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Evaluating the Extent of Language Barriers Among Health Professionals in the Saudi Arabian Health System

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ABSTRACT

This paper evaluates the cause, extent, and effects of language and cultural barriers within the Saudi Arabia healthcare system that have an indirect or direct effect on both the patient's perceived quality of care and the actual quality of care delivered. A systematic search of different databases (Google Scholar, PubMed, ProQuest, MEDLINE, and ScinceDirect.) was conducted. Using the following search terms language barrier' AND 'health' AND 'Saudi Arabia'. Additionally, the search terms 'safety' AND 'quality'. The findings illustrate that the Saudi Arabian healthcare system is subject to significant impacts due to poor communication as a result of evident language barriers. Accordingly, it is proposed that individual level and an overall strategy for enhancing language and communication in healthcare across the Kingdom are implemented, including both technological solutions and organisational and human resource-based solutions. A proposed timeline for implementing these various strategies has been provided.

Keywords: language barriers, Saudi Arabia healthcare system, language and communication in healthcare

1.0. INTRODUCTION

Language is an important component in our ability to translate meaning, and is,therefore, a crucial aspect of delivering messages across various healthcare settings.

Accordingly, barriers to language can significantly impede the safety and quality of healthcare delivered. Language underpins effective healthcare delivery at all stages, from the clinical bedside to the handover room and beyond. Barriers to communication are present in all working environments, with language competency and understanding being typically inadequate (McKenzie & Qazi, 1983). Nevertheless, few industries carry a larger burden of poor communication than the healthcare context.

Almutairi (2015) illustrates the impact of language barriers in Saudi Arabian health care, whereby the study of language and cultural discrepancies between patient and health care workers results in an impediment to the provision of quality care. Additionally, the outcomes indicate differentiators in non-Muslim nurses' lack of knowledge and competence regarding cultural practices. The determination of barriers in communication stems from the unclear provision of information and providing inadequate explanations concerning the care.

Communication within healthcare sectors is an essential determinant in patient understanding and satisfaction (Albougami, 2015; Ali & Mahmoud, 1993). The literature demonstrates that patients receiving healthcare in Saudi Arabia have experienced language barriers with medical professionals that could potentially compromise the quality of care delivered to

such patients (Albougami, 2015). Moreover, a study within which 900 primary care patients were interviewed depicted evidence that 19.4% of these respondents experienced language barriers with their physicians (Ali & Mahmoud, 1993). Furthermore, within this study conducted by Ali & Mahmoud (1993), 40% of patients report being dissatisfied with the service provided based on poor communication. In addition, the matter
of language barriers the basis of poor communication within the Saudi Arabian healthcare system could be correlated to the quality of the service provided.

The effectiveness of clinical and interpersonal care is undoubtedly affected by communication barriers. Al-Ahmadi & Roland (2005) demonstrated the occurrence of language barriers as being a key element in determining patient dissatisfaction and the quality of care given. With 40% of patients responding with the complaint of language barriers during their treatment, it is unsurprising that the variations in interpersonal care quality and satisfaction are so substantial between those who experience communication breakdown and those who speak the native language. The aforementioned study also notes that 80% of primary care doctors are expatriates who may not speak Arabic (Al-Ahmadi & Roland (2005). Given this fact, it is expected that quality and satisfaction would be compromised.

The obstacle of communication barriers among medical professionals is evident within all subsectors of Saudi Arabian Healthcare. From general practice to specialised care, language barriers have a major impact on a patient's quality of healthcare and their access to the level of required care (Bowen, 2001). This may lead to serious medical errors, especially in paediatric and critical care contexts (Cohen, Rivara, Marcuse, McPhillips & Davis, 2005).

Overcoming such an issue has been a difficult proposition in Western culture. However, given the considerable growth in multiculturalism, measures have had to be taken to ensure that all cultures and languages are attended to with the equivalent quality of care to those who communicate in English. One method of effectively achieving this is to provide interpreter services. The impact of interpreter services such as the price and utilization of these services has been shown to be a cost-effective solution to aid patients and Doctors with limited English proficiency. Furthermore, it has been demonstrated to improve services to patients in public health care, increasing access to healthcare services that were not prevalent previously, while providing a financially viable solution to deliver this service (Jacobs,Shepard, Suaya, & Stone, 2004).

Given the above-mentioned foundation upon which this paper is set. This research is aimed at systematically reviewing the literature to provide insight into the impacts of communication barriers in the Saudi Arabian healthcare system whilst looking to deliver practical solutions to the industry's problem. By doing so, this paper addresses the various negative effects caused by language barriers on the quality and safety of healthcare in Saudi Arabia and proposes several matched solutions to alleviate this issue.

2.0. METHODS

To measure the effect of language barriers within the Saudi Arabia healthcare system, a scoping review of available resources was performed, by searching the different databases such as Google Scholar, PubMed, ProQuest, MEDLINE, and ScinceDirect.

