https://doi.org/10.58256/j2whs893

Research Article

Section: Literature, Linguistics & Criticism

Published in Nairobi, Kenya by Royallite Global.

Volume 5, Issue 4, 2024

Article Information
Submitted: 3rd July 2024
Accepted: 1st October 2024
Published: 24th October 2024

Additional information is available at the end of the article

ISSN: 2708-5945 (Print)
ISSN: 2708-5953 (Online)

To read the paper online, please scan this QR code

How to Cite:
Lamouchi, A., Mohamed Sayed Abdellatif, & Hafez, W. E. (2024). Linguistic accommodation strategies in Non-Arabic speaking doctors' interactions with patients in Saudi hospitals and its role in enhancing healthcare for them. *Research Journal in Advanced Humanities, 5*(4). https://doi.org/10.58256/j2whs893

Linguistic accommodation strategies in Non-Arabic speaking doctors' interactions with patients in Saudi hospitals and its role in enhancing healthcare for them

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Abstract

From a sustainable development perspective in healthcare settings, the quality of communication between healthcare professionals and patients is crucial. The purpose of this exploratory descriptive analysis was to examine the communication strategies used by some non-Arabic speaking physicians in Saudi Arabia hospitals when communicating with their patients. Communication Accommodation Theory (CAT) was used as the framework for this study. Eight medical doctors were audiotaped, and the recordings were transcribed verbatim and coded by the researchers for the five *a priori* defined sociolinguistic communication adjustment strategies in CAT: 1) approximation; 2) interpretation; 3) discourse management 4) emotional; and 5) interpersonal strategies. The findings reveal that all doctors use convergence accommodation strategies. They focus mainly on approximation strategies where they pay great attention essentially to the quality of their language. It is recommended that this study be followed by a larger scale research.

Keywords: healthcare, linguistic accommodation strategies, Non-Arabic speaking doctors' interactions, Saudi hospitals, sustainable development

Introduction

In healthcare settings, sustainable development focuses on fostering multilingual education and enhancing healthcare professionals' cultural competence as key factors for service efficiency. It requires healthcare providers to develop their understanding of other languages and to speak effectively with patients from various linguistic backgrounds (Rodríguez, 2024). It, also, makes it necessary for them to understand linguistic diversity and to respect patients by allowing them to communicate in their own native language.

By adopting these principles of sustainable development, healthcare systems can encourage efficient doctor-patient communication, which in turn will enhance health outcomes and make healthcare more just. Communication failures lead to patients' inhibition, health errors (Watson, Jones & Hewett, 2016), poor diagnostics, and difficult treatment (Frantsve & Kerns, 2007; Hehl & McDonald, 2014). Hence, physicians, specifically, should be attentive to their patients' needs, desires, and wishes. They need to be able to adjust to the language of patients and to do away with all kinds of linguistic differences, leading to an overall environment of mutual therapeutic relationships (Hehl & McDonald, 2014), trust, and satisfaction (Feuerherm *et al*., 2021) for effective diagnostics and treatment (Angus et al., 2012; Farzadnia and Giles, 2015).

Many studies have been conducted in different countries to analyze the physician-patient interactions. However, this kind of studies is still very rare in the gulf-region countries like Saudi Arabia where many non-Arabic speaking physicians are working. The different linguistic background between the local patients and the foreign physicians makes it interesting to investigate the rapport between them. The present study's main objective was to explore the different verbal communicative strategies used by physicians in dealing with their patients. The Communication Accommodation Theory (CAT) was adopted as a basis for understanding and interpreting these communication strategies.

The purpose of this study was to describe the verbal communication strategies used by non–Arabic speaking physicians working in Saudi hospitals as they interacted with their patients. It looked to find out 1) whether non-Arabic speaking doctors accommodate to their patients; 2) the accommodation strategies used by these doctors and their indicators; 3) the most used strategies among these. This study has major implications. First, it uncovers an unknown aspect about non-Arab doctors in their relation with local Saudi patients. Second, it contributes to filling-in a research gap in this field in the Middle-East region. Third, it has practical implications, as the doctors, for instance, can benefit from "an increased awareness of adapting their communication style" to the preferences of their patients (Jones et al., 2007, p. 211). Finally, it opens new paths for further research in the same context.

Theoretical Framework

As demonstrated by Farzadnia and Giles (2015), early health communication studies have been a-theoretical. In their review of the literature, Beck *et al*. (2004 in *Ibid.*), for example, found that 75% of research on medical communication was not sustained by theoretical frameworks. This, of course, has started to change and medical communication research has begun to incorporate language approaches and theories to analyze patient-provider interaction (see Bylund, Peterson, & Cameron, 2012).

Communication Accommodation Theory (CAT) is one of the paramount theories used today in medical communication research. It is much used in the medical visiting settings research (Hehl & McDonald, 2014; Jones, et al., 1999; Jones, Woodhouse, & Rowe, 2007; Ryan, Hamilton, & See, 1994).

