dissatisfied if the doctors cannot speak the patient language, "So bad we feel sometimes. Otherwise, we do not face any professional issues with this. But for our satisfaction, we feel it is good to speak the patient language" (P2-Dr. N). Furthermore, feeling scared of not accurately conveying the message to the patient has a negative impact on the practitioners' psychologically and professionally, "The challenge I would say I am not very sure if I conveyed the message or not" (P7-Dr.

Ra). Added to that, doctors can see that if one member knows English, at least one member of the patient's family, then the doctor-patient communication process will be facilitated.

There are serious life or death matters which cannot be ignored sometimes. Quick urgent solutions should be implemented to resolve such matters, because of the language barrier, "that because of the language barrier I don't know how serious the condition can be if there is somebody with them who understands and I feel that when I am communicating with somebody else, the message is not as strong as I want to as it comes". There is a possibility for a negative impact on the medical doctors if their patients leave their clinic without understanding even half of the doctor's message and the explanation plus the instruction is given. The doctors prefer to speak to the patient directly without a mediator to translate, but this is not possible to most of the practitioners as they are illiterate in Arabic, "There are two scenarios, what I will say: 1) If the patient as an ectopic pregnancy or 2) the patient has a small baby because they are two life-threatening things. One for the baby and one for the mother". These are some of the potential risks that could occur as a result of the language communication barrier and that is a scary matter! "I want to ensure that they understand my message. They go with a little of half a message. It makes me feel a bit scared of how to communicate with such a scenario, I have used nurses also, but nurses or nursing assistants. But again, I feel I can do better if I can speak directly to them". Added to this, another example of possible risk which most of the research talked about was keeping some Arab medical staff busy to act as interpreters besides their duty which could cause having less quality of medical services provided to meet patients' health needs. Furthermore, majority of the research participants and their peers who also lack the Arabic language needed for communicating with Arab patients, rely most of the time on non-medical professional interpreters, such as receptionists and operators, "Then, there was a little communication gap and I have to ask for a translator to come in. So, one of my Bahraini receptionists would come to help and do the translation, so that is in the outpatient lip. And in the impatient, especially when I have had some complicated cases, talking about "neonatology", and when you explain it to the parents. It's already anxious and stressful. It makes it difficult to …unless if you are not able to convey the message. So, that's another challenge I faced".

Another type of potential risk that could take place in this study is that the increase of the demand from Arab patients and patients' next of kin to be transferred to an Arab medical doctor instead of non-Arab doctors as they feel more comfortable to communicate and express themselves with no language communication barrier. The risk in this scenario could be the increase of the workload on the shoulders of Arab doctors in comparison to their non-Arab medical colleagues. This matter may create an unbalance in the workload, which may increase staff complaints being overloaded in comparison to their colleagues who are having a light workload. Another risk that could emerge from this case is that the more potentials for making some medical errors or inaccuracy in patients' diagnosis because Arab doctors will have long

ques of patients to diagnose and treat in a short time and lack of facilities, “So, in some instance, the patient is requested to be transferred to a doctor who speaks Arabic. So, that happened a couple of times”. Suggested techniques to create the workload balance among medical doctors who work in the same workplace in this study context will be discussed and shared in both chapter five and chapter six of this thesis work.

To sum up, most of the medical practitioners are convinced that speaking the patient’s language could be the perfect solution to communicate with the patient, “but, again I feel I can do better if I can speak directly to them”. Techniques to cope with the language communication challenges are presented in the coming research sections. Some of coping strategies are being used by the research sample.

Sub-theme 4.2.2.h: Confusion in which Type of Arabic Language to learn to suit Medical Practitioners’ Language Communication Needs in a Diverse Arabic Medical Context

Arabic dialects are confusing to non-Arab medical practitioners and language learners. Therefore, sticking to standard Arabic when they learn the language as it is the mean of communication for all Arab, “Now, Bahraini Arabic is what I am mostly used to. Egyptian Arabic is sometimes difficult to understand because the terms they use are slightly different terms than what the Bahraini use”, “And those who are coming from Kuwait and Saudi Arabia, their dialect slightly different than what Bahrainis speak”. Again, these quotes extracted from participants’ interview scripts indicate that learning standard Arabic would be the perfect method to enable them to speak and communicate with all Arab patients from different Arab countries with no restrictions in comparison to the situation if they learn the language through the use of a specific Arab country dialect, for example, Egyptian Arabic to speak to only Egyptians, but not other Arab patients who are not Egyptians.

Summary of the second interview section “Difficulties & Challenges faced” findings

Language, cultural backgrounds, beliefs, and level of education as being elicited from the participants’ shared real clinical experiences and incidents are described to be challenging factors that emerged during doctor-patient communication. In terms of strong cultural beliefs, being able to speak the patients’ language could be more effective and could help in correcting some scientifically wrong concepts patients may have.

The examples in the participants’ quotes are having a mixture of focusing on both language and culture communication challenges faced on daily basis in their medical context plus the need for raising patients and their relatives’ health awareness. I find it difficult to separate the language and culture from each other and this is obvious in the real examples given through the study interviews.

Cultural beliefs are creating a big challenge to medical practitioners, then imagine what could happen if both patient's culture and language are absent from the doctor's side. As a result of the absence of language and culture, there is a possibility to have a huge communication barrier between doctors and their patients/patients' next of kin, "things like convincing them that scan from down will not make a difference. You can do it. Convincing a woman to take a pill to regulate her period is a quite common belief that if you give a pill to the woman, she will not get pregnant again. It means that even if she stops a pill, she will not be pregnant again".

4.2.1.2 Second Main Discussion Theme: Main Communication Challenges

4.2.1.2.a Sub-theme: The Differences in Healthcare Systems in Different Countries

Similarities and differences in healthcare systems among different countries may become a big challenge to expat medical practitioners who moved from their home country to other countries to practice medicine and in return, some expected consequences may take place and affect healthcare delivery and the quality of provided services. Van den Brink, Muinen, Verhaak, Bensing, Bahrs, Deveugele, Gask, Leiva, Mead, Messerli, Oppizzi, Peltenburg and Perez (2000) prove in a study on doctor-patient communication that due to experiencing different healthcare systems, medical practitioners adopted various communication styles and that have an impact on patient satisfaction and compliance. On the other hand, Van den Brink et.al. (2000) also added that the achievement of the effective communication may also be influenced by the GP's awareness of patient's expectations about doctor-patient communication, and this idea itself can be taken into consideration to design solutions and coping strategies for the doctor-patient communication barrier.

4.2.1.2.b Sub-theme: Language and Cultural Differences Impact on Healthcare Delivery: Western Culture Vs Eastern Culture in Term of Healthcare Delivery

Through the research participants' contributions to the study interview, it has been noticed that their language and cultural differences may have an impact on their clinical delivery. Added to that, the type of language and cultural differences could affect the level of challenges faced by non-Arabic speaking medical practitioners when practicing medicine in an Arab context which is a different culture to their home country culture, although cultures may share both common features but may also have some natural differences, this could require some techniques to help these practitioners to cope with the language and cultural change. However, the question here is how practitioners from different cultural backgrounds would cope with practising their profession in different cultural context. Would that have an impact on their professional delivery of healthcare and what consequences and implications could this have?? From the interviews, I noticed that western healthcare delivery is more evidence-based in compare to my eastern

clinical delivery which relies on doctor-patient communication in the first place “My practice is my practice. It’s an evidence-based practice. Ah, no, doesn’t change at all”, while the eastern healthcare delivery is more communication- based, “Right, you as a doctor of course when they listen to you, they are more convinced”, “Actually, as you know, I am working in critical care medicine and there are many sick patients. So, we have to tell their relatives about the progress of the patient. The patient improving or the patient not. Sometimes, they are asking about medications and investigation. So, we have to explain how to interpret these investigations. So, this is one aspect”. Hout, Ho, Ko, Lam, Tactay, MacLachlan and Raanaas (2019) state that language was identified as a barrier to healthcare providers in Northern Indigenous communities are non-Indigenous and so speak the local Indigenous language which is a similar case to the study issue. Added to that, Hout et.al. (2019) elaborated that the resulting communication challenges between patients and practitioners were found to have a negative impact on rapport, and impede the process of examination, diagnosis, treatment, nursing, and care.

4.2.1.2.c Sub-theme: Accepting Diversity between Different Cultures and Different Healthcare Systems

There is a need to raise awareness of the importance of respecting differences in different cultures by medical practitioners as they are treating patients from all around the world with different religions, races, beliefs, norms, and attributes in various medical contexts and countries. Therefore, based on the doctors’ vision and medical pledge, doctors have to show respect to all of their patients and treat them equally, “No, it’s different. It’s the beauty of the creation of the one who created us. There is a beauty. So, we must expect that the people we meet are not like you in many aspects and you have to respect these things”. It is important to understand that we are all human with similar features, but we also have difference, even brothers and sisters are not the same, “In something you agree and sometimes you disagree, but you have to accept that this is their culture. This is their behaviour. It’s their nature. Sometimes people are not aware of others’ cultures and behaviours”. In a study by Tarlier, Browne and Johnson (2007) which shows that not all people could accept diversity and working in different cultures, it is highlighted how nurses working in the northern regions of an unspecified western Canadian province were not prepared for the stark contrast between their own culture and that of the First Nations community, and that resulted in having social distancing by the nurses who engaged in a process of othering themselves.

4.2.1.2.d Sub-theme: Language and Culture are the Top Communication Barriers in the Interview

Both the language and culture emerge in the interviews together as complements and that is shown frequently in the participants’ shared information. This could indicate that learning a language comes hand-in-hand with understanding a culture of the spoken language of a country. When learning language skills, you need also to know what type of language terms and phrases you can use with different people and

different situations, formal or informal, “regarding cultural barriers, you know then you need to modify the way you communicate with the families. You have to ultimately tell them the truth that it’s serious, but you have to tell them… Yeah, step by step. And most of the time, they understand”.

Therefore, it is important when designing a language communication training or an orientation course to non-Arabic speaking medical practitioners to include both a language learning component and a cultural learning component. Both components are under the umbrella of professional communication training required to empower medical doctors to communicate with their Arab patients and that should be applicable to similar training in any other language and culture with any other countries.

4.2.1.2.e Sub-theme: Urgent Need to hire Professional Medical Interpreters in the Research Medical and Healthcare Context

All medical participants emphasized the urgent need for hiring professional medical interpreters perhaps on a part-time basis, as some of them already have their full-time jobs. They also shared that even nurses are not recommended to assist medical doctors and most of them prefer that medical interpretation should be performed by medical doctors who are trained to act as medical interpreters, “even the nurses and other healthcare staff will not be able to express certain medical issues”.

However, considering the professional nature of medical doctors and how hard it is for them to switch from their major roles to act as medical interpreters in case of any need beside their medical workload and daily routine of diagnosing and treating patients, it might be somehow impossible to rely on them to do a dual job. A possible alternative solution could be to empower some other medical staff who are not necessarily to be doctors, but with some good medical backgrounds. Having a good medical knowledge and background will enable these health care providers to become professional medical interpreters. For example, Patients Care Assistants (PCAs), nurses, or novice young doctors who are doing their internship. Perhaps also designing some professional training workshops or variable length courses and establishing a license or a degree in professional medical translation and interpretation. This could help them meet the needs for empowering some medical staff to assist medical doctors in daily doctor-patients/ patients’ next of kin medical communication.

4.2.1.2.f Sub-theme: Difficulty in Making Medical Decisions and Sharing them with Patients/ Patients’ Relatives Due to Language Communication Barriers

When patients or their relatives are in a situation that requires either the assistance of medical interpreters or to be transferred to other medical practitioners who speak their language; problems could be manageable by the medical staff and can be solved smoothly although it may leave some negative impression on the patients’/ their relatives’ side, because of the waiting time they spend for a medical service to arrive.

Whereas when have emergency medical incidents such as accidents or having patients in pain with unstable health status that require quick medical decision making for immediate treatment and cannot bear any delay or high rate of medical errors as these are human life-threatening matters, lack of proper language communication between their doctors and their patients/ their relatives would be considered as high risk medical matters which need quick actions and wise plans to be resolved, "talking to them about like you know if you have an infection to stay away from your husband for a week or two. That's also too a bit difficult to communicate with them/convince them", "And other challenges giving any medications to the husband. So, if there are some infections and the husband also needs the medications. That also was taken a bit negatively. And also, when asking a husband to take medication too. That is also a challenge sometimes".

Arabic is one example of common languages that causes the communication barrier in this research clinical context, Bahrain, but other common languages depending on the majority of patient population who live in this part of the world should also be taken into account when providing the professional medical interpretation support, such as, Hindi and Urdu, "There is staff from the Philippines. We have staff from Arab countries. We have staff from India who can speak probably three to four languages".

4.2.2.1 Main Theme: The Effect of Communication Challenges on the Professional Performance of the Study Participants

Question four of section B of the interview, "Difficulties/ Challenges faced" investigates the participants' insights and professional clinical experience if whether or not communication difficulties have affected their professional practices. As if so, they must express and explain how they have affected them professionally.

To start with, some participants can handle doctor-patient/patients' relatives' language communication challenges through using some coping techniques and strategies that are mentioned in the coming interview sections, "It's fine with me". Besides, despite having clear doctor-patient language communication challenges, one of the medical doctors tries to find out some sources of help to deal with this difficulty which are mentioned in detail in the coming interview sections of data analysis and findings, "No, not at all. No effect on treatment. No effect on other things, because we are getting any information, we want to extract either by patients or by other means". Furthermore, there is always a source for help for doctor-patients language miscommunication issues, "Not at all, actually mostly that moment, you will have it sorted out".

If the patients understand and speak English well, then doctors will not need the interpretation support for the miscommunication issues, "If the patients are well-educated in English speaking". However, patients'

English language level cannot be controlled easily, and logically speaking, language communication control and support can be provided to the non-Arabic speaking doctors who come to work in Bahraini clinical settings as part of their professional development training or support.

An issue brought up by the study medical practitioners about the availability of staff to help in interpretation carries some concerns around whether these staffs have good medical backgrounds and if assisting in interpretation would that affect their actual duties? “Well, communication on difficulties in the ICU setting, the one good part, we have a lot of Arab-speaking staff among us. We also have doctors”. However, it is not the case in all Bahraini hospitals and medical institutions to have enough number of Arab medical practitioners, especially in private hospitals where the number of non-Arabic speaking expat doctors is more than the number of Arab medical practitioners.

Although there are Arab-staff available on their duties and could take from their work time to assist their colleagues of non-Arabic-speaking medical practitioners in interpreting the doctor-patient communication, doctors find out that communicating directly with their patients without any mediators/ interpreters is more effective and would have positive impacts and satisfaction on both the patients/ their relatives and the doctors themselves. This is a good example that describes how it is always better to doctors communicate directly with their patients/ patients’ relatives, “There is the staff who are Arabic-speaking. In that way, there has been no major difficulty for me to communicate with them. But there is always something when you drive a car and you are driving at 100 km. and up; when you are driving, you feel more comfortable, safe, more in control of the car. And when someone else is driving the car even if you are going at 80 km. or 70 km., you are not sure, because someone else is driving the car and the control is not in your hand. Similarly, I think when we are communicating and someone else is translating for us, we will be thanking him for doing this. But, when you are communicating yourself, you know what you say, and you’ll be satisfied”.

As stated by some of the Intensive Care Unit (ICU) medical practitioners that there are available medical Arab staff members in ICU and they have a willingness to help with medical interpretation, “Yeah, they are available all the time, as we are closed ICU sort of thing. So, we have all the staff working around us. So, they maybe not with the patient I want to speak about, but they will be with some of the patients and they always are willing to help”. On the contrary, in ICU, the situation is different in comparison to other hospital wards as most of the patients are unconscious in the ICU and the communication is more with the patients’ relatives/ next of kin, “We have to ensure the accuracy. Even if I am in doubt, I can ask another colleague who speaks and understands Arabic. You can ask them to come and evaluate the patients and whatever they are suffering from and what do they want to tell us”; “Till now, it has not affected any professional decision to be honest, because every day whether we are in emergency or ICU, we always

have Arabic- speaking staff". Arab speaking medical practitioners are available in all hospital wards and all shifts, "As you know, we are here in critical care and it is a very demanding area, so there is honestly no scope of errors (he laughs) …If you are not understanding, you can ask the interpreter to repeat again and again and you can ask the mediator to explain to you clearly and to explain to the relatives clearly so that the patient will not be harmed or will not have any harm".

The majority of the study participants agree with the idea that Arab medical doctors will be the best people to rely on for medical communication interpretation to ensure the translation accuracy to both sides, the non-Arab doctors and the Arab patients, "We have to ensure the accuracy. Even if I am in doubt, I can ask another colleague who speaks and understands Arabic. You can ask them to come and evaluate the patients and whatever they are suffering from and what do they want to tell us".

The use of Patient Care Assistants (PCAs) exists in one of the research sites only and in chapter six a proposed future research investigation on PCAs is being addressed, "They are always willing to help, because not one or two Arab staff whom we have, but we have enough. We have around 35% -40% medical Arab staff including Patient Care Assistants (PCAs) and the nurses. I think it's not that difficult". More future investigation is required on the PCAs' medical backgrounds, specialization, and degree plus their role and abilities to assist doctors with medical communication interpretation. Is medical interpretation part of their job or are they volunteers and take some time from their actual job to assist doctors with the translation? "Actually, we are having nursing staff and we are having PCAs (Patient Care Assistants) are most of the time helping us. Not only nursing staff, because nursing staff sometimes may be busy with the patients, so the PCAs are helping us and at that time we are having focused history that is related to the event of what happened which is most important for the clinical decisions".

Medical decisions that are made by doctors on their patients' health care plans and treatments are affected by the language miscommunication issues. A potential risk is expected for such matters if being frequent. The use of technology and the saved patient data on computers have helped the doctors a lot in making urgent medical decisions if the interpretation assistance is absent, "To management, is not that very effective because of language issues. We make decisions based on the clinical condition of the patient. And second thing, most important thing, most of the patients' information is available online here. So, past history, current history, we can all see from the internet. So, technology has solved some problems".

More misunderstanding and miscommunication issues faced in the ICU with the patients' relatives more than the contact with the patients themselves who are mostly unconscious. For these matters, the language communication barrier is the main reason for having all of these problems plus patients' relatives' dissatisfaction of the doctors' performance and ability to help their patients, "The communication problem mainly not related to management but related to patient's understanding and relatives' understanding and

how do they interpret our decisions. Suppose I want to do an intervention. So, we have to explain and teach everything. Sometimes, they don't understand everything, because of some complicated things and so many technical terms. These things are a little bit difficult. It may not affect the safety of the patient, but it may affect the understanding and the satisfaction of the relatives. Because we have more contact with relatives than ICU patients".

Even with the language communication barrier, a western doctor expressed that she follows a western approach in diagnosing and dealing with patients "evidence-based clinical practice"; which means they rely on their patients' diagnosis and their medical records in the first place, patient history and family history, "No, not at all. My practice is my practice. It's an evidence-based practice. It doesn't change at all".

Most of the medical doctors who took part in this study felt that having language communication barriers could affect their professional practice in a way that makes their patients sometimes lost their trust in them due to their language misunderstanding and they ask for a transfer to see another Arab medical practitioner or even non-Arabic doctors who can communicate well in Arabic. You can imagine how negative is the impact on these doctors and their professional practice of not being trusted by their patients. This matter should be taken seriously by those in the authority of medical and healthcare services in this part of the world, "Like I said that the inpatient they wanted to get transferred, I did feel, you know, a bit of lack as in if I had if only for communication, you know the patients would not have requested a transfer. So, in that way, I started to feel it's affecting my professional practice".

Most of the medical participants in this study agreed on the idea that language learning is a priority in the medical context, "Yeah, language is the most important thing. If you do not know the local language, then you do not know what the other person is telling definitely". Added to that, medical practitioners proceeded to say that learning a language is the key to communication. They stated that it is important that medical practitioners themselves become convinced and value learning their patients' local language to assist themselves with the doctor-patient communication process and enhance their professional performance in such a context to emphasize the idea of how essential is to learn a language to communicate in a medical context, "it is a must to learn I think according to me. That's why I am trying to learn a little bit, ok. And it's …you can, you know some words…So, with that, you can make up what's the problem".

Language miscommunication issues can be frequent and faced on daily-basis clinical practice, "Affect my practice maybe. I cannot remember, but every day, you can face some problems yeah" But my question as a doctorate researcher is until when they will continue with these difficulties? The problem needs to be addressed with the suggested coping strategies and solutions. Leaving it with no solutions seems to be very risky!

4.2.2.2 Main theme: Examples of the Effect of Language Communication Difficulties on Medical Practitioners' Professional Practice

The study participants shared interesting real examples that reflect how communication difficulties affected their professional practice. To begin with, some medical practitioners find an interest in facing challenges and learning new experiences from different cultures, "Finally speaking, in referring to my professional practice, it was a fine journey. It's been nice. Some of my friends were in Saudi, it's the same kinds of challenges we face. But to them, it's worse as patients do not speak English at all. Arabic is the only way of communication there". Also, feeling bad and dissatisfied about their professional performance as medical practitioners is more likely to occur because of the language communication barrier. This psychological feeling may have a negative impact on their career and life. If I am in their shoes, I believe that I can show better performance and achieve more in my career and life, but I cannot due to an obstacle that I could not get rid of. Then, I will be demotivated to continue and may change my workplace country to suit my ability, "Sometimes we feel bad because our patients expect us to speak to them in Arabic. It's a matter of self-satisfaction. We are not able to speak in Arabic and are very keen to speak in Arabic. We'll feel bad. Learning a new language is uneasy".

Patients' understanding and appreciation of their doctors' efforts trying to facilitate the communication with their patients/ their relatives could help in reducing the number of difficulties doctors face in their profession.

