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Decision Makers' Perspectives on the Language of Instruction in Medicine in Saudi Arabia: A Qualitative Study

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Decision Makers' Perspectives on the Language of Instruction in Medicine in Saudi Arabia: A Qualitative Study

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Abstract

Background: The main language of instruction for teaching medicine in most of the Arabic-speaking countries is English then French to a lesser extent. To our knowledge, Syria is the only Arab country that uses Arabic as the language of instruction in its medical colleges.

Objective: This study explored the perspectives of decision-makers on the choice of English language for medical instruction in Saudi Arabia, in addition to, the academic, economic and social impact of this choice. This paper also explores their awareness of the languages used currently and in the past for teaching medicine and what obstacles are expected if Arabic language is adopted as the language of instruction in medicine.

Methods: This was a qualitative study that purposively interviewed eight decision-makers at the university, regulatory, and ministerial levels on the choice of language for medical instruction in Saudi Arabia. The semi-structured interviews were developed and conducted by the investigators. Each interview was audio taped and transcribed verbatim. Key themes were identified by the research team, with each theme representing an idea or a position.

Results: All decision-makers expressed a positive attitude towards the choice of English for medical instruction, but there was also overall support for a future Arabic curriculum, once obstacles are overcome. The availability of medical resources was the main factor which decision-makers agreed upon for the choice of language. There was also a consensus on the need to introduce Arabic in teaching communication skills.

Conclusion: There is an overwhelming preference of choice for the English language over Arabic language for medical instruction. The adaptation of Arabic language was seen to have major obstacles but could be overcome through a given nationwide initiative. It is recommended to have future studies in assessing periodic changes in the perspective of choice of language in medicine.

Abbreviations: IRB, institutional review board; UAE, United Arab Emirates; USMLE, United States Medical Licensing Examination

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1. Introduction

Almost all countries in the world have structured a medical education system in which they train their healthcare personnel locally or globally. These medical graduates complete their medical training with varying degrees of competencies which can have a significant impact on the economic, scientific and social aspect of the local population. Thus, great caution need to be exercised when designing and implementing a medical educational system. One of the key aspect of medical education is the language of instruction in which the training is conducted.

Supported by the growing political position of English speaking countries like the United States, English language dominance in the scientific field is growing decade after decade to the degree that it started to seem to some people that English will inevitably monopolize the scientific field. With such trend, many languages struggle to preserve their positions in the scientific field against all the political and economic factors that favor English language. Many countries still provide higher education in their native language, some of which have English programs that run collaterally to their native language or only as additional courses. Some countries with less educational resources refrain from using their native languages and resort to other widespread languages such as English. In medical education, using a foreign language can pose a great difficulty as the graduating physicians will be caring for patients who do not speak the language of instruction. Despite these difficulties, most medical schools in the Arab world, except in Syria, opted to use English as the medium of instruction instead of their native language. In Syria Arabization of medical education was started since the establishment of the first medical school in 1919, since then serious efforts have been made to continually back and strengthen the Arabic language in medical education in Syria. Other Arab countries, like Sudan and Libya, had trials with implementing Arabic in medical education but their mission did not progress as planned. Such attempts were minimal and not well documented due to non-conspicuous reasons which are not openly discussed.

Some studies found that using English as the language of medical instruction was associated with decline of students' performance and difficulty in communicating with patients. In addition, another study reported that introducing Arabic during lectures may enhance learning and knowledge retention. Furthermore, number of other studies from Arabic-speaking countries have assessed the perspectives of medical students and faculty members on using Arabic as the language of instruction and it is clear that year over year people are becoming less sympathetic to the use of Arabic language and are leaning more toward the use of English in teaching medicine. This is perceived be due to the growing position of English as a lingua franca for medicine. In Egypt, Students and faculty members were not in favor of using Arabic in scientific lectures, concerning mainly in the with the main concern being a lack of available medical resources, and an added academic burden. Students, however, favored Arabic in communication and clinical skills sessions as they will mainly encounter Arabic-speaking patients throughout their careers. In Lebanon, whilst being taught in English during their medical school, students have demonstrated a high level of confidence in history taking and communication skills when dealing with their local Arabic speaking population. Arabic medical terms were of a concern to many students, as they were perceived to be unfamiliar and non-equivalent to their English counterparts. It was also mentioned that translation of medical resources will be costly and not likely to keep up with the pace of scientific production worldwide. Moreover, majority of the students expressed apathy since they cannot control the choice of language in teaching, since this decision is made by those who are at the top of the hierarchy.

