Lack of interpretation services for limited English and Arabic proficiency patients in Saudi hospitals: challenges and perceptions

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Abstract

Purpose – The motivation for the current exploration follows from the fact that one-third of the population in Saudi Arabia (SA) is expatriates. According to the Saudi General Authority for Statistic (https://www.stats.gov.sa/en), the total population in SA in 2021 is estimated at 33,413,660 people, 20,768,627 of whom are Saudi citizens whereas 12,645,033 are expatriates coming from different countries across the world, such as Afghanistan, Bangladesh, Egypt, India, Indonesia, Jordan, Pakistan, Philippines, Sudan, Sri Lanka, among many others. In this study, the author targeted limited English and Arabic proficiency patients (LEAPPs) from only three countries in the Near East: (1) Bangladesh, (2) India and (3) Pakistan. The author selected these three countries because they represent the high number of expatriates in SA. According to www.globalmediainsight.com, the population of the abovementioned nationalities in SA in 2021 is as follows: India (2,550,000 million), Pakistan (2,450,000 million) and Bangladesh (1,300,000 million) (see https://bit.ly/3NR6SfT). The main official languages for Pakistan, India and Bangladesh are Urdu, Hindu and Bengali respectively. Although the English language is the second official language in both Pakistan and India, it comes as a second language, not as a mother tongue. In other words, these LEAPPs are unlikely to have a full command of the English language.

Design/methodology/approach – The current study makes use of both quantitative and qualitative approaches. The quantitative component follows from the use of questionnaires whereas the qualitative part comes from the execution of face-to-face interviews. This mixed approach has been influential in earlier explorations (see, e.g. Terrel, 2012; Dawadi *et al.*, 2021) and was used in this study to achieve two objectives: (1) to explore whether LEAPPs suffer linguistically when they visit a Saudi hospital, and this data can be elicited via questionnaires, and (2) to gain insights from LEAPPs' experience and attend to their suggestions towards the improvement of the linguistic landscape of the Saudi health system, and this can be gleaned from the interviews.

Findings – Based on questionnaires and interviews, the study shows that 64.5% of LEAPPs cannot express their health issues to Arabic-speaking physicians, while 54.8% cannot understand the details of their diagnoses and the guidelines of the prescriptions. Although there is a strong consensus among LEAPPs that interpretation services should be introduced to the Saudi health sector to achieve a better experience, 67.7% are generally satisfied with the current healthcare. Contra previous claims that patients are concerned about their privacy with the introduction of interpreters (see, e.g. Hadziabdic, 2011; Floyd and Sakellariou, 2017; MacFarlane *et al.* 2020), the present study shows that 70.9% of LEAPPs express no concerns regarding their privacy, whereas 19.3% adopt a neutral position.

Originality/value – Unlike Al-Khathami *et al.* (2010) who explored the perspective of Saudi patients towards nonArabic speaking nurses and contra Alhammami (2020) who examined the attitudes of the nonArabic speaking doctors towards Saudi patients, the current study shed more light on a neglected sample, namely the laborers, janitors and other craftsmen who have limited knowledge of both Arabic and English and who visited a Saudi clinic/hospital and were met by Arabic-speaking physicians.

Keywords Medical health care, Interpretation, Expatriates, Limited English, Saudi Arabia

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1. Introduction

Given the seriousness of the medical health issues, a considerable volume of research has been devoted to exploring the linguistic challenges that limited English proficiency patients (LEPPs) face during their visits to hospitals and clinics in different countries across the world (see, e.g. Divi *et al.*, 2007, Pytel *et al.*, 2009 for the United States of America (USA); Al-Khathami *et al.*, 2010 for Saudi Arabia (SA); Bischoff and Denhaerynck, 2010 for Switzerland; Hannouna, 2012 for United Arab Emirates (UAE); Albrecht *et al.*, 2013 for Germany; Friebe, 2017 for Egypt, Ali and Watson, 2018 for England; de Moissac and Bowen, 2019 for Canada, among many others). These studies argue that the absence of a common shared native language in clinics and hospitals precludes professional health provides from offering a high quality service to the immigrants (Albrecht *et al.*, 2013), leading to several consequences such as delayed medical intervention, incomplete comprehension of patients' symptoms, poorer assessment of emergency cases and finally a shaken rapport between the population and the health sector (de Moissac and Bowen, 2019).

For instance, de Moissac and Bowen (2019) argued that the lack of interpretation services in Canadian health centers left 70.7% of LEPPs in a state of less satisfaction and impaired confidence in the services they received for their regular medical check-ups. These LEPPs reported that the lack of interpretation services increased their concerns regarding the appropriateness of the diagnosis they had received for their health issues. The same scenario was found in the USA, where LEPPs expressed their concerns regarding the possible misprescription of harmful medications, causing serious side effects (Divi *et al.*, 2007). Taking California as a case in point, Wilson *et al.* (2005) maintained that 15.8% of LEPPs in California reported severe reactions to the prescribed medications, ascribing these errors to their poor comprehension of their doctor's instructions. Although the same complaint has been highlighted in other countries such as Norway, Kale and Syed (2010) reported that 37% of Norwegian physicians rather preferred to hold their patients accountable for any possible misdiagnosis or misprescription, arguing that LEPPs provided inadequate or incorrect information regarding their health history (see also Alshamsi *et al.*, 2020 for a review).

