Language Barriers in Doctor-Patient Communication with Arabic-Speaking Patients: A Qualitative Study in Milan's Outpatient Clinics

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Abstract

This study explores the language barriers encountered by volunteer doctors when communicating with Arabic-speaking patients in two outpatient clinics in Milan, Italy, and investigates the strategies they adopt to address these challenges. Based on twelve semi-structured interviews and thematic analysis (Braun and Clarke 2006, 2012), the findings highlight how language barriers affect communication in outpatient clinical contexts, limiting narrative richness and making it harder to construct a coherent clinical picture. Communication often relies on informal interpreters or digital tools, which provide partial solutions. The study also highlights the challenge posed by a mismatch between physicians' expectations and patients' ways of presenting symptoms. These difficulties are compounded by the linguistic heterogeneity within Arabic-speaking communities, which can further undermine informal interpreting practices. The research offers qualitative insights into how language barriers impact healthcare communication, anamnesis, and, as a result, the diagnostic process in multilingual outpatient settings involving Arabic-speaking patients with a migrant background.

Key Words – language barriers; Arabic-speaking patients; doctor-patient communication; multilingual healthcare; Milan (Italy)

1. Introduction

Communication stands as a cornerstone of healthcare, crucial for promoting patient safety through clear information transfer (Vange et al. 2024: 893). Given the reciprocal nature of patient-provider communication, healthcare delivery can be jeopardized if either party fails to clearly grasp the information exchanged (Ratna 2019: 1). In today's multilingual and multicultural societies, ensuring clear and effective healthcare communication is increasingly challenging. Language barriers, defined as «communication deficits between individuals who do not speak a common language, resulting in a reduced ability to exchange information» (Neipert et al. 2024: 29), severely hinder the delivery of high-quality, safe, and effective healthcare (Ellahham 2021: 357).

This issue is particularly relevant in Italy, where migration has reshaped the sociolinguistic profile of the population. As of January 2025, the foreign resident population has reached 5,422,000 individuals, accounting for 9.2% of the total population (ISTAT 2025), and rising to 14% in cities like Milan (ONC 2024). Among the largest foreign communities are Arabic speakers: the Moroccan community ranked third nationwide in 2024 (ISTAT 2024), while the Egyptian community was the largest in Milan (Comune di Milano 2024). Despite this demographic relevance and the complexity of these communities' linguistic repertoires (see Bassiouney 2020), research on language barriers in clinical communication with Arabic-speaking patients in Italy remains limited. In particular, little is known about how doctors navigate such barriers in outpatient settings, spaces where professional mediation is often unavailable. Existing studies have explored emergency care (Numeroso et al. 2015), vaccination settings (Bianconi et al. 2024), and the perceived communicative asymmetries between professionals and migrant patients (Benucci and Grosso 2021). In the Italian context, other research has examined healthcare communication involving migrant and Arabic-speaking patients, including studies on Iraqi patients in a Sardinian hospital setting (Grosso and Floris 2020, 2023, 2025). However, everyday communication in outpatient clinics, which often serve undocumented Arabic-speaking patients, remains largely unexplored.

This study addresses that gap by examining doctors' perceptions of language barriers and coping strategies in two outpatient clinics in Milan with a high proportion of migrant patients. Based on twelve semi-structured interviews and thematic analysis (Braun and Clarke 2006, 2012), it investigates barriers experienced by doctors and the strategies they adopt with Arabic-speaking patients to adapt communication in the absence of a shared language and institutional support. The findings also highlight how language barriers affect the quality of the doctor-patient relationship, anamnesis, and, as a result, the diagnostic process.

1.1. Research context: two outpatient clinics in Milan

This study draws on interviews with doctors volunteering in two outpatient clinics in Milan that provide healthcare to undocumented migrants and to patients in situations of social or economic vulnerability. In Italy, primary care is generally guaranteed by the Italian National Health Service (SSN - *Servizio Sanitario Nazionale*), which assigns every resident a general practitioner (GP). Individuals without a valid residence permit are entitled only to urgent and essential healthcare services through a temporary code (STP - *Straniero Temporaneamente Presente*, meaning 'Temporarily Present Foreigner'), which does not ensure continuity of care. In this context, outpatient clinics, such as those analyzed, play a crucial role in providing medical assistance to patients excluded from access to the SSN.

The first outpatient clinic considered is the *Ambulatorio per Migranti* of *ASST Grande Ospedale Metropolitano Niguarda* ('Migrant Outpatient Clinic of the Niguarda Metropolitan Hospital'), which

has been operating since 2018 and is staffed by volunteer doctors and nurses. The service operates once a week and is intended for individuals without access to the SSN. It provides services comparable to those of a GP, with the capacity to prescribe medical investigations and treatments using the STP code. Patients primarily access the clinic through two channels: the first is via local associations, which carry out an initial screening and selectively send those with complex pathologies; the second channel is via the emergency room, where many of the volunteers are employed. In this case, referral is motivated by the lack of continuity of care following emergency treatment for individuals not registered with the SSN. Patients are received by a multidisciplinary team (consisting of nurses, social workers, and physiotherapists) and subsequently cared for by volunteer physicians.

The second outpatient clinic is managed by the *Fondazione Fratelli di San Francesco d'Assisi Onlus* ('Saint Francis of Assisi Brothers Foundation, non-profit'). The multi-level facility offers a wide range of healthcare services, including general and specialist medical consultations (such as neurology, psychiatry, surgery, cardiology, and other specialties), psychological support, pharmaceutical distribution, basic diagnostics and blood tests. General medical consultations are available without prior appointment, while specialist consultations require a preliminary assessment by a general practitioner. It is primarily accessed by migrants who lack regular documentation, although access is open to any individual unable to use the SSN. These two clinical sites, despite operating under different models, represent linguistically rich and often understudied environments that offer valuable contexts for investigating experiences of communication challenges in multilingual healthcare. The following section outlines the methodological approach adopted in this study[1].