The main search terms used were 'language barrier' AND 'health' AND 'Saudi Arabia'. Additionally, the search terms 'safety' AND 'quality' were also used as a secondary search pass, to encompass a wider range of potential resources. The search results returned by PubMed, Science Direct, the Institute of Scientific Information (ISI) Web of Information and the Cochrane library, across the period 1999-2019. The Saudi

Medical Journal, as well as the Annals of Saudi Medicine, were also individually searched.

Resources were initially evaluated for relevance by scanning the title and abstract. This provided a way to quickly discard any resources that were not pertinent to the study. Studies that met the following inclusion criteria were examined: 1) focused on language barriers within the health environment in Saudi Arabia; 2) made reference to the impact of barriers in terms of healthcare delivery, quality or safety; 3) contain research published in peer-reviewed journals listed in the above databases. 4) were published from 2005 until current. The type of research was not exclusionary on condition that it was primary in nature (i.e. involved data collection, analysis, and interpretation of findings). All articles that present reflections, opinions or assessments, as well as those prepared primarily for educational purposes were excluded. Studies conducted outside Saudi Arabia published later than 2005 and those with sample sizes less than 20 participants were also excluded.

Once an initial evaluation pass was completed, and irrelevant resources discarded, the full text of the remaining resources was evaluated in more depth, as per the requirements of the PRISMA method (Blegen, 2010). The process of 'branching' was then applied through analysis of reference lists for pertinent papers that also met inclusion criteria. Searches were performed in September and October 2019.

Full texts were then individually examined in accordance with the aforementioned inclusion and exclusion criteria, and any duplicates removed. The scientific quality of each article was individually appraised utilising the following set of questions: 1) does the research establish a clearly defined research question? 2) Does the research apply a research design suitable for answering the research question? 3) Was the method of sampling suitable for the research question being examined? 4) Does the article demonstrate a clear method for data collection and systematic analysis? 5) Does the research form an analysis appropriate to answer the research question? Using the five above questions, each paper was scored from zero to five to provide an overall level of research quality, as outlined by Russel & Gregory (2003).

Subsequently, the author(s), date, region of Saudi Arabia, the study design, the sample size and characteristics, the response rate (percentage; where applicable), the type and number of clinical settings assessed (i.e. Military versus Ministry of Health) of each independently selected article was extracted and reviewed. The findings from the collated pool of included literature were examined via a narrative approach to identify underlying common themes concerning the extent of negative effects of language barriers within the health system in Saudi Arabia and their impact on the quality of health services delivered.

The remaining resources following this second pass at evaluation, all focus on language and cultural barriers that relate to Saudi Arabia healthcare and deemed to contain information thatwas wholly relevant to this study.

3.0. RESULTS

The initial search for relevant literature returned 46 potential sources as shown in the PRISMA diagram in Figure 1. These 46 sources were scanned for suitability, resulting in 24 of them being discarded as not being suitable. The remaining 22 sources were examined in more depth. As a result of this full-text examination, 14 were discarded due to being based oninformation that did not fit the focus of this study. The remaining 8 sources are included in this study and are outlined in Table 1.

Table 1. PRISMA results of the selected studies analysed in this review.

Reference	Region	Sample	Relevance
Kumar, A., & Maskara, S. (2016)	Saudi	N/A	60%
Abdulla, H., & Al-Doghaither. (2000)	Saudi	450	100%
Atallah, M. A., Hamdan-Mansour, A. M., Al-	Saudi	100	100%
Sayed, M. M., & Aboshaiqah, A. E. (2003)			
Al-Ahmadi, H., & Roland, M. (2005)	Saudi	N/A	90%
Ali, M., Shabrawy, M., & Mahmoud, E. (1993)	Saudi	30	80%
Almutairi, K. M. (2015)	Saudi	12	100%
Al-Amer, R., Ramjan, L., Glew, P., Darwish, M.,	Saudi	15	100%
& Salamonson, Y. (2016)			
Al-Khathami, A., Kojan, S., Aljumah, M.,	Saudi	116	100%
Alqahtani, H., & Alrwaili, H. (2010)			