Since this topic lies at the core of human rights where every individual (a citizen or an immigrant) has the right to receive an equal treatment (Bischoff and Denhaerynck, 2010), many health centers took the initiative to offer interpretation support to their patients. For instance, 30% of Norwegian health providers reported that they offer a daily translation services to their LEPPs (Kale and Syed, 2010). These linguistic interventions improved the quality of health services for the immigrants, but they presented new challenges related to the timing, cost and privacy of the process. For instance, two LEPPs from the Canadian Vancouver argued that the provision of an interpreter, if any, was not accomplished in a timely manner or in a way that maintains their privacy (Hadziabdic, 2011; Floyd and Sakellariou, 2017). Some other studies reported that these interpretive supports had not only lengthened the duration of the treatment for emergency cases, but they had also added an additional financial cost to the immigrants' medical bills, which is an unwelcome burden for poor people such as refugees and asylum seekers (Bischoff and Denhaerynck, 2010).

These financial challenges of interpretation services has been a controversy among many scholars, where some scholars such as Brandl *et al.* (2020) argued that the recruitment of interpreters came at a minimal additional cost with an improved satisfactory service in many countries, while others such as Bagchi and Stevens (2006) reported that the charges of the interpretation assistance given to Medicaid recipients in the USA were very high, reaching up to 4.7 million annually. To reduce these costs, some studies argued that health centers requested nurses to play the role of interpreters, or at least communicate with patients at a low pace and in a more intelligible manner (Pytel *et al.*, 2009). These interventions by nurses were proved to be convenient for LEPPs as reported by Pytel *et al.* (2009) who found that 89% of LEAPPs expressed their satisfaction with the nurse's attempts to speak in a way that meet

their linguistic needs. In addition to nurses' intervention, others studies, e.g. Cox *et al.* (2019), found that patients' relatives and companions could also contribute to 91% of an accurate interpreted speech.

Although SA is considering translation services in the health system (e.g. Mina Hajj Hospitals provide ten-language translators for the pilgrims around the clock, and Covid-19 health awareness campaigns and materials were all translated into many language by the Saudi Ministry of Health), the situation still requires further improvements across the kingdom. To illustrate, Al-Khathami *et al.* (2010) explored 116 Saudi Arabic-speaking patients admitted to King Abdul-Aziz Medical City in Riyadh, and based on face-to-face interviews, they found that 70% of the Saudi patients, who were illiterate in English, reported their complete dissatisfaction with the nonArabic-speaking nurses' inability to communicate with them regarding their medical status. According to the study, 30% of the Saudi patients doubted the reliability of the instructions given by their nurses, and 70% thereof reported that nurses ended conversations due to linguistic factors. To overcome these linguistic barriers, 61% of these patients suggested that the hospitals should provide interpretation services. Surprisingly enough, Al-Khathami *et al.* (2010) reported that the overall satisfaction of the health care delivery among these patients was still very high (90%). The authors ascribed this unpredictable high satisfaction to the usage of "a single direct question to rate the overall patient's satisfaction with nursing care. This method may not be reliable enough to detect the true satisfaction level" (Al-Khathami *et al.*, 2010, p. 1,357).

Alhamami (2020) also investigated the language barriers in a multilingual Saudi hospital located in the southern part of SA, particularly in Abha, Asir. He explored the perspectives of 37 participants: 11 physicians (consultants and specialists), 12 nurses, 6 cleaners and porters, 5 allied health personnel and 3 Saudi patients. According to his qualitative interview-based study, nonArabic speaking doctors reported that they had difficulties in communicating with older Saudi patients who embed local dialect words within their talks. These words, according to the physicians, were not part of the standard Arabic that can be learned. On the other hand, Saudi patients in Alhamami's (2020) study also argued that they suffered when communicating with nonArabic speaking health providers. Among the interviewees was Abdullah, who is a Saudi patient preferring "to be treated by Saudi physicians because they understand [him]. If there are no Saudi physicians, [he] prefers Yemeni doctors because their accent and culture are very close to [him]" (Alhamami, 2020, p. 7). In the same line of reasoning, Saleh, another Saudi patient, argued that doctors speak a few Arabic words without giving details regarding their health issues. These linguistic barriers caused a great deal of stress and concerns to the patients. As put by Saleh, "we sometimes feel suspicious that when doctors speak English, we might have big problems; they use English because they do not want to scare us" (Alhamami, 2020, p. 7).

As evident from the above two studies executed in SA, the two works shed light upon the perspective of either Saudi patients towards nonArabic speaking nurses (e.g. Al-Khathami *et al.*, 2010), or upon the attitudes of the nonArabic speaking health providers towards Saudi patients (e.g. Alhamami, 2020). No study has assigned attention to the nonArabic speaking expatriates who come to SA and are treated by Arabic-speaking physicians. The current study aims to fill this research gap given that SA is planning to receive more tourists in the near future. The study aims to explore the nonArabic speaking patients' perceptions of the status quo of the Saudi health system, particularly in terms of the patient-doctor communication in interlingual contexts. Given that these patients do not know full English neither do they know enough Arabic, we will refer to them from now on as "Limited English and Arabic Proficiency Patients" (LEAPPs).