2. Methodology and participants in the study

The current study is based on a qualitative analysis of interviews with twelve volunteer doctors, conducted between April and June 2024, in two outpatient clinics in Milan: eleven at the outpatient clinic of the *Fondazione Fratelli di San Francesco d'Assisi Onlus* and one at the outpatient clinic for migrants of the *ASST Grande Ospedale Metropolitano Niguarda*. The objective of the present study is to address the following research questions:

- Research question 1 (RQ1): What are the language barriers experienced by physicians when communicating with Arabic-speaking patients?
- Research question 2 (RQ2): What strategies or tools are adopted to address these barriers?

This research is part of a larger project on language and cultural barriers in healthcare, which also includes data collected in four emergency departments in Lombardy between May 2024 and February 2025. These data are not discussed in the present paper due to space and thematic limitations. The semi-structured interviews, conducted in Italian and in person, took place in the two outpatient clinics with the volunteers on duty. One interview was conducted in a private practice at the participant's request, while the interview at the *Niguarda* outpatient clinic was scheduled in advance. All participants provided written consent for their anonymity to be preserved, allowing only their professional qualification to be cited. The interviews were recorded, fully transcribed, and anonymized by means of an alphanumeric code (e.g. I1, I2), which was used for citations in the results. The questions, inspired by the RQs, encouraged spontaneous narratives, following the

[1] General information on healthcare access for undocumented migrants and on the clinics is based on interviews with volunteer professionals and on the *Fondazione Fratelli di San Francesco d'Assisi Onlus* website.

principles of the semi-structured interview. The interviewer's intervention was adapted according to the participation of the informants, encouraging more in-depth responses in the more concise cases and avoiding interruptions as far as possible in the more discursive ones. Consequently, the duration of the interviews ranged from five to forty-five minutes. The sample consisted of eight male and four female doctors, all of whom were specialists in general medicine, pediatrics, gynecology, psychiatry, neurology, anesthesia, surgery, or cardiology.

The data were analyzed following Braun and Clarke's (2006, 2012) thematic analysis methodology, a technique that enables the identification of patterns of meaning (themes) within a given dataset. The process consists of six distinct steps: (1) familiarization with the data, (2) initial coding[2], (3) theme identification, (4) review, (5) defining and naming themes, and (6) report writing. Coding was conducted manually, employing a data-driven approach, i.e., without predefined hypotheses, allowing content to emerge directly from the data and be interpreted. The transcripts were subjected to repeated reading, with comments noted in the margins and a sequential number assigned to the relevant extracts. The codes were then organized into individual matrices and thereafter grouped in a shared spreadsheet, which was divided into coherent topic domains. This approach facilitated the identification of fourteen themes, each of which was subsequently summarized in a dedicated document that served as a guide for the composition of the results. The coding and identification of themes were conducted through a constant iterative process of comparing data and codes with emerging themes. The present paper will exclusively address the themes that emerged from the outpatient context in relation to language barriers (RQ1) and the strategies adopted to address them (RQ2) (see Table 1).

Theme number	**Denominations**
Theme 1	*Language barriers in the doctor-patient relationship and their impact*
Theme 2	*Linguistic and socio-demographic factors influencing language barriers*
Theme 3	*Insufficiency of current tools and strategies*
Theme 4	*Digital tools and automatic translations as an initial, but not conclusive support*
Theme 5	*Family members, patients and community as informal communication resource*
Theme 6	*Communicative and relational adaptations*

Table 1. Themes discussed in this contribution with their names.

In presenting the results, the distinction between informants was maintained where their statements had important nuances of meaning in order to emphasize their complexity and relevance. For the sake of clarity of presentation, Theme 3 was introduced last.

[2] Braun and Clarke (2006: 18), following Boyatzis (1998: 63), define codes as the basic components of raw data that can be meaningfully examined in relation to a given phenomenon.

3. Results

Thematic analysis led to the identification of a total of fourteen themes, outlining a comprehensive overview of the experiences of the healthcare professionals involved. In this study, only the six themes concerning language barriers (RQ1) and the strategies adopted to address them (RQ2) are presented. The themes relating to cultural barriers and associated strategies fall outside the scope of this discussion, as specified in the methodology section.

3.1. Theme 1: Language barriers in the doctor-patient relationship and their impact

The findings of the study suggest that language barriers do not invariably impede doctors from «arrivare al punto della situazione» 'get to the heart of the matter' (I8); however, they frequently prolong the duration of the consultation (I8, I10) and significantly reduce the quality of communication (I1). In certain instances, these factors hinder the execution of a comprehensive visit (I1). The primary critical aspects pertain to three interconnected dimensions: the doctor-patient relationship, anamnesis and diagnosis, and therapeutic adherence.

3.1.1. *Doctor-patient relationship and communicative exchange*

In the presence of language barriers, the interaction between doctor and patient tends to take the form of a series of essential questions and answers, lacking the narrative richness necessary to grasp relevant semantic nuances. As one informant explains, even when basic information can be exchanged, «c'è sempre qualcosa che ti sfugge perché la comprensione di una sofferenza passa anche attraverso magari un qualche aggettivo, non passa solo attraverso la parola dolore» 'there is always something that gets lost because understanding suffering is not conveyed only through the word *pain*, but perhaps also through certain adjectives' (I3). The same informant adds that suffering also passes through «un racconto che è più elaborato» 'a more detailed narrative', which is often difficult to render in the absence of sufficient linguistic competence. This communicative impoverishment hinders the development of effective empathic listening, reduces the possibility of establishing a successful therapeutic alliance (I1), and increases the risk of clinical errors (I1). This impoverishment also affects the relational dimension of the encounter. As another interviewee notes, the patient has to express what is happening, while the doctor must then find an explanation «in modo da stabilire un'alleanza tra lui e il paziente» (I1), yet «queste sfumature non vengono, non si riescono a stabilire» 'in order to establish an alliance between himself and the patient' (I1), yet 'these nuances do not emerge, they cannot really be established'. The same informant adds that, in the presence of language barriers, communication remains «una cosa piuttosto automatica» 'something rather automatic', «più povera, più tecnica» 'poorer, more technical'. In particular, when concepts related to specific cultural practices, such as neonatal feeding, are at stake, the absence of a shared linguistic code compromises the very possibility of addressing them (I2). The lack of patient understanding is not always explicitly stated, creating uncertainty for the physician regarding the actual success of the exchange (I2). The issue of communication is further exacerbated by the frequent presence of informal interpreters, especially family members accompanying female patients (I6, I7), thereby hindering direct communication and reducing the efficacy of the interaction, which complicates the collection of accurate clinical information (I6).