It is an interdisciplinary theory of language and communication (Coupland & Jaworski, 1997) that has developed considerably in the last decades (for historical reviews, see Gallois, Ogay, & Giles, 2006; McGlone & Giles, 2011). It is an interface between linguistics, communication, and social psychology (Farzadnia and Giles, 2015). It focuses on understanding "how, when, and why speakers attune their messages to match that of their interlocutors (accommodation) or not (non-accommodation) and the ways in which conflict can be managed" (Gasiorek & Giles, 2013) (Farzadnia and Giles, 2015: 18-19). According to this theory, in every communication situation, partners establish communication distance between each other. This is referred to as "accommodation" which is "the process by which individuals use communication to signify their attitudes of their communicative other, thereby establishing levels of social distance (Giles & Ogay, 2007). Individuals have their own expectations and approach for accommodation dependening on stereotypes and norms (Giles & Ogay, 2007)" (Bonfiglio, p.7). The premise is that in communication situations, the involved parties try to adjust (attune) their language behaviors according to each other's communication styles and needs depending on the way they perceive one another (Coupland, et al., 1988; Hehl & McDonald, 2014). Communication adjustment strategies lead to accommodation or non-accommodation. Accommodation includes three strategies: convergence, maintenance, and divergence (Dragojevic, Gasiorek, & Giles, 2016). Convergence occurs when an interlocutor adjusts his/her communication to make it similar to the interlocutor's communication style. Maintenance refers to one's persisting in his/her style. Divergence refers to maximized verbal and non-verbal dissimilarities between the interlocutors.

The other face of accommodation is non-accommodation. It includes three strategies: over-accommodation, under-accommodation, and counter-accommodation. Over-accommodation occurs when the interlocutor "over-shoots the level of adjustment felt to be appropriate in a given situation" (Gasiorek & Giles, 2012, p. 311). Counter-accommodation occurs when the interlocutor accentuates the dissimilarities. Under-accommodation occurs when the communicator fails to accommodate to the interlocutor. Farzadnia and Giles (2015) conclude that over-accommodation can be considered as an extension to convergence, counter-accommodation as an extension to divergence, and under-accommodation as an extension to maintenance.

CAT suggests that there are at least five sociolinguistic communication adjustment strategies: approximation, interpretability, interpersonal control, discourse management, and emotional expression (Coupland, Giles, & Henwood, 1988; Farzadnia and Giles, 2015; Giles, Gasiorek, & Soliz, 2015). The use of these strategies depends mainly on the "focus or goal relative to a conversational partner's needs and characteristics" (Dragojevic, Gasiorek, & Giles, 2016:40).

Approximation strategies refer to the ways speakers adjust their communication patterns to make them similar or different from those of the interlocutors (Farzadnia and Giles, 2015; Mahadhir, Nor, & Azman, 2014). The focus is on the partner's language production (Dragojevic, Gasiorek and Giles, 2016; Watson, Jones and Hewett, 2016). Approximation strategies can be manifested through lexical (e.g., use of colloquial vocabulary, dialect), phonetic (e.g., modifying accent, intonation, pitch, pauses, interruption, speech rate, volume), and morphological features, and other non-verbal behaviors, such as conscious use of gestures, increased gaze and smiling (Dragojevic, Gasiorek and Giles, 2016; Farzadnia and Giles, 2015; Jain and Krieger, 2011; Watson, Jones and Hewett, 2016). In geriatrics, for example, studies report that approximation strategies included the so-called elderspeak characterized by the use of exaggerated intonation, high pitch and raised volume, reduced rate of speech, inappropriate terms

of endearment (diminutives), simplified syntax and lexis, and collective first person plural pronouns in speech (Farzadnia and Giles, 2015). This type of approximation is concluded to be a kind of over-accommodation.

Interpretability accommodation strategies are ways and tactics chosen by interlocutors, on the basis of the perceived interpretative and comprehension abilities of their partners, to make their communication more understandable (Jones et al., 2007; Mahadhir, Nor, and Azman, 2014). The partners' concern is about the mutual ability to understanding what is being communicated (Dragojevic, Gasiorek & Giles, 2016; Watson, Jones and Hewett, 2016). Interpretability strategies are treated in studies where interaction involved pain communication, neonatal care, and palliative care. From these studies, it can be concluded that in order to accommodate the others' level of understanding and increase intelligibility, communication partners need to, for instance, adjust their speech, adjust their voice, care about the degree of topic familiarity, decide upon how much technical medical jargon can be used, explain medical concepts, decrease the diversity of their vocabulary provide sufficiently clear, direct, and consistent information, and simplify syntax (Dragojevic, Gasiorek and Giles, 2016; Farzadnia and Giles, 2015; Watson, Jones and Hewett, 2016).