The impressions of patients and their relatives about medical doctors who cannot communicate with them due to the language communication barrier could cause harm to medical practitioners psychologically and professionally. In ICU, continuous communication with the patients' relatives is more than with the patients themselves as most of these patients are unconscious and stay in hospitals for a longer time. A daily verbal health progress report and details are expected to be requested by the relatives from the medical doctors. If these demands are not met, then medical practitioners involved in such scenarios are more likely to be affected professionally and beyond, "So, not a major thing, but last day when I was doing my night call, there was a patient who came in sick and the relatives knew some English, but not a lot. So, they didn't understand some of what I had to tell them is that you can wait and the other Arab doctor will come and explain. So, what I think is that when such a matter arises, you have to pack out and someone else has to pitch him for you. That basically, you know the family in certain situations might not feel confident about you. This is the impression they may get. They may think that this fellow is not the right person and the other person who is coming is the right person to talk to or maybe this doctor doesn't know his job. So, they may feel that I don't know what's I am saying, and I do not know what to say. So, that what may affect the clinical practice! Because our patients are not patients who come for one day and leave

the other day. They stay longer; ICU patients stay one week to one or two months. It depends on their medical conditions. So, communication here is not a one-day process. It's a continuous process".

The availability of Arab consultants to be asked for medical translation assistance is less in night shifts in comparison to morning and day shifts as being reported by the participants. As a result, more negative consequences are expected to occur plus affecting non-Arabic speaking doctors' professionally, "The night definitely is a more critical shift. If it is the day shift, we will at least have a consultant available who can speak Arabic, 3 to 5 Arab consultants will be available in the day shift", "There is some help. Again, in the night shift, this doctor who is with me will be in another ICU" and "We have two ICUs, so we are in two different places. But he comes to help me. And when he comes to help me, both in clinics and communication parts, he has to help me, because I don't know Arabic at all".

Such situations are very time and effort consuming and there may be a chance for more critical consequences to take place due to the shortage of medical staff to be able to move from one hospital ward to another to provide medical interpretation assistance to their colleagues, "It's difficult to the other doctors too as he has to be in/ cover two places (make a dual job)". More stress and workload will be added on the Arab medical practitioners' shoulders to do dual work with no extra payment or recognition.

Colleagues are alert and cooperative to assist with medical interpretation needed for doctor-patient communication, "In fact, in this hospital, I didn't face much communication challenges. Because the conversations with the colleagues, they understand English very well. So, they help".

There is an effect of language communication barrier on the patients' health and response to treatment based on the information participants shared- Verbal language is highly important in all hospital wards in general and in ICU in particular, "Sometimes, it happens, the patient is unconscious, and we want to tell: "Please, remain calm" and he's not understanding and because of this language sometimes he becomes more agitated. This sometimes will help in the ICU".

There may be some potential consequences of long waiting time for medical communication interpretation assistance, "When I was sitting with patients and waiting for 5 minutes or so, waiting for someone to come. That happened, waiting for interpreters".

Sometimes medical practitioners must deal with difficult patients (e.g., stubborn or aggressive or elderly) who could make doctor-patient communication more complicated, "Sometimes, I will say, a very difficult patient who will say to everything "No". I mean everything you tell them "No", you need to do this, "No". So, it's very difficult". With such difficult patients to deal with, communication could still be critical even with the availability of medical staff to help with medical communication interpretation, "And then talking

to them. Bring people to talk to them and then you still can't convey the message. They don't understand the importance".

Medical practitioners would like to treat their patients as total human beings; both physically and emotionally. However, with the existence of language communication barrier, they find their messages to their patients are not being conveyed, "Not just you do want to be in trouble. It's not just a doctor's trying to save a patient's life. You want to express the importance, but not able to…. The message is not conveyed". Lots of concerns and fears from medical practitioners' side for not having their important medical messages fully understood and conveyed to their patients. Possible negative consequences both psychological and professional are expected to occur as a result of this matter, "Yeah, and you worry that this patient is not listening, and she/he could come back having a bigger problem".

Another critical medical situation that requires sharing medical details with the patients and requires of course a good level of language communication is shared by one of the participants who is a gynecologist, "They misunderstand. Either they don't understand the importance of what their condition is or there is sometimes this concept which probably not to do with the other places in the other world that the doctor is overdoing things. They are overdoing the investigations. And a very good example is an ectopic pregnancy. See why we worry about ectopic pregnancy because we have lots of suspicions and we want to be sure. But the patient thinks that we are exaggerating about ectopic pregnancy. So, that's why we get difficulty".

Majority of the medical practitioners indicate that communication with critical patients' situations can be manageable sometimes with the help of the available colleagues who can assist in doctor-patient communication and interpretation, but at other times are not; especially if no language communication facilities are available, "Manageable, but sometimes frustrating and difficult".

One of the medical practitioners expresses that medical communication with patients or their next of kin requires proving evidence and detailed verbal reports like the job law and justice as both jobs deals with humans and could affect their lives, "It's like playing justice"; "Yeah, just to convey the message". Giving details supported by evidence by doctors to their patients/ patients' relatives would require a good language level, and in such a situation language communication challenges would occur.

There is always a need for a 24-hour stand-by language communication and interpretation assistants in clinical contexts, "Yes, these new-born care, all the children are Ok. I never had any difficulty that way, but for new-born care, there are couples of instances when they will understand pure Arabic and nothing else".

Most of the medical practitioners prefer communicating their messages directly to their patients or their relatives without the assistance of mediators and find that more effective. However, most of the time doctors do not have any choice rather than asking for their colleagues' help if they do not speak their patients' language, "You know having a translator, translating while you are communicating, it's not as effective as if you are speaking it directly".

The idea of transferring patients to other Arabic-speaking doctors which has been shared by most of the medical practitioners in this study may cause lots of pressure and workloads on these doctors plus result in some delays or medical errors, because of meeting many patients all at one time. Added to that, there is a potential of having an increase of some medical practitioners' complaints of doing more jobs than their duties with no payment if they are not convinced of voluntary cooperation, "Yeah, so those examples a couple of times. So, fortunately, we have an Arab-speaking doctor here, so we were able to transfer kids and the babies under his care"; "Yes, they do generally, colleagues don't because themselves are busy. But we have some receptionists who are Arabic speaking or a maybe a nurse who is an Arab speaking who comes and translates".

4.2.2.3 Main theme: Some Cultural Aspects highlighted in the Interview

There are some of the unique themes that were mentioned in the second section of the interview which talks about challenges/ difficulties faced beside the common themes that are stated above. To start with, one of the medical practitioners mentioned that a serious special language is needed for breaking bad news, "Telling the patients about their illnesses". Also, few of the participants mentioned that emotional language using patient's spoken language is needed to be used when sharing bad news with patients/patients' relatives, such as death and illnesses (e.g., cancerous diseases), "When patients die, breaking their death news to their relatives or friends, because it all has emotions". They continued saying that careful emotional language needs to be used when breaking bad news to patients' next of kin, for instance: death, in order not to lose another member as a result of the selection of the shocking words, "If I tell the patient's relatives or friends that their patient is dead, I may have another healthy person may die or collapse, because of the shock". Therefore, it is highly important to carefully select suitable words and phrases for such sensitive clinical situations.

There are also other sorts of communication challenges in a specific hospital department such as breaking bad news to relatives in the ICU. First, ICU very sick and unconscious Arab patients who stay for a longer time are creating more language communication challenges to non-Arab medical practitioners, "the main communication challenge may be the patients who are maybe very sick and unable to speak or communicate, and then it's communicated to the family, communicating with them, counselling them, it's a difficulty. It's a big challenge for us because you have to counsel them about the reality of the situation

(different settings/ different situations & different challenges). This indicates that medical practitioners should use careful language for breaking bad news to ICU patient's relatives and these words need to be selected accurately in order not to lose the ICU patients or any of their relatives or make their health status worse.

Language and culture come side by side; not only the language should be carefully selected, but also the language tone and intonation and the way you use the language, "If I know Arabic, I can go slowly, slowly. There you really need to have a different spoken tone". Language and culture are compliments, "Then will be apart from the language, the culture barrier. If you can call it a communication also. Culturally, even if it is bad news, they want to be told in a different way".

Cultural background differences could add more communication challenges to medical practitioners, "Their backgrounds and cultures are different". Understanding cultures when learning languages is essential and could help medical practitioners to be selective when choosing the language terms required to communicate with patients and reduce the potential of having patients' bad reaction as a result, "In some cultures, places you cannot break the news because you can see sad reactions"; "Their backgrounds or cultures are different".

When talking about doctor- patients /patients' next of kin communication considering the language the main communication element, it's always a bonus if one of the communication process's parties can speak more than one language in addition to the mother tongue, "Whereas back home in India, it's your mother tongue or even if someone from outside, you know English or you can speak Hindi. So, there are different languages where you can communicate with...". This could be a good witness to show how educated Bahraini people are and may indicate that there is good care of education as an essential element of civilized life not only young people but also elderly in this part of the world, "When you come in here to the Arab, one good thing what I noticed; most of the Bahraini nationals who come to us and their relatives, they can speak English, so that is one of the good advantages that I work in here. So, in the family, someone could speak in English, at least one person. They may not necessarily be the younger class; the older generation also speaks English". However, Arab patients in Bahrain are not necessarily to be always Bahrainis and well-educated or speak good English; many of them come from different Arab countries and rarely speak English.

The study participants compared cultural communication aspects between healthcare contexts in both India and Bahrain. Different countries have different cultures. Cultural education is needed for medical practitioners at least a brief during an induction or orientation programme, "In India, we are very direct most of the time. Here depending on the family, but usually, I feel you need to break the news slowly in steps. Maybe not in the first meeting". In addition, a small number of medical practitioners who practiced

medicine in other Arabian Gulf countries (GCC) made a comparison of cultural communication aspects between the Healthcare context in Bahrain and other Arab GCC countries. Different patients' attitudes as a result of cultural differences, "Yes, culturally I will say, there is, because these women, I just fit with all the cultures, they have a lot of… there is no right, like in the west and in my home country, women have stronger rights to make their own decisions. In Arab countries, families have more power on what has to be done. So, for instance, in Saudi, it's not so culturally common in here, if you tell the woman that you need to remove the uterus because there is a problem in the uterus. It's very difficult to convince them and she cannot make the decision. The husband will come in between, and the family comes in between. Sometimes, the mothers are very influenced, and they come as dominant parties". It is also very difficult to change people's strong beliefs and correct their negative attitudes. So, learning a language could enable medical practitioners to convince their patients to take a certain medication or treatment or avoid a bad habit that may threaten their health. Furthermore, it is obvious from the input of the study participants that there is a need to be culturally educated and to be aware of the religious beliefs of patients/ patients' relatives, for example, in a certain country and their possible influence on patients' decisions relevant to their health status, "Because a person has his/ her right to make a decision and sometimes they do want, but they can't. They do know what they want, but they are influenced by people and cannot make their own decisions"; "For even in Saudi Arabia for contraception, even in here in Bahrain also, I faced a couple of women. Not very much, but few women, they will say that we have to take permission from our husbands for insertion". Another example that is also related to the cultural beliefs of the patients and/ their next of kin which could affect medical decisions negatively is that: "Like for example, you will tell them that the best option for you is inserting a loop and they will say no. For that, we have to consult our husbands to ask, and there were even a couple of cases where they said we have to ask religious leaders for this, and these are kinds of challenges that we face".

Lacking the language needed to communicate with patients or their relatives may result sometimes in losing a patient's life in worse cases, "These are minor ones, these are nothing, but life-threatening conditions and sometimes we have faced that the woman is bleeding a lot in labour and she needs the removal of the uterus and the husband is not willing. In that case, we doubt to make decisions ourselves with another doctor".

Medical practitioners can communicate much better with their patients and the patients' next of kin if they know their language and understand their culture, "Caesarean can be another thing like, why are taking Caesarean and why are you not trying for a vaginal delivery? We know that we are doing our best and we know that we are trying the best of what we can have as normal as possible. But, certainly…And the other thing I will say in daily life; convincing a woman to have a vaginal scan, because scans from Abdomen can sometimes be inaccurate and there is so much common with that if you do a vaginal scan, the baby

will be discouraged. So, they take it very negatively and don't accept the vaginal scan. So, there are cultural things we face. Lots of awareness is required".

Several medical practitioners talked about the impact of language communication on daily life matters from their own experience in practicing medicine in other Arab countries. Medical practitioners require to know the language of their patients and the country they work in not only to communicate with their patients but also to protect themselves from life risks. One of the shared examples by the study participants which explains this point is that "Like when I came initially in Saudi Arabia, I came to Jeddah first, then from Jeddah to Dammam. Then, there was my passport stamping. I came actually to Saudi in Ramadan; it was the first day in Ramadan and I was not able to receive my passport from the first day I departed. Somebody told me: go, go. Go and others said: come, come, come. Something like: He did not know English and I didn't know Arabic. He wanted to take me to the Airport in Dammam, a particular airport and he couldn't understand me, and I didn't understand him. And he went to the computer and I said why??? He said something, he wanted to deport me. Yes, scary, sometimes misunderstanding communication becomes very difficult". Based on that, sharing language communication barriers between medical practitioners could help in convincing other reluctant medical doctors to start learning the language of their workplace country and patients seriously if they hear these stories directly from their work peers as they are all in the same pot.

Some medical doctors elaborated on the idea of 'Patients Cooperation' in being a valid source of medical information related to their health. The role of patients in educating their medical doctors with their health cases' details. **2B.7:** For the routine instructions and counselling, most of the medical practitioners expressed that by the time they practice medicine in Arab-based medical institutions and hospitals, they learn by themselves or through patients (i.e. The role of patients in cooperating with their doctors in teaching them some common phrases and medical terms such as human body parts or some signs and symptoms and medication which could indicate a good level of awareness of some patients, but not necessarily all of them in understanding that medical doctors are with good knowledge and experience but they lack the language of communication of the local country as they are non-Arabic speakers).

Summary of the Second Research Question Data Analysis and Findings

All in all, in this section, we had a showcase for some examples of language communication challenges faced in the medical and healthcare context. Bahrain is this research context, and it is an example of Arab diverse countries which other GCC countries could follow if facing similar language miscommunication problem in their medical contexts. Similar language miscommunication experience in healthcare settings had been shared by some medical practitioners who also practiced medicine in other Arabian Gulf

countries, like, Saudi Arabia, UAE, and Oman. Added to the commonly shared themes under the interview category of challenges/ difficulties, most of the research participants added to the study some of the unique language communication challenges faced by certain individuals, which is interesting to think about them and further investigate if these issues are unique or could be missed out some time from people when expressing themselves and sharing their experience. Other types of challenges were not frequently mentioned by all or most of the study participants but are categorized as important themes from the perspective of both the researcher and the research participants who shared these pieces of information. Both direct and indirect negative language communication effects were reflected in medical practitioners' professional performance and the quality of the medical services provided in the study context. One last point, while there is a clear focus in this study on language communication barriers in the medical context, a good number of participants frequently link language challenges with cultural aspects and challenges they have faced in Arab medical settings. This could reflect that in communication, language is a very essential component and when learning or using a language, another communication element will emerge, and it is uneasy to skip it and that is the cultural aspect which also causes lots of communication challenges in the medical and healthcare working environment.

Themes identified in the 3rd & 4th Research Questions:

Research Question 3: How has language miscommunication affected non-Arab medical practitioners' relationships with their Arab patients, colleagues, and other healthcare professionals from the medical practitioners' perspectives?

Research Question 4: What strategies have non-Arab medical practitioners adopted to cope with language miscommunication issues?

4.2.3 Main Theme: Consequences/ Effects & Coping Strategies

As it is clear from the second interview questions category that there are some communication challenges faced in the professional medical and healthcare context, then it is normal and logically expected that there will be some negative consequences in return. Some of those shared consequences have long-lasting effects such as losing a patient life in some cases or some other effects, such as time-consuming while having a mediator to help in medical communication interpretation between doctors and patients/ patients' next of kin. From the data collected for this section, there are some main themes and other sub-themes; some of them are also categorized as common themes shared by all or most of the participants or unique themes that are linked with certain individuals but not applied to all.

Sub-themes:

Sub-theme 4.2.3.a: The Importance of being Present as Doctors in the Interpretation Process to use "listen & repeat frequently Arabic phrases technique" for Self- language Learning

The first interview question in this section investigates if medical practitioners have come up with some personal coping techniques and strategies to help them overcome miscommunication barriers they usually face when communicating with their Arab patients/ patients' next of kin.

To start with, some research participants brought up the idea of trying to talk to their patients face-to-face directly using some coping techniques. If any mediator or interpreter is available from the medical staff, then this doctor tries to repeat certain medical terms and phrases said by the mediator or interpreter in the patient's language (i.e., Arabic language in this study context for example). This technique could be considered as a self-learning language communication done through observing mediators while interpreting and using the repetition technique of the common medical terms or phrases or questions and gaining more through learning and experience, "I have tried my best, like in those kinds of patients, I have tried my best, I convey, and I talk to the patient myself. Like if there are some difficult terms that I have to tell them. I listen to what the interpreter is saying and then I try to repeat it. I try to be there when they are talking and I try to be present in the scenario and when they are counseling, then in between, I'll just talk, So, that the patient will know that even I am involved in this. So, yeah. That's how I try to comment" (Dr. K.). Therefore, the presence of medical doctors while another person or staff is interpreting medical information or conveying the doctor's message seems to be very important to build up more trust between patients and their medical practitioners. Added to that, other doctors elaborate more on this point by emphasizing that doctors need to be present in the medical conversation interpretation process to learn more and rely on themselves next time, "so I cannot just leave the patients or tell them: Ok, fine, you translate, I am leaving. No, like that I try to be present there and I try to grasp how much ever possible and I try to learn, so that next time if I have something like that, I try my best to manage my own, but I keep the interpreter standby, just in case".

In all cases, majority of the medical practitioners suggested that having stand-by medical interpreters available in all shifts is a bonus to reduce the risk level too, **"**Yeah, night shifts when we come for emergency and all then it gets difficult, but some of the other nurses or somebody in the work or the emergency department. Somebody will be there. Yes". Some participants admit that the shortage of Arab medical staff during night shifts in comparison to the morning and the day shifts causes an increase in the language communication challenges faced. Most of the doctors rely on available Arab nurses and other staff (i.e., both medical & non-medical & the preference will go to medical staff to do medical interpretation) as being referred to by the participants. Another coping strategy that is shared by the

medical practitioners is that having self- learning of common terms in Arabic daily could facilitate medical practitioners in doctor-patient communication, “We are daily trying to learn more words by ourselves. First thing, yeah”. An important emphasis comes from medical doctors who take part in this study that learning Arabic medical terms more than general terms is more beneficial, “initiative to learn as many words as we can grasp related to the medical field at least will be nice”. Some participants also referred to the nursing colleagues and the medical consultants for medical interpretation of doctor-patient/patient’s next of kin communication, “and we are managing with our nursing staff and we are managing with our consultants too”. Another sort of coping strategies, several medical practitioners talk about is the use of pictures and diagrams with the learnt terms; logically combine them can be a good technique for learning a new language to a certain language level. This technique would enable medical practitioners to communicate clearly with their patients requires lots of practice and takes both time and efforts.

Since doctors’ time is very tight, then smart practical techniques could help like what has been recommended by some medical practitioners, “Yeah, sometimes. If the patients’ relatives come, then they don’t understand the things properly, so, we explain them in a diagrammatic way. Like the brain is like this and the kidneys. And in fact, they understand very nicely with that, those pictures. How liver is there, how kidney, how much percentage is working, and how much is not working, and they are very much satisfied”. Also, explaining patients’ health status by using medical diagrams and pictures help in clearing the patients’ doubts and making them happier and more satisfied, “Yeah, we clear all their doubts and they are satisfied with that. If you explain by diagrams and by the pictures, they are happy”. Another technique shared by the doctors is that combining English words with diagrams or pictures or combining broken Arabic with diagrams or pictures could work well when communicating with Arab patients/ their relatives plus referring to Arab nursing staff or medical consultants in worse cases if the language communication barrier is very challenging, “Because in comma patients…in a comma and they will know whether there is a clot or there is bleeding. So, if you can explain to them this is the thing and then they understand the picture very clearly. It’s very helpful. Even though, if you are not good in Arabic, in English also; with diagrams, you can manage with … (The Dr. is laughing, ha-ha) …They understand. Now, I am using pictures, diagrams, nursing staff, consultants, and a’ah…That’s all.”.

One medical doctor shared that he learnt some Arabic in his previous clinical practice in Oman through the help of the nursing or personnel staff in addition to linking Arabic and other languages he knows like Hindi and Urdu as there are some similar shared terms between different languages, “Yeah, yes. No formal training. That’s what exactly in the introduction initially I said how I tried to learn the language I mean the spoken language with the help of the Omani Arabic helper or nurse, nursing staff, and personnel. So, I mean because of the proximity of Arabic with the Urdu, Hindi, the spoken languages similar words. With the help of that and along with some of the commonly used words; like the dates, days, a’ah…numbers;

the common symptoms of this is related to my field in nephrology, internal medicine, like (Kaha (cough), balqham (flem), nafas (breath), sader (chest), alam (pain), zoah (vomit), aah…Ishal (diarrhea)…). Like these things I started I picked up learning and I used to know them and then by practicing when I used to use them". Patients appreciate that their doctors are non- Arabic speakers, and they are trying their best to use some terms in Arabic in their conversations to make the medical message clearer to their patients, "they also feel confident when I was new and talking like this way. It encourages one to the other and that's how I overcome slowly, slowly, one, one difficulty like this…".