3.1.2. *Anamnesis, symptomatology and diagnostic process*

The interviews (I1, I4, I6) revealed that the anamnesis process poses particular challenges because it requires articulate and detailed communication. Language barriers limit the physician's ability to ask in-depth questions and fully understand the answers (I1), preventing a detailed narrative (I4). Even machine translation tools return superficial data (I6). Difficulties increase in the presence of incomplete or absent clinical documentation (I6). Some patients report symptoms in a disorganized way, listing numerous problems, including symptoms and pathologies, without a clear hierarchy, in what one informant called a «cesto di patologie», literally, 'basket of pathologies' (I10), i.e., an undifferentiated list of pathologies: «io ho una malattia, ma le aggiungo un po' di cose insieme, tanto per fare un cesto di patologie. Che poi tu non sai più distinguere qual è la cosa importante per cui è venuto o quello, o il corollario che ha messo insieme» 'I have one disease, but I add a few other things to it, just to create a basket of pathologies ... and then you can no longer distinguish between the important thing – what the patient actually came for – and the additional things (literally, 'the corollary') that got bundled together' (I10).

Anamnesis is considered decisive for diagnostic purposes by some informants (I4, I11, I12): I4 estimates that it contributes more than 50% to the diagnosis, guiding the physician even when it is not conclusive. However, according to I11, not all patients appear to recognize its importance, as they often tend to live a «patologia del presente» 'pathology of the present' (I11), and language barriers prevent this awareness from being communicated. I6 estimates that such barriers reduce the quality of the patient's anamnesis by up to 60%. Furthermore, the description of symptoms is frequently lacking: some patients are unsuccessful in providing articulate explanations (I6), and doctors and patients often encounter difficulties in accurately conveying and comprehending symptoms, although interaction may eventually lead to mutual understanding (I8). As I11 explains, even apparently simple symptoms, such as pain, require a much more precise lexical specification: «Il dolore ce l'ha sempre, di giorno, di notte, quando respira, quando cammina … è un dolore puntorio, urente, diffuso … ci sono tantissime caratteristiche del dolore che al medico fanno venire in mente subito il tipo di patologia» 'The pain may be constant, it may occur during the day, at night, when breathing, when walking … it may be stabbing, burning, or diffuse…there are many characteristics of pain that immediately suggest to the doctor the type of pathology' (I11). These critical issues have also been observed in Italian-speaking patients but are significantly amplified in the presence of language barriers or third parties involved in mediation (I6). Moreover, according to I11, some patients appear to lack comprehension of the severity of symptoms and the clinical significance of pain localization. The issue of the untranslatability of certain words and concepts, even with the use of automatic translators (I10), adds a further layer of complexity.

To compensate for the limited nature of the exchange, I1 resorts to additional examinations or diagnostic tests, resulting in increased time and risk of error. In other cases, it is patients who directly request generic medical investigations without providing explanations (I4). I1 relies on his own clinical experience and semeiotics, which are not always sufficient, while I3 re-evaluates patients over time and observes the clinical progression, except in urgent cases. I12 reports having postponed a visit and rescheduled it in the presence of a language mediator because of communication problems. The difficulties described in this theme occur to varying degrees depending on linguistic, demographic and social factors, which are discussed in Theme 2.

3.1.3. *Therapeutic adherence and comprehension of medical indications*

Language barriers frequently hinder comprehension of therapeutic indications, particularly regarding dosage, timing, and mode of administration (I1, I9), as these aspects demand detailed and complex communication (I1). These barriers weaken the transmission of information, and it is challenging for physicians to verify adherence once outside the clinic (I9). Another obstacle is the difference in pharmaceutical nomenclature between Italy and patients' countries of origin (I8), which, however, is more likely to be overcome than other difficulties.

3.2. Theme 2: Linguistic and socio-demographic factors influencing language barriers

Among Arabic-speaking patients, the intensity of language barriers varies according to several interconnected factors: level of Italian proficiency, length of stay in Italy, educational background, age, gender, individual linguistic repertoire, and, where applicable, living in social reception facilities.

3.2.1. *Time spent in Italy and exposure to Italian*

Some informants (I4, I5, I8, I9) recognize a relationship between length of stay in Italy and reduction of communication difficulties, albeit with nuanced differences. I4 notes «moltissime» 'many' difficulties with Arabic-speaking patients, but distinguishes between patients who understand without being able to speak and others who, thanks to a longer stay in Italy, are able to engage in conversation, reducing barriers: «se i pazienti sono qui da qualche anno, allora loro almeno capiscono l'italiano, magari non si esprimono; ma se invece sono qui da molti anni e capiscono … possono anche colloquiare in italiano queste difficoltà vengono sempre meno» 'if patients have been here for a few years, they at least understand Italian, even if they cannot speak it; but if they have been here for many years and understand … they can also converse in Italian, these difficulties become much less frequent' (I4). I5 attributes the improvements not so much to the length of stay per se, but to the active study of the language. Similarly, I8 perceives recently arrived patients as having more communication difficulties. I9 links the difficulties to both recent migration and the tendency to live in closed communities with little exposure to Italian. Indeed, he emphasizes that prolonged residence alone does not guarantee good language competence, especially when strong cohesion is maintained within Arabic-speaking communities (I9). According to I5, learning Italian is often functional and unstructured, as doing so would represent «un ulteriore passaggio fuori dalla loro cultura» 'an additional step outside their culture' (I5).