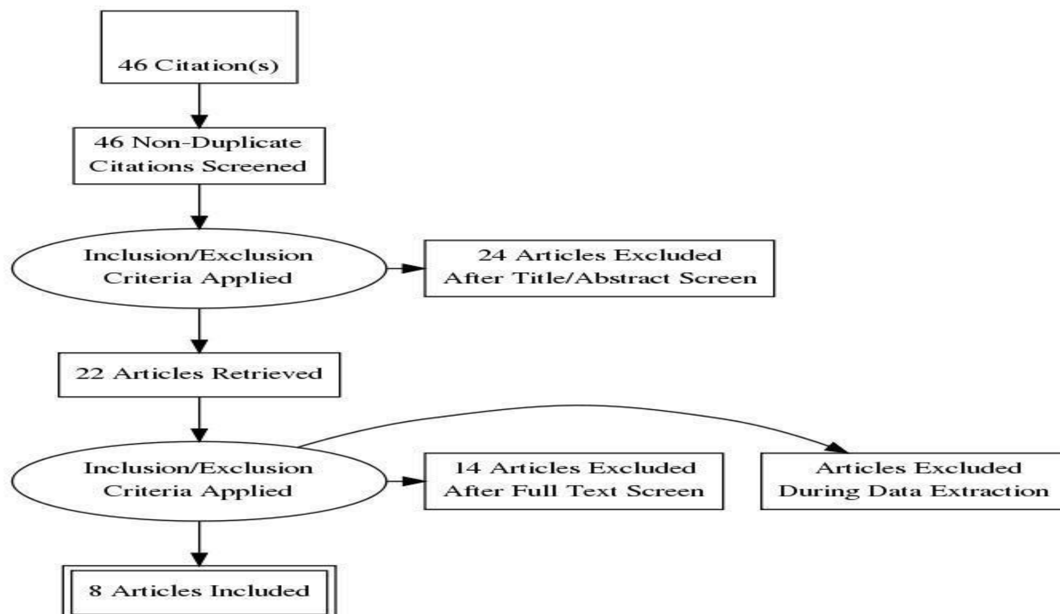

Figure 1. PRISMA diagram of the selected studies analysed in this review.

Each of the eight articles included in the study were conducted in the Kingdom of Saudi Arabia. The sample size ranged from 12 to 450 participants. Two studies were review articles and therefore the sample size is not reported in Table 1. Studies analysed were diverse in the methodology applied and the individual focus of the research questions, within the scope of the abovementioned theme. Overall, studies were indicative of language and communication being a key driver of high-quality health care delivery. Conversely, language barriers were seen to be associated with poor outcomes and poor patient satisfaction.

4.0. DISCUSSION

The scoping review found that the problem of language barriers within Saudi Arabia healthcare has been examined multiple times in the past.

As a primary service-driven facility, a hospital is charged with providing adequate healthcare for all patients, at all times. It is an expectation that this care is provided in such a way, that every patient is sufficiently satisfied with the level of care they have received, and that the treatment or aid they were provided addressed the problem with the patient's health effectively. This duty of care is one of the prime service delivery drivers, and as such, ensuring that patients are satisfied with the treatment and service they have received is an important aspect of healthcare service delivery (Al-Doghaither, 2000).

Within the Saudi Arabia healthcare system, the emphasis is given to the measurement of the patient experience, and evaluation of the outcome. The view of the patient is given

weight, with the patient having an active role in service evaluation. The opinions of patients are considered, and the level of satisfaction that each patient expresses is an important part of the overall process of monitoring service levels (Al-Doghaither, 2000). Patient satisfaction is derived from the sum of the patient's experience across every point of care. This includes actual treatment, and also interactions with hospital staff such as nurses (Atallah, Hamdan- Mansour, Al-Sayed, & Aboshaiqah, 2003).

Many aspects of service delivery, especially these patient experiences, can have either a positive or negative effect upon the patient's level of satisfaction. One aspect that can influence the patient's opinion of the service they have received is a communication and language barrier that stops medical staff from communicating with patients effectively. In a study carried out by Aljuaid, Mannan, Chaudry, Rawaf, & Majeed (2016), language and communication were attributed as being one of the key drivers of patient satisfaction, related to the quality of care that they received.

4.1 Causes of language barriers among health professionals

Saudi Arabia has a healthcare system that has evolved quite rapidly (Aljuaid, Mannan, Chaudry, Rawaf, & Majeed, 2016). This rapid growth has meant that there is a local skills shortage, in recruiting skilled and experienced medical staff of all types, especially nurses and low-level healthcare workers. This has forced the healthcare service to look at foreign healthcare workers as a solution to fill the shortfall in locally available professionals (Almutairi, 2015). This influx of foreign healthcare workers has been problematic in some ways. Most notable are the cultural and language barriers that are produced. Saudi Arabia is a conservative Islamic country, with unique cultural traits, and a single language that is predominantly spoken by every patient. By employing foreign healthcare workers, the healthcare system has created a situation whereby language barriers can and do have a negative effect on the quality of service that patients receive (Albougami, 2019).

The problem is twofold. Not only is language itself a barrier, but cultural aspects alsoeffect communication. Islam is the only religion that nationals of Saudi Arabia practice. The Islamic religion has cultural aspects that can directly affect the way that healthcare is provided, and that treatment is delivered (Almutairi, 2015). Cultural barriers cause foreign healthcare staff confusion, frustration, and often-insurmountable problems when it comes to providing needed treatment and healthcare. Furthermore, Muslims believe that death, sickness, and other health-related issues are the dictates of Allah (Albougami, 2019).

