GRADIVA

Volume 65 | Issue 07 | July 2026
DOI: 10.5281/zenodo.21350409

An Analysis of Doctor-Patient Bilingual Interactions in Nsukka Metropolitan Hospitals

Aruah, Virginus Onyebuchi[1], Eze, Jacinta Ukamaka[2], Odeh, Bestman[3] & Mamah, Juliana Ginika[4]*

1,2,3,4.PhD, Department of Linguistics, Igbo and Other Nigerian Languages, University of Nigeria, Nsukka.
Email: [1]virginus.aruah@unn.edu.ng, [2]eze.ukamaka@unn.edu.ng, [3]bestman.odeh@unn.edu.ng,
[4]Juliana.mamah@unn.edu.ng(*Corresponding Author)
ORCID: [1]0000-0001-6061-3288

Abstract

This study examines bilingual interactions between doctors and patients in public hospitals within Nsukka, Nigeria, focusing on language choice and code-switching practices. Drawing on Conversation Analysis (CA), the research explores the structural patterns of talk, the strategies of language accommodation, and how bilingual communication influences quality of care and patient satisfaction. The study adopted qualitative research design. Data comprised audio-recorded consultations in English and Igbo, systematically transcribed and analysed for turn-taking, adjacency pairs, repair mechanisms, and institutional talk. Findings reveal pervasive code-switching practices, strategic language choice to manage comprehension and rapport, and recurring accommodation behaviours such as convergence toward patient language. These bilingual practices play a vital role in mitigating misunderstandings, enhancing shared understanding, and shaping healthcare outcomes. The study contributes to scholarship on multilingual clinical communication and underscores the need for policy frameworks that integrate bilingual communicative competence into clinical training and practice.

Keywords: *Doctor–Patient Interaction; Bilingual Communication; Code-Switching; Conversation Analysis; Institutional Discourse; Nigerian Healthcare.*

1. INTRODUCTION

In multilingual contexts, language plays a vital role in shaping healthcare communication, influencing how medical knowledge is produced, interpreted, and acted upon (Heritage & Maynard, 2006; Street, Makoul, Arora & Epstein, 2009). In Nigeria, where multiple languages coexist, interactions between doctors and patients often unfold bilingually, particularly in clinical settings where English functions as the official language of medical practice while indigenous languages such as Igbo serve as primary languages of everyday communication (Bamgbose, 1991; Adegbija, 2004; Odebunmi, 2021). Nsukka, a linguistically diverse urban area in Enugu State, exemplifies such multilingual clinical environments. Within this context, doctors and patients frequently negotiate meaning across languages during consultations, resulting in patterned practices of code-switching, language mixing, and communicative accommodation (Wei, 2018; Auer, 2023).

Effective doctor–patient interaction is the basis for accurate diagnosis, patient satisfaction, adherence to treatment, and general quality of healthcare (Roter & Hall, 2006; Street et al., 2009; Ha & Longnecker, 2010). Recent studies further demonstrate that language concordance and strategic bilingual communication are associated with improved patient understanding, trust, and clinical outcomes in multilingual healthcare settings (Al Shamsi, Almutairi, Al Mashrafi & Al Kalbani, 2020; Diamond, Wilson-Stronks & Jacobs, , 2019;

Volume 65 | Issue 07 | July 2026
DOI: 10.5281/zenodo.21350409

Flores, 2023). However, in Nigeria, empirical research on healthcare communication has largely emphasised language barriers, miscommunication and the dominance of English as an institutional language, relying on surveys or interview-based approaches (Odebunmi, 2006; Adebayo, 2010; Nwoye, 2022).

As a result of this, there remains limited systematic analysis of how bilingual talk is organised in real-time clinical encounters, how participants manage bilingual exchange moment by moment and how these practices shape interactional outcomes such as understanding, participation and decision-making. This study addresses this gap by applying Conversation Analysis (CA) and communication accommodation theory to bilingual consultations recorded in Nsukka hospitals, with the aim of unmasking the structural features of doctor–patient talk. Doctor-patient talk such as turn-taking, adjacency pairs, repair mechanisms, and accommodation strategies are analysed. Furthermore, by demonstrating how bilingual communicative practices are mobilised to achieve mutual understanding and institutional healthcare goals, both doctors and patients are involved in decision-making (Sacks, Schegloff & Jefferson, 1974; Heritage, 2005; Ten Have, 2007).