Discourse management strategies are the communication adjustment ways adopted to manage a conversation. They are used to respond to the conversational needs of the interlocutor as perceived and assessed by the other interactant (Farzadnia and Giles, 2015). The focus is on the process of the communication rather than its content (Watson, Jones and Hewett, 2016). The accommodative discourse management strategies used by health service providers and addressed in studies in pain communication, geriatrics, and psychiatry contexts were of two types: linguistic and paralinguistic (Dragojevic, Gasiorek and Giles, 2016; Farzadnia and Giles, 2015; Watson, Jones and Hewett, 2016). These strategies cover different aspects. These may include controlling or sharing how topics are selected, introduced, and developed (selecting conversational topics of mutual interest or concern, maintaining topics and topic sharing, introducing new topics frequently and shifting topics rapidly), the management of interpersonal position and face (using subtle linguistic features such as question phrasing, pauses and interruptions, use of back-channels), and the structure of turn-taking (i.e. allowing or prohibiting equal turn-taking through, for instance, utilizing open-ended questions, adopting appropriate turn lengths, regulating speaking turns (Coupland, Coupland, Giles and Henwood, 1988) and Mahadhir, Nor, and Azman, 2014).

Emotional expression strategies are ways and tactics used to respond to the emotional and relational needs of the interlocutor (Farzadnia and Giles, 2015; Jones et al., 2007; Park & Watson, 2007; Williams et al., 1990), especially in cases where unpleasant medical information are disclosed (Jain & Krieger, 2011). The main concern is about the partner's feelings (Dragojevic, Gasiorek and Giles, 2016). In fact, in the health service contexts, service providers use these strategies in order to reduce the patients' negative emotions, comfort them, diminish their worries, and show them care. These strategies can be verbal (such as using simple statements expressing sympathy) as well as nonverbal behaviors (such as smile, supportive touch, facial pleasantness, and respectful silence) (Farzadnia and Giles, 2015). Interpersonal control strategies refer to the ways people attune their communication choosing whether to exert power and authority, control the interlocutor and the flow and length of conversation, emphasize formality and inequality, and direct the conversation or not based on preconceived role relations, professional status, and relative power (Farzadnia and Giles, 2015). If medical service providers opt for converging,

they need to account for and show respect for patients' level of autonomy and individuality, express interest in patients, allow shared decision-making with them, and balance the power dynamics with them by, (among other things, setting the communication agenda, maintaining the logical flow of that communication, and disclosing the appropriate amount of medical information (Farzadnia and Giles, 2015). On the contrary, to show authority and exert control, some providers might interrupt patients, change topics abruptly, terminate consultation, reduce the patient's ability to express their opinions, insist on the use of honorifics or insist on reminding the partner of their relative status or role (Dragojevic, Gasiorek and Giles, 2016; Farzadnia and Giles, 2015; Watson, Jones and Hewett, 2016). Further, they might claim power directly (Farzadnia and Giles, 2015; Harwood, Soliz and Lin, 2006; Mahadhir, Nor, and Azman, 2014).

Our review of the literature shows that a very important number of studies have used CAT as their theoretical framework in analyzing communication strategies used in medical settings. These studies deal with a variety of topics. Some focus on patients' evaluations of interaction with physicians (e.g., Jones et al., 2007; Lagacé, Tanguay, Lavallée, Laplante, & Robichaud, 2012). The aim is to depict the effective versus ineffective health interactions from the point of view of the patients (Jones et al., 2007). Some other studies are interested in intergenerational contexts and focus on how health care providers accommodate to elderly populations in order to assure an effective service to this category of patients (Ryan et al., 1995, Sparks & Balazs, 1997; Williams et al., 1990). More specifically, these studies aim at showing how the service providers' consciousness of the existing intergroup differences and their use of sociolinguistic strategies to accommodate this category of patients lead to creating a balance in role relations (Farzadnia and Giles, 2015). Other contexts for these studies involved pain communication contexts, geriatrics, psychiatry contexts, neonatal care, and palliative care.

As the Accommodation Theory (CAT) framework is proven to be effective in discussing medical settings communication and as it is not widely used in the Middle East (Farzadnia and Giles, 2015), it has been selected to be used in the present study as a basis for the analysis of the verbal techniques physicians used with their patients in some hospitals in Saudi Arabia.

Methodology

The purpose of this study was to explore the CAT strategies used by non-Arab medical doctors with their Saudi patients in emergency service in the south of Saudi Arabia. Of the different health service providers (Farzadnia and Giles, 2015), the sample of this study consisted of 8 non-Arab doctors (7 males and 1 female). Although the number of nurses is much higher in Saudi hospitals, the decision was to study doctors as they are the main decision makers in emergency services. The number of doctors dealt with in this study appears to be small. Yet, regarding the number of physicians who accepted to collaborate with us and given the exploratory nature of the study, the data collected in the study from these eight doctors was enough to answer the research questions. Data collection consisted in recording the doctor-patient conversations at the emergency service ward. These records were transcribed verbatim (Hehl & McDonald, 2014). Some non-formal and non-systematic interviews took place with some of the doctors, but they were not taken as a primary source of the considered data.