The motivation for the current exploration follows from the fact that one-third of the population in SA is expatriates. According to the Saudi General Authority for Statistic (https://www.stats.gov.sa/en), the total population in SA in 2021 is estimated at 33,413,660 people, 20,768,627 of whom are Saudi citizens whereas 12,645,033 are expatriates coming

from different countries across the world, such as Afghanistan, Bangladesh, Egypt, India, Indonesia, Jordan, Pakistan, Philippines, Sudan, Sri Lanka, among many others. In this study, we targeted LEAPPs from only three countries in the Near East: (1) Bangladesh, (2) India and (3) Pakistan. We selected these three countries because they represent the high number of expatriates in SA. According to www.globalmediainsight.com, the population of the abovementioned nationalities in SA in 2021 is as follows: India (2,550,000 million), Pakistan (2,450,000 million) and Bangladesh (1,300,000 million) (see https://bit.ly/3NR6SfT). The main official languages for Pakistan, India and Bangladesh are Urdu, Hindu and Bengali, respectively. Although the English language is the second official language in both Pakistan and India, it comes as a second language, not as a mother tongue. In other words, these LEAPPs are unlikely to have a full command of the English language.

Another rationale for this study follows from the growing number of Saudi doctors and nurses being recruited in the Saudi health sector. According to alwatan.com (a Saudi government-based newspaper), the current number of Saudi doctors in the "public" health sector increases up to 34,390 (33%) out of 104,775, whereas the number of Saudi nurses rises to 70,134 (38%) out of 184,565 (see https://bit.ly/3xTjyNV). The newspaper saudigazette.com (a Saudi English-written government-based newspaper) also reports that the number of Saudi doctors and nurses working in the "private" health sector rises by 15%, reaching 209.095 Saudis by the end of September 2021 (see https://bit.ly/3tEdLJv). Given these rapid changes in the Saudi health system, it is highly predicable that LEAPPs will be in a face-to-face communication with a Saudi or Arabic-speaking physician, undergoing a new set of linguistic challenges.

The remainder of the paper will be structured as follows. Section (2) will address the methodology of the study whereas section (3) will present and discuss the findings. Section (4) will conclude.

2. Methodology

The current study makes use of both quantitative and qualitative approaches. The quantitative component follows from the use of questionnaires whereas the qualitative part comes from the execution of face-to-face interviews. This mixed approach has been influential in earlier explorations (see, e.g. Terrel, 2012; Dawadi *et al.*, 2021) and was used in this study to achieve two objectives: (1) to explore whether LEAPPs suffer linguistically when they visit a Saudi hospital, and this data can be elicited via questionnaires and (2) to gain an insight from LEAPPs' experiences and attend to their suggestions towards the improvement of the linguistic-relevant landscape in the Saudi health system, and this can be gleaned from the interviews.

To achieve these ends, we recruited three research assistants from each country: Bangladesh, India and Pakistan. These assistants speak Bengali, Hindi and Urdu, respectively as native languages and English as a second language. The research assistants were requested to participate in the translation of the questionnaires and the interpretation of the interviews to our sample that volunteer to participate. Before undertaking these tasks, however, they were required to ensure that our LEAPPs meet two conditions. The first condition is that the LEAPPs visited a Saudi hospital since they entered SA. Those who answered with "no" to this enquiry were eliminated from the study. The second condition is that these LEAPPs were received, diagnosed and treated by Arabic-speaking physicians, be they Saudis, Egyptians, Syrians, Yemenis etc. Those who met nonArabic-speaking doctors were excluded from the study as well.

Following these two strict criteria, it became very difficult for our assistants to find participants who (1) visited a Saudi hospital and (2) met an Arabic-speaking physician. Most expatriates in SA are generally reluctant to visit public government domains, and some others have no full-coverage insurance to seek a sophisticated cure intervention. Others reported that they had less severe cases, making self-treatment the optimal option. Given that these difficulties reduced the size of our sample, we made use of the "snowball approach", a common and effective

method in the qualitative research (Sedgwick, 2013), where one LEAPP is requested to give the name of another possible LEAPP who in turns shares another name and so on. With snowballing, the number of LEAPPs who met these two conditions rose to 31 participants (for the questionnaire). As for the interviews, we could secure 6 participants (2 persons from each nationality) from the same 31-participant sample taking part in the questionnaires.

It should be noted that the number of the participants (i.e. 31) and the interviewees (6) are not too few for the purpose of our study; in fact, they are adequate and informative according to the methodologies of many scholars in the field (Creswell, 2009; Emmel, 2013; Robinson, 2014; Staller, 2021 among many others). As stated by the editor in chief of *Qualitative Health Research Journal,* Jan Morse, 30–50 participants suffice for health-related studies and a few as 6 interviewees is more than enough to "understand the essence of an experience" (Guetterman, 2015, p. 4).

Our questionnaire (see https://bit.ly/3GtUWzY) consisted of 12 questions, where the first five questions aimed to collect the demographic information of the participants (age, country, level of education and level of English and Arabic proficiency). The remaining questions intended to explore the type of hospitals the participant visited (public vs private), whether the participants faced linguistic problems during their communication with their health providers, either from their part (i.e. they were unable to express their health issues) or from the part of their physicians (i.e. their physicians were unable to understand LEAPPs). Some other questions were raised to examine whether the participants had been uncomfortable about the diagnosis and/or the prescription, whether they had needed interpretation services and whether they had been generally satisfied with their experiences at Saudi clinics or hospitals.

As for the interviews, we sat with our research assistants to have a clear understanding of our interviewees' feedback in case new questions arise. The interview consisted of six major questions presented in a semistructured manner, with the view to explore the participants' perspectives of their linguistic limitations and their suggestions towards the improvement of the Saudi health sector. These six questions are given below.

(1) Did you suffer when you communicate with your Arabic-speaking physician? Why or why not?