Most of the research participants had mentioned frequently that they seek help from some non-Arabic speaking medical staff who are somehow good at using Arabic due to their experience to cope with a language communication difficulty. Such staff members could help, observe, teach, and correct novice staff who just started to practice medicine in an Arab country like Bahrain. From their experience, medical doctors agree that learning Arabic through Arab native people is different from learning it through non-Arab, "Of course, a local person when is teaching you, they teach differently and… is also different". Doctors should have the passion to face language communication barrier in clinical practice with strength and confidence if they love their profession, "Different, different experiences come, but it has to be the person's concern is to tackle that. It has to be his way of tackling that. It all depends on his way of tackling. He has to face that, and he has to work on that". Added to that, patients could have a big role in teaching and educating their doctors to learn how to communicate in Arabic, "fortunately, for me the patients and the relatives, they also; although they are speaking in English and all, still Arabic speaking, they will try to speak slowly and then try to ask me slowly the questions, and then I understand, and then that's why also, I picked up many things. Because this is a survival of a fetus they said". Some medical doctors expressed that learning a language is not a punishment, but a pleasure and joy! So, enjoy learning new languages, medical practitioners! "Without learning, you won't enjoy it. You'll note, you'll suffer like this. And there's no use like this".

Learning a new language for communication purposes like learning Arabic by medical practitioners depends on their working period plan. So, if they are intending to settle down to work and live in an Arab country like Bahrain for years, then it is wise and a reward to learn Arabic in this case, "A'ah, but there are my colleagues who came to Oman that time, but their intension was to go to like USA, UK. So, they were …a'ah because of these… Because these are full-time things when you want to learn, you are interested, then you are completely rewarded. Yeah".

Not all medical practitioners value learning a new language to help themselves cope with everyday doctor-patient clinical language communication to save their profession as stated by medical doctors, "I know, long time I was not interested to learn because I work from here and then to India, but there are my friends

or colleagues or those who work under me; also, they came and they only wanted to…. It was a steppingstone like this way. They just are not interested. Fellows are staying for five years, and they can't speak one word also". Some medical practitioners are coming here just to work and save money and are not interested to learn or do an extra effort in addition to their tasks although they face the language communication barrier on daily-basis practice, "Because of their minds not like that. Because they just want to go, they just want to work, just want to do it for another reason for visa or …".

Another important point which had been added by some research participants is that patients' satisfaction and appreciation to their doctors' efforts in learning and using the patients' language to explain their health cases and convey medical messages, "If you talk to the patients and then you are treating, and they will also satisfy and they will bless you. You know. Yeah, they appreciate also, yeah, like this way". Learning the patients' language is one of the essential ways for solving the language communication challenges faced, "I've been here only for a month. All coming to these communication difficulties can only be solved through learning a language, and you know".

Added to that, some medical practitioners shared that seeking the interpretation help is fine, but it is not a permeant solution to solve a language communication problem faced in daily-based clinical practice, "seeking the colleagues' help is one way or seeking the staff help is another way, but that will not be a permanent solution to the problems that I face …a'ah. Even if you take this way two years, three, four years down the line …my problems which I said earlier, will still stay and the side of the language, it's going to be the same". To solve the language communication problem, learning the patients' language as Arabic will be the permanent solution to medical practitioners. Even if there is a sort of assistance for language communication provided by some of the colleagues, it will not have the same effect and impact like if you can communicate directly by yourself with your patients, "The permanent solution is only through learning the language". The more languages medical practitioners learn, the more patients/patients' relatives they can communicate with, "you'll get help, but unless you communicated by yourself, you are not going to feel confident about what you have communicated". Hiring professional medical interpreters is highly important in hospitals for multi-languages as patients coming to hospitals are with multi-nationalities, "There is staff from the Philippines. We have staff from Arab countries. We have staff from India who can speak probably three to four languages…".

Not only non-Arab medical practitioners face language communication barrier in clinical practice, but also Arab medical practitioners could face the same when dealing with patients who do not know Arabic or English like non- Arab labours whom we have a lot in Bahrain, "It can be the way around; especially if the doctor is an Arab, he can speak English quite well, but you know, maybe the coming person maybe a

laborer from Busaiteen area and the communication becomes very difficult. I think translators may be there, I am not sure".

Professional medical interpreters should be available and stand by in all clinical shifts and hospital wards including accidents and emergency to receive any emergency calls and assist in daily doctor-patient communication. The availability of professional medical interpreters essential because, one can imagine if the message is taken incorrectly, then no medical help will arrive in the correct place of the accident on time to save patients' lives, "In our setting at the moment (i.e., the ICU), translators maybe not a necessity, but I am sure the hospitals will have translators because they will have the issues coming from other nationalities as well. So, I think the hospitals should be having".

Medical practitioners also use the technique of drawing body parts, systems, organs, and medical diagrams when communicating with their Arab patients to increase their message understanding. The use of visual aids in addition to the verbal language is very effective and could solve both parties (i.e., the doctors & their patients/ their relatives), "Where a…ah, they are understanding. So, we use to make pictures, for example, that there are two lungs. So, in this way, it's very easy to explain to them, because they don't understand medical terms, and sometimes they do not understand English also. So, sometimes we use visual things also". Some doctors are either draw on papers or seek the help of mediators, "No, no, I didn't use like any video or YouTube. Only by paper or by verbal mediators".

Having different cultural backgrounds and different religions, then different language terms and tones are needed. So, most medical doctors tend to learn about the language and culture of their majority patients (e.g., Arab patients are the majority in an Arab country), "regarding cultural barriers, you know then you need to modify the way you communicate with the families. You have to ultimately tell them the truth that it's serious, but you have to tell them… Yeah, step by step. And most of the time, they understand".

Any Arab staff who is available on duty will be referred to for language communication and interpretation assistance, "we use whoever we get handy if from receptionists to nurses". Here one of the participants confesses that medical doctors try to avoid asking nurses to assist them with medical communication and interpretation as they are the busy staff. Therefore, they rely on receptionists, and the number of Arab receptionists in most of the hospitals in Bahrain (especially private hospitals) is less than non-Arab and you can imagine the number of possible risks as a result of this shortage, "We don't try to bring nurses, because they are busy people. But, if we find nursing people, most of the time the receptionists. There are quite a few receptionists who are Arab and help; come and help us".

Medical practitioners are sometimes seeking help and cooperation from their patients by asking them to bring someone of their next of kin who know how to speak English for their next visits, especially for permanent or frequent patients who visit clinics regularly or who have chronic diseases and stay in hospital beds for a long time, “this is one way we try to help ourselves. Sometimes, we also ask them to bring a relative next time. Somebody who understands English or who has a little bit more of education level”.

Some of the medical practitioners mention that the use of medical information leaflets in Arabic for example for Arab patients could help medical practitioners to facilitate their patients’ understanding of their medical cases and be able to solve at least part of the language miscommunication problem, “we give them sometimes these for some medical terms. We give them common these medical terms leaflets in Arabic to understand what we are talking about”.

Medical practitioners also try to assist their patients by writing to them in a piece of paper the important medical terms/ cases they would like their patients to learn about. So, they can type the term and google it, and then when getting the information in google they can choose the language they desire and the information will be viewed to them and they will be able to read it and understand its meaning, “Sometimes, I even ask them, I write the term for them and I ask them to google it. So that they go and read it and they understand it themselves”. The use of drawings, images, and googling medical information encourages patients to come back to their doctors after that with questions for further explanation, but with better understanding the next time they visit their doctors! “Yeah, drawing…drawing images use and google, asking them to do some reading themselves, and then come back with questions also help?”

Level of patients’/their relatives’ Education is also creating language miscommunication challenges as being shared by the majority of medical practitioners even if they learn their patients’ language, they need to be selective in choosing suitable language terms to suit each patient’s level of education and understanding. This is not an easy task even if the medical doctor is a native speaker (e.g., Arab practitioners could face similar issues when dealing with Arab patients), “We have, unfortunately, have these cases, very, very primitive, a woman probably has never been to a doctor, then suddenly comes to a doctor expect this problem to be solved in one setting and because the husband or somebody will not allow her to come again and when you said no, you need more than these Uterus tests. They don’t come back; they never show back. And you are by the day, they never come back, the problem is there. So, you become worried about the help also. So, this is something to face, even in Bahrain, very, very poor women who have no education level and who just want once to come in and to have all their health problems fixed up. One visit to come only one visit, everything should be fixed, whatever problems they have…”.

Language, culture, level of education and health awareness, all could affect doctor-patient/ their relatives' communication, “actually, she’s even alien to the Arabic people, because her level of education, her exposure to the culture is very very less. She just stays in the house and likes this. I had a patient who came one visit, she said first time she’s been to a doctor. She’s not having her baby and she wanted to fix that thing in one visit”. This is an example of language, culture, and level of education barriers faced in the clinical Arabic context and their impact on the medical communication process.

Even if medical practitioners’ intention is good and they have the initiative to help their patients, they will be faced by the obstacle of language miscommunication if they cannot communicate with their patients clearly, “In fact, sometimes I will try to go out of the way and if it is affordable for me, I even give them pay this thing, this consultation fees, so I can talk to them. But they don’t understand that this may not take one visit, this may take more than one visit”.

Language miscommunication delays medical practitioners’ work and waste both their time and effort, “It takes more investigations. We have encountered once a week, patients with very poor knowledge. I mean the knowledge of the outside is very poor. Very very primitive I will say”.

Effective language communication could help in saving patients’ life and vice versa, more potentials for losing patients’ life or causing medical errors will occur if the language for communication is absent (e.g., a patient with a cancerous disease who does not know about her illness), “the level of education and awareness is very very important. And there’s a lot of fear for us for women, who have breast cancer…things like that. Probably because they don’t understand what’s happening”.

Referring to the ward clerks to seek their help for language communication and interpretation with Arab patients/ their relatives is one of the coping strategies most of the medical practitioners follow in their daily basis clinical practice, “the ward clerks, so those are the strategies that I have as a way of communicating communication difficulties”.

Use the language before you lose it, even if you know a few words. That will help in making a difference when you speak with your patients by using their language, even greeting patients in their first language could help in breaking the barrier and increasing patients’ trust in their doctors’ ability and performance in treating patients, “no matter what language, French, Arabic, Hindi or whatever. When I greet a woman or when I see a woman in the labour room, I speak Arabic always. And that greet stands No.1: for breaking barriers; already breaking down. And you see the smile on the face and trust a rapport and trust is built. So, I always greet in Arabic…There you go and I introduce myself to Arabic as well”. Also, doctors could use some basic Arabic terms to introduce themselves to their Arab patients/ their relatives to break the barrier and start communicating with them with all the possible communication techniques they know.

Some medical practitioners add that they follow self-learning to learn the Arabic language for communication by using some language books or language learning software whenever medical doctors have time or break. They can even have language learning pocketbooks or bilingual dictionaries that they can carry and learn from any place they go. They need to learn and familiarize themselves with the most common and important medical and local terms, "that was the initial days of my practice. My best book was (Learn to speak Arabic in 20 days). So, I will carry this book along with me and read. Yeah, and I will read and familiarize myself with the local terms". There is no harm to start their first communication step to speak in a broken language and then gradually by the time and more use of the language will make these medical doctors more skillful and confident to use a foreign language in their daily conversations with their patients, "I actually started speaking. I said, I'm not going to stepping back because it might be grammatically wrong. I started speaking to the patients. Even though they would speak to me in English. I will encourage them to speak in Arabic, so I'll grow also communicate. So, that's actually improved. And over the years, patients have actually …. expressed… People have actually surprised that I know so much of Arabic. So, I don't gold myself with that ….". More language practice is required to improve both the level and the quality of language communication, "medical Arabic … I am ok. But maybe I still have to improve, learn more new words, and learn how to speak correctly".

Medical practitioners lack the time to learn new languages for communication if they are on duty and on-call most of their days. However, being positive and passionate about their profession could help them cope with such a challenge, "And being a busy practitioner, sometimes that is not possible all the time".

Another language example of the shared coping strategies by the participants: Medical practitioners' preference to speak to their patients using the patient's language if they can speak it, "And that's how I keep my other languages like for instance, there is a Kannada patient to come in… I prefer to speak to them in Kannada, so I preserve my knowledge of Kannada"; "Telugu if any of my patients speak the language come, I am very happy to speak to them in their own language". Patients are more comfortable if their doctors speak to them in their mother tongues. Not only patients, but anyone will also have the same feeling, "I think each one of us is most comfortable in our own mother tongue". Besides, if medical doctors communicate with their patients using their patients' language that will help in building a rapport and also, they will keep their patients. Patients will be loyal to their doctors and will come back again for another visit and consultation, "you have English as a medium of communication, but you most and you happy and you understand better I think when someone speaks to you in your own language". Most of the research participants continued sharing similar language miscommunication examples which could indicate that medical practitioners have some common language miscommunication issues. Furthermore, besides being comfortable when doctors speak to patients using their mother tongue, strong trust and relationship will be built between the doctor-patient, "it builds that rapport. It helps in creating that bond".

Added to that, when patients/ patients' next of kin trust doctors, they tend to ask for a consultation, "most of the Arab patients they come back because they know they can understand also, I think".

Both communication process parties will be affected, and their time and effort will be wasted as a result of the language barrier faced. Other consequences are expected to take place too. Added to that, potential risks behind making other staff busy doing other roles besides their major duty are expected to occur, "I think they've been perfectly good. When I only stuck for lack of understanding. Then, that's when I call for a translator to come in rather than getting stuck. So, and the hospital wherever I work so far have actually very proactive. There have been one or two or more Arab speaking people around who could help in translation".

Giving patients tasks to help them understand and learn is a good coping strategy mentioned by some of the study participants. They further elaborate that some patients are cooperative, and they contribute to facilitating the communication with their doctors, like when medical practitioners ask patients to google certain medical terms and health cases in their language to learn more and understand their health problems, "because everything I spoke, the father will google translate it into Chinese and then translate it to his wife…".

The language-communication barrier in clinical contexts exists in other languages too including Arabic. But, the problem in term of Arabic language in Arab clinical context the language miscommunication exists but not being well-addressed and described and it needs to be investigated closely to be able to describe the problem in details, share it with the people and the authority bodies in charge of medical and healthcare services plus coming up with some good coping strategies and solutions that could be implemented in Arab medical institutions and hospitals, " Most of the people coming from there they know broken English and some of them are just into Japanese or Chinese. One consultation for a Chinese patient at one point took one hour", "Although I am an Indian, there are several languages, like Malayalam, there is a lot of Malayalee population in here. And there are some couples who don't know much English at all and they speak only Malayalee. They wouldn't know Hindi much. So, even for them communicating in broken English, broken Hindi. And they speak in Malayalee I may understand a bit. So, it happens in other languages as well".

Some medical practitioners mixed the use of verbal language with the non-verbal language like the sign language as a coping technique to communicate with their patients, "I know sign language …Basically, in medicine, paediatric especially. Among nursery, years are better in science so to say. As the patient cannot express himself/ herself. So, the parents will communicate. Sometimes, even the parents are a little lost, they don't know, they just bring a child who is crying accessibly. That's it. That's the only symptom. So,

dealing with such cases medically-speaking is not a difficulty, because you can identify, you can probably come to a diagnosis and then treat. So, the treatment part does not get affected".

Sub-theme 4.2.3.b.: The Risk Behind Relying on Medical/ Non- medical Staff in Hospitals and Medical Institutions for Performing Medical Translation and Interpretation

Most of the doctors expressed that they refer to some Arab nursing colleagues to help with medical interpretation, "Get some Arabic translation from some Arab nursing colleagues" (P3 Dr. D.).

There are no professional interpreters recruited to assist medical practitioners with their daily communication with Arab patients, "No professional interpreters are hired and provided" (P5 Dr. Va.). Available staff members are called to help with communication. Both medical and non-medical staff in hospitals are called to assist with doctor-patient translation. If the patient, for example, knows Urdu or Hindi and the doctor is Indian or Pakistani, in this situation; patients' cooperation, awareness, and understanding to help medical doctors are shown and they switch to speak in the doctors' mother tongues or spoken languages. It can be vice versa as not all the patients know English or the doctors' mother tongues to switch with them and help them in communication.

I like this slogan given by one participant: "help us to help them" (P10 Dr. Sh.) which nicely describe the level of cooperation between both doctors and their patients if their patients are capable of communication and it shows patients' initiatives to help in doctor-patient language communication process, "If any practitioner needs translation, they call any available Arab staff, both medical and non-medical to translate. Sometimes Arab patients who know some Hindi or Urdu will switch and speak with us in our mother tongues to help us to help them. Interesting that patients are educating their physicians!" (P10 Dr. Sh.), "Bahraini or Arab staff within the same hospital were assisting in interpretation if they are available, but they are not hired as professional interpreters" (P1 Dr. K.), "Got some help to learn from Arab colleagues, especially when practiced medicine in Saudi, Arabic was a main language of communication there as people there are not competent in English" (P7 Dr. Ra.), "If any practitioner needs translation, they call any available Arab staff, both medical and non- medical to translate" (P10 Dr. Sh.).

Sub-theme 4.2.3.c.: Medical Practitioners Techniques for Dealing and Coping with the Language Communication Barrier as a Result of the Absence of Formal Language Communication Support and Training

- **Informal techniques to learn and practice the language needed for doctor-patient language communication:**

The research participants have mentioned some informal strategies they use to help them develop professionally and to enable them cope with the language communication barrier they encounter in their daily clinical practice. To start with, one of the coping strategies shared is that listening and repeating some frequent Arabic words and phrases said by both the Arab patients and Arab staff if they are cooperative to help the non-Arab medical practitioners. Another strategy used is that by practicing some years in Arab countries including Bahrain, some medical doctors try to learn some local words and phrases; especially those related to their specialization and used when diagnosing and counseling patients and they try to make links between Arabic and the languages they know such as Urdu, Hindi and Farsi/ Persian as a strategy used to help them acquire and learn another language which is 'Arabic', "As I have spent 28 years in the Gulf, I learned informally Arab patient language, but I am not fluent in Arabic. Know some Arabic words or phrases related to the dialysis ward. I try to make links between Urdu, Hindi, and Farsi language and Arabic in order to learn fast as there are lots of common terms and words similar to Arabic in Urdu, Hindi, and Farsi (e.g., numbers, days of the week…etc." (P3 Dr. D.). Another strategy used is keeping a notebook and noting down important terms especially the frequent medical terms of signs and symptoms and using the new language learned and practice it with others who speak the language well to enhance the new language learning, "Try to note down useful terms and vocabulary (e.g., common signs & symptoms) while learning Arabic informally from others" (P3 Dr. D.). Moreover, some medical doctors learn Arabic informally from different learning resources: **1)** Arab patients, **2)** Patients' relatives, **3)** local Arab staff and **4)** Arab consultants (i.e., learn from people who could either have or do not have medical backgrounds), "learned few social Arabic informally through some Arab patients and their relatives, national Arab staff and Arab consultants" (P5-Dr. Va.).

One participant has a little advantage from the time when she was a student and came with her father who worked for a period of time in Bahrain, "but I had my school learning and grew up in Bahrain. I took an elective course up to Intermediate Arabic Language level at Kent University in London. I have a sister who is married to an Arab Saudi, so I practice some Saudi Arabic with my sister and nephew. As well as, I practice some Bahraini Arabic even at home. I took an Arabic course for 1 year in London and then some private Arabic lessons also in London, but not in Bahrain" (P8-Dr. J).

Furthermore, other medical practitioners learned Arabic as a self-study through the use of CDs and books, learned some medical clinical-related Arabic terms by Arab consultants and listen to Arab and their way of speaking Arabic, "Just know little informal Arabic; very minimal communication, very medical Arabic to help me understand my patients. I also learned informally as a self-study through books and CDs. When I first started working in Bahrain, I learned some clinic-related Arabic informally by an Arab consultant who was the owner of the clinic. I also listen carefully to how Arab are speaking and were very helpful learning techniques" (P9-Dr. B). Some research participants take the initiative to do some Arabic language self-learning, "I studied informally as self-learning through books and CDs. Had some informal social communication" (P9-Dr. B).

All in all, medical doctors in this study context need at least to convey the message to their patients by knowing some Arabic. Majority of participants emphasize that it is always a bonus to know some of the patients' language better than being Arabic illiterate in this Arabic context, "Can speak a little broken Arabic for patient history taking, but not fluent Arabic" (P10-Dr. Sh.).

Sub-theme 4.2.3.d. The Impact of the Patients' Norms, Attributes, Beliefs and Level of Education on Patient-Doctor Communication

The level of education of patients or their next of kin and their different religious beliefs can be challenging in a way that affect the level of doctor-patient communication. Some research participants refer to the variables of traditional or religious or personal beliefs and the level of education and how that could either help or worsen the communication process between doctors and their patients, "Challenges have two types, the language and the most important one is the cultural challenge", Convincing a woman to take a pill to regulate her period is a quite common belief that if you give a pill to the woman, she will not get pregnant again. It means that even if she stops a pill, she will not be pregnant again".

Possible solutions for such matters faced by medical practitioners during their clinical practice would be by first, providing newly hired doctors with the host country language and culture induction course to help them understand their patients' language and background and support the doctor-patient communication. Second, in case of having patients with low levels of education, doctors need to be more flexible in dealing with patients and to ask them to preferably bring one educated person of their next of kin to act as a mediator in the doctor-patient process.

Main Theme 4.2.4: Examples of how Effective those Coping Strategies are used by Some Medical Practitioners to facilitate them When Communicating with Arab Patients

To start with, effective techniques, to the majority of the participants, nothing is impossible, but requires some efforts and are very manageable techniques, "I can't say it's 100% effective, but it helps I mean it's

not impossible or anything. It takes some effort, but it's manageable. Very manageable". Also, there is always a challenge in coping with such a language communication problem faced in clinical, but it is manageable and fine, "it works. It doesn't that oh, oh, what am I goanna (i.e., going to) do? I cannot practice, I cannot read the patient… nothing like that. It's very manageable. Just the counseling part. And I can work the way around it. It doesn't make a big difference, just a little bit of challenge is there, but it's fine. It's fine. It's manageable".

Most of the study participants agree that by combining the use of some affordable and available coping techniques, the result will be great. To these doctors, the best outcomes the doctor is waiting for after using these coping techniques are that being able to convey the message to the patients, ensuring patients' message understanding and gaining their satisfaction about the quality and level of medical and health care services provided to them, "Combining all of these things, I am finding it very very (said frequent effective, almost close to 100% you can say. I am not feeling like this thing. This is my question remaining. So, what's the thing I wanted to convey to them. It has been conveyed. And they also understood; they are satisfied. It has been done, but by other means; like by staff and by these things like staff or by other things…".