Analysis and Results

A classical content analysis approach was used to analyze the transcripts. In the first stage, the focus

was on identifying the verbal techniques used by the doctors. The different techniques depicted from the literature helped encoding the content. When possible, other techniques were also identified. In the second stage, the researchers developed an analysis chart with five sections. Each section included one of the five accommodation strategies (approximation, interpretability, interpersonal control, discourse management, and emotional expression) and 4 to 6 relevant techniques selected from the ones identified in the first analysis stage. Some techniques could be used with more than one strategy (like the technique of "interruption" that could be put with both discourse management strategy and interpretation strategy), but they were put under just one strategy to facilitate the analysis. The chart was used for analyzing the frequency of use of these techniques in order to rank the accommodation strategies. A three-segment Likert scale (frequently-rarely-never) was used for rating. This chart can be used in further research as a questionnaire or observation chart.

The results show that the five sociolinguistic strategies (namely approximation, interpretation, discourse, interpersonal, and emotional strategies) were used by non-Arabic speaking doctors. In this section, we present the main outstanding techniques used by the non-Arabic speaking doctors for each accommodation strategy.

As shown in figure 1, the results indicate that all eight doctors approximated their patients by using three main techniques. They always used the local Arabic dialect. They tried their best to speak in the language of the local people. They wanted to break the linguistic barrier by learning the Arabic dialect of the region and speak it. They permanently used also easy words. They tried always to avoid complicated words or pompous jargon that might cause problems of communication. Besides, they always avoided the use of the English language. They never tried to recur to English even with educated people. If they had to use this language, they would use it with the nurses working with them. 4 out of the 8 doctors attempted to approximate using simple words with the same local pronunciation. They found it interesting and more natural to imitate the words are pronounced locally. Finally, 2 doctors out of 8 approximated by using religious words. They seemed to think that the use of these religious words especially in a Saudi context would make them accepted easily by their Saudi Muslim patients.

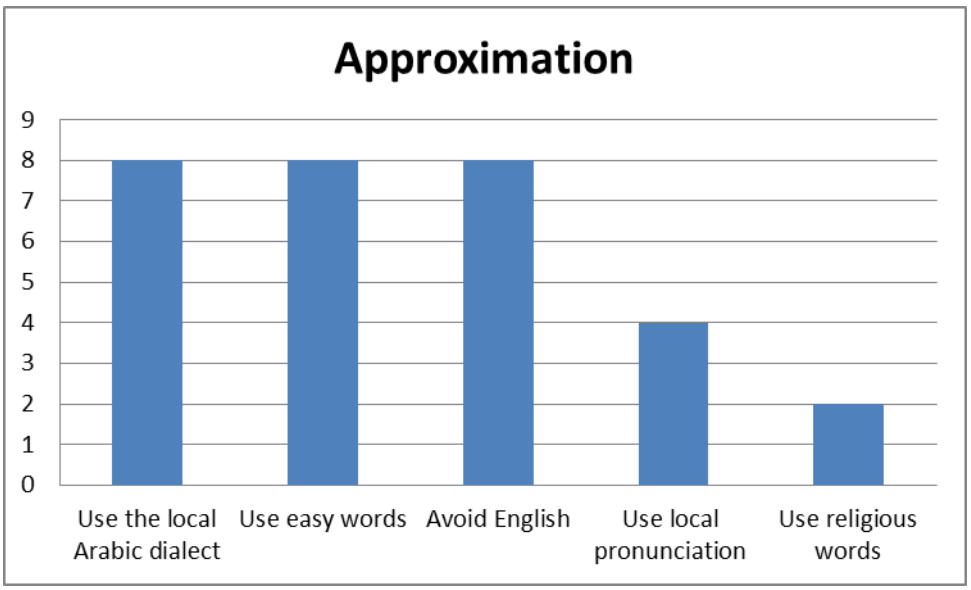

Figure 1. Approximation strategy

As shown in Figure 2, results reveal different features related to the discourse management strategy.

The overall analysis of the study data shows that one feature of the discourse management strategy is the use of meaningful, but non accurate, sentences. 7 doctors out of 8 produced meaningful Arabic sentences. Yet, these sentences are not always syntactically correct. They are developed according to doctors' idiosyncratic grammars. However, they are still able to deliver the message in a comprehensible way. Another feature of the discourse strategy is the use of functional words. 7 doctors out of 8 used short words (e.g., feeh, eesh, mushkila, tatreesh, ibra, eejee, awal, fih, alhin, ousbou, youm, ithneen). These are important for doctors as they are key words that are able to express wider implicit meanings and make reference to a lot of unsaid information. A third feature is the use of short questions (e.g., Yameen walla yasar? Ibra walla hboob?). 5 out of the 8 doctors use these short questions that require short but indicating answers. A fourth feature is that the questions are also mostly of the open-ended type (e.g., Alam keef? Eesh Mushkeela?) and they are frequently used by 6 out of the 8 doctors (e.g., Mushkila eesh? Feeh eelaj awal walla ma feeh? Gabel sena fee eelaj? Ana aktub eelaj ba'd khamsa youm tesawi maya barid, yeeji thani; eesh mushkila?; Enta shugil eesh?; Tatreesh feeh wala ma feeh? Dam feeh yejee?; kam youm mushkila?; Awal fi alam, fi istemal huboob? Awal fi alam fi katma?). Another fifth feature of the discourse management strategy is that the non-Arab speaking doctors' attempt to have the control at the level of discussed topic. Seven of these doctors were the ones who initiated the discourse and controlled the topic. They would guide the conversation by their own questions. In the rare cases where patients attempted to divert by making a comment or a joke, doctors pretended not to listen and reinitiated the conversation with a question in connection with another that had already been asked. They posed questions regarding whether the patients received treatment and medicine before or not, whether they suffered from certain symptoms or not, whether they suffered from diseases for a long time or not. According to the collected data, the doctors did not shift the topic but they did shift within the details of the topic itself.