(2) Were you concerned about your diagnosis and prescriptions because of the limitations in your linguistic competence?

(3) How did you overcome these linguistic challenges?

(4) Do you suggest that every Saudi hospital provides interpretation services? Why or why not?

(5) Will you be concerned about your privacy if interpreters are provided?

(6) Were you generally satisfied with the current health services? Why or why not?

For space limitations, we selected, transcribed and coded only crucial segments of the interviews that were relevant to our study purposes. As demonstrated by Davidson (2009, p. 38), selection of central parts of the interviews for transcription is common among researchers, and it is a major step towards an effective qualitative research. Given that the sample reported that they met Arabic-speaking physicians with different nationalities (Egyptian, Saudi, Sudanese, Yemeni), we carefully selected our interviewees based on their nationalities (Bangladesh, India and Pakistan) and the nationalities of their doctors (Egypt, Saudi Arabia, Sudan and Yemen). By doing so, we could test which physicians provided better communication skills, and with whom doctors the expatriates were comfortable the most. For privacy purposes, the interviewees' names were anonymously deciphered as follows: Alpha (a 46-year-old Pakistani meeting with an Egyptian physician), Beta (a 35-year-

old Bangladeshi meeting with an Egyptian physician), Gamma (a 38-year-old Bangladeshi meeting with an Egyptian physician), Delta (a 41-year-Pakistani meeting a Saudi physician), Epsilon (a 29-year-old Indian meeting with a Sudanese physician), and Zeta (a 56-year-old Indian meeting with a Yemeni physician).

In the following section, and for coherence purposes, we will discuss the results of the study, not separating the findings drawn from the questionnaire from those gleaned from the interviews. We will support the discussion of the sample's answers to the questionnaires with insightful segments from the interviewees' feedback.

3. Findings and discussion

As far as the demographic and linguistic information is concerned, the nationalities of our 31 participants come as follows: 12 participants (38.7%) are from Bangladesh, 10 (32.3%) from India and 9 (29.0%) from Pakistan. The majority (i.e. 17, 45.8%) are 36 years old or above while the minority (i.e. 2, 6.5%) are between 18 and 25. The remaining five (16.1%) and seven (22.6%) of the participants are between 26–30 and 30–35 respectively. The skewness of our sample towards the older generation (i.e. 17 out of 31 participants are 35 years old or above) is highly predictable given that these subjects are more vulnerable to diseases than the younger generation.

For the level of the education, 10 participants (32.3%) have no official schooling, whereas the rest (21, 67.7%) are graduates or drop-outs of school. No participants have joined the university or high studies programs. This distribution is also expected because most of these participants are laborers, janitors and craftsmen such as builders, plumbers, blacksmith, carpenters among others. When asked about their levels of English proficiency, 21 participants (67.7%) claimed that they have a limited knowledge of the English language, while the rest (10, 32.3%) maintained that they are beginners. No participants reported that they are intermediate or advanced. Concerning their level of Arabic proficiency, almost all the participants (30, 96.7%) claimed that their proficiency in Arabic is limited, and one participant (1, 4.3%) regarded himself as a novice. In other words, our sample did not include someone who knows English with a professional level. Also, none considered himself as a professional Arabic learner, and this is not uncommon given that "many workers [in SA] are not immigrant workers, but are instead contract workers who do not intend to stay in the country and therefore do not learn Arabic" (Alhamami, 2020, p. 2).

It should, however, be noted that the participants were the ones who assessed their own linguistic performance and who chose these categories of linguistic proficiency for themselves (limited, beginner, intermediate, advanced). In other words, these evaluations are personal judgments, and they may not be as accurate as required. For our purposes, however, it is sufficient that no participant in our sample rated himself more than a beginner. Consider Table 1 where a summary of the demographic and linguistic information is given.

Nationality	Bangladesh	India	Pakistan	–	Total
	12 (38.7%)	10 (32.3%)	9 (29.0%)	–	31 (0%)
Age	18–25	26–30	31–35	36-above	Total
	2 (6.5%)	5 (16.1%)	7 (22.6%)	17 (45.8%)	31 (100%)
Education Level	No School	School	University	High Studies	Total
	10 (32.3%)	21 (67.7%)	0 (0%)	0 (0%)	31 (100%)
English Level	Limited	Beginner	Intermediate	Advanced	Total
	21 (67.7%)	10 (32.3%)	0 (0%)	0 (0%)	31 (100%)
Arabic Level	Limited	Beginner	Intermediate	Advanced	Total
	30 (96.7%)	1 (4.3%)	0 (0%)	0 (0%)	31 (100%)

Table 1.
The demographic information of the participants

All the above participants reported that they have visited Saudi hospitals: 20 participants (64.5%) visited a public hospital whereas 11 (35.5%) went to a private one. All the participants were also received, diagnosed and treated by an Arabic speaking physician. According to our sample, the nationalities of the physicians were as follows: Egyptian (14, 45.2%), Saudi Arabian (14, 45.2%), Sudanese (2, 6.5%), Yemeni (1, 3.2%). No participants reported that they met with a doctor of Syrian or other citizenships. In light of these various nationalities, we found that doctors differed in terms of the quality of communication they provided to their LEAPPs. When asked about their preference of their physician's nationality, Delta (a 41 years Pakistani meeting a Saudi physician) and Zeta (a 56-year-old Indian meeting with a Yemeni physician) claimed that they prefer Saudi and Yemeni doctors over others, see (7) and (8). These results corroborate the findings reached by Alhamami (2020). Epsilon (a 29-year-old Indian meeting with a Sudanese physician) reported that he did not prefer his Sudanese doctor as shown in (9).