2. LITERATURE REVIEW

Doctor–patient communication and healthcare outcomes

Doctor–patient communication has long been established as central to effective healthcare delivery. Seminal work by Roter and Hall (2006) and Street et al., (2009) demonstrate that clear and participatory communication improves diagnostic accuracy, patient's satisfaction and adherence to treatment and health outcomes. From a discourse perspective, communication in medical encounters is not neutral but institutionally organised, reflecting asymmetries of knowledge, authority and control (Heritage, 1984; Drew & Heritage, 1992).

More recent international research confirms that linguistic alignment between doctors and patients significantly influences care quality. Diamond, Izquierdo, Canfield, Matsoukas and Gany (2019) show that language concordance improves patient understanding and engagement, while Flores (2023) provides updated evidence those bilingual and interpreted consultations reduce medical errors and enhance trust. In multilingual settings, the interactional management of language choice has therefore become a central concern in healthcare discourse research.

Bilingualism and code-switching in medical interaction

Bilingual interaction has been conceptualised as an interactional organised practice rather than a deficit or interference (Gumperz, 1982; Auer, 1998). Auer (1998, 2023) argues that code-switching is sequentially motivated and locally meaningful, functioning as a contextualisation cue that signals shifts in activity, alignment, or participation frameworks.

Recent empirical studies from Europe support this interactional view. Rodríguez Tembrás (2024), examining bilingual consultations in Galicia (Spanish–Galician), demonstrates that doctors and patients strategically switch languages to clarify medical information, manage affect, and negotiate institutional authority. Similarly, Li and Zhu (2013) and Wei (2018) show that translanguaging practices in institutional settings enable participants to draw on their full linguistic repertoires to achieve communicative goals.

Volume 65 | Issue 07 | July 2026
DOI: 10.5281/zenodo.21350409

In healthcare contexts, code-switching has been found to facilitate explanation of technical terms, mitigate face-threatening acts and promote rapport (Ferguson & Candib, 2002; Roberts, Sarangi, & Moss, 2004). These findings reinforce the view that bilingualism functions as a communicative resource embedded in interactional structure.

Language barriers and healthcare communication in Africa

In African multilingual healthcare settings, language discordance remains a major challenge. Recent studies from Malawi show that reliance on English as the default institutional language limits patient comprehension and participation, particularly among rural and elderly patients (Recent studies from Malawi show that reliance on English as the default institutional language limits patient comprehension and participation, particularly among rural and elderly patients (Taylor & Kazembe, 2024).

Similarly, Mphasha and Lebese (2015) report that patients in multilingual Southern African hospitals often experience exclusion from decision-making when indigenous languages are not accommodated.

In Tanzania, Makuilo (2025) demonstrates that doctors routinely engage in accommodation strategies, including code-switching into Swahili, reformulation and repetition, to repair understanding during consultations. These practices are shown to influence patients' perceptions of care quality and professional empathy.

Nigerian studies on language and medical communication

In Nigeria, research on doctor–patient communication has largely focused on pragmatics, discourse strategies and institutional power relations. Odebunmi (2006) provides one of the earliest discourse-pragmatic analyses of Nigerian medical interaction, showing how questioning strategies and explanations reflect institutional authority. More recently, Odebunmi (2021) examines institutional discourse in Nigerian professional settings and emphasises the role of language choice in shaping participation.

Nwoye (2022) explores language, power and participation in Nigerian institutional discourse, noting that English dominance often constrains patients' communicative agency. Empirical healthcare-focused studies indicate that Nigerian doctors frequently switch between English and indigenous languages to enhance patient understanding and rapport (Adebayo, 2010; Olajuyin, O., Olatunya, Olajide, Olajuyin, Olajuyin, Ogunboyo, & Oluwadiya, 2022; Robbin, 2023; Ajayi & Kilani; 2024). A cross-sectional study by Adegbite and Odebunmi (2006) further reports that medical practitioners perceive indigenous language use as crucial for effective diagnosis and patient cooperation.

However, most Nigerian studies rely on interviews, questionnaires, or observational reports, offering limited insight into the sequential organisation of bilingual talk. There remains a notable absence of conversation analysis-based studies that examine how bilingual practices are enacted moment by moment in naturally occurring doctor–patient interaction.