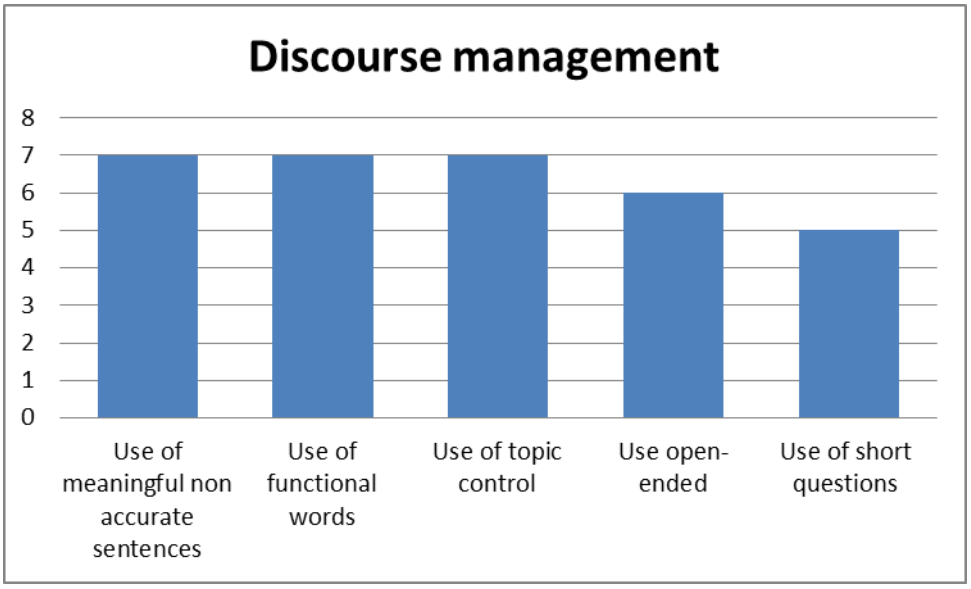

Figure 2. Discourse management strategy

As illustrated by figure 3, the doctors in this study use various techniques related to the interpretation strategy. Reading through the conversations, it appears that all eight doctors do not interrupt their patients while talking. In other words, the doctors let patients talk so that they can understand the cases. Second, the results reveal the high frequent use of simple medical words (for example, dawra, sadeed,

alam, tatreesh, kaha, hashwa and dam). 6 doctors out of 8 choose mostly not to use highly specialized medical jargon that patient would find difficult to understand. Third, it is shown that 3 out of 8 doctors adopted the technique of repeating instruction so that they can be sure that the patients understood them. Fourth, 3 doctors out of 8 usually attempted to provide clear explanations and instructions. Fifth, to make sure of their correct understanding, two doctors used English to ask some same questions to the nurses who translated in Arabic and confirmed their understanding.

