English as a Medium of Instruction in Arab-Speaking Hospitals: Opportunities and Challenges

Elmuiz G. Ali Dinar

CPD Department – King Salman Armed Forces Hospital, Northwestern Region, Tabuk, KSA Corresponding author: Elmuiz Gaffar Ali Dinar, Email: <u>dinar1@hotmail.co.uk</u>, Phone no.: +966 55 795 4542

ABSTRACT

Background: English is the main language of instruction in hospitals in Arab-speaking countries. Many Arab-speaking healthcare professionals struggle to achieve the necessary English proficiency, leading to limited comprehension, communication difficulties, and anxiety. This problem has academic, professional, and patient-safety implications.

Objective: This study focuses on Arab-speaking countries, using Saudi Arabia as a representative example to reflect wider trends in English as a Medium of Instruction (EMI) settings.

Method: A mixed-methods research design to explore English language proficiency among second-year healthcare professionals in three major Arab-speaking universities. Standardized language assessments, hospital setting observations, and semi-structured interviews were used to triangulate findings. The study also included input from hospital supervisors to examine instructional practices and perceptions of student language preparedness.

Results: Findings showed a significant gap between expected and actual proficiency. Most staff scored below intermediate on tests, particularly in listening comprehension and academic writing. Classroom observations revealed a strong reliance on Arabic. Hospital supervisors were concerned about language difficulties impacting learning and clinical competence. Interview data highlighted staff's lack of confidence, limited vocabulary, and insufficient exposure to authentic medical English.

Conclusion: English language proficiency is a critical yet often neglected component of hospital communication in Arabspeaking countries. Without strategic interventions—such as integrated English for clinical practice courses, content-based instruction, and hospital supervisor development—staff will continue to struggle. Addressing this issue requires collaboration among language departments, medical faculties, and policymakers.

Keywords: English language proficiency, Arab-speaking countries, Hospital communication, Academic language, Clinical communication, ESP, Bilingual instruction.

INTRODUCTION

In the context of global hospital communication, English has become the dominant language not only for academic instruction but also for scientific publication, international collaboration, and clinical practice. Arabspeaking countries, in alignment with this trend, has adopted English as the medium of instruction (EMI) in all its hospitals and health-related disciplines. While, this policy is well-intentioned—seeking to align local professionals with global standards—it presents considerable challenges for staff whose prior education has predominantly been in Arabic ⁽¹⁾.

This study focuses on Arab-speaking countries, while reflecting broader trends observed among Arab-speaking healthcare professionals in English as a Medium of Instruction (EMI) contexts. This paper examined English as a Medium of Instruction (EMI) across Arab-speaking hospitals, where Saudi Arabia was used as a representative example to highlight regional trends and challenges ⁽²⁾.

The Arab-speaking countriesese general education system, particularly in public schools, offers limited exposure to English beyond basic conversational skills. Consequently, staff entering hospitals often find themselves overwhelmed by the linguistic demands of their coursework, which includes advanced biomedical texts, clinical case studies, and interaction with hospital supervisors' members, many of whom are non-Arabic speakers. The shift from learning about English to learning in English is abrupt and often unsupported, leading to academic underperformance, high dropout rates, and reduced engagement ⁽³⁾.

Moreover, in clinical settings, the implications of poor English proficiency become more serious. Miscommunication with hospital supervisors, peers, or patients—especially during clinical rounds or case presentations—can result in medical errors, compromised patient safety, and ethical dilemmas ⁽⁴⁾. While English is the common language among healthcare professionals in Arab-speaking countries due to the multinational workforce, it is rarely the first language for either doctors or patients. This creates a complex web of secondlanguage interactions, where clarity and precision are essential but often lacking ⁽⁵⁾.

Given these stakes, this study investigated the nature and extent of English language challenges faced by Arabspeaking countriesese healthcare professionals. It aimed to analyze their current proficiency levels, identify areas of struggle, and offer practical recommendations for institutional and training programs reform.

LITERATURE REVIEW

English as a medium of instruction (EMI) in Arabspeaking countriesese Medical Colleges: The use of EMI in non-English-speaking countries has become increasingly common, particularly in higher education. In Arab-speaking countries, this shift was driven by the Ministry of Education's aim to improve the global competitiveness of Arab-speaking countriesese professionals and researchers ⁽⁶⁾. However, the adoption of EMI has not been accompanied by sufficient linguistic support. Studies have repeatedly shown that staff are expected to cope with complex academic materials in English with minimal preparatory training ⁽⁷⁾.