Conversation analysis and institutional medical discourse

Conversation Analysis (CA) provides an effective framework for examining institutional interaction by focusing on turn-taking, adjacency pairs, repair mechanisms and sequence organisation (Sacks, Schegloff & Jefferson, 1974). CA studies of medical interaction reveal how doctors design questions, how patients present symptoms and how understanding is negotiated (Heritage & Maynard, 2006; Ten Have, 2007).

Volume 65 | Issue 07 | July 2026
DOI: 10.5281/zenodo.21350409

Repair is particularly significant in bilingual medical encounters. Schegloff, Jefferson and Sacks (1977) show that repair practices maintain inter-subjectivity while Roberts, Sarangi, and Moss (2004) demonstrate that bilingual repair often involves language switching or reformulation. Recent CA-oriented health communication research continues to stress the importance of analysing naturally occurring data to understand how institutional goals are achieved through interaction (Gill & Roberts, 2012; Antaki, 2023).

Despite growing international scholarship on bilingual healthcare communication, there is a scarcity of CA-based studies focusing on Nigerian hospitals. Existing Nigerian research has not sufficiently examined how bilingual doctor–patient interactions are sequentially organised, how language choice operates as an interactional resource, or how accommodation strategies shape participation and understanding.

This study addresses this gap by applying Conversation Analysis to bilingual consultations in Nsukka hospitals, contributing African data to global discourse and communication scholarship.

3. DATA PRESENTATION AN ANALYSIS

3.1 Turn-taking and language choice in bilingual clinical interaction

This section examines how turn-taking is organised in bilingual doctor–patient consultations and how language choice functions as an interactional resource for managing institutional authority and mutual understanding.

Analysis shows that doctors typically control the interactional floor through question design in English, while patients either respond in English, Igbo, or a combination of both. Language switching frequently occurs at points where comprehension, epistemic access, or institutional progression is at stake.

Excerpt 1: Complaint presentation and language shift

(D = Doctor; P = Patient; Eng = English; Nsụka Ịdẹkẹ Igbo =NỊI; Standard Igbo= SIg)

01	D:	What seems to be the problem today?	(Eng)
02	P:	Doctor, my body dey pain me well well.	(Eng/Pidgin)
03		(0.4)	
04	D:	Where exactly are you feeling the pain?	(Eng)
05	P:	*Ọ na-arụ m n'ẹhọ, mana na-ere m ọkụ.*	(NỊI & SIg)
06		(It is paining me in the stomach and it is burning.)	
07	D:	You mean stomach pain?	(Eng)
08	P:	Yes, stomach pain.	(Eng)

In line 1, the doctor initiated the consultation with an open institutional question, establishing professional control of the interaction. The patient's response in line 2 combined English and Nigerian Pidgin, signalling partial alignment with the institutional language while maintaining an everyday mode of expression. The doctor's follow-up question in line 4 narrowed the complaint, sustaining turn-taking control through English.

Volume 65 | Issue 07 | July 2026
DOI: 10.5281/zenodo.21350409

It is observed in line 5 that the patient switched to Nsukka dialect variety of Igbo and the Standard Igbo, providing a more detailed and embodied description of pain. This language shift functions as a resource for precision and experiential authority, allowing the patient to articulate symptoms more vividly. The doctor's utterance in line 7 reformulated the patient's Igbo description into English, displaying understanding and reasserting institutional framing. The patient's confirmation in line 8 marked successful alignment and progression of the consultation.

This excerpt demonstrated that bilingual turn-taking is not random but sequentially structured. Code-switching emerged at moments where clarity is required, and doctors frequently accommodated patient language choices through reformulation rather than correction. Such practices facilitated mutual understanding while preserving institutional order.

Excerpt 1 also illustrated strategic language management as a tool for negotiating understanding and maintaining interactional balance in a bilingual consultation. The patient's initial partial use of Pidgin in line 2 reflected convergence toward the institutional language (English) while retaining familiar linguistic resources for comfort and expressivity.

By embedding Nsukka Igbo and Standard Igbo in line 5, the patient asserted epistemic authority over their bodily experience, signalling that certain experiential knowledge is best conveyed in the mother tongue.

This aligns with research showing that patients often switch to indigenous languages when describing subjective sensations or culturally embedded concepts that may not have direct English equivalents (Olajuyin et al., 2022; Li & Zhu, 2013).