Doctors are aiming at achieving the goal of ensuring that their patients receive good treatment as a result of using some coping strategies to solve the language miscommunication problem, "Yes, many other panels. Yes. And finally, whatever good things, the patient should get good treatment. That's all. This is the ultimate goal". Added to that, perfect and effective coping techniques used to solve the language communication barrier faced. Most of the study participants are satisfied with the results of using the coping techniques they come up with themselves to help them cope and deal with language communication barrier faced in their medical context, "I deal with my own. I find them perfect for me because of the immediate results you know". Speaking to the Arab patient directly even with a broken language is seen to be effective for the participants without the help of a mediator or causing work delay.

Some of the medical practitioners advised that doctors must learn how to cope with the language communication challenge by themselves and do not wait for others to help. Medical practitioners should learn the medical terms/phrases relevant to their medical field rather than a general language, "Like "Wahid / One, Ithnan/ Two, Thallatha/ Three, Mara Isbouh Ghaseel Yeegee/ You must come for one-week dialysis, Yum Sabt/ Saturday, Ithneen/Monday, thallatha/ Tuesday, Arba'ah/ Wednesday, Khamis/ Thursday". Its immediate effect, because patients want that. You don't want again, call the sister, that sister. Again, the sister will ask me".

Medical practitioners should have patient-centered learning to find out whatever serve their patients and facilitate the communication process with them, "the impact is straight forward. And ourselves, we have

to learn what we want, we have to learn; others cannot teach us. This is very important, so individually we have to learn specifically what they require for any (or in their field and to the patients). Ultimately, a patient is the main person. What are his requirements, then we have to satisfy? Then, it will be effective. Anything is related to patients, nothing is related to our field, everything is related to the patients, because he's there, so everything is there". The use of language communication possible strategies should focus on achieving more patients' satisfaction and be able to manage their health cases and treatments, "So only focuses on his satisfaction and management", "Whatever required in that, you have to demonstrate", "I think it will be effective, except for the fact that it does not give you the satisfaction of being able to communicate. Ya'a fully-satisfaction".

To achieve more patient-centered medical communication support, there is a call from all the study participants for some collaborative non-Arabic speaking medical doctors or those who are in the same situation to have the initiative to learn the local/ required communication language to facilitate their communication with Arab patients once consulting, observing, diagnosing or treating them. That refers to the idea that nobody can help the doctors facing language communication barriers if there is no formal support unless they help themselves to cope with the communication challenges faced. As stated by the research participants that they have tried to come up with or invent some coping strategies themselves- They will become creative doctors and that will be a bonus to their professional account for future promotion. They need to look at the extra learning and education aspect as an advantage, "The medical term is one thing, and the second thing is you want to tell your patients something to comfort them. And telling them that in English is one but telling them in their language is something else. They feel more comfortable".

Several study participants gave rated scale scores to evaluate the effectiveness of the coping techniques they use, "Will say effective 8 out of 10… If the patients are English speakers, then I will say 10 out of 10".

In the hospital Intensive Care Units (ICU), the use of the Arabic language in communication is more effective with patients' relatives as their patients are in the ICU and mostly unconscious. The use of gestures, pictures, and diagrams is very effective, "Yeah, so patients are not communicating here; mostly unconscious here. But families need the explanation; usually, for Arabic, we use hand gestures when they are speaking. So, usually, it's not if it's a language. It's ok, but sometimes we have to demonstrate the lungs, the heart, how the tube (i.e., the catheter) will go through, how is the feeding by using the catheter through the nose, the ventilator, or is it a urine catheter?"

As a recommendation, some medical practitioners recommend having a three-months orientation short course that offers to teach the local Arabic language and educating medical staff about the eastern Arab

culture. The priority for getting benefits from such an orientation course is to target the newly recruited non-Arabic speaking medical practitioners, “I mean if possible, all hospitals should have, especially for the doctors who are coming from outside should have some… I would say that there should be some formal at least a month or two months… a short course, three months maybe, a language orientation, and a little orientation to the culture also. Because you see as I said, sometimes, because we are also of the eastern culture, we do understand a couple of things more easily, but other colleagues who are coming from western cultures and they don’t understand why it worked, why these patients are reacting like this? Or why is this so unacceptable?” Suggests having a communication language scale induction in addition to cultural induction to newly hired non-Arab medical practitioners, “maybe when we want to hire doctors, we should have a communication language scale, induction, as well as induction to culture. Culture is important”.

In term of language and culture, the majority of the study participants can see that the knowledge of the local language and cultural awareness are required for any new hired non-Arabic speaking medical doctors in this Arab region, “ Because a lot of times what I feel… because as I said I am used to eastern culture, so I have an idea about what is an eastern culture”, “ We have the organizations to hire capable doctors from the west and they don’t understand totally different cultures”. Therefore, these two aspects, language and culture of the doctor’s workplace country and their majority of patients should be added to medical practitioners’ required recruitment competencies to be met when recruiting new medical practitioners.

Parents and relatives’ involvement in their patient’s health even if the patient is an adult is one of the cultural aspects in this part of the world participants have noticed. They recommend that medical doctors should be aware of that to know what language to be used and how to deal with such daily issues, “To them, involving a family member for a meeting, talking to patients, why should they involve the family? You know, and things like that. Including the language to the culture is also important. Yeah, yeah… have stronger influence”, “Like when a woman of 22 or 23 enters my room with her mother, to me like ok I can understand the culture. But, for people…”, “if you strictly follow the guidelines of medical ethics, they are not supposed to be here. The mother and the family are not supposed to be here. Others should be waiting. She has the right to come to the clinic and talk alone. And again, these things should be about the culture induction, should be about the culture. Not only the language but culture should be involved”.

Discussing the Issue of Combining both the Theory and the Practice: The idea that education does not mean the degree you hold, but also learning through your practice and experience, “Amm, I think they are very effective, and the reason why I say that; it’s for two ward clerks who work here for such a long time. They know the words, the obstetrics words even though they are not health care professionals, so they will

say the words that I don't know, forget, and works brilliantly! Yes, yes, yes very, very invaluable! Amazing!"

Some of the medical practitioners involved in this study appreciate and encourage having more research in the area of language miscommunication in medical and health care contexts and finds this topic very important and interesting, "I think the research is very important in communication because what I do see is a lack of communication is a certain ethnic group in health care professional; I see a total lack of communication, so I find it very interesting".

Summary of the Third and the Fourth Research Questions Data Analysis and Findings

To conclude, this part of the data analysis and findings presents types of consequences experienced by non- Arabic speaking medical practitioners who are practicing medicine and healthcare in Bahrain kingdom and how they managed to cope with such language miscommunication challenges. Added to that, medical practitioners shared some practical innovative coping techniques when they experienced having no formal professional training offered by their workplace and no professional medical interpreters are provided to assist in medical communication with Arab patients/ patient's next of kin.

4.2.1.3 Third Main Discussion Theme: Impact of Miscommunication on Professional Practice

Sub-theme 4.2.1.3.a. Potential Consequences of Relying on Non-medical Interpreters and Hospital Staff

All research participants shared the idea that for the doctor-patients communication process when struggling in communication with Arab patients and/ their relatives who cannot speak English or whose English language is very weak, especially when it comes to understanding medical terms or a full description of a medical case in English or making medical decisions, such doctors immediately seek the help of any available Arab staff on duty in the hospital.

Some of these staff members are medical staff who are not necessarily to be medical doctors, but have a medical background which is fine although, these medical staff are more likely to be not professionally certified or trained to act as medical interpreters. Hence, they are volunteering to help their non-Arabic speaking colleagues with their duties. However, a good number of this study participants share the idea of relying on some available staff who have no medical background, like, receptionists, ward clerks, operators…etc.

When these types of staff are providing medical interpretation, there is a big chance for encountering errors in meaning and the doctor message's accuracy in a way that may not convey the actual doctors' medical messages and instructions to their patients. As a result, negative consequences are expected to happen and

both parties would be badly affected. First, doctors would be blamed for not providing their patients with clear information about their health case and making wrong medical decisions and may face some legal issues in worse cases. Second, patients as a result, could have their health becomes worse or these medical communication errors may threaten their life and cause them death. The potential risk issues resulted from referring to non-medical staff should not be ignored and need to be seriously investigated. In addition, proper solutions need to be provided from the bottom to the top (i.e., starting from the hospitals' internal authorities and management and ending by the actions coming from the people in authority and who are in charge of ensuring quality medical and health care services in the country, like the Ministry of Health).

Sub-theme 4.2.1.3.b. More Stress and Workload will be added on the Arab Medical Practitioners' Shoulders to do Dual Jobs with no Extra Payment

Here we are highlighting one potential negative consequence which is resulted from the problem of clinical language miscommunication faced by non-Arab medical doctors when dealing with their Arab patients/ their relatives. On the side of Arab medical practitioners, there is an expectation of them adding more complaints about being overloaded during their shifts; extra tasks are added to their actual medical job. Added to that, medical practitioners involved in the extra task of interpretation may have more stress and will be always disturbed to assist other non-Arab speaking medical colleagues in providing high-standard medical interpretation assistance. Appreciating voluntary work is a quality that not all people have, and of course making organizational change and convincing every member of the organization to do an extra task without an extra payment or professional promotion or giving incentives of different types to motivate them to help does not always work.

Sub-theme 4.2.1.3.c.: The Effect of Language Communication Barrier on the Patients' Health

Another issue that attracted my attention as a doctoral researcher when conducting this study is the effective impact of the verbal language on the patients' response to take certain treatments. As well as, verbal language plays an important role and could cause psychological and emotional effects on the patients' health and their illness recovery. Meryn (1998) expresses that several studies and reviews clearly show a correlation between effective communication and improved health outcomes. The outcomes affected were emotional health, resolution of symptoms, function, pain control, and physiological measures such as blood pressure and blood sugar concentration. These roles of the doctors' verbal language are stated in some real examples and incidents, medical participants encountered and noticed in their daily clinical practice and contact with their patients. For example, in ICU in particular, one of the study participants who is a doctor in the ICU shared his clinical experience and finds that the doctor's verbal language when speaking the patient's language (e.g., speaking Arabic to Arab patients in ICU) is more effective as the patients in the ICU are either semi-conscious in hospital beds for a long time or fully unconscious and the main contact will be

instead with their next of kin.

Emotional verbal language could make a difference as elicited from the study interviews. First, it could psychologically heal and relieve patients' pain. Second, if the healing words are told in the patient's language by their doctors, then more hope in life and better recovery patients may have. In ICU, some patients may be able to listen to their doctors, but it could be difficult for them to see their doctors' non-verbal language while they listen to them (e.g., facial expression, body language, eye contact…etc.). McCabe and G.T. Healy (2018) refer to a meta-analysis found that the odds of having adherent patients were twice as high if doctors are good communicators.

Therefore, verbal doctor messages will be easier for such patients. Not only ICU patients prefer receiving verbal messages from their doctors using the patients' language, but also patients in other hospital wards including emergency and also patients whose medical and health status is stable prefer to listen directly to their doctors and they prefer the doctors who can speak their language because they feel more comfortable. Some of them for example, ask to be transferred to an Arab doctor who can communicate with them in Arabic even if the patients know some English.

Sub-theme 4.2.1.3.d. The Potential Risk of having Less Arab Medical Staff Available in Emergency and Nights Shifts in the Absence Time of Professional Medical Interpreters

A number of participants raised the issue of having less Arab staff in night shifts when emergency cases are expected to be more in compare to morning and day shifts where on the contrary a good number of Arab medical staff and consultants are available in the hospital wards, **"**Yeah, night shifts when we come for emergency and all then it gets difficult, but some of the other nurses or somebody in the work or the emergency department. Somebody will be there. Yes". Most of the non-Arabic medical practitioners state that the main source for doctor-patient communication assistance are medical and non-medical Arab staff on duty. Therefore, in night shifts when the potential of critical emergency cases which are admitted to hospital (e.g., accidents of different types) and non-Arab medical practitioners receive no communication support; there is a high expectation of high risk on the patient's side (e.g., patient's health status becoming worse, losing patient's life, dissatisfaction of the medical services provided and losing trust in the doctor's ability to treat their patients). On the non-Arabic speaking doctors' side, the risk may occur when making some medical errors and inaccurate medical decisions.

Also, possible risks on doctors could be when experiencing a delay in taking the patient's medical history and deciding on the patient's treatment. Added to all of that, these doctors may be faced by some time violent patients or their relatives or have some legal problems as a result of medical errors made or possibly to be fired and lose their job. This type of consequences on the doctors' side could happen if their

workplace management does not understand the problem case and that what happen is out of doctors' hands and require to be resolved in the first place by the hospital management. What may happen with one doctor because of language miscommunication could be encountered by other doctors too. Above all, we cannot miss or ignore negative psychological problems that affect medical practitioners if they find themselves full of knowledge but being unable to perform their jobs because of this barrier.

Sub-theme 4.2.1.3.e. Types of Non- verbal Language that may affect Doctor- Patient Communication Besides the Verbal Language

Through exploring the language communication scenarios shared in this study that doctor-patient and/their relatives language communication scenarios shared in what this study participants experienced in their daily job routines, I have noticed as a doctoral researcher that verbal language is an effective component in the communication process. Therefore, absence of the patients' spoken language in the medical practitioners' side who are supposed to have a direct communication with their patients/ their relatives is causing a huge communication barrier.

Added to that, this language absence results in a number of negative consequences which cannot be ignored once being frequently witnessed and encountered on daily basis without being formally addressed and solved. Beside the language being a major component in communication, there are other factors that emerge, such as cultural awareness from the side of non-Arabic speaking medical practitioners and the level of education, respect and cooperation from the patents/ their relatives' side.

These factors should be treated in a way that contribute positively to the doctor-patients/ patients' relatives daily communication and conversations. Suggested professional training to solve this issue and improve the medical communication process is shared in Chapter Five of this study- Conclusion.

Sub-theme 4.2.1.3.f. Patients' and / their Relatives' Impressions on their Medical Doctors who cannot communicate with them Due to the Language Communication Barrier and Psychological Professional Impact of this Impression on Medical Practitioners' Impact of this Impression on Medical Practitioners

It is sad to learn that this research language communication problem which is almost daily faced in our public and private hospitals and medical institutions has created an important phenomenon. This phenomenon needs to be explicitly shared, taken into consideration, and soon to be resolved by providing serious sustainable medical communication solutions. This problem as learnt from this study results has left negative impressions on both main parties in the typical medical language communication process; the medical doctors and their patients/ patients' relatives, "Not only have language differences been found to

create barriers for patients trying to convey their illness and symptoms but can also contribute to challenges in understanding health-related information provided by professionals". **(Huot, 2019, P.4)**

Themes identified in the 5h Research Question:

Research Question 5: What types of support are available to non-Arab medical practitioners to deal with the language barriers they face in their practice?

4.2.4 Main Theme: Available Support

This section focuses on available formal or informal communication support and coping strategies if any. Most of the available communication support is informal and voluntary come as initiatives by Arab medical or non-medical colleagues to assist their non- Arab medical practitioners in medical communication with Arab patients/ patients' next of kin. Other initiatives come from the non-Arab medical practitioners themselves if there is an absence of their colleagues to offer them their assistance on-site. Also, some non-Arab medical practitioners who have long experience working in Bahrain or other Arab countries and have a good level of Arabic language help I'm assisting the Novice medical practitioners who cannot communicate with their Arab patients in Arabic.

Sub-themes:

Sub-theme 4.2.4.a.: Support received by the Workplace if any to cope with Communication Difficulties

To start with, some medical practitioners find the voluntary cooperative staff to assist their colleagues of non-Arabic speaking medical practitioners with the doctor-patient communication and interpretation, "Colleagues, interpreters who know Arabic, they have helped a lot".

Some medical doctors refer to the idea of learning patients' language is a bonus to them with both formal or informal communication, "I try to pick up and learn here and there. It's always good to learn a new language. There is no harm in it. The more languages you know the better you will be. Always helps you. So, we have the help of our colleagues here. It's a very good support system".

A couple of the research participants who practiced medicine in other GCC countries, such as Oman, Saudi Arabia, and UAE explain that there is an absence of official professional medical interpreters in both the Omani and the Bahraini clinical sites.

All the study participants report that due to the absence of formal training in the field of doctor-patient language communication, informal colleague support is taking place instead, "In Bahrain or Oman support

is always there when I wanted something…Whenever I encounter a difficulty everyone is trying to support. It was not formal, but from the colleagues, the Omani staff, and the Bahraini staff, immediately they will translate whatever I wanted and like this. It was voluntary", "There were no official interpreters and there were never in Oman too", "There is no formal training".

Lucky doctors to have cooperative colleagues who can help them any time they require assistance with great pleasure and willingness too, "I never experienced somebody saying no, no. Everybody likes to help and convey the message. They also feel nice actually. They're very cooperative. Everybody, happily they will tell", "Yes, they will arrange for that and they will readily be available. They are not professionals. They are just Arabic-speaking staff. That's it. They are not like professional translators. They have their own jobs. They get off job, come here just to help out a bit".

Sub-theme 4.2.4.b.: Offered Communication Support Effectiveness

This question asks the research participants to evaluate the type of formal or informal language communication support received plus their coping strategies used when dealing with language miscommunication problems whether being effective or ineffective solutions.

All study participants admit that only informal language communication support from colleagues is available. No formal language communication support is provided in the workplace, "It's pretty effective. I have no complaint regarding it. And whenever you ask for someone to translate or get somebody, there is always someone available".

One medical practitioner gave a high rate to the language communication and medical interpretation support he gets from his medical colleagues- 99%, "Rating the support that I receive from my colleagues out of a 100, I think the support can take 99%, because what you want they will convey. They are already in the field. Because if the interpreter there, it will become more of a language than medicine and the medical field. I don't want the language, but the medical language to speak which is possible from Arab medical colleagues who can speak it".

Medical doctors emphasized the doctors' language of communication needs to be understandable and convincing, otherwise, the communication language will be of no use, "It is very important to learn the language that the patient can understand and that can convince them".

Most of the study participants recommend that medical communication and interpretation support must be provided by Arab medical practitioners who are medically specialized in the same area of specialization non-Arabic speaking medical doctors who are supposed to receive their support have. This issue is important from the perspective of these medical doctors to ensure the accuracy of the doctor's message

conveyed to the patients/ their relatives, “It’s very good. I think it works very well. As I said the only concern is when you have non-medical staff like if a nurse translating, I’ll be happier. When a receptionist’s translating, I am a little worried, is what I want to be translated is getting across right? It has to be as transparent as possible, as close to what I want to be translated”. This quote indicates that interpreters should be with a medical background to have more transparent accurate doctors’ messages to their patients/ their relatives. As being expressed by the study participants, there are some potential risks of relying on non-medical staff to translate doctors’ medical messages, such as hospital receptionists, ward clerks, operators, security guards…etc.

4.2.1.4 Fourth Main Discussion Theme: Coping Strategies followed by Medical Practitioners due to the Available Language Communication Support

Sub-theme 4.2.1.4.a.: Patient Cooperation to facilitate Doctor-Patient Communication

Some research participants referred to the important role of patients in facilitating the process of doctor-patient communication and making it productive and successful to serve the needs of both conversation parties (i.e., doctors and their patients/ patients’ relatives). This sense of cooperation could indicate the level of education and self-awareness some patients have if not all as it is natural to have 1:3 patient who is not cooperative or have a bad temper and cannot bear waiting for the doctor to explain his/ her health problem in a broken language or wait to have interpretation assistance for the doctor’s medical messages and instructions.

For that, if the population of non-Arabic speaking medical practitioners is about 50% at least or more in some hospitals; especially in private hospitals, the percentage of non-Arabic speaking medical practitioners will go up to 80% or more. In this case, there may be two logical ways to solve the language communication problem. First, hospitals should organize a campaign to educate Arab patients, raise their awareness and encourage them to understand the benefits of cooperating with their medical doctors in communication if their non-Arabic speaking doctors do not know their mother tongue “Arabic” and not fully understand all the cultural aspects relevant to Arab and in particular the country of their current workplace which is “Bahrain” in this study. On the one hand, Arab countries mostly share similar features, cultural aspects, and beliefs.

On the other hand, Arab countries have also some few differences in a way that people can at least distinguish between one Arab country and another. This awareness campaign could have different types of support, for instance, by delivering lectures or organizing short workshops or by establishing and distributing informative booklets, videos, and brochures.

On the contrary, non-Arabic medical practitioners could if settling down to live and work for a long time,

let's say several years, not months in an Arab country like "Bahrain", then it would be wise to them to either help themselves and take the initiative to learn their Arab patients' language as learning the language of their workplace country will facilitate them to communicate both inside the hospital with their patients and / their patients' relatives and outside their work in public (e.g. market, local people in public places…etc.). Some of the participants express that "It is always important to learn a language" and "learning a language is a bonus". However, not all doctors value learning a new language besides their duty.

Sub-theme 4.2.1.4.b.: The Role of 'Patient Care Assistants' (PCAs) in providing Language Communication Assistance

It is good to hear about this current title of Patient Care Assistants (PCAs) which has been lately emerged not in all hospitals, but some of them. However, more investigation is required to have a full view about this new medical role regarding the academic specialization and degree PCAs have, their professional duties and responsibilities, their working hours (i.e., Total working hours, working on shifts or not, is available in all hospital shifts or not, how many PCAs per shift in each hospital ward? Are they well-trained to act as professional medical interpreters? and what are the professional training gaps that are missing and required to enhance the PCAs job to prepare them to assist medical practitioners in language communication). PCAS main professional roles are observing, monitoring and recording patients' conditions by taking temperatures, pulse, respirations and weight, communicating with patients, relatives and carers, assisting with clinical duties, personal care including infection prevention and control, food, personal hygiene and overall reassurance, comfort and safety and promoting positive mental/physical/nutritional health with patients and checking and ordering supplies (https://www.open.ac.uk/). Most of the roles that deal withs require good level of language communication and accuracy and this requires further exploration to find out how to empower the role of PCAs to better assist in doctor-patient communication daily real scenarios.