Therefore, there can be "crossed purposes" between the Muslim faith, and the service that medical professionals provide. This means that the patient often has a far different view ofwhat healthcare is, and why it is needed.

As examples of this, foreign nurses have reported problems with communicating with patients in Saudi Arabia, in both verbal and non-verbal forms. Specifically, Saudi women covering their head and body, which removes the possibility to read the responses and reactions of patients, and can also make verbal communication much more difficult. Furthermore, touch and intimacy are also an issue, which can make the application of treatment problematic for both the medical professional and the patient (Albougami, 2019).

4.2 How extensive are the language barriers among health professionals?

The Ministry of Health (MoH) has a policy of recruiting healthcare professionals, and healthcare workers such as nurses, from countries such as the Philippines, India, Australia, Malaysia, America, South Africa and the United Kingdom (Almutairi, 2015). This is due to a significant shortfall in the number of qualified local candidates. As has

been shown above, cultural and language barriers are caused by the induction of a foreign healthcare workforce. With Arabic being the primary language in Saudi Arabia (Almutairi, 2015), even foreign healthcare workers who are proficient in English still face significant language barriers, as not all patients have English language proficiency. The direct result of this language barrier is a detrimental effect on the quality of service that patients receive (Almutairi, 2015).

Historical studies have shown that language barriers are a problem that many foreign healthcare workers encounter. This forms a barrier for nurturing a good patient-provider relationship within healthcare establishments. The patient-doctor relationship is a very important part of any treatment regime (Almutairi, 2015). This barrier then has a direct effect on the perceived level of care the patient has received, in the eyes of the patient. A study showed that 42% of patients who fall foul of this language barrier (Ali, Shabrawy, & Mahmoud, 1993), are unsatisfied with the service they received, and how medical professionals communicated with them about their medical condition and the treatment that they were being provided. Furthermore, for nurses who had become the victim of some formof violence, with the patient as the perpetrator, 36% blamed the language barrier as the trigger (Almutairi, 2015).

However, it is important that we put things in perspective, and show that the language and cultural barriers within a healthcare facility are not the single most detrimental effect on perceived patient satisfaction and quality of care. In a study conducted in Riyadh, Saudi Arabia (Al - Ahmadi & Roland, 2005), it was found that 40% of all patients were generally dissatisfied with the level of care that they were provided. The single most pressing cause for this dissatisfaction was the fact that there were serious delays in receiving treatment and assistance (63.9%). This was followed by a lack of specialists to deal with specific medical problems (38.9%) (Al - Ahmadi & Roland, 2005). However, there are three categories of complaints that do relate to language and communication. These three combine to create a significant problem. 19.4% of patients expressed frustration at the language barrier. 22.7% complained that the explanations given to them by medical staff were neither understandable nor clear, and 28.9% complained that that medical professionals failed to clearly explain their medical condition to them (Ali, Shabrawy, & Mahmoud, 1993).

As we can see, although cultural and language barriers are one of the main causes of dissatisfaction for patients, this is not the primary driver of dissatisfaction. However, due to the weight of dissatisfaction due to poor communication, removing or lessening language barriers could have a good effect on overall patient satisfaction scores. However, it is important to note here that perceived patient satisfaction is not the same as service quality. A patient who has complained about language or cultural barriers may have received perfectly adequate, professionally administered care. They simply did not comprehend the actual level of care they received, due to the communication issue.

4.3 Impact of language barriers among health professionals on healthcare delivery

So only the effect that language and cultural barriers have on patient satisfaction with the quality of care that they receive has been addressed. The patient's perception of the quality of care that is. Of course, this is an important consideration, but it is not the whole

picture. There are three ways that a language barrier can manifest an effect on healthcare. Firstly, it can affect patients, related to the quality of care they perceive they have received (Albougami, 2019). It can also have an indirect or direct effect on the actual quality of care and treatment the patient receives. Finally, medical staff are also impacted by the language barrier, in the

way they have to carry out their duties, and the problems they face in providing care and treatment during their workday.

4.4 The impact of language barriers on patient care

Since 1993, promoting the concept of quality of care has been one of the drivers of the way that healthcare is provided in Saudi Arabia. National guidelines provide a process for quality assurance across healthcare services such as child health care, immunization, referral, chronic disease management, prescribing, health education, maternal health care, management of communicable diseases, and environmental health (Al - Ahmadi & Roland, 2005).

One of the ways that quality of care is measured is to survey patient satisfaction.

However, the question has to be asked, whether the language barrier skews the results of such measurement? There is a difference between the actual quality of care a patient received, and the quality of care they perceive themselves to have received. Dissatisfaction with communication could potentially cause a patient to sufferer dissatisfaction, even though the actual quality of care they received was acceptable. Furthermore, failures in communication could mean that the patient simply is not aware of whether they have received a quality service or not (Aljuaid, Mannan, Chaudry, Rawaf, & Majeed, 2016).