The doctor's reformulation in line 7 demonstrated linguistic accommodations through convergence, whereby the doctor maintains the consultation in English while acknowledging and translating the patient's indigenous expression.

This achieved multiple goals: it confirmed understanding, re-established institutional norms and validated the patient's contribution without disrupting turn-taking. The patient's confirmation in line 8 functioned as an uptake repair mechanism, completing the adjacency pair and signalling successful communication alignment**.**

Moreover, the excerpt revealed an active interplay between institutional constraints and local linguistic practices. Code-switching occurred not randomly but at critical junctures requiring clarity, such as specifying the location and quality of pain.

The doctor's reformulation strategy reduced ambiguity while preserving the institutional hierarchy by ensuring the interaction adheres to professional protocols. At the same time, the patient's language shifts enhanced expressive care and emotional tone, highlighted the importance of bilingual competence and flexibility in achieving patient satisfaction and quality care.

3.2 Adjacency pairs and diagnosis delivery in bilingual interaction

This section examines how diagnosis is delivered and ratified through adjacency pairs in bilingual doctor–patient consultations. The analysis shows that diagnosis delivery is typically organised as a first pair part produced by the doctor and a second pair part in which patients display understanding, acceptance, or request clarification. Language choice plays an important role in shaping how diagnoses are understood and negotiated.

Volume 65 | Issue 07 | July 2026
DOI: 10.5281/zenodo.21350409

Excerpt 2: Diagnosis delivery and patient uptake

(D = Doctor; P = Patient; Eng = English; SIg = Standard Igbo)

09	D:	Based on what you told me, this looks like malaria.	(Eng)
10		(0.6)	
11	P:	Malaria?	(Eng)
12	D:	Yes, uncomplicated malaria.	(Eng)
13	P:	*Ọ pụtara na ọ dị njọ?*	(SIg)
14		(Does it mean it is serious?)	
15	D:	*Mba, ọ dịghị njọ, mana ị ga-aṅụ ọgwụ.*	(SIg)
16		(No, it is not serious, but you must take drugs.)	
17	P:	*Ọ dị mma, dọkịta.*	(SIg)

Taking a cursory look at line 9, the doctor delivered the diagnosis in English, marking a transition from complaint exploration to institutional assessment. The brief pause in line 10 suggested a moment of processing before the patient produced a repeat-based response ("Malaria?") in line 11. This repetition functions as a patient understanding, a common CA practice through which patients invited confirmation without directly challenging professional authority.

The doctor's confirmation in line 12 completed the initial adjacency pair of diagnosis–confirmation. However, rather than closing the sequence, the patient initiated a follow-up adjacency pair in line 13 using Igbo, asking whether the condition is serious. The shift to Igbo indexes concern and a need for reassurance, highlighting the role of indigenous language in expressing affect and epistemic uncertainty.

The doctor responded in Igbo in line 14, offering reassurance while simultaneously issuing a treatment directive. This response displayed language convergence, aligning with the patient's linguistic choice to ensure clarity and emotional alignment. The patient's acceptance in line 17 (*Ọ dị mma, dọkịta*) completed the sequence, signalling understanding and agreement, thereby allowing the consultation to progress.

This excerpt illustrated that diagnosis delivery in bilingual consultations is not a single turn but a multi-part interactional achievement, shaped by sequential organisation and strategic language accommodation.

Excerpt 2 also highlighted how language choice interacts with epistemic authority, affective expression and sequential organisation in diagnosis delivery. The doctor's initial turn in line 9, delivered in English, signalled a shift from exploratory to evaluative institutional talk, situating the doctor as the primary holder of medical knowledge. The short pause in line 10 served as a processing slot. This pause gave the patient time to comprehend the diagnostic label, which is then uptake-confirmed in line 11 through repetition ("Malaria?"). This practice aligned with conversation analytic findings that patient repetition functioned both as a confirmation check and as a mechanism for knowledge negotiation, allowing the patient to participate without directly challenging institutional authority (Heritage, 1984; Drew & Heritage, 1992).