3.2.2. *Gender, age and education*

Language barriers occur more frequently among women (I1, I2, I9, I11) and elderly individuals (I1, I9), who often exhibit limited proficiency in Italian and therefore rely on accompanying people during visits. Conversely, men and children who are exposed to Italian in a professional or educational context develop greater language proficiency and frequently assume the role of family mediators (I1, I2). As I2 notes, children who attend school in Italy often translate for their parents during medical visits: «i bambini parlano … dopo tre mesi che sono qua … quasi. Certe volte diciamo "hai capito?" e allora ci guardano e dico "allora traduci"» 'children speak [Italian] … after three months here … almost. Sometimes we ask "do you understand?", and then they look at us and I tell them "then translate"' (I2). Some informants trace back male mediation for female patients to cultural dynamics which, as indicated in the methodological section, will not be explored in the current study.

3.2.3. *Language repertoires and perceived linguistic competence*

The internal variety of Arabic and the plurality of individual linguistic repertoires constitute a further element of complexity in clinical communication. I1 provides an example of a Tunisian patient encounter that was facilitated by the intervention of another patient of Tunisian origin. On that occasion, the informant explicitly requested confirmation that «le lingue arabe» 'Arabic languages' (I1) were different from each other, signaling an intuitive perception of Arabic varieties, not always accompanied by a real linguistic awareness. I4, for instance, recognizes some differences by mentioning that «la lingua araba … gli arabi … non sono omogenei» 'the Arabic language ... Arabs ... are not homogeneous' (I4), but confuses Arabic with languages belonging to other ethnic groups (Turks, Iranians, Afghans), thereby revealing a conflation between religion, language, and ethnicity, which may lead to inaccurate assumptions[3]. The same informant reports specific difficulties with Egyptian patients, who are considered to speak a different variety: «l'egiziano non è proprio uguale a tutti gli altri eh [...]. Non è uguale perché ha una lingua sua» 'Egyptians are not quite the same as everyone else, eh [...]. They are not the same because they have their own language' (I4).

Proficiency in foreign languages has also been identified as a contributing factor to the quality of communicative exchange. As I11 asserts, proficiency in additional languages, notably French, facilitates communication with patients from countries such as Morocco, Tunisia, or Senegal. In contrast, according to I11, patients from Egypt, Libya, and Sudan demonstrate comparatively limited proficiency in these languages. Some informants (I1, I2, I9) claim that they experience fewer communication and cultural difficulties with Arabic-speaking patients than with other migrant groups. However, this perception is concomitant with the observation that Arabic-speaking patients occasionally underestimate their own language difficulties (I9), which has a negative impact on the perception of the need for a mediator (I9). This could be related to the discrepancy, observed by I10, between perceived and actual language competence.

3.2.4. *Social reception facilities and family support*

According to I1 and I2, the presence of a family member, most commonly the husband or a child with greater proficiency in Italian, can substantially facilitate the interaction with the doctor. In contrast, I6 posits that family mediation can impede clinical understanding, as symptoms are not directly described by the patient. In psychiatry, I5 underscores the significance of family linguistic and relational support, emphasizing that its absence undermines therapeutic continuity. The same informant reports a lack of understanding on the part of the family members of the seriousness of the psychiatric pathology or the meaning of the treatment, making clinically unrealistic demands. Finally, I10 observes that residence in a social reception facility may foster language learning, especially among younger patients.

3.3. Theme 4: Digital tools and automatic translations as an initial, but not conclusive support

Eleven out of twelve informants report using digital translation tools, in particular Google Translate, to overcome language barriers in the absence of a shared vehicular language. However, these tools are only used to collect essential information (I1), proving inadequate for in-depth clinical communication (see Theme 3). I2 reports using them only in the presence of high barriers, while

[3] These aspects were explored in Theme 10, on stereotypes and physicians' cultural representations, but fall outside the scope of this study.

expressing doubts about their reliability. I3 and I6 define them respectively as «un primo passo» 'a first step' and «tentativo iniziale, dovuto alla concretezza» 'initial attempt for practical reasons', noting that «un colloquio più approfondito non si riesce a fare» 'it is not possible to have a more in-depth interview' (I6), since they allow physicians to obtain only essential information. I9 observes that the use of digital translation tools is more common among young patients, while I10 considers this practice a partial solution that saves time, but defines it as «scarna» 'meager', especially in the rendering of complex concepts. I12 values its practicality, yet prefers to rely on accompanying people, deemed more effective due to their prior knowledge of the patient. Finally, I5 emphasizes that it is often the patients themselves who use these tools: «tanti arabi, in particolare, sanno usare i traduttori. Hanno il telefono e usano i traduttori e quindi usano il traduttore nei colloqui» 'many Arabs, in particular, know how to use translation tools. They have a phone and they can use translators, therefore they use them during the interview' (I5). According to the same informant (I5), this strategy may sometimes be useful in psychiatry, but remains inadequate in psychotherapy, which requires a deeper and more specialized form of mediation.

3.4. Theme 5: Family members, patients and community as informal communication resources

An analysis of the interviews reveals a recurring strategy (I1, I2, I4, I5, I8, I9, I10, I11, I12) employed to overcome language barriers: the involvement of informal interpreters, that is to say patients' accompanying people (typically family members and friends), or other Arabic-speaking patients present in the clinics. As I9 asserts, this practice is especially prevalent among female and elderly individuals, who often exhibit more pronounced language barriers. In certain cases, children, who are learning the language quickly (I2) through schooling in Italy (I11), act as interpreters, often on an occasional basis, particularly for mothers (I2). I12 believes that this form of informal linguistic support is particularly effective with Arabic-speaking patients, thanks to the frequent presence of an accompanying person with a good level of Italian. Consequently, it is regarded as the most functional solution currently, also using telephone (I12), although its limits are recognized in relation to the discontinuous availability of these figures. When patients are alone, they frequently resort to phone calls or video calls with relatives or friends to obtain a translation (I5, I9, I12), creating a three-way communication dynamic between doctor, patient, and informal interpreter (I9). As I9 explains, «chiamano gli amici; ci sono amici o parenti che col telefono in vivavoce ti fanno da interprete in simultanea; tu parli con l'amico, lui traduce per il paziente, il paziente chiede all'amico, l'amico chiede a me. C'è una specie di triangolo che avviene in tempo reale» 'they call their friends; there are friends or relatives who act as simultaneous interpreters on speakerphone; you talk to the friend, he/she translates for the patient, the patient asks the friend, the friend asks me. There is a sort of triangle taking place in real time' (I9). According to I2, female patients are often the ones who contact their husbands, who, having lived in Italy for a longer time, generally have a greater command of Italian.