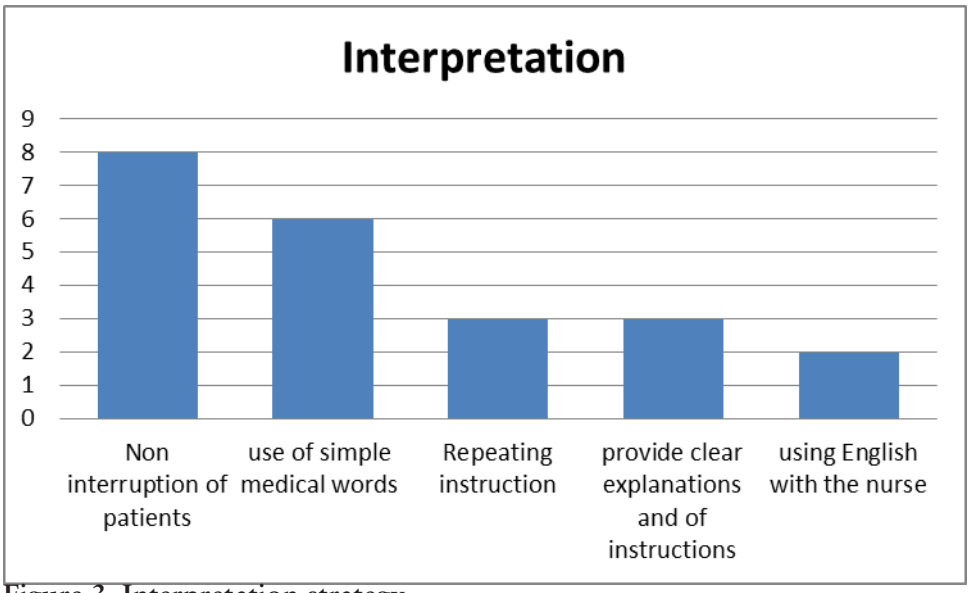

Figure 3. Interpretation strategy

Regarding the emotional strategy, the results show that the doctors use different ways to accommodate to their patients (see figure 4). Five doctors were observed to use positive expressions, such as "ma fi mushkela" (there is no problem), "Lish khouf enta?" (why are you afraid?). Three out of the eight doctors would usually salute their patients. They used the Islamic religious expression (assalamou aleikoum) or popular salutation expressions like "ahleen" and "hela." Two doctors adopted the technique of sharing the diagnosis hypotheses with their patients. Finally, one doctor used to repeat clear explanations to make sure the patient is assured and relaxed. In one case, for instance, the patient was afraid of having a dental x-ray:

> P: "Lazim?" (Is it necessary?)
>
> Dr.: Enta fi hashwa. Gabel tsawi ghyar, ya'nee, x-ray, ba'deen shouf. Ok?. Ba'deen yeeji okay. (You have a dental filling. Before making any replacement, I mean, an x-ray, then we will see. Ok? Then you come. Ok?).

With these repetitions, the patient got reassured and accepted what the doctor's reuirement.

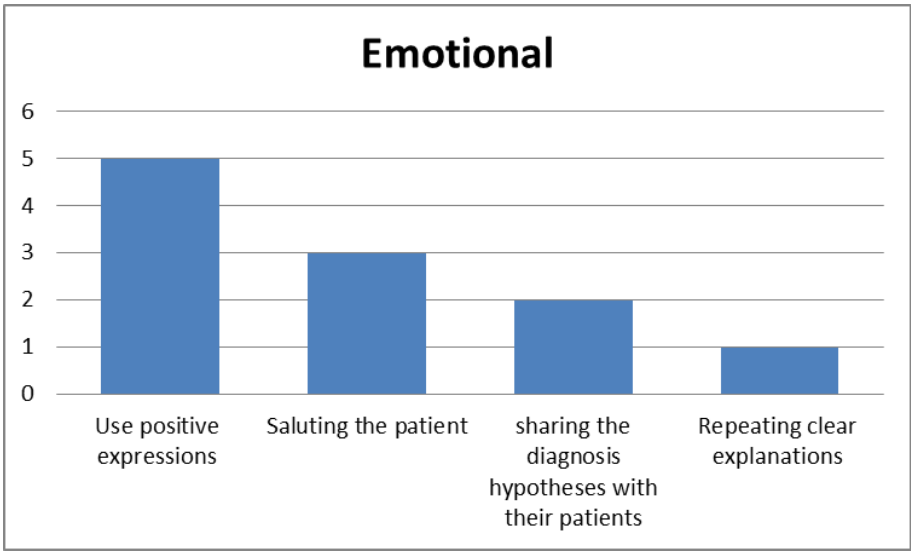

Figure 4. Emotional strategy

As figure 5 indicates, the results show that the doctors adopt the interpersonal strategy to accommodate to their patients. They do not exert power and authority, but they are very collaborative. The reading of the transcripts shows that 5 out of the 8 doctors attempt always to make the patient feel as a partner in the medical setting dialogue. 2 out of 8 doctors use long silence moments with their patients. Being silent, the doctor can listen carefully to the patient and accommodate with him/her. A third strategy adopted by two doctors is to make the patient contribute to the diagnosis of his illness. The doctors try to make the patients feel responsible and understand themselves their own sickness. A fourth strategy followed by two doctors is adopting short talking to female patients. It seems that they think that it is a sign of respect to women in a conservative culture, and by doing so they let the floor to these women to express themselves freely. A less used strategy that is frequently used by one doctor consist in letting the patient talk with a native Arabic speaking nurse. In one way, this behavior can be considered as a technique for giving the patient the opportunity for free expression and not feel manipulated by the doctor.