Academic language vs. conversational fluency: Cummin's model ⁽⁸⁾ distinguishes between Basic Interpersonal Communicative Skills (BICS)—social language used in everyday interactions—and Cognitive Academic Language Proficiency (CALP), which is essential for understanding lectures, writing reports, and participating in discussions. Many Arab-speaking countriesese staff appear fluent in casual English but lack the academic register required in hospital communication. This gap hinders their ability to grasp complex medical concepts and to articulate responses during examinations or clinical rounds ⁽⁹⁾.

Communication in Clinical Settings: Clinical communication is a core component of medical competence. In Arab-speaking countriesese hospitals, where teams include professionals from diverse linguistic and cultural backgrounds, English is the common language. Miscommunication due to language barriers has been linked to incorrect diagnoses, prescription errors, and patient dissatisfaction ⁽¹⁰⁾. El-Komi ⁽¹¹⁾ emphasize that many ESP (English for Specific Purposes) programs focus heavily on vocabulary while ignoring syntax, pragmatics, and pronunciation, leading to fragmented learning outcomes.

Faculty challenges and institutional gaps: Faculty members, especially those who are non-Arabic speakers, often face difficulties in ensuring that staff fully understand the course content. Some resort to using simplified English or switching to Arabic with the help of bilingual staff. This inconsistency in instructional language dilutes the clinical experience. In many cases, there are no clear language benchmarks for student admission or graduation, which makes it difficult to assess readiness or intervene effectively ⁽¹²⁾.

Need for curriculum reform: Several researchers ^(13,14) argue that ESP courses should include a balance of language skills: reading, writing, speaking, and listening—integrated with subject-specific knowledge. In Arab-speaking countries, however, language development is often treated as the responsibility of the English department, while medical faculties remain focused solely on content delivery. A more integrated, cross-disciplinary approach is needed to ensure that staff develop both medical knowledge and the linguistic tools to express it clearly and confidently.

THEORETICAL FRAMEWORK

This study was grounded in well-established theories of second language acquisition (SLA) and sociocultural learning that offer insights into why English proficiency is such a persistent challenge in Arab-speaking countriesese hospital communication.

Cummins' BICS and CALP:

Cummins' ⁽⁸⁾ framework distinguishes between Basic Interpersonal Communicative Skills (BICS) and Cognitive Academic Language Proficiency (CALP). BICS refers to everyday conversational fluency, which most learners develop within 1-2 years of exposure. In contrast, CALP refers to the language needed for clinical communication and typically takes 5–7 years to develop. This distinction is especially relevant in hospital communication, where language is highly technical, abstract, and context-dependent. Students may appear fluent in English during social interactions but struggle to comprehend or produce medical discourse, which requires CALP. In Arab-speaking countries, most healthcare professionals have not had sufficient linguistic preparation time to develop this deeper level of proficiency.

Vygotsky's Sociocultural Theory:

Vygotsky's ⁽¹⁵⁾ Sociocultural theory posits that learning occurs through social interaction within a Zone of Proximal Development (ZPD). In this model, staff can achieve more with the support of teachers or peers than they can independently. Applied to language learning in hospital communication, this means that staff benefit most when instruction integrates language scaffolding—such as vocabulary support, modeling academic speech, and guided practice. Unfortunately, most Arab-speaking countriesese medical classes prioritize content mastery over communicative competence, leaving staff without the necessary scaffolding to advance in both domains.

Input and noticing hypotheses: Krashen's ⁽¹⁶⁾ Input Hypothesis emphasizes the importance of exposure to language that is slightly beyond a learner's current ability ("i+1"), while Schmidt's ⁽¹⁷⁾ Noticing Hypothesis argues

that learners must consciously "notice" language forms in order to acquire them. Together, these theories support the need for explicit language instruction in medical settings—where staff are not only exposed to English but are guided to recognize patterns, structures, and meanings within academic content. This underlines the importance of integrating English for clinical practice courses that highlight and explain language use in context, rather than assuming staff will acquire it incidentally.

METHODOLOGY

This study used a mixed-methods design combining both quantitative and qualitative approaches. This allowed for a comprehensive understanding of staff' English proficiency levels and the pedagogical environment in which they are expected to function.