Volume 65 | Issue 07 | July 2026
DOI: 10.5281/zenodo.21350409

The patient's subsequent turn in line 13 marked a strategic language shift from English to Standard Igbo, indexed by the question "*Ọ pụtara na ọ dị njọ?*" ("Does it mean it is serious?"). This shift indicated several interactional functions:

1) Affective expression and epistemic stance: By using Igbo, the patient conveyed concern, vulnerability and a need for reassurance, which may be difficult to express with the same statements in English.
2) Negotiation of meaning: Patients' switching to the mother tongue allowed the patient to precisely articulate uncertainty, illustrating that code-switching is often motivated by the semantic and pragmatic demands of the interaction (Li & Zhu, 2013).

The doctor's response in line 15, delivered entirely in Igbo, demonstrated linguistic convergence and strategic accommodation. By matching the patient's language, the doctor simultaneously ensured comprehension, offers reassurance, and delivers treatment instructions while maintaining the natural progression of the consultation.

The patient's final uptake in line 17 ("*Ọ dị mma, dọkịta*") functioned as a sequence-closing signal, confirming understanding and agreement. This interactional closure illustrated that diagnosis delivery in bilingual consultations is inherently co-constructed, involving multiple adjacency pairs and language shifts that balance institutional authority and patient participation.

3.3 Repair mechanisms in bilingual clinical interaction

This section examined how repair mechanisms operate in bilingual doctor–patient consultations in Nsukka hospitals. Repair is treated as an interactional resource through which participants resolved problems of hearing, understanding, lexical choice, and medical interpretation. The analysis showed that repair sequences were triggered at moments of linguistic mismatch, use of medical terminology, or epistemic imbalance. These non alignment codes of doctor-patient interaction are resolved through code-switching, reformulation and repetition. Doctors predominantly manage repair to sustain institutional progress, while patients initiate repair to seek clarification and ensure comprehension.

Excerpt 3: Diagnosis explanation and other-initiated self-repair

(D = Doctor; P = Patient; Eng = English; Standard Igbo = SIg)

18	D:	From the test result, you have gastritis.	(Eng)
19	P:	Eh?	(Eng)
20		(0.5)	
21	D:	I mean stomach inflammation	(Eng)
22		(.) *ọnya afọ, ihe na-ere n'ime afọ m?*	(SIg)
23	P:	*Ah, ọnya afọ. Aghọtara m ya.*	(SIg)
24	D:	Yes, that's it.	(Eng)

3.3.1 Diagnosis explanation and other-initiated self-repair

Excerpt 3 demonstrated the dynamic role of repair in bilingual medical consultations, highlighting how language choice is strategically deployed to manage understanding, maintain interactional flow and negotiate authority. The doctor's initial delivery in line 18 used the

Volume 65 | Issue 07 | July 2026
DOI: 10.5281/zenodo.21350409

technical term *gastritis*, reflecting institutional authority and epistemic primacy. However, the patient's minimal response "Eh?" in line 19 functioned as an other-initiated repair, signalling comprehension trouble rather than resistance, in line with CA principles where repair initiation marks misalignment in inter-subjective knowledge (Schegloff, 2000; Heritage, 1984). The short pause in line 20 further emphasized a moment of processing and cognitive recalibration, creating space for the doctor to adjust the explanation. The subsequent other-initiated self-repair in lines 21–22 illustrated a multi-layered accommodation strategy:

1) Lexical simplification: By reformulating concept, "gastritis" as "stomach inflammation" reduces technical complexity while maintaining accuracy.
2) Linguistic and cultural adaptation: the ideology behind the patient switching to Standard Igbo allows the patient to access the meaning through familiar semantic and cultural frames, facilitating comprehension and epistemic alignment.
3) Sequential sensitivity: Repair is embedded in the ongoing interaction without disrupting turn-taking or consultation flow, demonstrating that bilingual repair strategies are integrated rather than interruptive.

The patient's uptake in line 23 (*Aghọtara m ya*) marked a successful repair completion, confirming understanding, while the doctor's line 24 provided an institutional closure, signaling that the diagnostic sequence is concluded. This pattern reflected the co-construction of meaning in bilingual consultations, where patients' comprehension and doctors' explanations are jointly negotiated across linguistic boundaries.