In Saudi Arabia, where a population which speaks Arabic predominantly, one of the general principle goals of Saudi education planning states that Arabic education should be provided in all levels of education but since the establishment of the first medical school in 1967, the English language was the sole language for teaching medicine. However, it is not well documented the reason why all the medical schools opted to use English and to discard the native language completely from the curriculum.
To date, few studies have looked at the perspective of students regarding the language of instruction and the question of using Arabic versus English in medical education. However, there is no data available regarding the stance of decision makers toward the current use of English language instead of Arabic as the medium of instruction in medicine. Especially, many students stated that this question should be mainly directed to leaders and decision makers. Recording and analyzing such stance would help establishing the rationale behind such choice and its future. Therefore, this paper tries to assess the perspectives of decision makers at the university, regulatory, and ministerial levels on the choice of English language for medical instruction in Saudi Arabia, in addition to, the academic, economic and social impact of this choice. This paper also explores their awareness of the languages used currently and in the past for teaching medicine and what obstacles are expected if Arabic language is adopted as the language of instruction in medicine.

2. Methods

2.1. Sampling

To ensure in obtaining the richest data and maximum variation, this study purposively selected educational leaders and decision makers with different roles and responsibilities in the development and implementation of the undergraduate medical curriculum. One of the most important tasks in the pre-data collection phase was to identify the most relevant institutions that play a role in developing medical curricula, accrediting medical colleges, and assessing medical students. Among the universities in Riyadh, King Saud bin Abdulaziz University for Health Sciences in Riyadh, Saudi Arabia was chosen as the institution that creates medical curricula, the Ministry of Education as the governmental sector that accredits medical colleges, and the Saudi Commission for Health Specialties as the body that evaluates medical students after they complete their undergraduate medical education. The hierarchical structures of these institutions were identified using the information gathered from their websites, phone centers and information provided by colleagues working in these institutions. People who were directly involved in making decisions were identified and their names sorted, and a list was compiled with their contact details.

Prior to conducting these interviews, the interview questions and themes were piloted with one decision maker, with no modifications applied. Then, participants were contacted by email followed by telephone calls to fix a date for the interviews. Depending on their availability and responsiveness, interviews were conducted until saturation was reached and the data collected were sufficient to compare and contrast views. Overall, eight decision makers were finally included: two deputy ministers, a deputy secretary general, a senior executive member, a dean, two associate deans and an assistant dean. Seven out of the interviewee were Saudi national and speak Arabic as their first language while one was a non-Saudi national and speaks English mainly. Two of the decision makers were females while the rest were males.

2.2. Data collection and analysis

Semi-structured in-depth interviews were conducted and took approximately one hour each. Every participant signed a consent form that detailed the purpose of the study, as well as ethical approval from King Abdullah International Medical Research Center’s institutional review board.

To minimize bias, one investigator conducted all of the interviews between October and December 2015. The interviews were audio-recorded and transcribed verbatim. Data were coded by the interviewer and connected codes were combined to form themes, with each theme representing an idea or position. Key themes were the frequently recurring ideas. A different investigator did another thematic analysis independently. The two sets of themes that emerged, were compared where only the themes identified by both investigators were chosen. In case of conflict, the two investigators met to discuss their differences, and a third investigator was consulted in case of further conflicting analyses. Finally, unified and repeated themes emerged from the data and were agreed upon.