(7) Delta: *My doctor spoke simple, very simple. I understood Saudi people everywhere but I did not understand Egyptians and Syrians. Egyptians know well but they speak very quickly, like "Izaaya" (How), I do not know Arabic.*

(8) Zeta: *I understood my doctor. He spoke very clearly and slowly. He always raised questions if he did not understand. You have a high temperature? You have an ache in your back of your head? You have diarrhea?! He knows everything.*

(9) Epsilon: *I couldn't understand my doctor. He is from Sudan. He sometimes spoke with me in Arabic, and sometimes in English. I couldn't understand a word, and I couldn't ask him to talk slowly.*

We assume that this is the case because expatriates from Pakistan, India and Bangladesh are known for speaking Gulf Pidgin Arabic (GPA) which is a simplified Arabic communication system established by nonArabic immigrants, traveling to Gulf countries in the Middle East (Næss, 2008). GPA is a simple version of Arabic evolved from Gulf Arabic, spoken in states such as Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates and Yemen. The most salient particle in GPA is *fi* which is found in existential sentences (e.g. *fi aqalam bagalah* "is there pens in the grocery") or in linking verbs (e.g. *ana fi tabaan* "I am sick") (for an in-depth discussion of GPA, see Potsdam and Alanazi, 2014).

Given that both LEAPPs and Gulf doctors know GPA and use it as a mode of communication on a daily basis, it is very likely that Saudi and Yemeni doctors (both from the Gulf regions) became more advantageous than other nationalities in their communication with LEAPPs. Unlike Gulf doctors, those doctors coming from nonGulf countries to SA may require more time to mingle with expatriates on the street and realize how GPA is used in communication.

Despite these privileges, GPA does not always facilitate the communication in the hospital contexts. When asked in the questionnaire whether they could express their health issues to their Arabic-speaking physician, only six of the participants (19.4%) claimed so. However, the majority of the participants (20, 64.5%) argued that they could not express themselves clearly to their doctors. Five participants (6.1%), however, took the neutral stance as shown in Figure 1 below:

When Gamma (a 38-year-old Bangladeshi meeting with an Egyptian physician) was inquired how he suffered linguistically when he expressed himself to his doctor, he claimed that he cannot speak English neither does he know enough Arabic. He had no mode of communication. Although he speaks very little Arabic that makes the case clear, he argued that his doctor listened to him without responses. Gamma attributed his physician's nonresponses to his own poor communication skills.

(10) Alpha: *My doctor listened a lot. He nodded his head when I spoke, but I did not know if he knew what I was saying. I think I couldn't tell him what I feel, but he seemed to know*

the problem. He just took the measurements such as weight, height, heat, blood pressure and samples from my blood. He listened to my heart and he decided upon problem. I was always silent. He made the prescription and he knew the problem. He graduated from America.

Besides "speaking" which is a productive skill that might be harder for our participants, we decided to test our participants' perception of their own and their physicians' comprehension skill (i.e. a receptive skill). In other words, we inquired whether our participants understood their doctors or whether they felt that their doctors understood them. When encountered with the statement "I personally understood my physician's Arabic version", 6 participants (19.4%) reported that they understood their physicians, whereas 8 others (25.8%) claimed that they sometimes understood and other times did not. However, more than half of the sample (17, 54.8%) reported that they did not understand their doctors at all.

When the question was reversed and the participants were inquired whether "they feel that their Arabic-speaking physicians could understand their health issues via their ways of expressions", 17 participants (54.8%) claimed that their doctors understood their languages. Although 3 (9.7%) could not make up their mind regarding their doctors' comprehension, 12 (35.5%) of the participants reported that their physicians did not seem to understand their talk. These results are summarized in Figure 2 below.

As a summary, it is obvious from the above findings that LEAPPs had a genuine hardship when they communicated with their physicians. The majority of the participants (20, 64.5%) claimed that they could not express themselves clearly to their doctors; while more than half of the sample (17, 54.8%) reported that they did not understand their doctors at all. A good number (12, 35.5%) of the participants reported that their physicians did not seem to understand their speech. These findings suggest that LEAPPs encounter linguistic challenges when they visit Saudi clinics and/or hospitals, and interpretation services may be the ultimate goal that the Saudi health system should pursue.

With these hard situations in mind, we turned to explore how these LEAPPs overcame these miscommunications with their health providers. When the second question of the interview "How did you overcome your problems in communication?" was raised, 5 out of the interviewees argued that they sometimes sought help from nurses as well as their friends. Given that 113,831 of the nurses in Saudi hospitals are nonSaudis (62%) (see https://bit.ly/3xTjyNV), some of the interviewees claimed that they talked to nurses of their own nationality when they needed to express themselves to their Arabic-speaking doctors. These reports do not only support the findings of earlier works where nurses are claimed to play the