Sub-theme 4.2.1.4.C.: Combining both Verbal and Non-verbal language for more Effective Language Communication

Verbal language communication cannot work effectively on its own. Therefore, it is better to combine both the verbal and the non-verbal together to convey the doctor's message.

The non-verbal includes the doctor's gestures, their emotions, their body language in showing care and empathy to the patients and their relatives. These are one of the effective coping strategies for language communication with patients shared by some participants from their realistic daily-basis medical practice. A number of doctors use drawings and visual aids as one type of non-verbal language plus adding some

basic verbal medical language and blend them together to enable them to convey the message to their patients, “So, we use to make pictures, for example that there are two lungs. So, in this way, it’s very easy to explain them, because they don’t understand medical terms, and sometimes they do not understand English also. So, sometimes we use visual things also”.

Themes identified in the 6th Research Question:

Research Question 6: What do non-Arab clinical practitioners think can be done to help them overcome the language barriers they face in their practice?

4.2.5 Main Theme: Suggested future coping strategies & support by medical practitioners

To benefit more from medical practitioners’ valuable professional input, this interview section comes to elicit what medical doctors have as expectations for proper professional support and effective practical coping strategies to help them survive with daily-basis faced language communication barriers with their Arab patients/patients’ next of kin. These suggestions are considered to be the study recommendations for future implementation. This last interview section consists of five open-ended questions as they are stated above.

Sub-themes:

Interview Question F.1: Q1: Apart from language, have you faced any other communication difficulties in your clinical practice in Bahrain?

Sub-theme 4.2.5.a.: Other Types of Non- language related Communication Difficulties

Under this interview question, all the research participants shared both common communication difficulties under communication broader scope and some of them shared some unique challenges under the same scope which could make an interesting, blended experience for the research data analysis and interpretation.

To begin with, some medical practitioners find that learning key medical terms is very important to enable them to communicate clearly and convey the correct medical message, “Maybe when you’re asking, when trying to examine the patients. I am trying to convey something to the patient ok. How and where to look to keep their eyes? Whether to open their eyes. For those terms, I have learnt”.

Seeking or asking for patient cooperation is another effective strategy to facilitate the doctor-patient communication have been shared by non-Arab medical practitioners, “In Ophthalmology, we need the patient cooperation if they are squeezing their eyes, if they are closing their eyes, so it’s difficult”.

Patients' cooperation makes a difference in the process of doctor-patient communication and this this could require some techniques from the doctors to follow to involve their patients in communication process and encourage them to cooperate for the patients' benefit.

Another technique recommended by most of the research participants is by using main medical terms used in the doctor's field of specialization in Arabic and mixing them with some English or any other patient's common languages like Hindi and Urdu if doctors know other languages than English, "If you learn those keywords as you said, they will understand. They are pretty cooperative", "Patients do respond to me even if not the whole sentence, I tell them just the important words and I just mix and match it with a little bit of English in it".

There is a positive impact on patients when they know that the doctor can speak in their language, "they are happy if you try to talk in Arabic. They say: "Oh doctor! You know so much Arabic! Good, Good! You get a positive response from patients", "Yes, I feel positive satisfied when I hear this response from my patients". Doctors feel more satisfied if they communicate directly with their patients without mediators, "I feel it's always better when it is one-to-one with the patients. You have that connection and the patient-doctor connection is there". The level of language communication difficulties differs from one Arab country to another. That could be due to certain reasons and factors, "Language communication difficulties in here was less in compare to Oman".

Majority of the medical practitioners find that both language and cultural differences can create a communication barrier and may lead to potential negative consequences as a result, "I stay in here, there is no signals in this area. This is a communication difficulty for a doctor. It's very important to me to have connection as I am always on call and if they call me and I cannot communicate, this is dangerous!", "I have a specific example which I clearly remember is one Chinese parent who'd come. He came with a specific need of getting his child vaccinated against a particular disease. When I looked at the child's vaccination record, he's actually received all of them. There was no need for him to take any further. But, because in China there was a need and this child was staying in Bahrain and was not going back to China. So, this parent kept insisting that he wanted to get the other one done and I was explaining to him: "You know that there is no need". He was unable to understand English and it was only he had broken English knowledge. So, I could see his anger level is rising and he became more impatient. He wanted to check if whether I have enough knowledge about vaccination. I said go through your vaccination three times over and this what's needed… this not needed according to the Bahrain schedule. And vaccines are not to be given only like that. So, this patient's parent was a difficult parent, communication-wise", "Sometimes they have some expectations in their minds. And when these expectations were not met, then it leads to frustration".

Repetition of the words “very often, very often” could have an indication of a certain matter this medical practitioner encounters in the daily clinical practice and when communicating with patients, “Doctors can easily get frustrated. Well, I can I have in some occasions when I am really busy to explain the same thing over and over and over, three times I explained. And just before they leave, they ask you the same questions again. So, I was just wondering whether they are actually listening or can speak in their language, were just hearing…And very often, very often patients call back”. These shared incidents indicate that both time and efforts are wasted for first, doctors when communicating with their patients and repeating medical instructions a number of times and second, for patients’ side when listening to their doctors with no understanding and calling back to ask the same questions again and again. Added to that, it could be very risky if these patients left the clinic misunderstanding their doctors’ messages. As potential consequences, doctors may be blamed for making medical errors for being unable to understand their patients and convey

Interview Question F.2: Q2: Have you faced communication difficulties due to cultural differences?

Sub-theme 4.2.5.b: Cultural- based Communication Difficulties

In this research interview last section, broader communication scope is narrowed down to focus specifically on cultural communication difficulties if being faced by non-Arab medical practitioners in this study.

To begin with, one of the shared communication difficulties is that lack of awareness of patients’ cultural backgrounds faced by doctors when diagnosing and examining their patients, especially women in an Arab community, who need their doctors to ensure them a confidential secure place for medical diagnosis and examination. Some medical participants mention that most of the time, they have to convince female patients and justify for example why they should remove their hair cover or scarf, “When they wear the face musk or Abaya (i.e., a name of an Arabic gown that is worn on the cloth and covers the whole women body when going out, usually it has a black colour, but it could have different colours). It’s usually some people wear it all the way till here. So, it’s difficult to open the eyes and then we have to tell them specifically. Well, they don’t do it on their own. Then, we have to tell them: “No, please, remove the whole thing”.

Interview Question F.3: Q3: If yes, could you give me some examples?

Sub-Theme 4.2.5.c: Shared Real-based Examples of Non- language Related Communication Difficulties

Religious beliefs can be a challenge if doctors have not been pre-educated about their work local culture

or if they are not being flexible to learn a new language to help them with their daily-basis doctor-patient communication. What for example proves that one of the medical doctors who was not being exposed to an Arab Muslim culture by her workplace is that her use of the word "Priest" as a religious Muslim leader. However, the correct titles for a religious Muslim leader are: Sheikh, Imam & Mulla, "Once I examine a priest, I think he was a patient from Iraq, so like if we are trying to open the eyes or something, the guy with him told me: "Please, don't touch him. Use a tissue paper or use gloves". Another shared example refers to the case when a doctor talks to a patient with a smile while sharing some serious patient health-related information could have some cultural miscommunication, "Also, the cultural aspect, as sometime I talk with a smile, but I'm talking seriously, maybe this is not acceptable to my patients. So, we need to learn about the patient's culture".

Interview Question F.4: Q4: In your opinion, what else could be done to assist you to overcome your communication difficulties?

Sub-Theme 4.2.5.d Recommended Communication Coping Strategies by Medical Practitioners

Various responses were gathered from medical practitioners who had emphasized their need to learn more job-related specialized medical terminology and useful phrases in the patient's language like Arabic in this study context. This can be applied to any other language used in communication, "The terms that I need to know will be completely different from a surgeon. Like a general surgeon, what he needs to know, that will be completely different. So, maybe like they could have somebody who knows how the department works or who has worked before in Ophthalmology for them to just tell us a little bit, like how to communicate and just to have a smaller training sort of a thing. Taking general training outside will be completely different because I don't want to know other Arabic terms and all. Basically, I want to practice. So, related to Ophthalmology".

In-house training is being also recommended by the majority of the study participants, for instance, relying on some experienced Arab staff in the medical field to train and teach novice non-Arabic speaking medical practitioners who just have started to work in an Arab clinical context like Bahrain. As being advised by most of the medical practitioners that each group of practitioners needs to be taught their workplace country's and patients' language of communication within their medical area of specialization. This training can be part of the new medical practitioners' orientation or induction programme, "Like one Bahraini girl who's working in the department four-five years. So, they can pick those, pick them, and then can tell us in general, how to talk, how to communicate". This indicates that the more medical practitioners' practice in the Arabic medical context, the better they will be. (i.e., Learning through practice & experience- elicited grounded theory), "Only at the beginning. Otherwise, after sometimes, maybe six months you'll get used to it". Another grounded theory elicited here: The more patients, medical

practitioners have, the easier doctor-patient communication will be, “You learn on your own a little bit terms; here and there. It’s fine, the more patients you have, the easier communication will be. Yeah with the time you can”.

When medical practitioners come from a foreign country to practice medicine in an Arab country, then they should be aware and convinced that they will need to learn this new country language which will enable them to communicate with this country patients effectively, “Coming fresh from your country to work in another country, so two things are there: 1) One is the person himself has to learn that and it also depends on different factors, how far are his/her plans, like how much he/she will stay and work in a country, one year, two years or more or not sure. 2) Then, the language comes as a second thing as a priority. Also, where he/she will work in public healthcare. Then, he/she has to learn the local language and directly dealing with the local Arab people. But, in the private sector, patients are more diverse and more educated. Then, the language barrier becomes less”. So, in the private sector, the potential for local people who do not know how to speak English is less and that will reduce the potential for having language miscommunication. However, opposite cases are expected to be in public hospitals that provide free medical and healthcare services to the whole community regardless of their social and economic status.

Some medical doctors state that every time they need some help with patient language communication, they refer to their Arab medical and non-medical colleagues who are available on their shift to assist them, “Already everywhere Bahraini are working and there are Arab people. So, we take help from them as much as possible when facing difficulty. That will solve many problems. Of course, I know that everybody is not free to help. Everybody has his/her work”, “There are always a nurse there”. This extra duty assistance could delay many medical practitioners from doing their duty and will add to their workload.

Another suggestion came from some medical practitioners that there should be some lectures that teach medical terms to new non-Arabic speaking medical doctors who freshly come to work in the country, “We should learn the basic terms like one or two formal lectures will be definitely useful. They will learn slowly, slowly. But they can be taught the simple words of important symptoms in some lectures like this. So, they can focus on communication. It all depends on the setup of the hospital. In a place where more non -Arabs are there, then, definitely, they will need to learn the language in all medical fields; including breaking the bad news”, “In some places, in the induction time, they can keep two to three lectures. That’s ok. But, long-term wise if more non-Arab doctors and you are staying more in such countries, then you require to learn the local language and to be more friendly to create a more effective atmosphere for the patients and understand them. It’s very important. The patient will listen to you in English, but still, he/she needs to know in detail in his/her own language. If they are not satisfied, they will not digest the information. If I am giving the best of the best treatment and I’m not communicating, then my patients are

not satisfied. It's part of the treatment "the good communication".

Some medical practitioners brought up the idea that it could be more stressful to medical students as their chance to get the language communication support in clinical practice is much less and limited in comparison to the medical practitioners in the real practice, "Language is very important for international medical students who are non-Arab and particularly in an Arab country like Bahrain", " Language is very important for international medical students who are non-Arab, practice medicine in an Arab country like Bahrain and deal with Arab patients in usually daily-basis. These students need to learn from their patients and listen and respond to them very well. So, this is a part of their medical education like outside practitioners if they come to practice in here, they need to learn some language. For students, learning their patients' language is more important as they don't get the amount of help like medical practitioners on their duty where they get support from their Arab colleagues. Above that, medical students will be assessed on their performance and the way they diagnose and counsel their patients. As it makes a difference if you learn a few words".

Several medical practitioners suggest having a medical terminology book (e.g., both in Arabic & English provided with pronunciation and term usage examples in clinical practice), "Maybe I said a medical book of medical words. Medical terms and short questions, I think. Maybe it could be specialties-wise. Because sometimes in pediatrics you have specific questions related to development and growth and feeding. So, maybe you could have a section for general medicine as just medical terms. And then you could have some specialized terms for different sections".

Another suggestion from some medical doctors is that having a daily-basis practice to learn one Arabic word or sentence a day monitored by some Arab medical practitioners at work to their non-Arabic speaking medical practitioners' colleagues, "Arab- speaking doctors, they can come up with, say, learn an Arabic word a day or learn an Arabic sentence a day. So, on a daily basis if someone takes the initiative to send across these terms. It's easy. It's not very difficult. About a year, they should have learnt at least 300 words. But they should be committed to doing this practice".

4.2.1.5 Fifth Main Discussion Theme: Types of Support/Future Action to improve Communication

4.2.1.5.a. Sub-theme: Justification for the Variation in the Level of Language Communication Difficulty faced in the Clinical Context in Different Arab Countries

Some research participants who had practices in different Arab countries and particular GCC countries like Bahrain, Saudi Arabia, Oman, and the UAE claimed that they experienced a different level of language communication challenges in the process of doctor-patient communication. Those practitioners say that in Bahrain they encounter fewer language communication barriers in comparison to other GCC countries.

To justify the possible reasons for having these differences although all of them are Arab and all are GCC countries which are known to share some common features, for example, having similar geographical and historical backgrounds, the main local mother tongue is Arabic and all of them are Muslim countries. However, there is some slight variation between these countries, such as the level of diversity it is more in Bahrain than other GCC countries although Bahrain is the smallest GCC country in terms of size. Added to that, the formal education from nursery to university, Bahrain is on the lead in education among other GCC countries and it had been in the same leading ranking in other fields, like healthcare and sport. Lots of Bahraini people speak English as a second or a foreign language and the English language is a major part of the school curriculum from early education stages and the same is in most of the university studies for both undergraduate and postgraduate programmes are also taught in English.

In contrast, in other GCC countries, English is not considered as the main language and is taught starting from middle school like in Saudi Arabia. Moreover, in Bahrain, English is the main mean of communication in international schools, universities, and professions, such as in medicine and healthcare even between Arab staff as most of the paper and computer work plus medical reports are all written in English. Whereas in other GCC countries, Arabic is the main mean of instruction and communication. Furthermore, living in a highly diverse country like Bahrain, Bahrainis are very exposed to other cultures and this feature makes them more flexible to deal with, work, and live with people from different cultural and religious backgrounds. Also, many of the Bahraini people know other languages like Urdu, Hindi, Persian, and French besides Arabic and English, and this matches with the theme raised by the study practitioners that some of their patients are cooperative and because they know their doctors' mother tongues, they switch to speak with the doctors in their languages as an initiative from them to help the doctors communicate with them and convey their medical messages.

Sub-theme 4.2.1.5.b.: Examples from real practice:

Patients Understanding and Appreciating of their Doctors' Efforts trying to facilitate Doctor-Patient Communication could help in Reducing the Communication Difficulty Doctors face in their Profession:

Some doctors attempt to learn and speak the main basic medical terms and phrases in the medical Arabic language through the help of their patients. It is a reciprocal process of learning; patients learn about their health from their doctors and doctors learn common terms and phrases to help them in doctor-patient communication from their patients.

If we imagine that we live in a utopia and utopian hospitals, then for sure we can have this atmosphere that both medical practitioners and their patients/patients' relatives are both cooperative in case of any language

miscommunication matter emerged. From the patients/ their relatives' side, we require them to have a good level of understanding and appreciation to every single effort their doctors pay to make the communication process goes smoothly without encountering any delays or negative consequences. Raising this type of art for communication and respect awareness would logically take plenty of effort to have this goal achieved and fulfill a positive change in this community. However, even small initiatives could do in achieving a noble aim, because cultural beliefs are easy to be changed in a short period.

From the medical practitioners' side who lack their patients'/ their relatives' language required for medical communication and for making fundamental medical decisions to solve and save some critical patients' health and life-threatening urgent matters in a utopian medical context, all non-Arab medical practitioners would either have the initiative and have a self-learning of their patients' language or all of them receive proper formal professional training to support their daily language communication process.

Sub-theme 4.2.1.5.c.: The Need to provide a Sufficient Number of Arab Medical Practitioners/ Consultants in Night Shifts in Compare to Morning/ Day Shifts

As all of the research participants concurred together that the main informal clinical language communication and interpretation assistance is provided in the first place by the available medical and non-medical staff on their duties. Most of the medical practitioners who participated in this research recommend referring to Arab medical practitioners for seeking medical translation rather than non-medical staff who may not convey the doctor's messages accurately as they are not medically specialized. Added to that, some of the participants are not even recommending using nursing staff to translate and convey medical doctors' messages to their patients. This does not mean underestimating the nursing profession and the role of nurses in contributing to the medical and healthcare process.

I think even between medical doctors of different medical specialties, more accuracy will be scored if the medical doctors used for providing medical interpretation are translating within their area of medical specialty, the expected benefits will be more than if selecting a medical doctor to translate another doctor's message but in a different field of specialty (e.g. an ICU doctor is translating another ICU doctor's message= High rate of translated message accuracy, a Paediatrician is translating to an ophthalmologist= Medium or Low rate of translated message accuracy).

Based on the above discussion and due to the absence of formal training provided to non-Arabic speaking medical practitioners in the area of clinical language communication and as well as having no formal support of hiring Arab medical staff to assist their medical colleagues with clinical interpretation in all shifts, then the only main source is relying on the availability volunteered Arab medical staff to offer their

medical interpretation assistance to their colleague. The help of Arab medical doctors in solving language miscommunication issues is described by the research participants to be effective and excellent.

However, Ministry of Health and other medical institutions or hospitals in Bahrain if not being able to hire professional medical interpreters, then they need to recruit more medical practitioners instead in each hospital wards in all medical specialties to ensure having enough staff in each duty shift and all hospital wards and emergency. Furthermore, HR (i.e., Human Resources/ Personnel) departments in each medical hospital or institution in the Kingdom of Bahrain should revise the job descriptions and the roles and responsibilities of the new hired medical doctors and add the task of "assisting in medical interpretation/ translation if needed as a mandatory job task for doctors. but there should be a professional recognition for the doctors who are performing this extra professional task".

By adding this additional task to the list of the Arab medical doctors to be recruited, additional incentives or job privileges should be given to them including their basic salary. If this attempt is done by the HR or personnel departments in our hospitals and medical institutions (both public & private), then critical language communication issues which happen frequently on daily-basis clinical practice will be formally solved and covered by medical professional medical practitioners as an essential part of their profession and they will then avoid negative consequences and potential risks from happening or being worse.

Sub-theme 4.2.1.5.d. The Need of a Proper Cultural Language to Communicate with Patients/ Patients' Relatives

Culturally, you may need different techniques to those you know to break the bad news. Telling patients about their illnesses especially critical chronic diseases or breaking bad news to patients' relatives would require medical practitioners to have a good bank of communicative language terms and phrases.

Also, these practitioners require the ability to select a culturally suitable language for different situations. For instance, in case of a patient's death or a patient suffering from a chronic critical illness (e.g., kidney failure, cancerous disease, informing mothers/ parents about their newborn illness or a health problem such as disability or heart diseases…etc.). Hout et.al. (2019) suggest that future research should address the identified barriers by studying opportunities to enhance equitability. For example, research should consider specific training programmes (e.g., cultural training) for healthcare practitioners.

4.3 Summary of the Study Findings

To sum up, we can now summarize the main findings and themes that came up in each interview section. The research interview is semi-structured consists of six categories. The first category is the social

demographic data section. Some descriptions and Table 4.1 under the sub-title section, “Diversity”. This table includes four main data categories**,** 1) Medical sites, both public and private, 2) Types of medical specialties of the study participants, 3) Research participants’ nationalities and diversity table category is 4) Range of professional years of experience spent in clinical practice and relevant category. The other interview sections that represent the research objectives and questions are first, research-related interview category main theme is “professional training received relevant to the Arabic language”. Under this main theme, there are some sub-themes. First, all interview sections follow the same system in presenting the information. Each section starts with the research question that matches the study interview section. Second, the interview questions are then listed in sequence. Third, the main theme is included as being reflected in the research interview. Fourth, some developed sub-themes, some of these sub-themes are common themes shared by all/most of the research participants. Other themes are unique, relevant to certain individual research participants. Both main themes and sub-themes, both common and unique, are supported by some relevant study participants’ shared quotes from the interview scripts. At the end of each interview section, a summary is included which summarizes the whole gist of each interview section.

4.4 Conclusion

All in all, using the thematic analysis method to analyse the interview data served the purpose of this study because it enabled the effective categorization of both common and unique communication and language communication barriers faced by medical practitioners. This study confirmed the notion established by Braun and Clarke (2006) that it is appropriate to choose a method of analysis that is driven by both research questions and broader theoretical assumptions.

Braun and Clarke (2006, p.85) also claim that using the data collection questions (such as from an interview schedule) as the 'themes’ are the ‘worst examples of thematic analysis’, because they are entirely deductive and fail to take account of emergent themes based on a process of induction. The questions employed in the interviews were always more open-ended, to begin with, followed by some semi-structured and probing questions keeping the key points relevant to the research questions ready appropriate to the participants’ job nature. The main categories and themes were identified from the collected data. Although the stages used in the analysis of the data look sequential, they iterative and built upon the previous stage as Braun and Clarke (2006, p.86) have already highlighted, ‘Analysis is typically a recursive process, with movement back and forth between different phases. So, it is not rigid, and with more experience (and smaller datasets), the analytic process can blur some of these phases together.’