The interview schedule consisted of four parts:

- Part I enquired about the perspectives of the interviewees on the reality of the language of choice in Saudi Arabia.
- Part II asked the perceived factors that should be involved in choosing the language of instruction for teaching medicine.
- Part III explored participants’ awareness of other countries' experiences in using native, foreign or blended language for teaching medicine.
- For Part IV, participants were asked whether they believe that Arabic should be the language of
instruction in medical schools in Saudi Arabia, and what steps would be required to achieve such a goal.

3. Results

3.1. The reality of the current language of choice in Saudi Arabia

All the participants agreed that the language of instruction can significantly impact the outcomes of the medical educational system, yet none were aware of how the current language of instruction (English) was chosen, or of any research preceding this choice. One participant suggested that the current choice was “obvious” and “did not need research to be proven.” Furthermore, decision-makers were not actively questioning the current selection, as only three participants saw the language question being raised. Another participant said: “People are more concerned about improving the quality of English in the curriculum than changing the English language.” One respondent from the Ministry of Higher Education noted that the law did not enforce this choice, which all Saudi medical colleges make: “Nothing forbids [using Arabic] and this is by law. In addition, nothing forbids the use of English. This is what the law says. The standard language for teaching medicine is Arabic, but it is no problem to use English.”

The participants generally expressed a positive attitude toward the current choice of the language and its outcomes. They think it has helped produce more capable and highly knowledgeable personnel with an access to a vast array of high-quality and up-to-date resources. One participant added that Saudi Arabia has the best educational system among the Gulf countries, and the results of its current system can match those of any other country: “Our universities are among the best in the Gulf region and are at the same level as other countries.”

3.2. Factors that affected the choice of language

3.2.1. Factors that favored English

The participants were asked about the academic, economic, and social factors that play a role in the current choice of language. Among the academic elements, all the respondents agreed on the “availability of medical resources.” They also reported that English was the de facto language for medicine, and that they mostly needed English to attend international conferences, take exams, and apply for jobs. One respondent said: “International exams are all in English, the international research, on which we depend daily, is in English.” Another academic factor was the ability to continue one’s education abroad, which would be more difficult if students were not originally studying in English.

Most respondents thought that Arabic was better suited for memorization and understanding, but one participant reported that using English for instruction can improve memorization: “When students make more efforts to learn in English, the information will stick in their memories longer.” Another point emphasized was the need for multilingual healthcare teams in Saudi hospitals.

Regarding economic factors, three respondents said that using English saves a lot of costs and effort by eliminating the need for translation and hiring a cheaper, English-speaking workforce. In terms of social factors, most decision-makers thought there were no social elements that favor English over Arabic, but one participant reported that using English boosted the students’ prestige, since English speakers usually have high social status.

3.2.2. Factors that disfavored English

Despite the overall positive attitude towards using English, most participants (6/8) mentioned some disadvantages, mostly in regards to communicating with patients. On the bright side, one respondent said that even while studying in English, Saudi physicians were able to deliver information in Arabic with no problems: “I can translate what I am saying into the common language.” Another reported drawback was the limited medical information available in Arabic as a result of teaching medicine in English.

The use of English was thought to cause an academic burden for students as they would need to go through a lengthier, more costly educational system that necessitates learning English, with a questionable quality of English teaching in pre-college and college settings. In addition, the respondents thought it would be more difficult for students to understand scientific content while not using their native language, which one participant explained “might result in reduced student performance.” Another respondent commented that one downside was a “threat” to Arabic culture, identity, and language: “I feel ashamed of the status of the Arabic language.”

Two participants argued that such a threat does not exist, with one of them citing the experiences of other countries: “Korea and Singapore did not lose their cultural identity when they taught in English.”
3.3. Views on different experiences

3.3.1. General impressions

Participants were asked about their knowledge of the language of choice around the world and how they assessed other countries’ experiences. All participants believed that English was the default language of instruction, and that most medical colleges around the globe used English as the main language of choice. Four decision-makers thought that the overall advancement of English-speaking countries strengthened the position of English. For them, the sciences were taught using the language of the countries that lead in these arenas. They asserted that English-speaking nations have played such a role for a long time. They expressed that when the Arab world was in its golden age, other parts of the globe taught the sciences in Arabic. One of them said: “European countries [specifically] used to teach medicine in Arabic.”