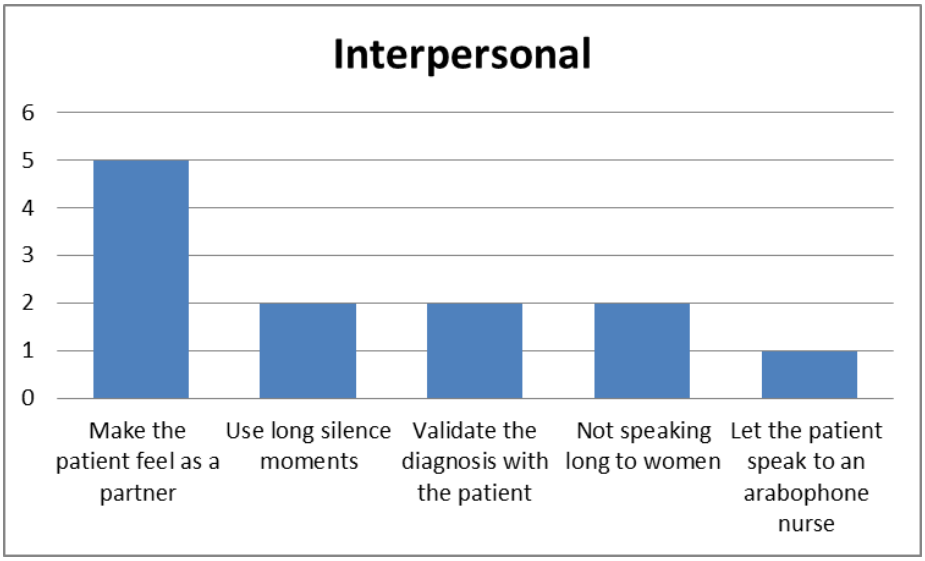

Figure 5. Interpersonal Strategy

As figure 6 illustrates, the frequency of use of the five accommodation strategies is not the same. The approximation strategy is the most used accommodation strategy with a frequency usage rate of

2.55 out of 3. The discourse strategy comes second with a frequency usage rate of 2.35 out of 3. The interpretation strategy is the third most used accommodation strategy with a frequency usage rate of 1.72 out of 3. The emotional strategy is ranked fourth with a frequency usage rate of 1.65 out of 3. Finally, the interpersonal strategy is the least used accommodation strategy with a frequency usage rate of 1.6 out of 3.

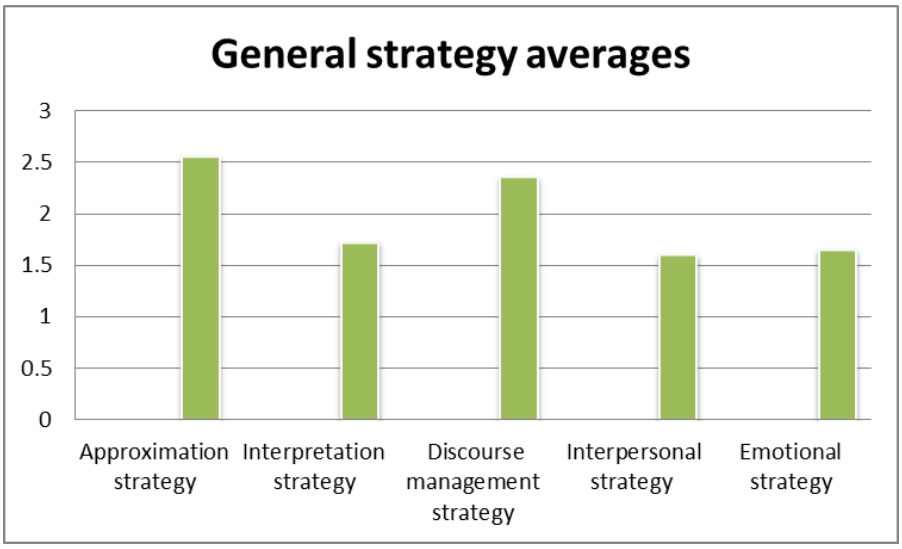

Figure 6. Use frequency of the accommodation strategies

Discussion

The results of this study yield very interesting findings. First, they confirm that the participant doctors accommodate to their patients. They use different accommodation strategies in order to attune to the needs of their patients. Accommodation, in fact, helps these foreign doctors to gain acceptance by their host patients. Besides, doctors want to make patients forget for a while the cultural background of the doctors and all the stereotypical prejudices they may have about those culture. They also want patients to trust them and be confident with them. Thus, the accommodation efforts may show that there is a kind of reassurance that these doctors are able to conduct good diagnosis and provide appropriate treatment.

Second, the findings show that in most of the time, the doctors converge to their patients during conversation. It is, exceptionally, only in the control of talk that they always try to maintain their power of control and do not surrender when the patients want to take that control. This is due to the fact that meetings in the emergency context should be short given the big number of patients waiting and the necessity of reacting quickly. In these cases, doctors are interested in getting the gist of talk in order to make their diagnosis and prescribe the appropriate treatment.

Third, the findings reveal that the participant doctors insist on using approximation, discourse, and interpretation strategies and rarely do they focus on interpersonal and emotional strategies. These doctors tend to use the approximation strategy most in comparison with the other strategies because they feel that they can be very close to the patients in order to gain social approval and lose cultural conflict. Besides, they want, in a way, feel that they are members of the local group. So, as they felt that their identity speaking the Arabic dialect was accepted, they insist on using speech convergence, i.e. use similar linguistic features in their speech, to have the favorable approximation with Arab (Saudi and

resident) patients. Moreover, the use of approximation strategies, interconnected mainly with discourse and interpretation strategies, helps these doctors to be sure of their patients' understanding and to make their patients understand what to talk about, the diagnostics results, and the instructions to be followed. It is, in fact, to be sure that they are safe of making diagnostics or treatment errors.