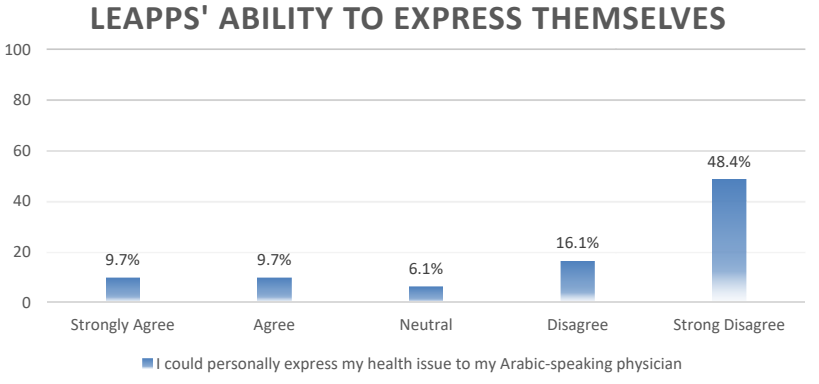

Figure 1.
Participants' Responses to "I could personally express my health issue to my Arabic-speaking physician"

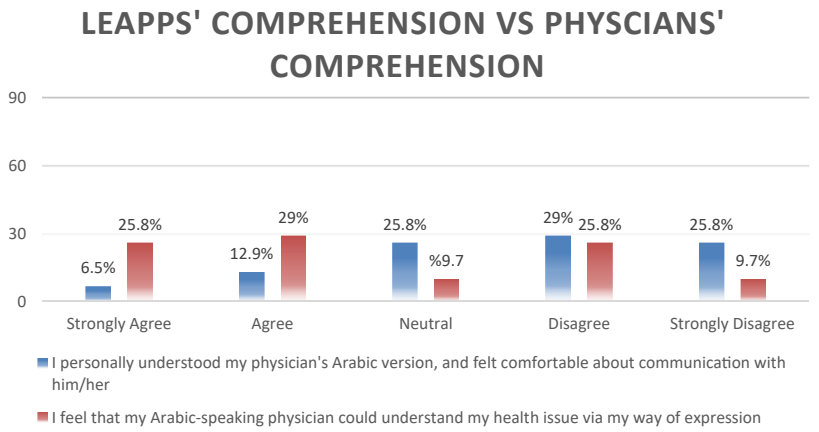

Figure 2. Participants' evaluations of their understanding and their Physician's understanding

roles of interpreters (Pytel *et al.* (2009)), but it also underscores the importance of the interpreters in healthcare. According to Alpha (a 46-year-old Pakistani meeting met with an Egyptian physician) in (11), it seems that LEAPPs felt more comfortable speaking with nurses than depending on their own friends, and this might be attributed to the medical knowledge nurses have in comparison to lay persons (van Rosse *et al.*, 2016).

(11) Alpha: *Me and my friends both needed help from the nurse. The nurse was good and was speaking English and she could make the doctor understand my issue. We both did not understand English. We did not know the problem. We are poor guys.*

Epsilon (a 29-year-old Indian meeting with a Sudanese physician) also took a similar stance pointing out that an Indian nurse talked with him more than his doctor did. According to him, the nurse was switching between English and Hindi, supporting earlier studies which found that code-switching practices are a common operation in the health contexts (Wood, 2019).

(12) Epsilon: *Nurses are more caring, and everything I asked the Indian nurse, she responded to me. The doctor was always busy, running from a room to another. He came and saw me and left. No talk. Nurses talk and I asked this Indian nurse when I needed help. If I had a pain . . . I asked her about what the doctor said about me and she told me everything in detail.*

The questionnaire then took the participants to a different route, exploring whether they had concerns about (1) any possible misdiagnosis or misprescription due to language barriers and about (2) the violation of their privacy if an interpreter is provided. When questioned about their evaluation of the statement "I personally felt concerned about any possible misdiagnosis or misprescription on the part of my Arabic-speaking physician", 10 participants (32.2%) showed their consensus on this issue. However, more than half of the participants (18, 58.1%) argued that they disagreed with the statement. They rather had full confidence in their doctors' correct diagnosis or accurate prescription regardless of the linguistic barriers. 3 (9.7%) participants, however, took the neutral stance, expressing no certain feelings towards this possibility.

When encountered with the statement "I will be concerned about my health privacy if interpreters are available to help me", only a few participants (3, 9.7%) agreed that their privacy might be violated with the company of interpreters. However, a large number of the participants, (22, 70.9%), showed no concerns regarding their privacy. 6 (19.4%) of the

participants were neutral and did not voice a preference on this issue. The results regarding these concerns are summarized in Figure 3 below:

When the interviewees were asked whether they felt anxious about any possible misdiagnosis or misprescription due to linguistic challenges, all of them seemed to agree that this was not a possibility in their minds. They claimed that doctors are mature enough to decide when to reach the appropriate diagnosis and when they need to prescribe a specific medication. Some interviewees ruled out these errors in diagnosis and/or prescription due to the accountability of the physicians who would have to pay financial amends in case harm was inflicted. Consider the two segments below from Gamma (a 38-year-old Bangladeshi meeting with an Egyptian physician) and Delta (a 41 years Pakistani meeting a Saudi physician).

(13) Gamma: *Doctors will never give you any medicine until they know your problem. I always go to them and they only give me Asprin, Asprin, Asprin. Asprin will not bring you harm. They know they will be responsible if they give you a heavy medicine. They start small dose every time.*

(14) Delta: *My father died of a wrong prescription. However, I do not think that there will be something like this here. Here are laws and rules. Doctors cannot get away with their mistakes. So, I am sure that nothing bad will happen inshallah.*

When inquired further about their privacy, Beta (a 35-year-old Bangladeshi meeting with an Egyptian physician) and Epsilon (a 29-year-old Indian meeting with a Sudanese physician) disagreed on this point. Although Epsilon was concerned about privacy, Beta seemed to let it go.