Another strategy consists in involving other Arabic-speaking patients present in the clinic (I1, I2, I11). Specifically, I1 observes spontaneous cooperation between patients who share the same linguistic background, particularly among men, whereas I2 considers this solidarity to be an element that helps reduce language barriers. I6 observes that, in comparison with other communities, it is often easier to find Arabic speakers among patients or staff (in a hospital setting), given that it is the official language of many states. The informant asserts that this facilitates access to informal interpreting compared to less widespread languages, such as those of Bangladesh or Sri Lanka. Furthermore, I5 reports relying on the help of trusted patients to assist with interpretation during psychiatric interviews, while emphasizing that this practice is not compatible with psychotherapy, which necessitates specialized

mediation. However, I11 highlights the potential for conflict between the need for confidentiality and the requirement for care when other patients are involved as interpreters.

At the *Niguarda* clinic, there is a volunteer of Moroccan origin who is occasionally contacted by staff, even by telephone, for quick translations. The hospital also has an office for foreign nationals that provides linguistic and administrative support, despite the absence of cultural mediators within it. In some cases, patients are accompanied by operators from social reception facilities (I8), whose role, according to I10, is particularly important in supporting young Egyptian patients, who benefit from an environment that facilitates adaptation. Furthermore, I11 observes that the operators from the communities of the *Fondazione Fratelli di San Francesco d'Assisi*, despite not knowing Arabic, are able to mediate effectively because of their daily contact with patients, thereby facilitating more efficient and reliable diagnoses.

3.5. Theme 6: Communicative and relational adaptations

In addition to the use of digital tools and informal interpreting, some physicians implement alternative communication strategies to address language barriers. As discussed in Section 3.2.3, proficiency in foreign languages may constitute a communicative resource in the presence of language barriers. However, it is not always sufficient to resolve communication difficulties, as doctors and patients do not necessarily share the same linguistic repertoire. In such cases, speakers may try to adapt to each other's linguistic resources to communicate. As I5 explains, «Se parlano francese [...] io il francese non lo conosco, però lo capisco un po', quindi con alcuni ci sono state situazioni surreali che parlano francese, io rispondo in italiano più o meno … o mi invento qualche [cosa]. Se parlano inglese, l'inglese lo parlo» 'If they speak French [...] I do not know French, but I understand it a little, so with some of them there have been surreal situations in which they speak French and I reply in Italian more or less... or I make something up. If they speak English, I speak English' (I5). When no partially shared language is available, the physician may instead rely on automatic translators or informal interpreting, depending on the resources available (I5).

Other professionals opt for simplified language, avoiding specialist terminology and favoring simple structures: I1, I2 and I11 report selecting clear and simple words, which I1 considers complex even for Italian-speaking patients, especially the elderly. I2, for instance, reports deliberately replacing technical terms with more common words, so that «la gastrite diventa mal di stomaco e la cefalea diventa mal di testa» 'gastritis becomes stomachache, and cephalalgia becomes headache' (I2). Indeed, as implied by the unfinished remark «già con gli italiani a volte … » 'even with Italian patients, sometimes … [it is difficult already]' (I2), medical vocabulary may already pose communicative challenges with native Italian speakers. I11 states that clear and simple words are selected when speaking with adults, while the understanding of more complex vocabulary is considered to be within the capabilities of younger and educated patients. However, I2 highlights that patients do not always verbalize their challenges in comprehending, resulting in uncertainty among medical professionals about the effectiveness of communication. Among the strategies used, nonverbal communication also appears: I11 uses drawings and gestures to facilitate understanding, while I4 mentions «linguaggio figurato» 'figurative language', although the expression appears to be used loosely and may refer more broadly to illustrative or other supportive resources. A salient element that emerges from the interviews is the role of the doctor's relational attitude. I3, while acknowledging the problematic nature of linguistic barriers, underlines that a positive attitude, marked by openness and mutual commitment, can contribute to mitigating communication difficulties. Showing commitment in wanting to understand the patient in fact favors the development of a climate of trust (I3), while a hostile or detached attitude can aggravate misunderstandings and

compromise the therapeutic alliance. By contrast, in an ironic tone, I7 compares the doctor's work in the presence of linguistic barriers to that of a veterinarian, suggesting that it is possible to obtain a clinical outcome even in the absence of verbal communication. Finally, some doctors adopt practical solutions to ensure therapeutic adherence. In particular, I2 writes the dosage instructions directly on the drug packaging, or reports that patients themselves sometimes transcribe them into their own L1.

3.6. Theme 3: Insufficiency of current tools and strategies

A significant number of informants highlighted the limitations of the strategies currently used to address language barriers. Despite the heterogeneity of these strategies, they frequently prove insufficient to ensure complete and effective communication between doctors and Arabic-speaking patients. Automatic translations are regarded as preliminary support tools (see Theme 4), yet considered inadequate for achieving a comprehensive understanding. I10 observes that they only permit a superficial exchange, thus preventing doctors from grasping relevant semantic details and nuances. I3 highlights how suffering is also expressed through lexical elements, especially adjectival ones, which these tools fail to accurately convey. I6 and I7 also highlight the limitations of these tools; this situation is worsened, according to I7, by some patients' lack of familiarity with these digital tools. Furthermore, telephone-mediated communication is described by I10 as «*scarna*» 'meager' and sometimes ineffective, also due to the presence of concepts or lexemes untranslatable from one language to another: «Naturalmente questo sistema è molto scarno perché le cose da dire tu fai fatica a farti capire e certi temi sono intraducibili dall'italiano, e certi temi sono intraducibili in italiano» 'Of course, this system is very meager because it is hard to make yourself understood and some topics are untranslatable from Italian, while others are untranslatable into Italian' (I10). Difficulties increase when dealing with complex or culturally rooted topics, areas in which automatic translations are particularly lacking (I2, I12) and fail to render the entire social and ideological context of the patient (I12). In these cases, according to I12, mediation that integrates linguistic and cultural dimensions is essential, especially with non-European patients. Furthermore, other informants (I2, I7, I11) highlight the absence of organized and structured ways to deal with these situations, thus having to resort to improvised solutions. I4, for instance, mentions the occasional presence of interpreters or accompanying people, and also refers, somewhat vaguely, to «linguaggio figurato» 'figurative language', ultimately suggesting that little can be done to overcome such barriers.