The focus of doctors is on the quality of language they use. In their review of the literature, Farzadnia and Giles (2015) found out that in intercultural settings, patients and providers who actually represent different ethnic, national, or religious categories focus mainly on language barriers. For instance, Scholl, Wilson, and Hughes (2011) found that both patients and providers were interested in overcoming linguistic discordance more than other problems of ethnicity, religion or nationality. As for Jain and Krieger (2011), they found that international medical graduates use approximation strategies to overcome the more subtle language barriers either verbally or non-verbally. The present study confirms these findings. The doctors seem to be too much preoccupied by language as a means to overcoming their integration problems in the new Saudi setting and to dealing effectively with patients. Their language is characterized by the use of local Arabic dialect, the use of simple language without recurrence to technical words, the use of the same local pronunciation of words, and the focus on meaning rather than the accuracy (i.e., the grammaticality) of language.

It is noticed also that participating doctors afford a significant effort in speaking the local Arabic dialect, because they seem to believe that speaking the local language helps them overcome linguistic and cultural barriers. The results show the doctors' insistence on the use of Arabic. They try their best to use a language that is close to the local people despite their low level of interlanguage in this language. They afford a big effort to learning and practicing the Arabic language. To play it safe, they use simple expressions and common vocabulary. This is a strategy that enables them to find a way out of their limited vocabulary, to win their patients' admiration of how they are speaking their language, and, hence, to guarantee their comfort and trust.

Moreover, the findings show that the doctors in this study do not recur to English as a lingua franca (ELF) in their conversations with their patients. Generally, in contexts where different interlocutors have different first languages and different cultures, they use English as a medium to communicate together (Seidlhofer, 2005). Doctors insisted on the use of Arabic despite the fact that some patients are educated, have good English command, and can communicate with non – Arab doctors easily in that language. This seems to be due in part to the local people's non-mastery of English. Besides, it appears that doctors want to ensure a good approximation to their patients and gain their trust by means of talking their language. Furthermore, they do not use English lest the local people feel offended and uncomfortable. They want to avoid unnecessary conflicts with them about the language used as it is commonly known that local people generally expect foreigners to speak the formers' local language as they are working in their territories. The only instance when one of the doctors was using English was with the nurse, not the patient. The purpose was to make sure that he understands correctly what the patient was saying.

Furthermore, the language used by participant doctors is void of side talk (such as speaking about the weather or economy). Side talk is revealed by some studies to be one of the strategies that medical service providers use in order to win their patients. In the present study, the results show that the doctors do not use side talk with their patients. This is due to their poor lexical store that hinders their venturing in talking about topics outside the medical realm. Besides, the shortage of time for consultation does

not allow doctors to talk about other topics. Furthermore, doctors are afraid that going on side talk may make them lose their authority over the interaction, lose their face, and be misinterpreted by some patients.

The findings bring to the surface the important role of Arab nurses or staff in solving the linguistic barriers facing non-Arabic speaking doctors when they help them in translation or interpretation. The results in the present study show that translating nurses helped doctors especially at the level of correct understanding and interpretation. They can bridge the linguistic gap between non-Arab doctors and Arab patients. Moreover, they can save time and effort for non-Arab doctors, enabling them to see and treat a larger number of patients. So, the ministry of health should think about making available qualified medical bilingual interpreters

Conclusion

The purpose of this exploratory descriptive study was to examine the communication strategies used by a group of non-Arabic speaking physicians in Saudi Arabia hospitals. The findings revealed that all these doctors were eager to use converging strategies to accommodate to their patients. Second, they helped identify the most important accommodation strategies utilized by non-Saudi non-Arabic speaking doctors. Third, they allowed the development of an analysis grid including the most used accommodation strategies and their indicators. This grid may be used in future research in the form of surveys or observation checklist. Fourth, they show that non-Arabic speaking doctors have a big enthusiasm to speak the local Arabic dialect.

It is recommended that non-Arabic speaking doctors landing in Saudi Arabia should get familiar with the local Arabic language and should be able to speak it to facilitate their communication with their patients. From a sustainable development perspective, doctors should have the opportunity to attend training workshops to learn the local language and recognize patients' linguistic diversity (Rodríguez, 2024).

This research is not without limits. It focused on accommodation from the perspective of the service providers only. In future studies, it will be interesting to treat accommodation from the perspective of the patients to investigate their own accommodation strategies and to study their satisfaction. Besides, the sample was very limited in number. A larger scale research, including other parameters, such as the cultural origin, gender, field of specialization, job rank, must be conducted to verify the present findings.

Funding:

The authors extend their appreciation to Prince Sattam bin Abdulaziz University for funding this research work through the project number (PSAU/ 2024/02/29507)"

Acknowledgment:

This study is supported via funding from Prince sattam bin Abdulaziz University project number (PSAU/2024/R/1446).

The authors also extend their appreciation to the Deanship of Scientific Research at Northern Border University, Arar, KSA for supporting this research work through project number (NBU-FFR-2024-3171-03).

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