Aside from perceived patient satisfaction, there are tangible effects that a language barrier can have on a patient. The patient may be unable to communicate their symptoms and health problems to a medical professional, and this could lead to a wrongful or late diagnosis. This could be a serious problem in some cases, for example, a cancer patient going without critical treatment in time to ensure they recover fully. It could also lead to the patient being provided with the wrong treatment, or even being denied treatment. Additionally, the patient may not understand what their responsibilities are as an outpatient. They may not understand the dosage of medication they must take or other ways that they are expected to care for their medical condition when they are discharged from the hospital (Albougami, 2019). This could lead to the patient's medical condition going untreated once they are at home, or to patients taking the wrong dose of medication, causing a further health problem, for example.

4.5 The impact of language barriers on the quality of care

Nursing staff within the Saudi Arabia healthcare system have commonly noted a language barrier. One of the primary aspects of this problem, uncovered by a 2016 study, was related to communicating to a patient about safety (Aljuaid, Mannan, Chaudry, Rawaf, & Majeed, 2016). Understandably, any language barrier will create a healthcare vacuum, wherein optimal treatment results cannot be achieved. Misunderstandings, oversight or simple mistakes could lead to a member of the medical staff failing to provide the correct treatment, administering the wrong treatment, or even failing to provide any treatment at all (Abdulla & Al-Doghaither, 2000).

A language barrier between local healthcare staff speaking Arabic, and foreign healthcare staff who do not speak Arabic could exacerbate this problem. When we consider the general level in inter-staff communication that is required of healthcare professionals, just to perform their daily duties, it is very easy to see how this particular language barrier could result in mistakes being made during the day to day running of a healthcare facility. In fact, in certain cases, such a mistake could be construed as clinical negligence, if it results in harm to a patient either indirectly or directly (Almutairi, 2015).

Of course, a language barrier is not the only driver of care quality, it is simply one of them. The broader picture includes failures of leadership, and a requirement for better management and a need to establish a culture of safety and diligence, alongside

leadership reform in hospitals. However, it remains that the inability to provide patients with instruction and medical advice due to problems with communication is still a key factor that can and does impact the quality of healthcare in Saudi Arabia (Health & Medicine Week, 2016).

4.6 The impact of language barriers on medical staff

So far only the problems that a language barrier can cause from the viewpoints of perceived patient satisfaction, and also how a language barrier can have an actual effect on the quality of care provided in healthcare establishments within Saudi Arabia have been examined. The final negative effect that language and cultural barriers have, is on the actualhealthcare staff themselves.

Patients see nurses as individuals and form one on one healthcare relationships with nurses that are attending them. Nurses are expected to provide care in a respectful way and tobe attentive to the needs of the patient (Atallah, Hamdan-Mansour, Al-Sayed, & Aboshaiqah,2003).

Medical professionals evaluate their performance throughout the day, and one of the main ways they can know if they are doing their job properly is from the interaction that they have with their patients and the patient responses to actions that they take. For example, if a nurse provides medication intended to lessen a symptom that a patient exhibits, the nurse requires feedback from the patient to understand whether the treatment has had the desired effect. This is an important part of the treatment delivery process (Abdulla & Al-Doghaither, 2000). When such feedback is not possible to capture, due to a language barrier, this leaves the medical professional without the ability to evaluate their performance, and check that each patient receives due care and attention (Abdulla & Al-Doghaither, 2000). Put simply, it means that the medical professional is unable to evaluate whether they have fulfilled their duty of care towards a patient that they cannot effectively communicate with. This can lead to
work-related stress, as the medical professional fails to receive the confirmation that theyneed.

Interpersonal communications with other medical staff can also be frustrated by a language barrier between co-workers. This can lead to unfulfilling or even adversarial relationships with other hospital staff. This is again, something that can contribute towardswork-related stress.

A language barrier can even be the cause of physical abuse towards a member of the healthcare staff. In 36% percent of instances of work-related violence to nurses in Saudi Arabia, it was found that some form of communication breakdown, caused by a language or cultural barrier, was the underlying reason for the event taking place (Almutairi, 2015).

4.7 Combining the impact of language barriers on healthcare in Saudi Arabia

We can now see that it is not only patient satisfaction that is affected by cultural and language barriers within the Saudi Arabia healthcare system. Indeed, although patient satisfaction is the most easily and often measured metric that is affected by a language barrier(Atallah, Hamdan-Mansour, Al-Sayed, & Aboshaiqah, 2003), it is not potentially the most serious, with the direst consequences.

Communication problems between medical professionals and their patients can have serious, dangerous or even fatal effects on the quality of care that patients are provided, due to no other reason than miscommunication. Furthermore, the working lives of medical staff are negatively impacted by both a language barrier between themselves and their patients and also between themselves and their co-workers, managers or subordinates (Health & MedicineWeek, 2016).