Moreover, several informants have reported difficulties associated with the use of accompanying people or family members as non-professional translators, or with telephone translations provided by friends and relatives. Such strategies are not always effective or appropriate (I1, I5). In certain instances, other patients are engaged as interpreters, a practice that, although implemented with the patient's consent, gives rise to significant concerns regarding confidentiality (I11). At the same time, the informant acknowledges that, in such situations, the patient's health ultimately takes precedence: «in un ambiente come questo, vale il discorso: è più importante che io capisca che cos'ha questo paziente e lo possa curare, piuttosto che un altro… non venga a sapere?! Eh son due, diciamo, valori di cui bisogna far prevalere la salute del paziente» 'in an environment like this, the question is: is it more important that I understand what is wrong with this patient and can treat him, rather than someone else ... not coming to know?! Well, let's say there are two values, and the patient's health must prevail' (I11). The critical issues appear even more marked in the psychotherapeutic context, where, according to I5, it is impossible to conduct an effective clinical interview without trained interpreters. The issue is also linked to the difficulty of carrying out psychotherapy in a language other than the patient's L1 (I5). In the domain of psychiatry, as outlined in I5, the absence of a linguistic mediator further complicates the clinical management of the most severe cases. Moreover,

it is important to note that numerous informants (I1, I3, I5, I6, I11, I12) have emphasized the crucial role of the linguistic-cultural mediator, whose absence or the difficulty of finding one represents a recurring criticality, especially in emergency contexts. Finally, some informants propose improvements: I6 suggests the adoption of alternative digital tools to Google Translate that are more suitable for supporting detailed conversations. I11 instead recommends the introduction of a multilingual form for the classification of pain, which includes the different typologies alongside the generic term.

4. Discussion

The present study used thematic analysis (Braun and Clarke 2006, 2012) of twelve physician interviews to examine language barriers in communication with Arabic-speaking patients (RQ1) and the strategies adopted to address them (RQ2) in two Milan-based clinics. This method enabled a qualitative exploration of doctors' perspectives on a phenomenon that remains under-documented in the Italian outpatient context, particularly with Arabic-speaking patients. Despite focusing solely on doctors' voices, the study offers original evidence of communicative challenges and practices adopted in the absence of institutional resources, contributing to interdisciplinary reflection on doctor-patient communication in multilingual contexts.

4.1. Language barriers in clinical communication – RQ1

The findings indicate that language barriers compromise the quality of care, affecting three related dimensions: the doctor-patient relationship, the collection of anamnesis and adherence to therapeutic indications. In the presence of language barriers, the doctor-patient relationship is reduced to basic and mechanical exchanges, hindering the possibility of fully exploring the patient's experience and building a therapeutic alliance. Some professionals reported that interactions are frequently reduced to sequences of questions and answers, lacking descriptive articulation and exhibiting a paucity of lexical richness. This contracted communication increases the risk of misunderstandings because the doctor has more limited access to semantic nuances and to the kind of rich and functional narrative needed to frame the symptoms in a complete anamnestic framework. Furthermore, the ambiguity surrounding the patient's actual comprehension, which is not always explicitly stated, introduces an element of uncertainty with possible diagnostic and therapeutic implications. In congruence with these observations, Flugelman (2021: 1) emphasizes that history taking constitutes a pivotal moment not solely for the collection of clinical data, but also for getting to know the patient and establishing trust, a fundamental component of the therapeutic relationship that increases the effectiveness of the consultation.

More specifically, the collection of anamnesis emerges as one of the phases most susceptible to language barriers. The difficulties concern both the lack of a shared linguistic code and the structure of the clinical information itself, which frequently appears fragmented, lacking in cohesion, or overloaded with non-hierarchical symptoms. As one informant (I10) noted, the presentation of symptoms and pathologies is characterized by confusion, as a metaphorical «cesto di patologie» 'basket of pathologies' (I10), where it is difficult to distinguish the main problem from the collateral elements. This mode of expressing information is accompanied by the difficulty in transmitting to the patient, according to another informant, the severity of the symptoms and the relevance of the anamnesis, which is not always perceived as an essential stage of the care process. These observations suggest a discrepancy between the doctor's expectations and the patient's way of communicating, which can lead to misunderstandings in accurately diagnosing the main health problem. The

experience reported by informants highlights the dependence of the diagnostic process on the quality of verbal exchange, which significantly guides clinical reasoning. Indeed, one of the informants estimates that over 50% of diagnoses depend on the collection of anamneses, which, according to Joksimović and Bastać (2022: 154), allows for the diagnosis of between 50% and 70% of pathologies. To overcome the difficulties in collecting a complete anamnesis, some professionals have reported the use of additional diagnostic tests or subsequent reassessments as compensatory strategies to reduce clinical uncertainty and strengthen the diagnostic process.

The challenges posed by language barriers are also evident in other critical moments of the clinical encounter, such as those related to infant feeding, when these diverge from medical recommendations. The difficulties also concern the understanding of therapeutic indications, since language barriers make it difficult to clearly explain the dosage, timing and method of taking drugs, as also highlighted by Al-Yateem et al. (2023: 2). Particularly problematic is the fact that physicians are often unable to verify with certainty whether these indications have been understood and followed correctly, thereby weakening the link between prescription and therapeutic adherence. In this respect, the present findings suggest that language barriers may intensify a pre-existing asymmetry between doctors and patients (see Macagno and Bigi 2017: 61; Orletti and Iovino 2018: 26; Grosso and Floris 2025: 187-188), since they reduce patients' possibilities to narrate their experience in detail, clarify semantic nuances, and contribute directly to the construction of the clinical picture, while doctors are often forced to rely on reduced, fragmented, or mediated information.