3.3.2. Using native-language system

Participants were asked if they were aware of any countries that use their native language instead of English. A number of countries was mentioned, but six respondents said they did not have enough information. One participant said that “Japan and Korea used their mother tongues, but unlike Saudi Arabia, these nations also had a rich history of literature and active translation movements”. The same participant talked about Iran and Japan being “long-standing civilizations” which was not the case of Saudi Arabia. Another respondent had a negative attitude toward countries using their native languages, and considered their contribution to medicine to be marginal: “Medicine is a science as well. What are [Japan, Korea, China, Iran, Hungary and Israel] contributing these days? It’s less.”

3.3.3. Using a hybrid system

Participants were asked about their opinion on the use of multiple languages in a single educational system. They reported that this was feasible depending on the requirements of each part of the system. Furthermore, one participant emphasized that it is beneficial to use multiple languages in a “balanced” manner. Such a system can have a positive impact on academic outcomes: “Multiple languages open more horizons for students in many ways; for example the availability of resources, books, conferences, and interacting with scientists and researchers in the other language.”

Most participants thought that scientific lectures should be conducted purely in English, while two said they should be carried out in both Arabic and English. One respondent distinguished between basic and clinical science lectures and proposed that although basic sciences are less challenging, they could be taught in Arabic, while clinical sciences are more frequently updated, and should thus be taught in English to keep up with international literature. The same participant thought that “family medicine should be taught in Arabic, depending on the availability of staff and references”.

Three participants said they supported teaching communication skills purely in Arabic. One explained: “A doctor has an obligation to deliver information to both the patient and society. You may find one doctor who is very great, a professor! However, you might find some of his words to be in English when he talks to the general population.” Three other decision-makers reported that communication skills should be taught in both English and Arabic. All the participants agreed that if students were taught in a certain language, they should take exams in it as well.

3.3.4. Arab countries’ experiences of using Arabic in medical education

Regarding different experiences of using Arabic, participants were only aware of the Syrian one. Two respondents reported that the Syrian educational system was good overall and produced competent physicians, with one expressing appreciation of Syrian pride of the Arabic language. On the other hand, five participants pointed out difficulties facing Syrian students in finding resources, which makes them less able to keep up with the most recent literature. One participant questioned the outcomes of Syrian medical education and its ability to produce physicians in keeping with expected standards: “Those who come directly from Syria, without passing through a Western country, lack the standards we expect of them.” Moreover, the respondents mentioned that Syrian physicians still needed to learn in English outside the curriculum, to be updated, and to continue their postgraduate studies abroad, which resulted in extra effort and more time spent than Saudi students: “Good Syrian students have to study the most recent English references. Arabic references that Syrian students use are 5 or 6 years old.”
3.4. Seeking Arabic in Saudi Arabia

3.4.1. General impressions

The participants were asked: "Do you think that using Arabic as the main language of instruction is a future goal to be sought after?" Three said it is not something they are seeking.

One participant insisted that we should question the motive behind such a move: "Why do we want to teach medicine in Arabic? Is it because of racism, ego, or because it is good? Why? I don't mind speaking Arabic. I hired an Arabic tutor for my daughters to teach them Arabic language and poetry because I started to forget. I feel ashamed sometimes for not knowing some of the basics. Nevertheless, I feel very proud of my language and I like to speak it. That's why I speak in Arabic a lot. However, I don't think there is a problem using English in medicine."

The five other participants reported that they sought to use Arabic in the future, but that this would require a number of steps and barriers to be overcome. One participant said: "No doubt that we look forward to the day when all the sciences will start to be taught in Arabic; however, hoping requires work and prerequisites, such as resources."