Participants: The study sample included 150 secondyear healthcare professionals from three public Arabspeaking countrieses universities (in Tabuk, Omdurman, and Port Arab-speaking countries) and 12 hospitals supervisor's members from the departments of English, medicine, and clinical education. Students were selected using stratified random sampling to ensure representation across gender and workplace performance. Faculty participants were selected purposively based on their experience teaching in English-medium medical programs.

Instruments: To capture the multifaceted nature of English language use in hospital communication, the following instruments were used: **Standardized English Language Proficiency Test** (based on TOEFL frameworks), measuring listening, reading, writing, and speaking abilities.

In addition to **Classroom Observation Protocol** including indicators such as language of instruction, student participation, code-switching, and use of academic vocabulary.

Also, **Semi-Structured Interviews** with both staff and hospital supervisors, exploring experiences, challenges, and perceptions regarding English usage in academic and clinical settings.

Procedure: Data collection occurred over one academic semester. Students were tested in the first month of the semester, followed by two weeks of hospital setting observations across core subjects (e.g., Anatomy, Physiology, Pathology). Interviews were conducted mid-semester to allow reflection after some instructional exposure. Faculty were interviewed toward the end of the semester to incorporate their perspective on student development.

Data analysis:

Quantitative test results were analyzed using SPSS to compute descriptive statistics and identify proficiency patterns across institutions. Interview and observation data were transcribed and coded using invivo qualitative software. Thematic analysis was applied to draw out recurring ideas, beliefs, and recommendations. Triangulation across data sources ensured reliability and reduced bias.

Ethical considerations: The study received formal ethical approval from The Research Committees of participating universities. All participants the provided informed consent. Anonymity and were confidentiality strictly maintained. and participation had no impact on staff' academic evaluation. This work has been carried out in accordance with The Code of Ethics of the World Medical Association (Declaration of Helsinki) for studies involving humans.

RESULTS

The results of this study were presented in three categories: (1) Quantitative proficiency scores, (2) Hospital setting observation findings, and (3) Interview themes from staff and hospital supervisors.

Quantitative Findings: Analysis of the standardized English test showed the following trends:

Listening: Average score 43/100. Most staff struggled to follow lectures or audio clips containing native or near-native speech rates.

Reading: Average score 52/100. Comprehension of dense, academic texts was limited, especially with technical vocabulary.

Writing: Average score 48/100. Students produced grammatically weak essays with poor organization and limited use of academic language.

Speaking: Average score 46/100. Pronunciation, fluency, and medical terminology usage were inconsistent. Many staff paused frequently or switched to Arabic under pressure. Only 37% of staff scored at or above the intermediate level, with clear deficiencies in all four language domains. The results confirm that a majority of staff are not linguistically prepared for English-medium instruction, especially in a field as demanding as medicine. Only 37% of staff scored at or above the intermediate level, with clear deficiencies in all four language domains.

Observational insights: Across all observed classes, the following patterns emerged:

Frequent code-switching: Both staff and some hospital supervisors regularly switched from English to Arabic to ensure comprehension.

Minimal student talk time: The majority of verbal interactions were teacher-centered. Students rarely asked questions or initiated dialogue.

Minimal student talk time: The majority of verbal interactions were teacher-centered. Students rarely asked questions or initiated dialogue.

Limited academic vocabulary use: Even during discussions on complex topics (e.g., cardiovascular pathology), staff used basic vocabulary or relied on memorized terms without full understanding.

Avoidance behavior: Students often avoided presenting in English or participating in discussions due to fear of making mistakes.

These observations indicate a hospital setting culture where English is present but not fully functional as a tool for learning or interaction.

Interview themes: Three major themes emerged from the interview data:

Theme 1: Language anxiety and low confidence: Students expressed anxiety when required to speak English, particularly during clinical role-plays or presentations. One participant noted, "*I know what to say in Arabic, but when I have to say it in English, I forget everything.*"

Theme 2: Lack of systematic language support: Students reported that they had not received adequate language preparation before entering the medical program. Faculty agreed, with one saying, "We are teaching medicine, not English. But without English, staff can't learn medicine."

Theme 3: Need for contextualized English instruction: Both staff and hospital supervisors emphasized the need for English instruction tailored to medical settings. General ESL courses were seen as irrelevant or ineffective. Instead, participants called for case-based language practice, vocabulary drills, and communication workshops embedded in the training programs.