More generally, the present findings suggest that language barriers do not operate as a simple or uniform condition, but are shaped by the interaction of several factors, including age, gender, education, length of stay in Italy, social networks, linguistic resources available within the encounter and the mediation services or tools available in the specific context (see Sections 4.2.1 and 4.2.2). In this sense, language barriers do not affect all encounters between Arabic-speaking patients and doctors to the same extent but are linked to a wider range of socio-demographic, contextual and interactional factors. In the present data, some physicians associated greater communicative difficulties with recently arrived patients, female and elderly patients, who are often less exposed to Italian and therefore more dependent on informal interpreters, although one doctor noted that long residence in Italy does not necessarily guarantee better linguistic competence when patients remain primarily within Arabic-speaking social networks. Learning Italian was also described by one interviewee as functional and unstructured, and at times perceived as «un ulteriore passaggio fuori dalla loro cultura» 'an additional step outside their culture' (I5).

Alongside linguistic repertoires and other socio-demographic factors, another variable that may shape the effectiveness of doctor-patient communication is health literacy, understood as «people's knowledge, motivation and competences to access, understand, appraise and apply health information [...]» (Sørensen et al. 2012: 3). Although not directly investigated in the present study, health literacy may represent a relevant complementary factor, particularly in relation to patients' comprehension and use of treatment-related information and may intersect with language barriers in shaping communication outcomes. Furthermore, research on Arabic-speaking patients in Iowa (USA) shows that language proficiency does not necessarily guarantee adequate health literacy, while limited English proficiency is strongly associated with low health literacy (Al-Jumaili et al. 2020: 6).

Overall, language barriers represent an element that crosses and influences different phases of care, demonstrating that attention to the linguistic dimension is not a secondary aspect, but an essential requirement for ensuring fair and safe access to care. The results of this study fit into a framework outlined by international studies (Al Shamsi et al. 2020; Ellahham 2021; Al-Yateem et al. 2023), confirming how language barriers negatively impact the quality of care, while highlighting

features that are specific to the organizational and sociolinguistic context of the Milanese outpatient clinics investigated.

4.2. Strategies adopted to mitigate language barriers – RQ2

4.2.1. *Main strategies adopted and their limitations*

In the absence of professional cultural mediators, the interviewed physicians employ a range of strategies to mitigate language barriers. The main resources reported by informants include automatic translation tools, telephone-mediated exchanges, and informal interpreters such as relatives, friends, or accompanying people. These offer some initial support, but are not sufficient to overcome the barriers, which remain a significant challenge in clinical practice. Firstly, the use of the telephone and automatic translators provides initial support for basic exchanges, but proves inadequate for conveying complex, articulated, or culturally situated content (see Section 4.1). A similar pattern emerges in Ceulemans et al. (2020: 379), where Arabic-speaking pregnant women in Belgium reported frequent recourse to translation tools, including Google Translate, while also stressing their limited reliability and the time-consuming nature of their use. Furthermore, as one informant in the present study observed, these tools are unlikely to convey the patient's ideological and social context and may represent a further barrier, especially for elderly doctors and patients (see Rosendahl and Larsson 2025).

Secondly, the use of informal interpreters (family members, friends, or accompanying people), either in person, by phone or via video call, entrusts one individual with the dual role of caregiver and non-professional interpreter. While one informant highlights the advantage of familiarity with the patient and their history offered by this type of intermediation, two other interviewees emphasize its limits in terms of accuracy and effectiveness. These findings align with the existing literature: Hilder et al. (2016), in a study in three New Zealand clinics, report that four out of ten patients prefer family members as interpreters because of personal ties, knowledge, trust, and cultural norms. However, some professionals report risks of omissions, inaccuracies, breaches of confidentiality and difficulties in building the therapeutic relationship. More specifically with reference to Arabic-speaking patients, Al-Yateem et al. (2023: 8) show that relying on family members or bilingual staff may compromise the quality of communication and increase the risk of inaccurate translations and misunderstandings. Similarly, Alkhaled et al. (2022: 5), examining Arabic-speaking patients in Norwegian hospitals, found that many participants preferred not to rely on relatives as interpreters because of the misunderstandings, delays, and sense of detachment associated with non-professional mediation. Likewise, in the present study, although two informants reported positive experiences, one interviewee highlighted that third-party mediation can hinder direct communication with the patient, reducing the quality of the clinical information collected. In particular, the use of children as translators – a practice that also emerged in the present research – can inhibit the sharing of sensitive content (Al-Yateem et al. 2023: 8) and pose confidentiality issues. This limitation, as noted by one interviewee, also arises when other patients are asked to help with translation. Indeed, an additional strategy identified in the data, albeit less frequently, was the involvement of other Arabic-speaking patients to facilitate communication when language barriers emerged. However, in the specific case of Arabic-speaking patients, the apparent availability of other Arabic speakers as informal interpreters does not necessarily guarantee effective communication, since Arabic-speaking patients do not constitute a linguistically homogeneous group, and ad hoc mediation may be complicated by differences in repertoires, literacy profiles, and access to Standard Arabic, as discussed in the following section.

4.2.2. *Linguistic varieties and multimodal resources: potentials and limits*

The involvement of other patients to obtain a non-professional translation poses further limitations, which are related to the internal variation of Arabic itself and to the heterogeneity of individual repertoires. From a sociolinguistic perspective, Arabic has classically been described as involving the coexistence of Standard Arabic, mainly associated with schooling, literacy, and formal domains, and a wide range of spoken varieties acquired from parents and used in everyday interaction, although more recent work has also highlighted the fluidity of actual usage and the presence of intermediate and mixed practices (Ferguson 1959; Albirini 2016; Bassiouney 2020). While colloquial Arabic varieties employed in the Arab world and within diasporic communities exhibit commonalities in phonology, semantics and morphosyntax, they can also differ to the extent that they may be mutually unintelligible (Barontini and Wagner 2020: 245). Moreover, colloquial Arabic varieties are not internally uniform, but may themselves display diatopic, diastratic and diaphasic variation (Abdelsayed and Bellinzona 2024; see also Haeri 1997).