(15) Epsilon: *I think privacy is very important. I do not want my friends to know. If the nurse tells them what I have, they may tell all the community. They may not want to sit with me. You know what happened during Corona. If they know you have Corona, they run away! How about if I have cancer, I do not want my family to know.*

(16) Beta: *I am sick, and there is no shame of being sick. Why do I have to hide this information. What is the problem if the interpreters, or the nurse or my friends know. Everyone will know later. I want the cure. Let all the world get lost, let them know about my health problem. What is the problem? Tell me! The doctor knows also. If the world knows what my health issue is, they may help me. I think there is no problem in that my friends know my case, and my tribe. They will make Dua [religious prayers] for me.*

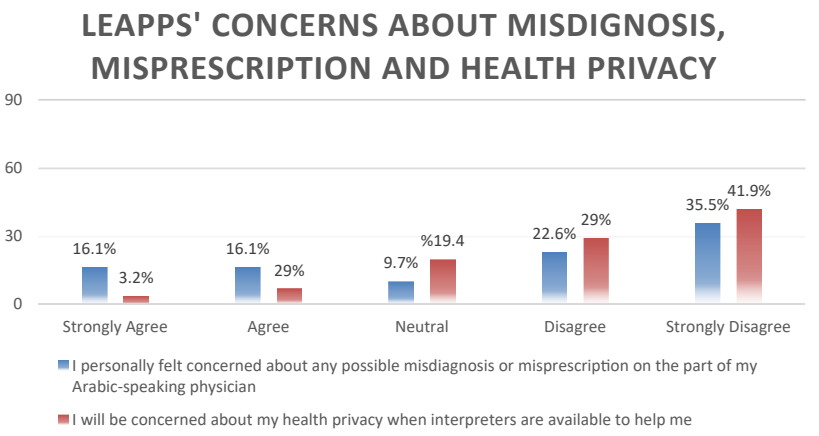

Figure 3.
Participants' concerns regarding misdiagnosis/ misprescription and their privacy with the presence of interpreters

The lack of concerns regarding privacy among the majority of the participants is intriguing. Although many studies argued that the confidentiality and privacy is at the core of the patients' interests (see, e.g. Hadziabdic, 2011; Floyd and Sakellariou, 2017), 22 (70.9%) of our participants expressed no concerns regarding their privacy and 6 more participants were neutral. We ascribe these tendencies to the culture of the third world countries in comparison to the developing ones. According to Knopp (2019), the difference between the industrialized countries and the underprivileged ones in terms of privacy follows from the culture, religion and economic status of a person or a community. The poorer the person is, the less concerned he/she becomes about privacy. Given that these LEAPPs have menial, low-paid as well as low-class jobs, it is therefore predictable that they put their health privacy at the bottom of their priorities.

The last two questions in the questionnaire intended to see the overall satisfaction among the LEAPPs regarding the heath care they received at Saudi clinics and hospitals. It also aimed to explore whether they need further assistance in terms of interpretation. When faced with the statement "I was generally satisfied with the health service I received at the hospital?", 21 participants (67.7%) voiced their support to this statement, claiming that they were overall content with the services they received. Although 3 (9.7%) of the participants took no clear position regarding their level of satisfaction, 7 others (22.6%) claimed that they were disappointed. Consider the summary in Figure 4.

Although it is clear why some participants expressed their dissatisfaction with the services they received, it was not completely obvious whether this was related to the linguistic challenges they encountered during their visits, or whether it was related to their doctors' inability to diagnose them and help them overcome their health problems. Although one interviewee, Delta (a 41 year old Pakistani meeting a Saudi physician), clearly claimed that he was completely satisfied regardless of the linguistic barriers as shown in (17), another interviewee, Epsilon (a 29-year-old Indian meeting with a Sudanese physician), argued that his dissatisfaction was related to the unclarity of his health issues as well as the language barriers he could not override during his visit.

(17) Delta: *I was satisfied with the surgery I made. It was successful, Alhamdulliah [Thanks God]. No complaints about the language as long as things were good.*

(18) Epsilon: *I was honestly dissatisfied because nobody could diagnose my problem until now. The doctor seemed writing more than listening. I spoke and he wrote and flipped through papers on his desk. He did not listen. I think he did not understand me. He gave me Fevadol. I can get Fevadolfrom everywhere. But it is good that he gave me Fevadol, better than something that could kill me.*

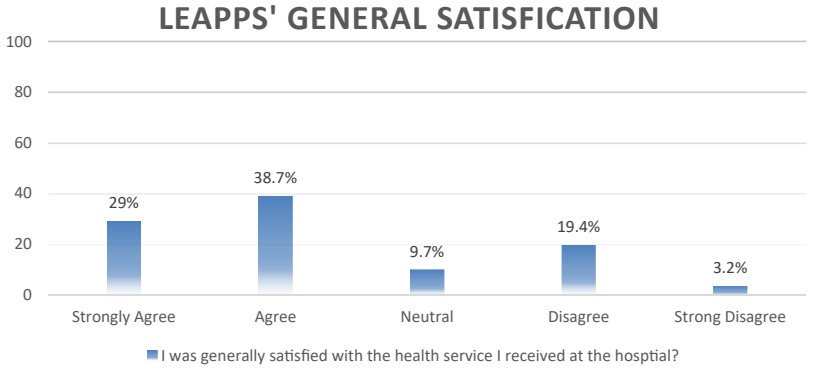

Figure 4. Participants' satisfaction of the health care services they received at saudi clinics and hospitals