DISCUSSION

The results of this study revealed a persistent and deeply rooted challenge in Arab-speaking countriesese hospital communication: The misalignment between the linguistic demands of English-medium instruction and the actual language proficiency of staff. These findings, viewed through the lens of second language acquisition theory and clinical practice, hold significant implications for staff, hospital supervisors, training programs designers, and policymakers.

Integration with theoretical frameworks: The staff' struggle to meet academic and clinical English demands strongly supports Cummins' (8) distinction and CALP. between BICS Most participants demonstrated basic interpersonal communication in English but lacked the academic register necessary for success in medicine. This reinforces the need to view medical English not simply as vocabulary acquisition but as a specialized language domain that demands targeted instruction. Vygotsky's (15) Sociocultural Theory also provides critical insight. Students were observed to operate more effectively when working collaboratively. especially when supported by peers or bilingual instructors. However, current teaching practices do not consistently provide these scaffolds. In most hospital settings, teacher talk dominated while staff remained passive, likely due to a combination of anxiety, lack of preparation, and insufficient interaction opportunities.

Krashen's Input Hypothesis ⁽¹⁶⁾ and Schmidt's ⁽¹⁷⁾ Noticing Hypothesis suggest that acquisition requires both meaningful input and active attention to language forms. In the Arab-speaking countriesese context, staff may be exposed to English, but without explicit teaching of grammar, pronunciation, and usage patterns within medical contexts, most of that input remains incomprehensible or unnoticed.

Academic and clinical consequences: The consequences of limited English proficiency were significant. Students who cannot comprehend medical texts or participate in English-based lectures fall behind academically. More critically, in ward rounds, miscommunication may result in misunderstandings about patient care, inappropriate treatment decisions, and even medical errors. One hospital supervisors' member noted: "We sometimes simplify diagnosis or ask another student to translate during clinical training. It's not ideal, but there's no alternative." Language difficulties also erode staff' confidence. Interviews consistently reflected fear, avoidance, and shame-especially when required to speak publicly. This social anxiety diminishes student participation and inhibits skill development, creating a cycle that further entrenches language-related gaps.

Institutional shortcomings: The study also points to institutional and curricular shortcomings. English is treated as a gatekeeping mechanism or assumed skill, rather than as a competency to be developed. While most programs require English proficiency tests for admission, there was often little or no follow-up training once staff begin their studies. ESP courses, where offered, focus narrowly on memorizing terminology without teaching how to use English effectively in clinical interactions, case discussions, or written reports. Additionally, few hospitals supervisor's members are trained in how to adapt their instruction to linguistically diverse hospital settings. Some over-simplify content or rely on bilingual staff to act as translators, while others persisted with dense academic English, assuming staff will "catch up." Neither approach has proven effective.

Cultural and sociolinguistic factors: The issue was further complicated by sociocultural dynamics. In Arabspeaking countries, clinical systems are highly teachercentered, and questioning instructors is culturally sensitive. When coupled with linguistic insecurity, this leads to disengaged hospital settings where staff rarely speak, ask for clarification, or volunteer responses. Furthermore, hierarchical relationships in hospitals may prevent staff from admitting confusion or asking for help during clinical rounds.

CONCLUSION

This study aimed to examine the extent and impact of English language proficiency challenges in Arabspeaking countriesese hospital communication. The findings underscored a significant gap between the language expectations of English-medium instruction and the actual readiness of staff. Despite years of English classes prior to hospital, most staff are not equipped with the academic and clinical English skills required to succeed in medical school and beyond.

Without strong English proficiency, staff struggle not only to absorb course material but also to engage in crucial activities like patient interviews, clinical presentations, and collaborative case reviews. These struggles are compounded by institutional neglect of language development, hospital supervisor's inconsistent teaching practices, and the absence of systematic support for improving communication skills. Without strong English proficiency, staff struggle not only to absorb course material but also to engage in crucial activities like clinical patient interviews, presentations. and collaborative case reviews. These struggles are compounded by institutional neglect of language development, hospital supervisor's inconsistent teaching practices, and the absence of systematic support for improving communication skills.