3.4.2. Advantages and disadvantages

The participants were asked about their views on implementing an Arabic-language curriculum; their perspectives reflected the advantages and disadvantages of doing so.

For the advantages, six participants thought that using Arabic would improve understanding and memorization, and enable students to more easily express themselves: "No matter how good the student is at understanding, and no matter how accomplished he is [at using English], he will perform better when using his native language. This is a burden [using English] added to the difficulty of the scientific subject itself." Furthermore, these six participants thought that using Arabic would help bridge the communication gap between physicians and patients. One respondent mentioned that the current English system makes medicine a very specialized science that laypeople cannot access: "This only makes science accessible for a limited group of people who understand English and doctors, and doesn't make it widely [available to the rest of] society." From an economic point of view, two participants thought that using Arabic would be less costly than using English, while the rest were not certain if this was true.

In terms of disadvantages, participants thought that the availability of resources was the foremost obstacle to using Arabic. They considered Arabic resources to be "only a few" and "slowly updated" which would negatively impact students' performance.

3.4.3. Steps towards implementing the Arabic language

Several steps were identified as paving the way for using Arabic as the main language of instruction. All respondents mentioned the initiation of an active translation movement, while two participants said that translation must be quick and efficient to prevent delays. Furthermore, they stressed that translation is not enough, and that original scientific content has to be produced in Arabic via research publications and books. Six participants suggested introducing Arabic to parts of the curriculum as a hybridization process before fuller implementation. Some respondents were not pleased with the performance of colleges and asserted that they must be actively involved in this process. One participant suggested more intense Arabic language education: "We need to strengthen the students' Arabic language. It is very bad, even worse than English."

There was a general consensus that such a step would require a nationwide movement supported by leaders and institutions, and collaboration among the education, health, and business sectors. The major role of partnerships between Arab countries was also mentioned, but one participant thought this would not be applicable since different Arabic countries have different agendas and goals: "Everyone always has their own agenda. For example, the United Arab Emirates (UAE) might conclude that adopting Arabic would not benefit our country, so the UAE would probably not cooperate in this regard. Everyone will consider how this could be applicable. For example, the UAE is going global now." Another participant thought that to launch such a move, Saudi Arabia should not wait for other Arab countries: "If we wait for cooperation to start, it will never happen. Somebody has to start. That somebody has to be us." Finally, two respondents maintained that further research was needed to decide on the most appropriate measures and to identify potential barriers; one of them mentioned the need to examine both successful and failed experiences of implementing one's native language.

According to the participants, there would also be obstacles to implementing Arabic, with many steps related to the process of translation. Translation would require extensive efforts to translate the massive
contents of scientific literature. The barriers also included a lack of trained personnel, and the lack of a system to ensure the accuracy of translation. Even after translation, another problem would arise: the inability to understand translated content due to unfamiliarity with terms and the difficulty of Arabic medical terminology. Some participants thought Arabic medical terminology to be "very unusual" and remarked that "it constituted a third language" that both practitioners and laypeople do not understand. Another participant proposed that the process of introducing Arabic medical terminology would be long and difficult, but had to be started. Only two respondents saw cost ineffectiveness as the main hindrance.

4. Discussion

This study provides four primary contributions to local research on medical education. First, it reveals that, some fundamental, value-dependant questions escaped rigorous debate, with technocratic institutions stepping in to answer them without a process to debate the value aspects of these questions or to systematically assess the different positions. Second, this study confirms the wide agreement on considering English as the current preferred choice of language for teaching medicine, but also the overall support for a future curriculum where Arabic is the choice of language in medical instruction. Third, the findings reveal a wide agreement on the need to introduce Arabic for communication skills, with some suggesting a bilingual approach and others supporting a pure Arabic approach. Fourth, the study demonstrates agreement on the political aspects of this issue, and the fact that implementing Arabic would take initiative and nationwide coordination.