Chapter Five

Conclusion

5.1 Introduction

This chapter provides an overall final summary of the findings in this study. By reflecting on the literature themes presented in this study to support its topic, further conclusions are drawn and contributions to the research are discussed. Added to that, this chapter highlights and discusses the study limitations, the benefits gained, the challenges faced by the researcher at the thesis stage, and the lessons learnt. Furthermore, this chapter refers to the implications for potential future research and publications plus referring to study-related gaps in the literature. The study outcomes aim to benefit different community parties who study, work, or care of medical education and healthcare services provided for the sake of saving the life of mankind and ensuring a healthier life.

5.2 Limitations

This research study has a number of limitations as it has been conducted by an individual doctorate researcher to obtain an academic degree and not collaborative research. In addition, the study focuses on Bahrain and no other country as research context. Moreover, the research sample are only non-Arabic speaking medical practitioners and medical doctors in particular, not nurses or pharmacists or other medical staff. The language focus is Arabic language and there is a reference to other common international languages who have similar case as Arabic, like English, Spanish and Japanese. Also, the research is restricted and conducted in three research sites (one public & two private). The selection of the sites was in purpose to meet the study purposes in selecting the medical hospitals/ institutions that have a good number of non-Arabic speaking medical practitioners. The choice for Arabic language came for some reasons that the researcher took into consideration when choosing the study topic and writing the research protocol. First, the student researcher chose a topic that had a relevance to the higher education scope as she is doing and EdD (A Doctorate in Higher Education in the University of Liverpool). Second, the student works as an Arabic Language Programmes Coordinator and lecturer in a diverse Irish Medical University and teaches medics and nursing students, therefore, she chose a topic related to her field of specialization and elicited the study problem from her daily teaching practice to non-Arabic speaking

medical students who go to clinical starting from their third year of the BSc. in Medicine programme and mostly communicate with Arab patients as they are doing their degree in an Arab country "Bahrain". Most of the non-Arab medical students in the researcher's work institution are absolute beginners in Arabic as they are not long-term resident in Bahrain, but they come directly from their country to study in an Arab country with no intensive practice in the country main local language which is Arabic.

5.3 The Study Benefits and Challenges faced

The outcome of this research study had a mixed- blessing returns on the researcher, research participants, medical practitioners, patients, the local context including medical and healthcare institutions and authorities plus medical education and professional education research. Both gains and challenges are elaborated in the sections below.

5.3.a. The Study Academic and Professional Gains and Positive Returns

This study has accomplished countless significant benefits to different parties. To begin with, from the researcher's side, first, the study has helped in building up more intellectual personality with strong confidence and understanding appreciation to research, research ethics and publications. In addition, it has assisted the researcher to expand her scope of thinking and to be able to think out of the box in term of potential new research areas, research problems and phenomenon that are relevant to language, culture, communication, and medical education. Added to that, the language communication phenomenon encountered in the study medical and healthcare context is now well- explored and clearly defined which could now facilitate the way of the researcher to share with confidence along with the research-based evidence, the study findings and recommendations in initiatives to raise the self-awareness of the community and the local medical and healthcare authorities of this case plus showcasing both the coping strategies followed by the non-Arab medical practitioners to help them cope with language communication barriers faced when communicating with Arab patients and their relatives. The study has also informed the type of improvement that should be done to the curriculum of the language communication courses designed and taught to medical students. Furthermore, from the study findings, discussion and recommendations, the researcher has now created a clear plan for future project implementation to contribute to the improvement process of medical and healthcare services in Bahrain. These future projects also aim to empower the non-Arab medical practitioners and medical students to be able to communicate effectively with Arab patients/patients' relatives in the doctor-patient communication and increase the quality of medical and healthcare services in this part of the world.

From the research participants' side, there are a number of benefits gained and these are either being expressed by the medical practitioners during the interview or elicited from the interview transcription

common and unique themes and sub-themes. First, medical practitioners got the chance to express fully and describe the language communication challenges they come across in their daily clinical practice, the consequences, and the impact of this communication barrier on them professionally and psychologically. Second, participants got the chance to think about the language communication from different perspectives and angles through the interview questions which helped in enriching the study. Third, to volunteer and participate in profession-related research would add more professional bonuses to these medical practitioners and will contribute in supporting more medical practitioners who are facing the same communication problem. Last but not least, by discussing this study phenomenon, medical practitioners are more encouraged now to work seriously on taking the first steps towards enhancing their language communication skills when communicating with their Arab patients/ patients' relatives. This motivation comes as a result of medical practitioners' belief that the better they communicate with their Arab patients, the better professional performance they will have, and the better quality of medical and health care services will be provided in hospitals and medical institutions in this local context.

From the medical practitioners' side, first, the study research findings and recommendations will contribute indirectly to medical practitioners in generals who work in different medical or healthcare departments in different countries and applicable to different languages and cultures, because the research discusses an issue that many healthcare providers struggle with and could threaten their professional performance and reputation. In this context, the reference is to Arabic languages because it is an Arab context and Arabic is the main language and the mother tongue of all Arab patients and not only Bahrainis. Second, since the study is explored from the perspective of medical practitioners, then medical practitioners who work in any area of medicine or healthcare and in different contexts can benefit from the shared experiences of medical doctors; especially the coping strategies established and followed by the study participants and the recommended future solutions. Also, those medical practitioners who are interested in research would definitely would benefit from the identified gaps in literature in relevance to the study topic, proposed future research topics and projects and will be able to establish new fresh research ideas for either individual or collaborative research.

From the medical students' side, the initial research idea came to the researcher from her experience in teaching medical students who are non- Arabic speakers. They expressed their own language communication challenge when they first started their clinical and practice and met with Arab patients which the researcher noticed that it was common and not just relevant to one student. Therefore, sharing with medical students the study findings coping strategies and recommendations would be an invaluable benefit to students to learn from the experience of medical practitioners in real practice and who have longer expertise than them. Effective coping strategies could be followed by students to help them cope in medics- patient communication. One further gain will be the gaps in literature in relevance to this research

topic could be of great interest to medical students who have fresh young minds to conduct some summer research and projects.

From the medical institutions' and hospitals' side, the study findings and recommendations would help these institutions and employers to put a clear plan to empower their staff of non-Arab medical practitioners to be capable of effectively communicate in the doctor-patient communication process. In addition, the study would help these institutions to enhance the quality of medical and healthcare services provided and to design language communication and culture professional training sessions and induction programmes in this local medical and healthcare context. Furthermore, achieving the goal of having competent doctors who are well-trained to communicate effectively with patients would result in having good quality of medical services and good reputation which are major aims of all medical hospitals and institutions. When speaking about medical institutions, like medical universities and healthcare colleges, the study findings and recommendations could inform designing new curriculum and establishing new interactive courses that focus on clinical language communication and culture for medics and nursing students. Such courses if being implemented and offered to medical and nursing students will contribute to reducing the cost of hiring professional interpreters who may not have a medical background to work as mediator in the non-Arabic speaking medical students clinical exams where students have to take the patient history for Arab patients and diagnose them while their examiners are assessing their clinical performance and their skills in taking proper patient history.

From the medical and healthcare authorities' side, the study provides them with research evidence-based data relevant to language communication barrier in local clinical context real cases and offers recommended solutions and copying strategies. The study outcomes could create a strong base for the local medical and healthcare authorities to adjust certain policies or perhaps issue new ones to help enhancing the doctor-patient language communication process and reduce the potential of having serious medical errors due to miscommunication. If these aims are fulfilled, they will lead to having good quality of medical and health care services, raise up the quality of the local medical and healthcare system. Some of the recommended study-related projects for the local medical authorities to lead are for example, hiring professional medical translators and interpreters or mediators to assist in doctor patient/ patients' relative clinical communication. Fund and support projects and action research which help in establishing and implementing new policies to ensure training newly hired medical practitioners and healthcare providers on effective doctor-patient language communication and culture.

5.3.b. Challenges and Research Difficulties Faced by the Researcher

Since I started my research thesis stage after completing the EdD nine taught modules as a prerequisite to start working on the doctorate dissertation and after having a surgery, I had encountered some obstacles

and experienced hardship. I have a cure for that which I call it the two Ps, the first "P" is the passion of the doctorate researchers towards their study research and the second "P" is the people around them (i.e. close relatives' & friends' support throughout the EdD Journey). Above all of that, I depend on faith in God and in myself as an individual that I can complete this journey successfully no matter what challenges I came across during this long time.

To begin with, when I just started my thesis stage after attending the second UOL EdD student residency in Liverpool in 2015, and after the supervisor-student matching process finalized, my beloved mother passed away which was an unexpected shock as my mum was a very healthy strong woman. It was very hard for me to receive such sad news and to continue my EdD journey smoothly. Moreover, being a full-time working mother of five little children, started the EdD programme with two kids and had the other three during my doctorate journey, it was not easy from the beginning of how to make a good balance between my life, health, family, home, my demanding job and my doctorate study. Throughout that time, I never stopped to take a student or a maternity break or even a sick leave as my cure was the study continuity itself. Furthermore, it was not easy to have a robust research proposal which took me a while, a draft after draft till I got the UOL approval at last.

A second critical stage but resulted from research difficulties faced was the type of study whether to consider it an exploratory case study or an exploratory phenomenological study. That led me to make some modifications and more literature reading to decide on what could have better suited my study research problem and context. Another similar research-based difficulty encountered was the choice of research approach that would perfectly match with my exploratory phenomenological study. I first proposed going for a mixed-method (qualitative-quantitative, sub-sequential) when my study was an exploratory case study. Then, by further investigating the study problem from different dimensions, and because the language communication problem existed in my research context, in both public and private sectors as a phenomenon, but lacked the information needed to describe it and raise it to the relevant authority bodies to take some actions. Besides, one more research challenge was seeking the ethics committee approval from the three research sites was not as accessible and easy as I thought. I experienced some delays from some committees, and I had to wait for their meetings to be held and then for their feedback and decisions to be made. I also had to make several amendments to the research ethics committees' documents and applications to meet their standards and fit with their rules and regulations. Entering hospitals and meeting with busy people like medical doctors who were always on shifts and on-call for any emergency cases was not something easy at all, and that what I witnessed by myself when conducting the study in the research sites. Luckily, I got approval after the second submission for those committees with the required changes and improvement. As well as, I had to change my interview appointments and meet with the hospitals' HR departments to approach these doctors. Those delays were because sometimes doctors had surgeries

and I had to wait for them or they had some late patients or received calls from nurses seeking their information at the time of conducting the interviews. Those matters forced me to stop recording for a while and then proceed once the doctors were done. On the contrary, that was a benefit to me to learn how to work and continue my research under pressure and sudden circumstances. At the same time, that experience exposed me to the real daily life, and incidents of language miscommunication matters work pressure, medical doctors encountered in their profession.

To sum up, the doctorate was my childhood and my parents' dream which I made a vow to myself to achieve it one day no matter what circumstances I had. It is true that I went slower from time to time and then regained power and speeded up to continue and proceeded to the study next stages till fulfilling my ultimate goal. Here I am sharing my thesis stage study journey and my research product with you which I think will open a door to me to conduct more research studies and publications as I am very interested in; being a language programmes coordinator and a lecturer in conducting more research and going for more professional development training. My research and professional training interest are mainly relevant to medical practitioners and medical students. At the same time, I am planning to work on enriching the Arabic language teaching and learning resources and developing curriculum. Developing a curriculum will make it ready to be taught in diverse higher education medical institutions, not only in the middle east but also internationally under the umbrella of medical and professional education.

5.4 Recommendations

The research tool concluded by asking and eliciting some future recommendations and coping strategies to solve the issue of language communication barrier faced in the local clinical context. Also, the study literature review has informed the examples of coping strategies that could fit to become some recommended solutions to help non- Arabic speaking medical practitioners cope with the daily language communication barriers when dealing with Arab patients. One further point the recommendations listed in this section could expand its benefits to be showcase these suggestions to the local medical hospitals and institutions management and the Ministry of health to help them start planning for future projects, research and professional training programmes in the area of language and cultural communication in diverse clinical context.

5.4.a. Education and the Choice of Physicians by Patients

Kronfol (2012, p.1230) states that "in Saudi Arabia, manpower factors (choice of physician, an Arab-speaking health team, and free services) are the most important factors in the utilization of ambulatory

facilities…etc." He continues to emphasize that patient education is considered to be one of the most important factors of patients' characteristics associated with the utilization of primary healthcare including the elderly…etc.

Kronfol (2012, p.1230) refers to the idea that in most Arab countries, government-owned hospitals are the reference places for service excellence, tertiary care, training of human resources, and research. Then, I believe our local medical institutions and hospitals if searching for ways to achieve medical and health care excellence, then caring about patient education in terms of the importance of good patient-medical practitioner communication can be one step for solving the language miscommunication faced in daily-basis clinical and healthcare scenarios. Not only solving communication barrier issues through patient education but also as suggested by Kronfol (2012) that giving more care to the elderly (e.g. hiring professional medical interpreters to facilitate elderly patients' communication with their doctors & healthcare staff), providing job-relevant professional development training and a very important thing is that encouraging more relevant medical education research of different types such as action research which could be finalized with organizational project implementation.

Through the experience of the efforts made in some hospitals which are located in some Arab regions (as advised by the WHO Regional Office for Europe's Performance Assessment Tool for Quality Improvement in Hospitals (PATH) model), we need to implement this tool in the hospitals in Bahrain and use it to evaluate the implementation of language communication support as a professional development programme. I would be interested to know how that will be impacted by the level of quality of healthcare services provided.

As a good recommendation for my current study, I agree with Kronfol (2012, p.1236) that "Governments have an important role in health development in the Arab region. The efforts initiated by governments to build modern health systems must be continued and adapted to the new changes and challenges in the political, economic, social, and cultural fields". My language communication study could fit in the previous quote within both challenges in the social and cultural fields.

To sum up, this proposed study would explore and look into the available language communication programmes and support to suit the language communication needs of on- Arabic speaking medical practitioners who work in this Arab medical and healthcare setting. The research also is going to look for the shortages or the gaps that may occur in the learning and professional development programmes in the area of language communication provided by the Ministry of Health in Bahrain to non-Arab medical

practitioners who work in Bahrain hospitals and health centers and work on bridging the gaps and recommending suitable solutions.

5.4.b. Global Communicative Language Issue:

This matter emphasizes the need and the urgent call for establishing a global communicative language to facilitate and solve the communication needs of people from different cultures and in particular to deal with the language communication issues faced in diverse medical and healthcare context. This claim will be discussed further in detail to draw its proposed future implementation action plan.

To solve this Bahraini exploratory phenomenological study issue and similar global universal language communication barrier matters, we need to establish a global language like the traffic signs (i.e. universal signs). However, such a global agreement needs time to be implemented and utilized worldwide. Added to that, there are a number of coping strategies and methods that are already experimented in other languages in which experts in the Arabic language can use, adapt, and test their suitability in solving Arabic language communication barriers or this solution investigation effort could lead them to think of new innovative ways to be invented to match the Arabic language's structure and nature, suit its culture and help in solving the issue of having a shortage of Arabic language resources for teaching and learning, especially Arabic for specific/ special purposes (e.g. Arabic for medical & healthcare purposes).
Despite some differences between languages' in their structures and grammar, one can find some similarities in the skills of all languages; both in teaching and learning. This shared feature between international languages itself could facilitate the study recommendation of implementing teaching Arabic language for medical and healthcare purposes for both non-Arabic speaking medical students and medical practitioners in an interactive realistic educational atmosphere. This new professional education curriculum could be part of the school of medicine study programme and continues to be part of the professional training or induction programmes provided to non-Arabic speaking medical practitioners in both public and private medical hospitals and institutions in the Bahrain Kingdom.

Future recommended research as a solution to the phenomenon of medical errors in the Kingdom of Saudi Arabia (KSA) hospitals Albougami (2015) could study the impact of the medical practitioners' level of language communication when communicating with their patients on the type of medical error made.

All in all, there are a number of benefits from solving language communication problems faced in health care contexts as indicated by Gregg and Saha (2007). For instance, patient comprehension will be increased, and health care utilization will be equalized and both parties (i.e., patients & medical &/ health

care practitioners) will be more satisfied. Overall, as a doctoral researcher, I aim that such benefits can be fulfilled when implementing the study recommended coping strategies and techniques for daily doctor-patient language communication.

5.4.c. Adapting the patient-centered model

In the nursing and health care journal, Augmentative and alternative communication (AAC), it is mentioned that "Effective communication is recognized as a priority across the healthcare continuum because it directly affects the quality of patient care, safety, medical outcomes, and patient satisfaction". (www.aac-rerc.psu.edu). Through this journal article, new strategies and techniques are presented by using the AAC: Augmentative and alternative communication. The aim of using this technique as stated in the article is to find a way to support *all* patients who experience communication difficulties in diverse clinical areas. The word "all" is controversial here; as it is difficult to have one technique that is applied to all patients; taking into consideration patients are of different health statuses, different educational backgrounds, and different communication needs. After the completion of my thesis study, I am planning in future research to investigate the suitability of the AAC technique to my thesis study context and find out its contributions to medical practitioner-patient language communication in my professional academic context too.

5.4.d. The Global Communicative Competence (GCC) and the Development of a Project-Based Learning (PBL) – The Recommendation for a call for a global language to be used for special purposes, such as the medical and healthcare context

Another supporting study by Sakamoto and Miyatani (2017) uses student survey responses to examine its effectiveness in fostering global communicative competence (GCC). To meet the need of establishing a global communicative language to solve the problem of complexity of intercultural interactions due to globalization and the increase of cultural differences, Sakamoto and Miyatani (2017) developed project-based learning (PBL) university course to cultivate global communicative competence in learners. Ming-Chen (2005, p.1) states that "As a result, the increasing frequency of face-to-face interaction among people from different cultural, ethical, social and religious backgrounds demands that we develop intercultural communication competence". All of this indicates the importance of focusing on intercultural aspects when talking about diverse communication issues.

As a good solution to the challenge faced by language teachers in simply passing the knowledge in the globalization era, a Project-Based Learning (PBL) approach suggested by Sakamoto and Miyatani (2017) enables teachers to face this challenge, activate and cultivate in their students the skills required for effective global communication. The study by Sakamoto and Miyatani (2017, p. 297) concludes by emphasizing the following notion, "Globalization has brought increased complexity to intercultural interactions, necessitating a pedagogical shift from traditional intercultural communicative competence-based goals towards global communicative competence". This quote represents an agreement on exactly what skills language learners need for effective global communication is yet to be achieved, but the authors, Sakamoto and Miyatani (2017) suggest Project-Based Learning (PBL) as a useful approach. Project-Based Learning (PBL) allows students to deepen their knowledge and apply it to real-world situations and in so doing to develop skills we perceive to be necessary for global communicative competence. Students' comments indicated that The Local Business Student Collaborative Project was successful in developing their communication skills, problem-finding and problem-solving skills, adaptability to other cultures, management abilities, and presentation skills. However, it has been noticed based on a trial for the implementation of the Local Business Student Collaborative Project that it may carry some challenges, although the benefits for students are evident. For example, this project continues to evolve beyond the scope of the classroom, morphing into spin-off projects and even employment opportunities for students.

Louhiala-Salminen and Kankaanranta (2011) discuss the issue of creating a "Global Communicative Competence", such as the idea of having English as a Lingua Franca (ELF) and it presents a model for Global Communicative Competence (GCC), which can be further adapted to design a unique model for a specialized Arabic Language for Medical and Healthcare Purposes. The language in the presented model is a key component, which is in alignment with my current doctoral study wherein the language constitutes the main focus of the communication process. My study has a broader scope and addresses professional education and correspondingly, in this article by Louhiala-Salminen and Kankaanranta (2011), the concept of "Global Professional Communication" is a fundamental element. This, alternatively, implies a language communication that can cater to all sorts of professions, with utility qualities as a global language to serve in different professional contexts. Louhiala-Salminen and Kankaanranta (2011) concentrate on international business communication and the study projects a wider aim of creating an international medical and healthcare language for communication.

Thus, the central idea is to establish a global Arabic language for medical and healthcare communication. The latter task seems to be more challenging in consideration of the fact that globalizing the Arabic

language to serve specialized professional purposes is a new area for the Arabic language. This is also compounded by the fact of the present shortage or semi-absence in relevant existing literature sources in comparison to the English language and other international languages, such as Spanish and French.

Besides, Louhiala-Salminen and Kankaanranta (2011) suggest the idea of having *technical education communication* as an alternative communication solution for Chinese professionals, because companies did not expect a good level of writing from the Chinese employees. Therefore, this presents an impending need as suggested by this study to explore global professional communication in its multilingual and multicultural contexts. A review of Louhiala-Salminen and Kankaanranta (2011) study projects three major key elements that require essential consideration while contemplating creating a language for global interaction, such as interactional skills, rapport building, and the ability to ask for and provide clarifications. As a linguist, I believe that these three key elements are essential when thinking to structure a global language for communication purposes, no matter what context we are aiming at (e.g. General, medical, business, management …etc.).

5.4.e. The Integration and Collaboration between the Education System and the Health System (An Academic & Service Continuum) plus an Inter-professional Approach for Human Resources Development

The study by Kronfol (2012, p.1164) summarizes important study recommendations by emphasizing that "Universities and medical schools will need to improve the fitness for purpose of medical graduates. There is a need for continuous integration and collaboration between the education system and the health system (an academic and service continuum), as well as an inter-professional approach to developing human resources. Medical education globally is changing in line with changes in societies, to which the medical profession and other health and allied professions are responding, adapting, or planning ahead". Kronfol (2012, p.1164) continues to add that "There are many external and internal factors today which influence the theory and practice of medicine. These include changes in the level of morbidity and diseases patterns, expectations for the health services, demand for a delivery of high-quality care, changing healthcare needs, medical advances and technology and inter-professionalism in the future workforce". As evidence for the need to cope with the increase in the number of diverse university students and the expats who work in our Arab region and their needs for professional development, I concur with what Kronfol (2012, p.1164) claims that "The last 3 decades have witnessed important developments in the number and diversities of health professionals in the Arab states. The time to come to expand efforts towards further development in the quality and relevance of education, the professionals, their service and commitment to improving

the health systems and the welfare of communities, and the production of research and studies in cooperation with policymakers to enhance decisions and policies based on evidence."