From a conversation analytic perspective, excerpt 3 exemplifies the following:

i. Sequential organisation of repair: The repair is triggered by patient uptake difficulties, addressed first through simplification in English and then through translation into Igbo, reflecting layered responsiveness.
ii. Language accommodation and convergence: The doctor adapted to the patient's preferred linguistic channel, aligning professional authority with patient-centered communication.
iii. Adjacency pair expansion: The repair sequence extended the basic diagnosis-confirmation pair, demonstrating that institutional talk can flexibly accommodate patient comprehension needs.
iv. Multilingual resource deployment: While switching between English and Igbo indicates strategic, not incidental; the doctor leverages the full selection of institutional and indigenous linguistic resources to restore mutual understanding.

In a nutshell, this excerpt highlights that in bilingual clinical consultations, repair is a collaborative and facilitative mechanism. It is both corrective and pedagogical, bridging the gap between institutional language norms and patients' linguistic and cultural competencies. The doctor's multilingual repair practices enhance patient comprehension, trust, and cooperation, while preserving the sequential and institutional integrity of the consultation.

3.3.2 Analysis of self-initiated repair mechanism

1) Identifying the repair trigger

In line 18, the doctor introduced a technical term ("gastritis"), which represents institutional and professional knowledge encoded in English. Line 19, the patient responded with "*Eh*?", signalling trouble in understanding. While this might seem like other-initiated

Volume 65 | Issue 07 | July 2026
DOI: 10.5281/zenodo.21350409

repair, the doctor immediately self-repaired before any explicit clarification request is fully articulated by the patient, making it a self-initiated repair.

2) Nature of the self-initiated repair

In line 21, the doctor reformulated "gastritis" as "stomach inflammation", simplifying the technical terminology. This is a lexical simplification, a common type of self-initiated repair (Schegloff, 2000), where the speaker corrects or clarifies their own prior turn to make it more accessible. It encourages doctor-patient consultative interactions in Nsukka hospitals.

3) Multi-level repair strategy

After lexical simplification in English, the doctor further switched to Standard Igbo in line 22: "*ọnya afọ, ihe na-ere n'ime afọ m*?" This bilingual repair served multiple purposes such as

i. It aligns with the patient's linguistic resources (accommodation/convergence).

ii. It addresses semantic and cultural gaps, ensuring the patient fully understands the diagnosis.

iii. It maintains sequential flow, avoiding interruptions or breakdowns in turn-taking.

4) Functional outcomes

Line 23 showed the patient uptake: "*Ah, ọnya afọ. Aghọtara m ya*," confirming understanding. Line 24, the doctor affirmed: "Yes, that's it," completing the repair sequence. This illustrated that self-initiated repair is both corrective and facilitative, restoring comprehension while reinforcing interactional cooperation.

5) Interactional significance

The repair highlighted the doctor's sensitivity to patient knowledge needs. By initiating repair on their own, the doctor ensured that institutional authority does not override patient comprehension. Self-initiated repair reduces the need for the patient to explicitly request clarification, which can be face-threatening in hierarchical contexts like doctor-patient interactions. The bilingual nature of the repair demonstrated how code-switching functions as a repair strategy, not just a communicative convenience (Li & Zhu, 2013).

6) Conversational analysis insights

By following CA perspective, sequential organisation is needed while exhibiting repair sequences. The repair extends the diagnosis–confirmation adjacency pair into a multi-turn explanatory sequence. On the hand, preference organization is also achieved through self-initiated repairs. The CA principle indicates that speakers prefer self-repair over other-initiated repair when possible, maintaining smooth interaction (Schegloff, Jefferson & Sacks, 1974). The doctor managed the patient's knowledge gap without challenging the patient's autonomy, reflecting sensitive knowledge management.

4. DISCUSSION OF FINDINGS

From the analysis of excerpt 1, turn-taking in bilingual consultations is characterised by:

i. Doctor-initiated sequences that maintain institutional control

ii. Patient code-switching at points of symptom elaboration

iii. Doctor reformulation as a strategy for managing bilingual input

Volume 65 | Issue 07 | July 2026
DOI: 10.5281/zenodo.21350409

iv. Successful sequence closure through language convergence

These patterns indicate that bilingual language use is an interactional achievement, jointly managed by doctors and patients to accomplish diagnostic and communicative goals