These three underlying problems combine into a single, compelling reason for tryingto minimise the negative impact of language

barriers on the healthcare system within Saudi Arabia. This will improve the quality of care, the satisfaction of patients, and the workinglives of the healthcare staff.

5.0Recommendations

5.1 Proposed strategies to overcome language barriers among health professionals.

Reasons why language barriers between patients and medical professionals persist within the Saudi Arabia healthcare system have been discussed. Adverse effects this barrier has on a patient's perceived quality of care, the actual quality of care, and also the working environment for healthcare workers are now addressed. Now this paper will discuss a range of potential solutions that could solve the problem in the short-term, whilst working towards a permanent solution.

This paper begins this process by proposing an in-depth evaluation of the extent of the problem and then moves on to cover several types of potentially viable solutions. Each of which can be combined with any of the others, to begin working towards removing the language barrier within the Saudi Arabia healthcare system completely.

5.2 A methodical evaluation of the extent of the problem

To begin developing a solution to the problem of language and cultural barriers within the Saudi Arabia healthcare system, the true extent of the problem must first be evaluated, measured and quantified. Most past studies have focused solely upon the way that language barriers affect the quality of care (both actual and perceived), that patients receive. This evaluation was done across patient-facing touchpoints, based almost entirely on the experience of the patient (Abdulla & Al-Doghaither, 2000). Therefore, not every aspect of service delivery that could be affected by language barriers, and therefore could also affect service quality, have been evaluated effectively. In effect, only part of the overall picture can be seen from the results of previous studies.

It is proposed that a new study be undertaken, that encompasses five separate aspects of the healthcare service delivery. These would be overall service quality (similar to previousstudies in its execution), infrastructure (and the effects of language barriers on infrastructure provisioning, operation, and maintenance), access to healthcare services (that may be limited by language barriers), and finally customer satisfaction. Each of these could be the basis of a specific KPI (Casey, 2017). KPI could be evaluated to uncover the major ways that language barriers affect healthcare delivery on every level, within the Saudi Arabia healthcare system, and to find out how the overall quality of healthcare services is affected. Overall quality mustbe understood, as this would be key data required to feed the decision-making process on how to make changes (Vergara & Maza, 2018).

5.3 Changes to underlying deficiencies in education in Saudi Arabia

The underlying reason why the Saudi Arabia healthcare system has to employ a vast number of foreign doctors, nurses, and other medical professionals, is that there is a shortfall in locally educated, trained and experienced medical staff. In a 2008 study, it was discoveredthat only 17% of the Saudi Arabia healthcare workforce was made up of local people (Walston, Al-Harbi, & Al-Omar, 2008).

There are many reasons for this shortfall. Some are cultural in shape. For example, most nurses are female, but under Islamic culture, it is much harder for a female to receive the kind of education and training that is needed to qualify as a professional nurse. This problem is well-known. Crown Prince Faisal recognised the detrimental effect this situation has on national growth and educating a skilled workforce. Faisal attempted to begin reforming this situation, by introducing "the right of females to receive an education" (Mohammad, 2016).

On top of these cultural issues, there is also an economic aspect related to educating medical professionals. As with many emerging nations, the role of doctors, surgeons, etc. is
generally filled by people who have been able to leverage a quality education from a well-off family. Put simply, few senior healthcare professionals come from poor backgrounds.
However, even the level of education required to become certified as a nurse in Saudi Arabia, one of the lowest tier healthcare roles, is outside of the financial means of most people. Put simply, the kinds of people that in western countries would be targeted as being good candidates for an education focused on nursing or lower-level healthcare roles, simply cannot afford this kind of education in Saudi Arabia. Even though the Saudi Arabia welfare system guarantees education to all citizens, the actual education received varies greatly based on the financial resources of the student (Mohammad, 2016).
Therefore, the barriers to receiving the kind of education that produces qualified medical professionals in Saudi Arabia needs to be reduced or removed entirely (Health & Medicine Week, 2015). This will encourage young people who otherwise would have to settle for a lower level of education, to invest the time needed to become medical professionals. After all, the very fact that the Saudi Arabia healthcare system relies so heavily on foreign workers, shows very clearly that there is a high demand for locally educated medical professionals of all kinds, specialisations and skill levels.
However, this would be a long-term solution, as even if this were implemented immediately, it would be many years before the first generation of newly qualified local medical professionals would be able to join the Saudi Arabia healthcare workforce.