From my point of view, language communication training for social- medical and healthcare purposes should be allocated as a priority training programmes for medical practitioners for its importance and this study would investigate the level of needs of such a coping strategy in the medical and clinical setting in Bahrain in particular and in the Arab region in general.

5.4.f. The Adoption of the Patient-Centered Medical Home Model (PCMH)

The Patient-Centered Medical Home (PCMH) is a model of enhanced primary care that shows promise for reforming health care by changing the way care is organized and delivered. This model is presented here to be proposed as part of my conceptual framework as a researcher but will redesign it to become a non-Arabic speaking medical practitioner- centered. This idea has come to me after finding out from some literature sources the positive successful outcomes obtained by implementing the patient-centered model which resulted in bringing tremendous benefits to patients' health in the first place and for the healthcare services in general. By adopting this model, I aim at keeping the focus on medical practitioners being the core components of this doctorate study, reforming it to study their language communication barriers faced and be able to find some suitable coping strategies which should benefit these practitioners in the first place and this benefit will be expected to contribute to the quality of healthcare services provided to Arab patients in specific and the whole process of healthcare in general. This model concentrates on certain key elements, for instance, patient/physician relationship, patient-centeredness, enhanced access, payment reform in alignment with the Patient-centered Medical Home (PCMH) values, comprehensive care/whole–person orientation, care coordination, quality and safety, and team-based care.

To facilitate the work in that path, the study by Davidson et.al. (2004-2005) follows the Institute of Medicine's patient-centered model. Davidson et.al. (2004-2005) claim that "several studies have demonstrated that patient-centered care is associated with better clinical outcomes". From my experience in following the approach of student/learner-center in the teaching and learning process and how that had contributed to enhancing the level of my learners' involvement in their classes, I can see that the approach could be adopted when studying the language barriers faced by medical practitioners and making them in the focus and the core of this study (e.g. non- Arabic speaking medical practitioners-centered). That will be in a later stage of my study conceptual framework to support non-Arabic speaking medical practitioners and encourage them to act as a major party of the medical practitioner-patient language communication rather than being a passive listener. In other words that means studying language communication barriers

in health care setting from the medical- practitioners' perspective and real-practice experience and finding them supporting solutions which should strengthen the quality of healthcare services and the level of communication provided to their Arab patients in particular in this study context.

As evidence of implementation success, this model of care (PCMH) has been implemented in several states and agencies, both within the public and private sectors. It has been stated by Rissi, Baker, and O. Hatfield (20l2-2013, p. 1) that by the end of 2012, more than 26 states had adopted the PCMH model in their Medicaid programs, including Oregon which shows a good status of acceptance to this model.

This model is claimed to be viable to achieve a "Triple Aim" of first, better population health. Second, a better experience of care and third reduced costs. Also, other positive outcomes of implementing the patient-centered model providing its success and encouraging other researchers to adopt it in other areas of medical education and health care. The evidence includes reductions in hospitalization, hospital readmissions, and emergency department (ED) visits, improvements in quality and annual savings ranging from $ 71 to $ 640 per patient; increased patient satisfaction and access to care, and, better disease management, patient engagement, and preventative care.

Grumbach, Bodenheimer and Grundy (2009, p.1) refer to some specific benefits gained from implementing the patient-centered model, for instance, reductions in emergency department visits and inpatient hospitalizations which have resulted in producing savings in total costs. Not only the benefits of the cost but as well as a positive impact on having a better quality of health care services provided to patients.

The main focus in a research paper by Davidson (2005) concerns concentrating on patient-centered issues and establishing what is entitled as "patient-care team" which means the patient is the main component in the healthcare professions and plans.

As a new medical approach, Rissi et.al (2012-2013, p. 2) draw a way of assessing and evaluating the patient-centered model to find out how effective it is in the healthcare context. This assessment includes six core attributes of the model that provide defining criteria and six dimensions include, **1)** implementation, **2)** fidelity to the model, **3)** clinical quality, **4)** cost and efficiency of care, **5)** patient experience of care, and **6)** provider and staff experience.

To evaluate the implementation of the Patient-Centered Medical Home Model (PCMH), Grumbach et.al. (2009) used logical models to look for future improvement in implementing this approach.

It has been claimed by Gumbach et.al. (2009, p.1) that the implementation of the patient-centered approach for medical home interventions is still in its first stages and will require further review and evaluation for

future improvement. This implantation as being stated by Grumbach et. al. (2009, p.1) has come up with an excellent return on investment in the field of medicine and healthcare, particularly in the area for the quality of care, patient experiences, care coordination, and access.

To sum up, Grumbach et.al. (2009) have found out through the real experience of using the logic models to evaluate the implementation of the patient-centered approach for Medical Home Interventions that "Logic models that illustrate how an intervention is expected to produce desired outcomes are not only useful evaluation tools but also valuable planning tools that form the foundation for monitoring implementation". Added to that, Grumbach et.al. (2009) include that a strong logic model can guide evaluation design, data collection, and analysis plus serving as a useful framework for interpreting results.

5.4.g. The Impact of Globalization on Shaping the Type of Global Communicative Language

Globalization has been a common term and therefore, more efforts are needed to establish a globalized language to facilitate global communication, "Globalization has added complexity to the notion of communicative competence. Although globalization has now become a central focus in sociolinguistics, speech communities continue to be treated as homogeneous entities in which language shifts affect everyone in a similar fashion, and smaller speech communities as particularly vulnerable to language shift" (Besnier, 2013). One reason to choose Bahrain to be a branch for my work university RCSI-Bahrain is that its high rate of diversity among its population of both citizens and non-citizens and geographically. Bahrain has a strategic position and it is an attraction for establishing various international businesses and enterprises throughout history till now.

Language-communication has become a fundamental demand in the last two decades, "In the last couple of decades, an increasing number of scholars of language in its social and cultural context have turned their attention to the question of how globalization is affecting linguistic practices in speech communities around the world" (Besnier, 2013, p.1). Globalization is not the main objective of my study, but this described global aspect of language communication can be recognized and encountered throughout conducting my research and I could then link it to the importance of integrating cultural aspects with language communication in a highly diverse context such as Bahrain.

Besnier (2013) refers to an example of a language communication barrier which is about a famous hairstylist who speaks different languages and this example shows the level of embarrassment she encounters when she communicates with her audience. In comparison, I think communicative competency

is important in various professional contexts; however, there is no comparison when it comes to human life/death matters, such as the importance of language communication in medical and healthcare settings which I assume it deserves the investigation and research effort to find radical solutions.

"Only through global communication competence can people from different cultures communicate effectively and productively in the globalizing society" (Chen 2005, p.3). I do not concur with the restriction made by Chen (2005) when deciding that the only way diverse people can communicate effectively is by following a global communication competence, because this could close the door for more innovative thinking of other possible effective communication coping strategies. By raising the multicultural awareness in the country, Bahrain has become a global civic culture as being discussed by (Alder, 1982; Boulding, 1988; Frederick, 1992).

Chen (2005) listed some life areas in which Global Communication Competence will be positively impacted, for instance, education, business, travel, and social interactions. I assume that nowadays people's minds are more materialistic and there is an absence for the area of medicine and healthcare although it is a crucial area of study and is linked with human being's life and this is a gap in the literature which hopefully be bridged and filled in through this doctorate study. I find the idea Chen (2005) points out interesting to be more investigated that all sorts of technologies play a remarkable role in facilitating the way for raising effective Global Communication Competence. However, among these communication and information technologies, the internet makes the most significant contribution to global interconnectivity. As a lecturer who lives and works in a multicultural country and a diverse medical institution, I am urged to go for more global learning, blended or online learning and these solutions have been suggested to solve time and space issues. This institutional goal for more global online interactive learning could be expanded by aiming to create a global town square starting with my target research medical practitioners' work settings as an initiative and a suggested coping strategy to solve the language communication barrier faced in diverse medical and healthcare contexts. This created a global communication network that could be enlarged and connect the local medical multicultural practitioners with those of similar medical environments oversea. By implementing an online network for global medical-social communication competence in my research settings, medical practitioners will enjoy some privileges. First, they can enjoy the freedom of expression. Second, through the process of self-image projection and reality construction on the internet, our physical being and environment are extended and new communities will be established where medical practitioners could interact, learn, exchange information and expertise on the best global tools and strategies for communicating with Arab patients in particular or patients who speak different languages than what the practitioners speak in general. On the

other hand of implementation, there is a possibility of facing some challenges besides the advantages to be gained. To start with, require putting follow-up assessing criteria to help to monitor the learning progress of the medical practitioners who are involved in online global medical communicative language learning and to ensure that they are committed to learn and interact effectively. Besides, Chuang (2000) and Zhong (2000) refers to another possible challenge to be faced in this regard, "it also reflects a dilemma, which represents a pulling and pushing between local and global diversity, or between homogenized world culture and heterogenized local cultures".

5.4.h. Transferred Knowledge of Teaching English for Medical Purposes into Teaching Arabic for Medical and Healthcare Purposes as a Step to Solve the Language Miscommunication Barriers Arabic Medical Students and Practitioners face

Need Analysis in Arabic for Specific Purposes (ASP) would be a cornerstone in identifying the clinical language challenges faced, understanding the problem, and designing suitable learning materials. Chambers state (1987) that the main focus of the NA (i.e. Need Analysis) in the intended study is to focus on identifying specific communicative needs and their realization in the course delivery. Similar goals will apply to my intended Arabic language course designed for non-Arabic speaking learners.

Molhim (2011) specifies a section in the study about curriculum development and advises that ESP instruction needs to be based on student-centered perspectives. He goes on to say that this will turn the curriculum to be more goal-oriented and designed to meet the needs of learners and maximize their learning benefits, and this applies to design Arabic for Specific Purposes (ASP).

To come up with a quality ASP teaching and learning materials, cooperation with nursing/medical instructors and practitioners would be beneficial and will add to the curriculum from the perspectives of medical practitioners' real-life knowledge input. This is because language instructors use more authentic input to develop their learners' communication. In this case, transferred knowledge of my former and current academic and professional experience in being a bilingual tutor and in teaching English for Nursing/Medicine could be utilized in constructing the newly developed curriculum of Arabic for medical and healthcare purposes in the coming future.

Savignon (1972) described communicative competence as "the ability to function in a truly communicative setting-that is, in a dynamic exchange in which linguistic and paralinguistic, of one or more interlocutors" (Savignon, 1972, p.8), we may need to form a description of the level of communicative competence required for non-Arabic speaking medical practitioners when learning the Arabic language for doctor-patient communication purposes. Like many theoreticians in the field of language learning and teaching

(e.g., Stern, 1986) and building on the ideas of Halliday and Hymes (in the 1970s) following Chomsky, Savignon equates communicative competence with language proficiency. In contrast, my context does not need meeting the proficiency level of communicative Arabic language learnt by non-Arabic speaking medical practitioners and I emphasize this particular aim to any confusion or lack of clarity which my audience may have.

Bachman (1990) suggested using the term "communicative language ability", claiming that this term combines in itself the meanings of both language proficiency and communicative competence. On the other hand, I find myself in agreement with Hymes (1972), Widdowson (1983), Bachman (1990, 1996) concerning the definition of "communicative language ability" as a concept comprised of knowledge or competence and capacity of the appropriate use of knowledge in a contextual communicative language use plus what Bachman (1990, 1996) states that "communicative language ability" means the way how language is used to achieve a particular communicative goal in specific situational context of communication. These couple of descriptions of "communicative language ability" have added to this term more flexibility in using it and in interpreting its meaning which I also find matching with my participants' needs (i.e., aiming to acquire the language proficiency /Language Advanced Level).

This research topic is somehow challenging to me as a doctoral researcher, but yet is very interesting as it is being more exploratory than being descriptive. Added to that, my work institution's innovative vision supports academic projects that contribute to education, research, and community service; and these are the three main pillars of the RCSI-Bahrain strategic plan (2012-2017). I can see my doctorate thesis study fits under these three pillars. First, in terms of education (i.e. Teaching & Learning Pillar); my study aims to find out suitable language communication coping strategies and techniques that can assist the intended medical practitioners' language communication needs both for academic and professional purposes. When referring to the second pillar, research, I can say that addressing RCSI-Bahrain medical practitioners' clinical language communication problem through conducting research and coming up with evidence-based findings and facts could meet the objective of this strategic pillar. Going finally to the community service pillar, I can find that the essence of conducting this research study is to highlight the importance of this research idea. The outcome of this research study is expected to support non-Arabic speaking medical students and medical practitioners in my Bahrain medical context to enhance their medical and healthcare performance through acquiring a good level of communication competency.

Molhim's (2011) study focuses on the English language for medical purposes, unlike the professional focus that I work on creating teaching and learning aids and curricula to teach the Arabic language for

specific purposes (Medical & Health Care Purposes). Due to the shortage of both learning and teaching resources for the Arabic language for special purposes in comparison to English for special purposes' available resources; this issue should be taken seriously and more research work and effort should be offered to fill in ASP literature and resource gaps. Focusing on learning and designing language courses for academic purposes is the main discussion focus raised by https://www.teachingenglish.org.uk. However, there would be a need I assume based on my experience of teaching languages (i.e. both Arabic & English) in a medical institution situated in an Arab diverse country, to design Arabic language courses that meet both academic and professional purposes in the clinical and healthcare areas in parallel to teaching specialized English language courses. Nowadays, higher education institutions require bridging the gap and building up inclusion for both knowledge (i.e. academic part) and practice (i.e. professional part); as (http://www.aashe.org) points out that "Higher education can serve as a model of sustainability by fully integrating all aspects of campus life". This sustainability model is the modern higher education level we would like to reach through this research. This cannot be fulfilled without linking between knowledge and practice. One of the suggested educational methods by Howard S. (1994) to instructors and faculty members who teach medical students is to follow what is called "Practiced- Based Learning or Problem-Based Learning method", which could be translated into designing Arabic language courses for practical professional purposes; in particular, for medical and healthcare purposes. The course's structure could be designed for presenting real medical scenarios that are small case studies or problem-based cases elicited from the daily real clinical context, which will be discussed in more details in the thesis chapters in the coming research stages in term of the design and implementation for future language communication teaching and professional training.

Nagy (2014) points out that the English language has been developed to be more specialized and meet learners' professional needs and development; that is why this doctoral research is categorized under the professional education cluster; aiming to form a type of Arabic language to meet the medical/ healthcare professional needs and purposes. Since English for special purposes has a long history and it had been established in the 1960s as Nagy (2014:262) refers to; then this is a long experience, which could create a framework to construct a strong base to start teaching Arabic for special purposes and building up suitable teaching and learning curricula and resources.

Galova (2007) explains that the role of higher education context is to base its teaching and learning curricula and programmes on both the local and international workplace's needs to cope with the rapid change in the professional market. CEL/ELC (2002) assert that if higher education programmes are to be relevant to the European labour market, graduates have to be able to communicate in some languages and to expand their repertoire in changing needs. It is the responsibility of higher education institutions to provide opportunities and incentives for students to acquire these abilities. This quote message is a part of

what I need to convey through this research to both my work medical institution and the local diverse clinical areas (e.g., hospitals, clinics, health centers, medical institutions…etc.). This goal can be achieved by proving that some serious language communication challenges occur in our local clinical areas and by highlighting and describing the type of negative consequences that are expected to happen as a result of such challenges. Besides, the level of awareness for the need of studying these language communication matters closely and trying to propose realistic solutions can be raised by educating the community of this study clinical language miscommunication phenomenon.

In reference to Aladdin (2016) and what he points out about the compulsory Arabic language course delivered at the National University of Malaysia, I compare this course with the Arabic language course implemented and delivered at RCSI-Bahrain as a compulsory course too which is advised by Bahrain Higher Education Council (HEC). Students who study the Arabic language course designed for non-Arabic speakers in both referred countries have different cultural, language, religious, and ethnic backgrounds; as they come from different countries around the world. Most of the Arabic language non-Arabic speaking learners, both in Malaysia and Bahrain are at the beginners' level, but some are at a pre-elementary or elementary level who are mostly non-Arab Muslims who know how to write and read perfectly in Arabic but do not know how to speak and communicate using Arabic properly. Added to that, there are also another unique group of learners who are from Arab origins but brought up abroad in non- Arab countries and did not get the chance to learn or practice Arabic language and need to start learning the language from the beginning and are at a similar language level to the non-Arab learners who are either at the beginner or elementary level. This study by Aladdin (2016) has identified through conducting a need analysis that the Arabic teaching materials used to teach non-Arab learners at the National University of Malaysia were major language-learning challenges for students to learn the Arabic language. Therefore, the university has taken over the task of designing Arabic language teaching and learning materials to suit that target group. By linking this highlighted challenge with my personal experience as an Arabic language programmes coordinator and my knowledge about both the local and international market of Arabic language learning resources, I could see that there is a clear shortage in Arabic learning resources in general. Also, in particular, there is a shortage or absence in Arabic language teaching and learning resources designed for teaching non- Arab learners.

Aladdin (2016) refers to the elective course which is available in their Malaysian university and that offers some international language courses and Arabic is one of them. Their main reason for including language courses within the elective programme is to ensure having their students "equipped with a competency to face the challenges in the real world; specially to compete and survive in the workplace", I like the word "survive" as this is what I imagine suits best describing the non-Arabic speaking medical students' and

practitioners' communication status in my Bahraini context when dealing and communicating with Arab patients.

In a research study by Eckhardt et.al. (2006, 19), it was stated that "a qualitative descriptive design informed by phenomenology was applied through the means of semi-structured, in-depth interviews that were tape-recorded and transcribed. Three main themes were identified: "nursing for the masses", "nursing the individual" and "communication and language". In contrast, this study paper is more focused and studies in depth the third identified theme only which is communication and language. Eckhardt (2006, 19) further discusses that "While doctors booked interpreters for meetings with patients, nurses did not do so and consequently misunderstandings, frustrations, and unsafe practice occurred. Language and communication issues far outweighed considerations about culture. These findings challenge nurses to respond to and address the mutual frustration of language barriers between themselves and patients". If more language communication misunderstanding occurs from the nurses' side as Eckhardt et.al (2006) claim, misunderstanding and language barriers will be increased between nurses and their patients who speak different languages than they do in an absence of proper interpretation support. As a result, some consequences will occur, for instance, diagnosis and medical errors in addition to negative impacts on both the psychological and performance sides of both parties (i.e., nurses & patients).

In this doctoral study context, an adaption and an adjustment can be made to the patient-centered to turn it to non-Arabic speaking medical practitioners-centered. This would possibly create a medical practitioner-language communication support team to study the communication challenges faced by these practitioners and design some practical solutions and coping strategies. Some implementation ideas from my prior training knowledge of professional coaching and mentoring could help in shaping my study conceptual framework of a non-Arabic speaking medical practitioner-centered model for Bahrain medical and healthcare context.

This study elicited the input of information from the experienced non-Arabic speaking medical doctors, who are in the real clinical practice for a number of years and that will be reflected in the type of language communication intervention support given to the non-Arabic speaking students throughout their study in their six-year medicine programme.

Moreover, the study aims to improve the intended medical students' and practitioners' clinical communication skills and performance when communicating with Arab patients in Arab-based clinical areas. This could lead to future recommendations for higher education programmes implementation and a call for future world-wide collaborative research in relevant fields to this research study.

All in all, many important obstacles for workforce enhancement have been identified by Kronfil (2012), which I can see that it needs to be addressed and taken into account when designing any future professional education training programmes for medical practitioners. First, there is an absence of a comprehensive national health development strategy for the health sector. Second, education programmes of academic institutions are not linked to the needs of the country. Third, admission policies to institutions of higher education and universities are often unrealistic. Fourth, little attention is given to the continuing education of health professionals. Fifth, primary healthcare and non-clinical activities are overlooked. Finally, there is little or no coordination between ministries of health, universities, training institutions, and the public.

5.5 Implications for Future Research and Publications

5.5.a. Proposed Future Publications based on the Main Topic of this Study

Medical practitioners whom with lots of thanks and appreciation took part in this study and gave me a lot of their valuable time shared wonderful real stories and examples they encountered in their daily-basis medical clinical practice in Bahrain and/ other Arab countries' hospitals and medical institutions. Those scenarios can be collected together and organized in a booklet that includes real doctor-patient language communication stories or what we could call them in research vignettes. This booklet could be published in the future to help other medical practitioners and medical students "i.e., Doctors to be" to learn lessons and morals from these stories. The booklet could also assist medical practitioners and students in adopting some doctor-patient language communication techniques used as coping strategies to deal with patients from different cultures and countries and whose mother tongues are different than the languages the doctors speak. Once this booklet is published, it can be circulated to all medical practitioners and medical students in hospitals and other medical institutions in Bahrain. Once this work achieves some success and benefits to the target group, then it can be expanded in a new edition adding more content from more future research in this area. In a further step, this work can be published and shared internationally. All in all, through the literature search and the input of this study, I learnt that the language communication barrier is a common issue that also exists in different countries, different cultures, and with different languages because many countries are diverse like Bahrain.