Analysis across the dataset of excerpt 2 or under sub-section 4.2 reveals that adjacency pairs surrounding diagnosis delivery are characterised by:

v. Doctor-initiated diagnosis statements typically produced in English

vi. Patient repeat-questions functioning as candidate understandings

vii. Patient shifts to Igbo to express concern, seek clarification, or manage affect

viii. Doctor language convergence to provide reassurance and ensure comprehension

ix. Sequence closure marked by patient acceptance and alignment

In 4.2, these findings demonstrate that bilingual adjacency pairs are central to how diagnoses are understood and ratified in Nsukka hospitals. Language choice operates as an interactional resource for managing epistemic authority, emotional alignment, and institutional progression, underscoring the importance of bilingual competence in effective clinical communication. The analysis of excerpt 3 demonstrates that repair mechanisms in Nsukka hospital consultations are systematically organised and closely tied to language choice. Other-initiated self-repair frequently occurs when doctors deploy specialised medical vocabulary in English, prompting patients to seek clarification. Doctors commonly resolve such repair sequences through reformulation and code-switching into Igbo. By using the indigenous Nigerian language, it serves as a communicative resource rather than a deviation from institutional norms.

Generally, repair practices contribute significantly to patient understanding, reduce interactional asymmetry and support effective clinical decision-making. The strategic use of bilingual repair indicates the role of language as a tool for negotiating authority, knowledge and care outcomes in doctor–patient interactions.

References

1) Adebayo, T. (2010). Doctor-patient interactions in Nigeria: A critical-cultural perspective on the role of power. *Journal of Intercultural Communication Research, 50*(1), 21-40.

2) Adegbija, E. (2004). *Language attitudes in West Africa*. Ibadan: Spectrum Books.

3) Adegbite, W. & Odebunmi, A. (2006). *Discourse tact in doctor-patient interactions in English: An analysis of diagnosis in medical communication in Nigeria. Nordic Journal of African Studies, 15*(4).

4) Ajayi, O. B., & Kilani, S. O. (2024). *Communication in healthcare discourse: A cultural and linguistic exploration of exchanges between healthcare practitioners and patients among Jukuns of Nigeria. Studies in Media, Journalism and Communications, 2*(1), 40–47. https://doi.org/10.32996/smjc.2024.2.1.5

5) Al Shamsi, H., Almutairi, A. G., Al Mashrafi, S., & Al Kalbani, T. (2020). Implications of language barriers for healthcare: A systematic review. *Oman Medical Journal, 35*(2), e122. https://doi.org/10.5001/omj.2020.40

Volume 65 | Issue 07 | July 2026
DOI: 10.5281/zenodo.21350409

6) Antaki, C. (Ed.). (2011). *Applied conversation analysis: Intervention and change in institutional talk*. London: Palgrave Macmillan.

7) Auer, P. (Ed.). (1998). *Code-switching in conversation: Language, interaction and identity*. London: Routledge.

8) Auer, P. (2023). *Code-switching and the organization of interaction*. London: Routledge.

9) Bamgbose, A. (1991). *Language and the nation: The language question in sub-Saharan Africa*. Edinburgh: Edinburgh University Press.

10) Diamond, L., Izquierdo, K., Canfield, D., Matsoukas, K., & Gany, F. (2019). A systematic review of the impact of patient–physician non-English language concordance on quality of care and outcomes. *Journal of General Internal Medicine, 34*(8), 1591–1606. https://doi.org/10.1007/s11606-019-04847-5

11) Diamond, L. C., Wilson-Stronks, A., & Jacobs, E. A. (2019). Do hospitals measure up to the national culturally and linguistically appropriate services standards? *Medical Care, 48*(12), 1080–1087. https://doi.org/10.1097/MLR.0b013e3181f5353f

12) Drew, P., & Heritage, J. (1992). Analyzing talk at work: An introduction. In P. Drew & J. Heritage (Eds.), *Talk at work: Interaction in institutional settings* (pp. 3–65). Cambridge: Cambridge University Press.

13) Ferguson, W. J., & Candib, L. M. (2002). Culture, language, and the doctor–patient relationship. *Family Medicine, 34*(5), 353–361.

14) Flores, G. (2023). The impact of medical interpreter services on the quality of healthcare: A systematic review. *Medical Care Research and Review, 80*(1), 3–24. https://doi.org/10.1177/10775587221107841

15) Gill, V. T., & Roberts, F. (2012). *Conversation analysis in the medical context* [Unpublished manuscript].

16) Gumperz, J. J. (1982). *Discourse strategies*. Cambridge: Cambridge University Press.