5.4 The roll-out of training initiatives within healthcare establishments

Whilst improving the opportunities for an education that will produce newly qualified medical professionals is possibly the only real permanent solution to the problem of language barriers within the Saudi Arabia healthcare system, there is a more short-term solution that issimilar.
Several training strategies could be introduced, that could potentially make up for some of the short-term deficits in locally educated medical professionals (Health & MedicineWeek, 2015). As was shown in the previous section, only a low percentage of actual healthcare professionals within the Saudi Healthcare system are educated locally. This is the single main driver of employing foreign healthcare professionals. However, there is a potential for improvement here through internal training.
Locally educated healthcare staff could be up trained to improve their knowledge and expertise. Effectively, shifting them up into jobs that require more knowledge and experience, and then taking on of more responsibility. What this would do, is create a mid- level tier of healthcare professionals in Saudi Arabia that are locally educated. They would be well placed to provide knowledge transfer to newly inducted locally educated people in less important healthcare roles. In effect, this would provide a much more effective way to nurture fresh healthcare staff, in their language, with no language or cultural barriers. This strategy could be repeated, slowly training healthcare staff, and those who are capable, could shuffle their way up in seniority, and provide a core of locally educated healthcare workers, supervisors, and managers (Kumar & Maskara, 2016).

5.5 Reducing the turnover of experienced healthcare professionals in Saudi Arabia

The previous two sections proposed a combined strategy that would firstly increase the number of local educated healthcare professionals working within the Saudi Arabia healthcare system, and also promote capable, existing locally educated healthcare workers into more responsible roles, to create a better environment for

nurturing new healthcare staff without any language or cultural barriers. However, there is a specific problem related to the churn rate of senior and lower-level medical professionals in Saudi Arabia. The average tenure of healthcare professionals is just 2.3 years (Walston, Al-Harbi, & Al-Omar, 2008).

Of course, in a healthcare service that is predominantly populated by a foreign workforce, a high churn rate is to be expected. However, it does pose specific problems. Primarily related to the vacuum caused by senior medical staff who leave. The propensity is to simply find another foreign medical professional to fill this vacuum. This is the path of least resistance. However, it is also expensive and does nothing to nurture the local healthcare workforce.

Therefore, this problem needs to be addressed. While it may not be possible to entirely solve this problem, it could be leveraged in some way. For example, more interns working with the kinds of medical professionals who are most likely to churn after a short tenure. This would boost knowledge transfer from the foreign workforce to the local workforce. It is also important to note that if a strategy of up training local healthcare workers was adopted, the high churn rate would mean that there are frequent possibilities to promote a retrained local medical professional into a more senior role, as a foreign worker finishes their tenure (Walston, Al-Harbi, & Al-Omar, 2008).

This rapid churn rate is a costly problem in financial terms and the loss of knowledge.

However, it could be leveraged as a basis for both knowledge transfer and shifting locally trained healthcare professionals into new roles more rapidly.

5.6 Leveraging the value of technology to solve immediate language problems

Saudi Arabia is not the only nation that suffers a language barrier between healthcare staff and patients. China has a similar problem, in the number of foreign residents that need to visit healthcare facilities that are staffed by Chinese healthcare workers. It has been observed that foreigners would use a smartphone to translate English into Chinese, for them to be understood by Chinese healthcare workers (Kumar & Maskara, 2016).

This demonstrates how even simple consumer technology such as a smartphone with mobile internet can begin to bridge the gap that language barriers create within a healthcare environment. Arabic is a language that is frequently translated using technology-related tools. Arabic is one of the most widely spoken languages in the world and is a primary language within 22 countries (Al-Amer, Ramjan, Glew, Darwish, & Salamonson, 2016).

With Arabic being a language that modern computer translation can manage very well, to a high level of accuracy, this means that simple technology could be used to help alleviate some of the problems caused by language barriers between patients and medical professionals in the Saudi Arabia healthcare system. There is a variety of simple to implement solutions. For example, medical staff that work in a patient-care role could be provided with a simple PDA/smartphone-style device, that can perform on the fly translation (Zhou & Xiaodong, 2013). This could be either text-based, with the medical professional typing and reading English, or it could be voice-activated, providing real-time audio input and output and live translation.

A further example would be publicly available smart terminals, that patients could use to get translations of English words and phrases. For example, prescriptions that contain English drug names, or medical terms that are generally written in English.

Additionally, similar tools could be used by medical professionals in their working relationships with their co-workers. Foreign healthcare workers would be able to bridge the language barrier with their local opposites.

Overall, in the short-term, technology if leveraged intelligently, it could go a long way to solving some of the more immediate problems caused by language barriers within the Saudi Arabia healthcare system.

5.7 Changes to recruitment processes to minimise localised language problems

The Saudi Arabian healthcare system relies heavily on foreign workers just to function. The constant need for new healthcare workers, due to the rapid churn rate discussed above, means that the recruitment process is ongoing and never-ending. There may be ways
to improve the recruitment process, in a way that could go some way towards addressing cultural and language barriers.