5.5.b. Suggestions for further research

All the research participants discussed in chapters four and five had confirmed that no formal medical professional training was provided to them to assist them with the language communication barrier faced in the medical context. Most of them rely on their Arab colleagues both medical and non- medical staff to help in translating their messages to the patients and vice versa. By referring to translating messages or responses from patients to doctors, one of the study practitioners mentions that informal medical translation assistance is received from Patient Care Assistants (PCAs). For the use of PCAs in some of our local and private hospitals and medical institutions, I would be interested after completing my doctorate programme to conduct a research to further look into both the academic and the professional competencies PCAs have. Added to that, I would also be interested in looking into whether or not PCAs are well-trained to act as medical professional interpreters or not since I am specialized in the field of linguistics and translation and interpretation. At the same time, I have a scientific background and experience in teaching both medics and nurses in an international Irish medical institution which would make such research more relevant and interesting to me. This would be a good task for me to conduct a professional training needs analysis to highlight the areas of weakness where these PCAs could be empowered to act as professional medical interpreters. The outcomes of this future research would become a base for structuring a strong professional training plan which could make its way towards real implementation if being approved by those in authorities and in charge of medical and healthcare services in this country, Bahrain. In the coming future, I also have the intention of establishing a local or international professional license which could enable the interested staff in hospitals or general interpreters to act as certified professional medical interpreters. For that, I think collaborative research with medical staff would be a good idea as I would of course need to seek their medical knowledge and clinical experience.

5.5.c. Themes to be investigated in coming future studies

Through searching in literature and previous studies for relevant information to this thesis work, several research ideas have come to my mind for future investigation following the completion of my doctorate. As examples of such topics of future research interests are, first, studying the impact of enhancing language communication skills of medical and healthcare practitioners on their professional performance. Second, investigating the impact of enhancing language communication skills of medical and healthcare practitioners on the quality of healthcare services provided. Third, find out the impact of enhancing the language communication skills of medical and healthcare practitioners on the patients' satisfaction with the healthcare services they received. Although the three suggested future research areas all study the same impact which is the "impact of enhancing language communication skills of medical and healthcare practitioners", but on different variables, it would be better I assume to have these proposed research study

more focused and to study each variable separately for the accuracy, reliability, and richness of information and research data.

All in all, the same proposed studies plus this core doctorate study could be investigated in the future from the perspective of non-Arabic speaking nurses instead of medical doctors. This preference of nurses to the research participants for future studies is because we have a huge number of non-Arab nurses in Bahrain. Added to that, nurses in nature are very close to their patients and have more chances for communication with them more than other health care providers.

Davidson (2004-2005) emphasizes that cultural attitudes of the patient and family need to be addressed and respected when using the patient-centered and the decision-making models. I find as a researcher that attitudes of both patients and their families must be strongly addressed and taken into account when tailoring patient-medical practitioner language communication support tools to have the communication process between both parties gone smoothly.

5.5.d. Gaps in the Literature of Issues Relevant to this Study Topic:

There are some examples of some missing relevant literature topics to be addressed or investigated in the coming future research projects. For instance, how the miscommunication problem level differs from one medical professional to another (e.g., medical doctors, nurses, lab technicians, and surgeons). In addition, whether or not the level of miscommunication differs among medical practitioners from different areas of medical specialties. One more possible relevant topic for future is to study the same study but from the perspectives of international nurses, "The Impact of Language communication barriers on non-Arab international nurses in the local Bahraini medical and healthcare setting). Also, if being funded as a researcher, I would be interested to expand the study to include other Gulf (GCC) countries as learnt from the study to have similar cases of language communication barriers faced by non-Arabic speaking healthcare providers. The countries are UAE, Saudi Arabia and Oman. It would be also interesting to follow a different research approach, such as the mixed method, enlarge the number of participants, conduct a case study and comparative study to figure out both the common and unique language communication barriers encountered in health care settings of different countries which share similar geographical features, almost similar cultures and the same language.

To sum up, this could lead to further investigation to explore available language communication programmes and support to non- Arab medical practitioners in the Ministry of Health. The research also

is going to look for the shortages or the gaps that may occur in the learning and professional development programmes in the area of language communication provided by the Ministry of Health in Bahrain to non-Arab medical practitioners who work in Bahrain hospitals and health centers. The main aim of this proposed future research is to work on bridging the gaps and recommending suitable solutions.

5.6. Final Conclusion

In conclusion, this study thesis has taken years from my age and health, but it is something that I will be proud of throughout my life. Doing a doctorate had been my childhood dream which I hope to accomplish by taking the EdD programme. By completing my doctorate journey, all agony and hardship will vanish from my life, only sweet memories will remain. This doctorate will help me stand on a solid base to continue contributing more to humankind's healthcare, both locally and internationally. Now, I can tell my beloved mother who passed away years ago and was a victim of the language communication barrier; mum, now you can rest in peace, I will do my best to help those patients who are in your shoe to cope with language communication and survive. The best achievement I will consider from this study if I could translate the recommended coping strategies shared by the study participants and the best practices of language miscommunication in the health care context that comes in literature into approved policies that are put into real action.

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Appendices:

Appendix 1

A sample of the final approved Semi- Structured Interview Used for collecting the study qualitative data:

Interview Questions
Research Title:

Title: The impact of language communication barriers on non-Arab medical practitioners' healthcare delivery and ways of addressing miscommunication issues: An exploratory-phenomenological study of Bahrain

Research Questions	**Questions to ask the participants**
General Questions:	**Q1:** What is your mother tongue? **Q2:** Can you speak any other languages? **Q3:** What is your field of specialization? **Q4:** How long have you been practicing medicine? **Q5:** How long have been practicing in Bahrain?
All the research questions from **a.** to **f.:** **a.** What kinds of training in Arabic language do non-Arab medical practitioners from different specialties receive to work in Bahrain? ***"Professional Training Received"***	**Q1:** Can you speak Arabic? **Q2:** If yes, how did you learn Arabic? **Q3:** Have you received any Arabic language training in Bahrain? **Q4:** If yes, what kind of training was that? **Q5:** Who provided the training?
b. What main difficulties have non-Arab medical practitioners experienced when communicating with	**Q1:** Have you faced any challenges in your practice in Bahrain? **If Yes:** What main challenges have you faced? **Q2:** Have you faced any communication challenges in your clinical practice in Bahrain? **Q3:** If yes, what communication difficulties are those?

Arab patients, colleagues, and other healthcare professionals? ***Difficulties/Challenges faced***	**Q4:** Have those communication difficulties affected your professional practice? If Yes, how? **Q5:** Can you give me some examples of situations where communication difficulties affected your professional practice?
c. How has language miscommunication affected non-Arab medical practitioners' relationship with their Arab patients, colleagues and other healthcare professionals from the intended medical practitioners' perspectives? ***Consequences/ Effects*** **d. What strategies have non-Arab medical practitioners adopted to cope with language miscommunication issues?** ***Coping Strategies***	**Q1:** How have you tried to overcome those communication difficulties that you have faced? **Q2:** How effective have you found those strategies in facing the communication difficulties that you have faced in your practice?
e. What types of support are available to non-Arab medical practitioners to deal with the language barriers they face in their practice? ***Available support & coping strategies***	**Q1:** Have you received any support in your workplace help you cope with communication difficulties in your daily clinical practice? **Q2:** How effective do you find that support?

f. What do non-Arab clinical practitioners think can be done to help them overcome the language barriers they face in their practice? ***Types of coping strategies & support medical practitioners suggest to have in future***	**Q1:** Apart from language, have you faced any other communication difficulties in your clinical practice in Bahrain? **Q2:** Have you faced communication difficulties due to cultural-differences? **Q3:** If yes, could you give me some examples? **Q4:** In your opinion, what else could be done to assist you to overcome your communication difficulties? **Q5:** Before we finish, do you have any further information to add?

Appendix Two: Letters of Conducting Research Approval

King Hamad University Hospital (KHUH) Approval & letters of approval extension

KHUH Research Center

Criteria for Accepting Research Proposals in KHUH

1. Conducted by health professionals in KHUH.
2. Addresses common diseases or health care priorities in Bahrain.
3. Research aims for increasing our understanding of common diseases, the etiology, diagnostic or therapeutic investigations.
4. Applicant should submit a structured research proposal according to the attached format.
5. The research proposal should be scientifically sound and ethically acceptable.
6. The research proposals will be peer-reviewed to identify the high-quality research projects.
7. Principal Investigator should be a consultant working with KHUH.
8. Fund will be available for high quality research projects. Maximum amount of funding for any single research will not be more than BD 2000.

Research Proposal Format

The Premise of the study: The hypothesis of the study

Title of the project: The title should be comprehensive, covering the main study objective(s) and study area.

Background: Literature review of previous studies on the subject; justification of the study by stating the problem and its public health importance (4-5 references).

Statement of the problem: What is the problem you are aiming to solve/answer with this research?

Significance of the problem: The prevalence of the problem, what studies have been done to address it and what are the problems faced (4-5 references)

Objectives of the study:

- **General objective**: The aim of the study and goal that you need to achieve.
- **Specific objective**: Detail of general objective.

Method: The method by which the study objectives could be best achieved.

- **Setting:** Describe the area or setting where the study will be conducted.
- **Study subjects:** Inclusion and exclusion criteria of the study subjects.
- **Design:** Prospective, retrospective, analytic experimental: randomized clinical trials and non-randomized clinical trials, analytic non-experimental: cohort, case-cohort, case control and cross-sectional, descriptive: community survey, etc.
- **Sample size:** Mention the input criteria for sample size estimation. This might need the expertise of an epidemiologist.
- **Sampling technique:** Mention the sampling technique that will be used in order to obtain a representative sample for your target population. This might need the expertise of an epidemiologist.
- **Timeframe of the study:**

Data Collection methods, instruments used and measurements: Describe the instruments to be used for data collection (questionnaire, observation recording form, etc.)

Data management and analysis plan: Describe the overall plan and tests used for data analysis and the statistical package used.

Implications of the study results to population health and health system policy in KHUH and Bahrain: Expected results and potential contribution of the project to the decision making related to health care and policy in Bahrain.

References: Mention at least 10 recent articles relevant to the study subject.
(Within the last 5 years)

Ethical Consideration:

1. **Informed consent form:** If needed, please attach extra documents.
2. **Other funding agency:** Specify if your study funded by another funding agency.

KING HAMAD UNIVERSITY HOSPITAL
مستشفى الملك حمد الجامعي

Research Proposal Application Form		
1. Title of the Study:		
2. Name of the Principal Investigator and Institutional Affiliation:		
Full name		
Occupation		
Place of Work		
Postal address:		
Telephone (office): Fax: Telephone (mobile): E-mail:		
2. Name and Signature of Other Investigators:		
1. Full name:	e-mail:	
Tel(mobile):	Signature:	
2. Full name:	e-mail:	
Tel(mobile):	Signature:	
3. Full name:	e-mail:	
Tel(mobile):	Signature:	
4. Full name:	e-mail:	
Tel(mobile):	Signature:	
Principal Investigator Signature:		
Official Use only **Scientific approval** ☐ Yes ☐ No **Ethical approval** ☐ Yes ☐ No		
Date of receipt:	ID number:	
Research Area:		
Referee 1: Referee 2: Committee Approval: ☐ Yes ☐ No Date:		
Budget requested from other sources: o Yes o No If yes, what is the source? Amount in BD:		

If you wish your research to be funded by KHUH, please include the following form

Ref. KHUH/Research/No. 187/2017
24 August 2017
Rabab Al Muqahwi
Arabic Language Programmes Coordinator
English Language Lecturer
RCSI- Bahrain
Kingdom of Bahrain
Dear Ms. Rabab,
Re: The Impact of Language Communication Barriers on Non-Arab Medical Practitioners' Healthcare Delivery and Ways of Addressing Miscommunication Issues: An Exploratory Case Study of Bahrain
We are pleased to inform you that your research proposal with Professor Martin Corbally has been accepted by the Research and Ethics Committee King Hamad University Hospital.
We would appreciate if you can inform the committee members on the date that you wish to start your project and kindly send us a preliminary report on your target sample and data.
Yours Sincerely
Dr. Jaffar M Albareeq
Director of Research and Ethics
King Hamad University Hospital
Kingdom of Bahrain
Ref. KHUH/Research/No. 187/2017
24 August 2017
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English Language Lecturer
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Dr. Jaffar M Albareeq
Director of Research and Ethics
King Hamad University Hospital
Kingdom of Bahrain

The Royal College of Surgeons in Ireland- Medical University of Bahrain (RCSI-Bahrain)

Royal Bahrain Hospital (RBH)

Qualitative Study Participant Information Sheet (PIS)

Participant Information Sheet

1. Title of Study

Title: The impact of language communication barriers on non-Arab medical practitioners' healthcare delivery and ways of addressing miscommunication issues: An exploratory-phenemenological study of Bahrain

2. Version Number and Date

This Information Sheet Guidelines V3.4, April 2017.

3. Invitation Paragraph

You are being invited to participate in a research study entitled: "The impact of language communication barriers on non-Arab medical practitioners' healthcare delivery and ways of addressing miscommunication issues: An exploratory-case study of Bahrain". Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask me if you would like further information or if there is anything that you do not understand. Please also feel free to discuss this with your friends, relatives and colleagues if you wish. I would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

Thank you for reading this.

4. What is the purpose of the study?

1. Abstract

This topic presents the issue of language communication barrier between non-Arab medical practitioners and Arab patients that exists in diverse medical institutions/hospitals in the Kingdom of Bahrain.

This project; assesses the situation by eliciting the real picture from medical practitioners' actual experience and searching for suitable learning support tools and assisting techniques.

This proposed research aims to assess the situation through highlighting the language barriers faced by non-Arab medical practitioners in communicating with their patients and other health care professionals in diverse local medical contexts. It is hoped that the outcomes of this research suggest possible ways of helping non-Arab medical practitioners overcome the communication challenges. This research is an exploratory case study and will follow a mixed-method approach with a Qual-Quan sequential design.

5. Why have I been chosen to take part?

You have been chosen to take part because you are a non-Arab medical practitioner and thus in a vantage position to provide information needed for the purposes of this study.

6. Do I have to take part?

Your participation in this study is voluntary and you are free to withdraw at any time without explanation and without incurring a disadvantage.

7. What will happen if I take part?

Please read the following section study-related information to get an overview of this proposed study.

- **the methods are used in this study**

This research will have two phases: a qualitative and a quantitative.

For the qualitative phase three participants from different specialties will be selected from each institution based on professional experience and specialty as follows: one at the junior stage of their career (1-4 years of experience), one in the middle of their career (5-10 years of experience) and one at the advanced stage of their career (Above 10 years of experience). A total of 9 participants will take part in the first exploratory phase of the study. For the interviews, the participants will be selected following a Maximum Variation sampling. If the number of volunteers is greater than the number of participants to be purposefully selected, then participants will be randomly chosen for each career stage group. This will give all the volunteer participants the chance to be selected for the interview. The researcher will select 9 participants in total from the three identified study sites. The chance will be given to all interested participants in the study to send back their signed consents for phase 1 interviews. Interested participants will first be categorized based of the research selection criteria of having different medical professional years of experience as mentioned above and then a random selection by the researcher will be applied to select the require number of participants from each study site and each phase of professional medical experience to apply a fair selection process. Should you not be selected for the interview that will be due to the selection criteria.

- **who the researchers are**

This research is conducted by one researcher whose name is Mrs. Rabab AL Muqahwi – A Doctorate Student in the University of Liverpool and an Arabic language Programmes Coordinator & Lecturer in the Royal College of Surgeons in Ireland- Medical University of Bahrain (RCSI-Bahrain).

- **who will be carrying out interviews**

After receiving signed consent forms from the participants (i.e. non-Arab medical practitioners) showing their acceptance to take part in the study's phase 1, arrangements will be made for the time, venue and duration of the interview.

If you agree to participate, the interview will take place in a quiet and comfortable place of your choice. I would like to record our conversation with your permission, so that I have an accurate record of our conversation, but you can choose to not be recorded (but I need to take some notes). At no time will I display your name, to ensure complete anonymity. After the interview, I will transcribe the recording, or if

no recording is made, write up my notes of our conversation and send it for you to review for accuracy. You may make suggestions for changes and then send back your approval of the transcription or notes. The interview will take 1-hour duration and the place of the interview will be agreed between both the interviewee and the researcher to ensure providing a safe comfortable place for the participants to share their views freely. During the interview recording, participants will not be asked to mention their names or identities.

- **what the duration / frequency of the interview**

Details of the duration of the study interviews will be clearly identified and participants will be notified of that in a later stage prior to the start of these phases. The interview will be conducted once only and will carry comprehensive clear details, including information about the time duration taken and allocated by each tool and procedures followed.

The qualitative phase interview will be conducted once for each intended participant. However, in case of a need for further explanation and clarification, another time will be allocated and agreed between the researcher and the participants to ensure the accuracy of the data collected.

- **Who will be carrying out the qualitative phase of the study**

The researcher herself will be carrying out the two phases of the study (i.e. the qualitative & the quantitative) under the supervision of her University of Liverpool supervisors.

8. Expenses and / or payments

None of that will be required and applicable to the research participants. Interviews will be conducted in the place agreed between both the researcher and the participant. No payment is foreseen for taking part in this study.

9. Are there any risks in taking part?

Participants will encounter no risks or discomforts or disadvantages when taking part in this study. Your name will not be recorded as codes will be used for the purposes of data analysis and organisation. All the information gathered for this study will be anonymised and all identifiable information will be removed. Your identity and personal details will be anonymous and the data collected will be used only for the purposes of this study. Participants will be made aware of possible risks of revealing occasions of miscommunication

with implications on both their own professional conduct and their patients' safety. In order to minimize such risks, participants will be advised to keep names of patients and other health care professionals anonymous, and all efforts will be made by the researcher to hide information in the research reports that may cause such risks.

10. Are there any benefits in taking part?

The study aims to improve the intended medical students and practitioners' clinical communication skills and performance when communicating with Arab patients in Arab-based clinical areas, and this will lead to a future recommendations for higher education programmes' implementation and a call for future world-wide collaborative research in relevant fields to this research study.

All in all, the chief benefit that is aimed to be achieved through this study is to enhance the quality of medical and health care services provided by the non-Arab medical practitioners to Arab patients in the Kingdom of Bahrain; which is expected to contribute to mankind's health and life in this particular part of the world (i.e. the Kingdom of Bahrain) if communication problems are solved.

11. What if I am unhappy or if there is a problem?

"If you are unhappy, or if there is a problem, please feel free to let us know by contacting [Researcher's Name: Mrs. Rabab AL Muqahwi, email: rabab.almuqahwi@online.liverpool.ac.uk, Mobile: +973 37774024] and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact my supervisor Dr. Jose Reis Jorge at josemanuel.reisjorge@online.liverpool.ac.uk. If you will remain still unhappy you can contact the Research Participant Advocate. When contacting the Research Participant Advocate at USA number 001-612-312-1210 0r email address: liverpoolethics@ohecampus.com, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make."

12. Will my participation be kept confidential?

Yes. Anonymity & participants' data privacy will be ensured during the data collection process in both study phases.

In phase 1 (i.e. qualitative –Interviews), participants will be interviewed in a place of their own choice, outside their work place, where no other people will attend, so that the participants may feel comfortable to express their own ideas in a confidential manner. Only the researcher and the participant-the interviewee will be in the interviews.

All the signed consent forms, the transcriptions of the interviews will be kept safe in a password protected personal computer that can be accessed only by the researcher. The audio tapes of the interviews will be kept safe in a locked cupboard that can be accessed only by the researcher. The audio recording devices will be password protected too.

13. What will happen to the results of the study?

The study results and recommendations will be accessible to all participants to keep them informed and updated of the study outcomes. Participants' identities will be kept anonymous and the collected data will be used only for the study purposes. Pseudonyms and codes will be used to identify the participants in the process of data analysis and dissemination of results.

Participants' names and contact will be destroyed after when data collection will be over.

14. What will happen if I want to stop taking part?

You can withdraw at any time, without explanation. The information provided up to the period of withdrawal may be used, if you are happy for this to be done. Otherwise you may request that they are destroyed and no further use is made of it.

15. Who can I contact if I have further questions?

Researcher's Details:

Name: Mrs. Rabab Almuqahwi

Contact Email:

rabab.almuqahwi@online.liverpool.ac.uk

Researcher's Primary Supervisor's Details:

Dr. Jose Reis Jorge- University of Liverpool

Email:

josemanuel.reisjorge@online.liverpool.ac.uk

Researcher's Secondary Supervisor's Details:

Dr. Martin Gough- University of Liverpool

Email:

martin.gough@online.liverpool.ac.uk

UOL Research Governance Officer Details:

Email: *liverpoolethics@ohecampus.com*

Notice: *When contacting the Research Participant Advocate, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make."*

End of the PIS

Thanks for your cooperation & time

Warm Regards,

Researcher's Name:

Rabab Almuqahwi

Researcher's Contact Details:

Email:

rabab.almuqahwi@online.liverpool.ac.uk

Appendix 3: UOL Participants Consent Form

UNIVERSITY OF LIVERPOOL

Committee on Research Ethics

PARTICIPANT CONSENT FORM

Title of Research

Project: Title:

The impact of language communication barriers on non-Arab medical practitioners' healthcare delivery and ways of addressing miscommunication issues: An exploratory-phenomenological study of Bahrain

Please initial box

Researcher(s):

Ms. Rabab AL Muqahwi

1. I confirm that I have read and have understood the information sheet dated [June 2017] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. In addition, should I not wish to answer any particular question or questions, I am free to decline. ☐

3. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish. ☐

4. I understand that confidentiality and anonymity will be maintained and it will not be possible to identify me in any publications. ☐

5. I understand and agree that my participation will be audio recorded and I am aware of and consent to your use of these recordings for the following purposes of data analysis and report of findings of the present study. ☐

6. I understand that I must not take part if I do not meet the selection criteria for the interviews in phase 2 of the study. ☐

7. I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. ☐

8. I understand and agree that once I submit my data it will become anonymised and I will therefore no longer be able to withdraw my data. ☐

9. I agree to take part in the above study. ☐

Participant Name	Date	Signature
Name of Person taking consent	Date	Signature
Ms. Rabab AL Muqahwi	01-04-17	Rabab AL Muqahwi
Researcher	Date	Signature

Principal Investigator:

Name

Work Address

Work Email

Student Researcher:

Name: Ms. Rabab AL Muqahwi

Work Address: RCSI-Bahrain

Work Email: rabab.almuqahwi@online.liverpool.ac.uk

[Version 2.1 June 2013]