17) Ha, J. F., & Longnecker, N. (2010). Doctor–patient communication: A review. *Ochsner Journal, 10*(1), 38–43.

18) Heritage, J. (1984). *Garfinkel and ethnomethodology*. Cambridge: Polity Press.

19) Heritage, J. (2005). Conversation analysis and institutional talk. In K. L. Fitch & R. E. Sanders (Eds.), *Handbook of language and social interaction* (pp. 103–147). Mahwah, NJ: Lawrence Erlbaum.

20) Heritage, J., & Maynard, D. W. (2006). *Communication in medical care: Interaction between primary care physicians and patients*. Cambridge: Cambridge University Press.

21) Li, W., & Zhu, H. (2013). *Translanguaging identities: Creating transnational space through flexible multilingual practices amongst Chinese university students in the UK. Applied Linguistics, 34*(5), 516–535.

22) Makulilo, P. B. (2025). *Doctor–patient communication in Tanzanian public hospitals: Language use, code-switching, and accommodation strategies*. *Informasi, 55*(1), 14–28.

Volume 65 | Issue 07 | July 2026
DOI: 10.5281/zenodo.21350409

23) Mphasha, L. E., & Lebese, R. T. (2015). The importance of indigenous languages in health-care services: Some observations from Limpopo Province, South Africa. *Ethno Medicine*, *9*(1), 89–95. https://doi.org/10.1080/09735070.2015.11905425

24) Nwoye, O. G. (2022). Language, power and participation in Nigerian institutional discourse. *Discourse & Society*, *33*(4), 458–475. https://doi.org/10.1177/09579265221082879

25) Odebunmi, A. (2006). Meaning in English medical discourse in Nigeria. *Nordic Journal of African Studies*, *15*(3), 348–366.

26) Odebunmi, A. (2021). Institutional discourse and pragmatics in Nigerian professional settings. *Pragmatics and Society*, *12*(3), 381–400. https://doi.org/10.1075/ps.19025.ode

27) Olajuyin, O., Olatunya, O., Olajide, T., Olajuyin, A. B., Olajuyin, A. A., Ogunboyo, F., & Oluwadiya, K. (2022). *Use of indigenous language for clinical clerkship: a cross-sectional survey in Nigeria*. *Eastern Mediterranean Health Journal*, *28*(2), 158–162.

28) Roberts, C., Sarangi, S., & Moss, B. (2004). *Presentation of self and symptoms in primary care consultations involving patients from non-English speaking backgrounds. Communication & Medicine*, *1*(2), 159–169. https://doi.org/10.1515/come.2004.1.2.159

29) Robbin, A. (2023). *Language preference and selection during nurse-patient service encounter at Adeoyo Teaching Hospital, Yemetu, Ibadan. British Journal of Nursing Studies*, *3*(2), 23–31.

30) Rodríguez Tembrás, V. (2024). *Two languages, one goal: Code-switching in doctor–patient communication in the Galician healthcare system. Languages*, *9*(6), 209. https://doi.org/10.3390/languages9060209

31) Roter, D. L., & Hall, J. A. (2006). *Doctors talking with patients / Patients talking with doctors* (2nd ed.). Westport, CT: Praeger.

32) Sacks, H., Schegloff, E. A., & Jefferson, G. (1974). A simplest systematics for the organization of turn-taking for conversation. *Language*, *50*(4), 696–735. https://doi.org/10.2307/412243

33) Schegloff, E. A. (2000). *When 'others' initiate repair*. *Applied Linguistics*, *21*(2), 205–243.

34) Street, R. L., Makoul, G., Arora, N. K., & Epstein, R. M. (2009). How does communication heal? Pathways linking clinician–patient communication to health outcomes. *Patient Education and Counseling*, *74*(3), 295–301. https://doi.org/10.1016/j.pec.2008.11.015

35) Ten Have, P. (2007). *Doing conversation analysis* (2nd ed.). London: SAGE.

36) Taylor, A., & Kazembe, P. (2024). Assessing language barriers in health facilities in Malawi.
BMC Health Services Research, 24, 1393. https://doi.org/10.1186/s12913-024-11901-4

37) Wei, L. (2018). Translanguaging as a practical theory of language. *Applied Linguistics, 39*(1), 9–30. https://doi.org/10.1093/applin/amx039