The choice of a language for instruction is inherently value-dependent, with decision-makers expressing varying positions and reflecting different sets of values. Similar questions of value need to be recognized and embraced as such, and debated with an aim to help build a mature, shared, nationwide vision, instead of relaying them to top-down, technocratic institutions.

The overwhelming preference for English is consistent with a global trend, with over 90 percent of scientific publications in the natural sciences are in English. This trend was previously described in Saudi Arabia. Findings from Egypt revealed a similar preference. In some regards, the rationale of participants' preference for English in this study was similar to the reasoning expressed by students and faculty members in previous investigations, but different in other ways. Both groups tend to favor English for accessibility and the availability of English medical resources. Previous researches have explored the availability of Arabic resources in engineering, but no similar studies have been carried out to assess medical resources. Unlike decision-makers, students and faculty members frequently point to prestigious social status as an important factor in studying medicine in English. On the other hand, decision-makers in this study were generally satisfied with the academic status of medical colleges in Saudi Arabia, which uses English, and cited "more serious" issues that deserve focused attention instead of the choice of language of instruction.

In regard to the competence of Arabic-language instructed medical graduates, some decision-makers had a critical view of the outcomes of Syria's medical education system, which uses Arabic. However, it is important to note that this critique lacks evidence; in fact, there are indications to the contrary, such as that the Step 1 and Step 2 average scores of the United States Medical Licensing Examination (USMLE) are higher for Syrian medical students than their Saudi counterparts. Some previous studies have shown that students tend to perform better when taught with their own native language. Another investigation conducted at Gezira University in Sudan showed no differences in performance between students taught in Arabic and those taught in English. One study reported that an overwhelming majority of students indicated that the choice of language was a political one and had no power in changing it. Such a finding confirms the critical importance of specifically examining the views of decision-makers at various levels.

This study demonstrates the lack of awareness of current and past uses of languages for medical instruction. Conducting comparative studies that look into the local educational system versus other systems can solve this problem. Moreover, additional medical education tracks should be included in healthcare conferences.

For Arabic to have any future as the language of medical instruction, large public investment in national projects would be required, including translation projects. In the current climate of privatization with calls for more limited role for the public sector, such an attempt would likely face difficulties. As private firms are motivated by maximizing profits, rather than long-term social utility, they are unlikely to be pioneers in achieving this goal. While it is conceivable that market opportunities could result from an
Arabization project, it is hard to assume that private-motivated firms would seek the universality of access to knowledge in Arabic language, and abandon more immediate profit goals.

This study’s strength lies in the fact that it explored the perspectives of decision-makers at multiple levels of Saudi Arabia’s medical educational system. A limitation of this study is that it does not go beyond exploring the opinions of people toward this subject, which remains in conflict and under debate. Further research should focus more on carrying out trials to explore the impact of introducing Arabic language versus the current use of English on the performance of medical students in Saudi Arabia.

5. Conclusion

The respondents in this study showed an overwhelming preference for English over Arabic. Most of the participants supported introducing Arabic as the medium of instruction in light of anticipated obstacles (such as translation cost and effectivenes) and considered whether implementing Arabic is a pressing priority. Further studies need to be conducted whereby students, faculty, and frontline healthcare workers are asked about their views on the choices of language for teaching medicine at their respective institutions.

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Competing interests

The authors declare that they have no competing interests.

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Authors’ contributions

- MS was involved directly in conceptualizing and formulating the research question and constructing the study design along with data collection, analyzing the data and writing the manuscript
- OM was involved directly and in conceptualizing and formulating the research question constructing the study design along with data collection, analyzing the data and writing the manuscript.
- MM helped directly in developing the study design, data analysis, writing and reviewing the manuscript.
- ZR helped directly in developing the study design, data analysis, writing and reviewing the manuscript.
- AH helped directly in formulating the research question, study design, writing and reviewing the manuscript.
- BH helped directly in developing the research question, study design and reviewing the manuscript.

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