This complexity becomes particularly evident in national contexts that are highly relevant in the Italian migratory landscape, such as Morocco, one of the main countries of origin among Arabic-speaking migrants in Italy (see Section 1). Recent research shows that, although 92% of Moroccans report using Moroccan Arabic in daily life, 24.8% of the population is estimated to speak one of the regional varieties of Tamazight; moreover, these figures do not capture the broader diversity of multilingual practices across speakers and households (Hachimi and Smail 2025: 4)[4]. More generally, diasporic repertoires may differ not only in terms of spoken variety, but also in terms of access to Standard Arabic, literacy, family language practices, and exposure to other languages. As Martari (2021: 76), drawing on Della Puppa (2006), notes, profiles may range from non-literate individuals in diaspora who speak only a colloquial variety, to literate speakers who use basic standard Arabic alongside a colloquial variety, up to people who speak Standard Arabic, a colloquial variety and a foreign language. Similarly, D'Anna (2020: 304) observes that the sociolinguistic profile of Arabic-speaking communities in the diaspora is quite diverse across different parts of the world. This point is relevant to the present study because the ad hoc solutions adopted by the interviewees often rely on a presumed common Arabic linguistic background. However, such solutions may prove less effective than expected, especially when communication depends on other patients or on translation tools operating through Standard Arabic or through a variety not fully shared by the patient. This interpretation is consistent with findings from healthcare settings, where Arabic-speaking migrants report that the interpreter's dialect and origin may affect mutual understanding (Hadziabdic and Hjelm 2014: 9), and may influence patients' preference for an interpreter of the same background, speaking the same colloquial Arabic variety and being of the same gender (Hadziabdic et al. 2014: 6).

The interviews also show that some physicians perceive internal differentiation among Arabic-speaking patients, but this awareness often remains partial, intuitive or inaccurate. In some cases, differences are identified only in relation to specific groups, such as Egyptian patients, without recognizing the broader internal variation of Arabic. In other cases, such intuitions coexist with inaccuracies, as when Arabic is associated with Turkish, Persian, or Afghan backgrounds. These findings suggest that some doctors are sensitive to linguistic differences, but do not always have the sociolinguistic tools to interpret it accurately. Where this complexity is not adequately recognized, informal mediation may be treated as more transparent and reliable than it actually is, automatic

[4] For Moroccan Arabic in the European diaspora, see also Boumans and De Ruiter (2002); for Arabic in diaspora more broadly, see D'Anna (2020).

translation may be over-relied upon, misunderstandings may be more easily overlooked, and the communicative burden may shift onto patients.

Finally, certain professionals resort to forms of nonverbal communication, such as gestures and drawings, while one informant (I4) refers more broadly to «linguaggio figurato» 'figurative language', a term that appears to be used loosely and may refer to illustrative or other resources, in the hope of bridging language barriers. In this respect, previous research on healthcare interaction in Italy has shown that communication with Arabic-speaking patients may be supported by the simplification of specialist language, the use of everyday vocabulary, other languages, informal interpreters, and multimodal resources such as gestures (Grosso and Floris 2020, 2023, 2025). Although the present data do not document these practices interactionally, they emerge from physicians' retrospective accounts, for instance when interviewees describe replacing technical terms with more accessible ones or relying on gestures, drawings, English, or French to support comprehension.

Overall, the findings suggest that physicians make considerable efforts to adapt communication and to render the clinical encounter as effective as possible in the absence of professional interpreters, drawing on a range of linguistic, relational, and multimodal resources. At the same time, these strategies often remain context-dependent, and their effectiveness may be constrained by the heterogeneity of patients' repertoires and by the persistence of communicative asymmetries within the clinical encounter. Moreover, even nonverbal or paraverbal strategies may be culturally shaped and may therefore generate ambiguity.

5. Conclusions and future directions

The present study offers an original contribution by documenting, through thematic analysis (Braun and Clarke 2006, 2012), language barriers in communication with Arabic-speaking patients (RQ1) and the strategies used to address them (RQ2) in two Milanese outpatient clinics. The results show that language barriers profoundly compromise the doctor-patient relationship, therapeutic adherence and the collection of anamneses, potentially affecting diagnosis. The lack of a detailed and lexically rich exposition of symptoms sometimes makes it difficult to place them within a complete anamnestic framework. In some cases, the difficulties go beyond the mere absence of a shared language and concern the misalignment between symptom presentation and doctors' expectations, complicating identification of the main problem. In the absence of professional mediators, doctors rely on alternative strategies such as automatic translators, informal interpreting or nonverbal communication. Although these offer initial support, the data show their limitations, especially with complex or culturally sensitive content. The linguistic heterogeneity of Arabic-speaking patients, including differences in spoken varieties, access to Standard Arabic, literacy, and other languages within individual repertoires, makes informal and ad hoc communicative strategies particularly complex and not always effective. The main contribution of this research lies in documenting, from doctors' perspectives, the impact of language barriers on different dimensions of clinical practice – from the doctor-patient relationship to the collection of anamnesis and therapeutic adherence – in two Italian outpatient settings. More specifically, the study offers a detailed picture of the difficulties encountered, as well as of the practices and resources activated by physicians in the absence of institutional tools. Through the qualitative approach, it was possible to grasp not only the critical aspects of these encounters, but also the considerable communicative and relational effort invested by professionals in trying to make care possible under structurally constrained conditions, thereby offering insights for both linguistic reflection and clinical practice. The focus on doctors aimed to explore the views of those facing this communicative complexity daily but represents a limitation as it excludes patients' perspectives and a fuller

understanding of communication dynamics. A further limitation is the sample's concentration in one outpatient clinic, as eleven out of twelve interviews were conducted in the same setting, due to practical circumstances in data collection and the availability of professionals during the data collection phase. In the case of *Niguarda*, only one contribution was collected, but it was consistent with trends observed in the other interviews. One informant suggested developing a multilingual pain classification form, distinguishing different types of pain beyond the generic term. This proposal, although isolated, highlights the need for visual and linguistically accessible tools to support physicians in understanding symptoms and improving communication. Future studies may include patients' voices, explore possible correlations between specific colloquial Arabic varieties and language barriers, and test ad hoc tools to reduce such barriers in outpatient settings.

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