When encountered with the statement, "It will be better if all hospitals provide interpretation services", all the participants (31, 100%) agreed that this would add positively to the services in the healthcare. These positive responses were expected given the findings of Quigley *et al.* (2019) which stated that the patients' satisfaction increased in a positive correlation with the extensive use of patients' native languages. However, when asked about the practicality of the interpretation services, Beta (a 35-year-old Bangladeshi meeting with an Egyptian physician) claimed in (19) that this cannot be accomplished easily and may make the process more costly, supporting the results of earlier studies (see, e.g. Bagchi and Stevens, 2006; Bischoff and Denhaerynck, 2010; Brandl *et al.*, 2020). Gamma (a 38-year-old Bangladeshi meeting with an Egyptian physician) also found these interpretive interventions neither impractical nor helpful in (20), stating that interpreters may not be honest in providing accurate information to the doctor, and they may hurt the patients adversely.

(19) Beta: *I do not think it is easy to provide interpreters for every patient. Even America does not do this. This is impossible. And if it was implemented, they will ask for money.*

(20) Gamma: *The interpreter is good, but how do I know that he is telling the doctor exactly what I am suffering from. I may say something and he may say something different. I need to know what he is saying about me. The interpreter may say something wrong to the doctor and the doctor may prescribe something harmful to me. And I do not know anything and what they were talking about.*

Among the unexpected suggestion for the improvement of the health sector in general came from Epsilon (a 29-year-old Indian meeting with a Sudanese physician), who proposed that Arabic-speaking physicians should know a little about Hindi and other languages, and that they can use technological applications (such as Google Translate or India Translator Dictionary) if they need to say something important to their patients.

(21) Epsilon: I think it will be smart if my doctor knows a little bit Hindi. He will not help me alone. A lot of Indians here in Saudi Arabia. I always use Google translate and India Translator Dictionary here and it is really helpful. My doctor can use them too if he thinks he urgently needs to share something very critical to expatriates who know Hindi.

This suggestion from Epsilon seems to throw the responsibility over the doctors more than the patients, requiring them to know a few words about the LEAPPs' language rather than holding the LEAPPs responsible for their low linguistic abilities. In fact, the use of interpretation applications in electronic devices such as Google translate and MediBabb has been suggested in the previous literature, and they were found financially cost-effective (Albrecht *et al.*, 2013). According to Albrecht *et al.* (2013), these free and easy-to-access applications save the interpretation time by 92%, and improve the health care delivery by the same percentage (i.e. 92%).

4. Conclusion

Unlike Al-Khathami *et al.* (2010) who explored the perspective of Saudi patients towards nonArabic speaking nurses and contra Alhamami (2020) who examined the attitudes of the nonArabic speaking doctors towards Saudi patients, the current study shed more light on a neglected sample, namely the laborers, janitors and other craftsmen who have limited knowledge of both Arabic and English and who visited a Saudi clinic/hospital and were met by Arabic-speaking physicians.

The current study has two major contributions to the field of translation and interpretation studies. First, it shows that 64.5% of LEAPPs suffer from difficulties in expressing themselves to

their Arabic-speaking physician, and these difficulties may cause several consequences, such as erroneous diagnosis, inaccurate prescription and/or incomplete treatment. The study also reveals that 54.8% of the LEAPPs do not understand their physicians, which is another serious issue contributing to taking overdoses of the medicine, missing important check-up appointments and/or being unaware of the steps of the health program under way. All these consequence suggest that the introduction of the interpretation services is a crucial step that will add positively to the healthcare system in SA. Similar results were found in earlier studies for other countries (Pytel *et al.*, 2009 for the USA; Albrecht *et al.*, 2013 for Germany; Ali and Watson, 2018 for England; de Moissac and Bowen, 2019 for Canada, among others).

The second contribution of the study follows from the fact that the patients' level of satisfaction may not be related to the presence of interpreters as much as it is to the practical treatment they received for their own cases. Although there is a strong consensus among the LEAPPs that interpretation services should be introduced to the health sector for a better experience, 67.7% of the LEAPPs were generally satisfied with the current health care in SA. Also, and in contrast to the previous literature that privacy might be violated with the introduction of interpreters (see, e.g. Hadziabdic, 2011; Floyd and Sakellariou, 2017), 70.9% of our participants expressed no concerns regarding this issue, whereas 19.3% of them took a neutral stance. This lack of concerns regarding privacy may be accounted for by the economic status of our sample (Knopp, 2019).

Given that the interpretation services may encounter some major limitations at the practical or financial level (Bagchi and Stevens, 2006; Bischoff and Denhaerynck, 2010; Brandl *et al.*, 2020), we suggest that the health sector introduces cost-effective electronic systems supported with the languages of all the expatriates living in SA. These electronic systems may relatively facilitate the communication between LEAPPs and their Arabic-speaking physicians especially that the recruitment of the latter is on the rise in SA. Given that it may seem better for Arabic-speaking physicians to learn basic health vocabulary from the expatriates' native languages as suggested by one interviewee, this proposal should be conducted with utmost care, due to the high likelihood of misunderstanding on the part of the physicians. As a short-term solution, Arabic-speaking doctors, coming from nonGulf countries, should at least learn more about GPA, which is a simplified pidgin extensively used among the expatriates living in SA (see Potsdam and Alanazi, 2014). For future work, we suggest that more work should be done on the communication between doctors and nurses of different linguistic backgrounds in the Saudi context or at an international level as a whole.

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