If we look at the case of Filipino nurses working in Saudi Arabia, we find that the single most common cause for them leaving employment in the country is the low salary that they receive. 18.3% of all Filipino nurses working in Saudi Arabi stop work due to their salary being too low (Alomari & Aljohani, 2018).

This tells us that that healthcare facilities in Saudi Arabia are likely buying in foreign workers at the lowest salary rate possible. What this means, is that only the lowest skilled medical workers are likely to apply for a position. Not just those that are the least skilled from a medical viewpoint, but those that lack advanced social skills, and the ability to adapt to, and embrace foreign culture. There is a reason why some people with the same education and skills outperform others in the same career. They generally have tertiary skills that give them an advantage. By paying the least possible for foreign healthcare workers, the healthcare system is missing out on the cream of the crop (Alomari & Aljohani, 2018), those that would be better suited to adapting to the cultural problems involved in working in Saudi Arabia.

Therefore, it could be beneficial to review the recruitment process for foreign healthcare workers, to find a way to highlight applicants that may be more capable of adapting to the local culture than others. There would also need to be some provision for remunerating more capable workers better.

5.8 Providing minimal language and cultural skills to foreign medical workers

Moving to a foreign country to live and work is a traumatic, often frightening experience. As an example, students who move overseas to further their education face a confusion of cultural clashes and hurdles to overcome (Savicki, 2010).

Foreign workers also face these kinds of challenges when moving to a new country and encountering a fresh culture for the first time. Not all foreign workers will be confident, outgoing individuals who are equipped to deal with these kinds of challenges. Efforts should be made to induct them in a way that lessens the trauma, and also prepares them better to deal with cultural and language barriers. Previous experience with travel and exposure to foreign languages could act is a basic primer to the shock or working abroad (Savicki, 2010).

This could include basic training in the fundamentals of the Arabic language. Of course, full fluency is not a possible goal, but even a little understanding can go very far. However, the main training that foreign workers should be given, is a basic grounding in the social aspects of the culture within Saudi Arabia. The various taboos, the way social interactions traditionally take place, how to deal with conflict situations, and simply how to communicate with local people without causing offense or confusion (Abdulla & Al- Doghaither, 2000).

Potentially, all newly recruited foreign healthcare workers could attend some form of induction and training course, that would last several days, and provide them with the basics of Saudi culture, and a little understanding of the Arabic language in its spoken form. This would help to boost the healthcare worker's confidence, and also ensure that they do not make serious

cultural mistakes simply due to ignorance.

6.0. CONCLUSION

In the sections above, several potential solutions were put forward, that could partially solve the problem of language barriers between foreign healthcare workers and patients in the Saudi Arabia healthcare system. Whilst some of these, such as the improvement of the educational prospects for potential healthcare workers in Saudi Arabia could have a great impact, they will take a long time to make this impact. However, it is in concert that these solutions could go much of the way towards solving the problem entirely. Therefore, this proposed strategy for implementing these solutions could be adopted.

Firstly, an exhaustive study of the extent of the problems that are caused by a language barrier. Once this has been done, the results can be used to fine-tune the rollout of the combined solutions. In the short-term, technology would be leveraged to provide a stopgap, until the more far-reaching solutions have been implemented and begin to bear fruit (Abdulla & Al-Doghaither, 2000).

Changes to the recruitment process of foreign healthcare workers should be implemented, to attempt to attract a more capable workforce. Foreign workers should also be given a basic grounding in Arabic and Saudi culture before starting work. This should be combined with the up training of locally educated healthcare workers, to improve skills transfer and to create a more nurturing environment for newly recruited local staff. Finally, for the long-term, changes to the way that potential healthcare workers gain access to the required education need to be made. Promoting a greater throughput of young people training as medical professionals, and taking up a suitable post within the Saudi Arabia healthcare system (Abdulla & Al-Doghaither, 2000).

The result of implementing this strategy would be a more adaptable foreign workforce, that has been prepared to face the language and cultural barriers they will come across in their role at work. Local healthcare workers would begin to receive better training, and slowly take on more senior positions within the healthcare system. This mid-echelon oflocal healthcare professionals would then nurture future generations of local healthcare professionals that are the result of the easier access to a suitable local education. Only by making all of these changes suggested can this result be achieved.

The strategy outlined above should not be seen as a one-time fix to the problems that language barriers in the Saudi Arabia healthcare system create. Instead, it should be seen as an iterative tool for improving the situation, and a tool that needs to be maintained. Therefore, the evaluation phase needs to be iterated upon regularly, to discern where improvements have been made, and where problems still exist (Casey, 2017). The current strategy can then be modified to or adjusted to make up for shortfalls, or additional strategies can be conceptualised, evaluated and implemented.

Only by constantly monitoring the extent of the problems caused by the language barrier in the Saudi Arabia healthcare system, and the effectiveness of each solution that has been deployed, can steady work be made towards solving the problem entirely.

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7.0. REFERENCES

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