In sum, English language proficiency is not an auxiliary skill in Arab-speaking countriesese hospital communication—it is central to workplace performance, patient safety, and professional success. As Arabspeaking countries continues its ambitious Arab-speaking countries's national education and healthcare development goals reforms, improving English language education in hospitals must be a top priority. To address these challenges, the following **recommendations** are offered:

- **Curriculum reform:** Introduce compulsory English for Clinical Practice courses in the first and second years. These courses should focus on speaking, writing, and reading medical texts, and include role-plays, simulations, and writing assignments related to clinical tasks.
- **Faculty training**: Provide training for subject instructors on how to scaffold language within content instruction using CLIL (Content and Language Integrated Learning) approaches.
- Language policy revision: Establish clear benchmarks for academic and clinical English proficiency, not just for admission, but as exit requirements or milestones throughout the program.
- **Cross-Departmental collaboration**: Create collaboration between English departments and medical faculties to co-develop instructional materials and assessments.
- **Support systems:** Provide language labs, tutoring services, and peer mentoring to help struggling staff bridge the proficiency gap.

Funding: None.

Conflict of interest: None.

REFERENCES

- 1. Elbeheri G, Al-Hammadi S, Al-Otaiba T *et al.* (2014): English as a medium of instruction in the Arab world: A review of challenges and opportunities. Procedia-Social and Behavioral Sciences, 158: 268-275.
- Al-Motairi M, Al-Arifi M, Al-Manasef A (2017): English Language Needs of Saudi Healthcare Professionals: Implications for ESP Program Design. English Language Teaching, 10 (12): 173-182.
- **3.** Al-Qashami S (2017): English as a Medium of Instruction in Saudi Higher Education: Challenges and Opportunities. International Journal of English Language Teaching, 5 (10): 45-55.
- 4. Al-Tayar A, Al-Musallam A, Al-Shehri A *et al.* (2021): Communication barriers in healthcare settings in Saudi Arabia: A systematic review. Journal of Family & Community Medicine, 28 (4): 273-279.
- 5. Aboul-Enein F, Heupler L (2014): Language Barriers in Healthcare: A Middle East Perspective. Journal of Health Communication, 19 (11): 1279-1281.
- 6. Mahboob A, Elyas T (2014): English in the Kingdom of Arab-speaking countries. World Englishes, 33 (1): 128-142.
- Alharbi A (2016): English language proficiency and workplace performance. Journal of Medical Education, 12 (3): 45-52.
- **8.** Cummins J (1979): Cognitive/academic language proficiency, linguistic interdependence. TESOL Quarterly, 13 (2): 175-187.

- **9. Ibrahim H (2017):** Grammar and syntax in nurse-patient communication. International Journal of Healthcare Linguistics, 6 (2): 112-120.
- **10.** Derwing T and Munro M (2005): Second language accent and pronunciation teaching: A research-based approach. TESOL Quarterly, 39 (3): 379-397.
- **11. Mahmoud A, El-Komi M** (**2018**): Curriculum gaps in ESP programs for healthcare workers in Arab-speaking countries. Arab World English Journal, 9 (4): 112-125.
- **12.** Almutairi K (2015): Culture and language differences as a barrier to provision of quality care by the health workforce in Saudi Arabia. Saudi medical journal, 36 (4): 425.
- **13. Basturkmen H (2010):** Developing courses in English for specific purposes. Palgrave Macmillan. https://link.springer.com/book/10.1057/9780230290518

- **14.** Ellis R (2006): Current issues in the teaching of grammar: An SLA perspective. TESOL Quarterly, 40 (1): 83-107.
- 15. Vygotsky L (1978): Mind in society: Development of higher psychological processes. Harvard university press. https://books.google.com.eg/books?hl =en&lr=&id=RxjjUefze oC&oi=fnd&pg= PA1&dq=15.%09Vygotsky+L+(1978):+ Mind+in+Society. +Harvard+University+Press .&ots=okz1T4p2cp&sig=Sph7cKtvvg0lyBNeEZIQBgzyg 81&redir_esc=y#v=onepage&q=cita&f=false
- 16. Krashen S (1985): The Input Hypothesis: Issues and implications. https://www.researchgate.net/profile/Richard-Young-5/publication/231773756_Input_and_Interaction/links/55c 3acae08aebc967df1b4b1/Input-and-Interaction.pdf
- **17.** Schmidt R (1990): The role of consciousness in second language learning. Applied Linguistics, 11(2): 129-158.