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Research Article

Code Switching and Code Mixing in a Doctor-Patient Clinic Session in General Hospital in Ìkàré Akoko Town, Ondo State

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Abstract

This study examined of the use of code switching and code mixing in a doctor-patient clinic session as a linguistic mechanism to achieve effective health care delivery especially in a heterogeneous society using General hospital in Ìkàré Akoko Town, Ondo state. The study draws data from two doctor-patient clinic sessions taken from General hospital in Ìkàré Akoko Town, Ondo State. The sampling technique employed to arrive at the data was spontaneous sampling. The qualitative data were transcribed and translated to English for the sake of proper understanding, and further subjected to descriptive analysis. The data for this research was collected through audio recordings in the office of the doctors. Findings showed that code mixing and code switching are veritable tools to bridging communicative gap in a bi/multilingual society. This is especially so in cases where misunderstanding and misinterpretation of utterances can have far reaching consequences such as in a case of health care dialogue. The findings also underscore inter-sentential switching, intra-sentential switching, tag switching, lexical insertion and lexical borrowings. The pattern of code switching and code mixing in datum 2 is a little different from the pattern in datum 1. The study concludes that effective communication is sequel to efficient health care delivery; and to achieve effective communication, the participant in a discourse, especially a crucial discourse such as in the case of health care delivery must be afforded the opportunity to express themselves in the most convenient linguistic code for them to explain best their health signs and symptoms and at the same time such linguistic code has to be at equilibrium with the health care giver at the particular speech time and event.

Keywords

Code Switching, Code Mixing, Doctor-patient Communication, Multilingualism, Healthcare Delivery, Sociolinguistics

1. Introduction

In any society, to achieve effective communication, language is needed, the roles of language in communication cannot be over emphasized, it is through language that we are able to communicate with the world, define our identity, express our history and culture, learn and defend ourselves. Language helps preserve community history, customs and traditions, memory, unique modes of thinking and meaning of expression.

The hospital is one of the important places in the society, communication is also needed in the hospital to pass information across. The hospital environment captures a scenario where many people of different linguistic background go for

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amelioration of their various aliment. This will usually involve sessions with either the medical records officer, nurses, doctors among various hospital staff. Principally, patients must see the doctor in the hospital and their communication must be carried out in the language which both will understand to be effective. Sometimes when patients and doctor have different linguistic background and they must communicate effectively, there is need for linguistic alternation which may involve code mixing or code switching among others in their communication.

Coding, or language switching occurs when an individual who is bi or multilingual alternates between two or more languages during his/her speech with another bilingual person [3]. A person who is bilingual may be said to be one who is able to communicate, to varying extents, in a second language. This includes those who make irregular use of a second language. Such people are able to use a second language but have not done so for some time (dormant bilingualism) or those who have considerable skill in a second language.

Language barrier has been shown to be a threat for quality health care. Studies have shown that lack of adequate noticing, reporting and bridging of language barrier is a major factor responsible for risks in health care. However, studying on the link between language proficiency and patient safety/risks due to language barriers during hospitalizations and the way language barriers are detected, reported and bridged in hospital care is an effective tool in achieving good and efficient health care services. It was also observed that medical care depends largely on effective communication between doctors and patients. Ineffective communication can lead to improper diagnosis and delayed or improper medical treatment.

Patients with Limited English Proficiency (LEP) or those who live with hearing impairment may require interpreters or other services to help them communicate effectively with healthcare providers. Many hospitals are actively taking steps to improve effective communication however, hospitals face increasing challenges to meet the communication needs of an increasingly diverse population in Nigeria.

2. Statement of the Problem

Communication between people from different linguistic background presents a more complex situation than could be imagined especially when there is not unified or common language, a sort of lingua franca that can resolve this communication challenge. Due to the great need to bridging the linguistics gap in communication between people of different linguistics background, code mixing and code switching are introduced as linguistics tools, needed for such linguistic complex situation.

In as much there is need for communication, there are bound to be communication barriers, these hinders or prevent smooth communication between individuals. These barriers are factors that impedes smooth interpretation and effective response between the encoder and the decoder. This communication challenge also presents itself in form of communication barrier in terms of code differences and code selection in a mixed or heterogeneous society especially when the medical practitioners and the patients do not belong to the same speech community. This is a common situation in Nigeria, being a heterogeneous country, and quite obvious in Ìkàré Akoko, which is our study locale. Many times, the communication gap between the practitioners and the patients in the course of their interaction with each other are usually responsible for wrong diagnosis, wrong interpretation of prescription and other complications. This may arise as a result of inadequate supply of information from the patient to the doctor while describing the symptoms of his/her ailments or health conditions. On the other way round, it arises from the doctor to the patient while prescribing drugs/treatments. This study is set to investigate the described problem.

3. Objectives of the Study

1) To identify the actual pattern of language use as a tool for metalanguage in the health sector using General hospital Ìkàré Akoko as a case study.
2) To examine how codemixing and codeswitching are used as a linguistic tool to bridge linguistic gap and barriers in communication using General Hospital Ìkàré Akoko as a case study.
3) To describe trigger points and possible causes for switching of codes in a doctor-patient clinic session using General hospital Ìkàré Akoko as a case study.

4. Literature Review

4.1. Code-Switching

One of the inevitable consequences of bi/multilingual situation is switching of linguistic codes whether at phrasal level or clausal level, intra-sentential or inter-sentential [2]. Code can be said to be taken as a verbal component that can be as small as a morpheme or as comprehensive and complex as the entire system of language. It can be said to be a message represented by rules intended to conceal its meaning. Encarta Dictionary also defines it as a system of letters, numbers, or symbols into which normal language is converted to allow information to be communicated secretly, briefly, or electronically [2]. Codes-witching occurs in many situations influenced by linguistics and social factors. One prominent condition where codeswitching occurs is in a multilingual education context, which can be beneficial and detrimental [8].

In his own attempt at defining code-switching, three contexts in which code-switching may take place are identified [20]. These include that;

1) The listener has changed.

2) The setting has changed or the other language is habitually associated with the new setting.
3) The topic has changed or the other language is associated with the new topic.

Code-switching occurs when a speaker alternates between two or more languages or language varieties. In the context of a single conversation, multilinguals sometimes use elements of multiple languages when conversing with each other.

While examining different views on code-switching, she observed that most earlier studies either maintain that code-switching never existed or treated code-switching as an interference phenomenon with 'interference' being interpreted in its most literal sense [10]. Hence, such studies consider code-switching as part of the performance of the imperfect bilingual, motivated by inability to carry on a conversation in the language on the floor at the moment. She equally observed that Labov treated code-switching as one of the 'puzzling problems' in trying to study linguistic variation within a community' [7, 10, 17].

She further maintained that in one of her researches on language use in African multilingual communities especially among urban workers in Kampala, Uganda, and Lagos, she had heard some workers saying; 'we sometimes mix languages when speaking with fellow workers' [10]. In her analysis, Myers-Scotton therefore interpreted the statement to mean; 'we use language X with such and such persons and language Y with other persons'. She confessed that she equally fell a victim of ignoring the existence of code-switching initially by taking such phenomenon to be cases of borrowing which seems nobler to study rather than code-switching [10]. Myers-Scotton maintains that she therefore established her research on code-switching on two prevailing models [10]. The first was the 'domain model' of Fishman which views linguistic choices as predictable on the basis of the domain in which they occur [4, 5].

The second model was the 'binary-choice' model, which is exemplified by tree diagrams with binary branching at the nodes as presented by Rubin on choices between Spanish and Guarani in Paraguay, Sankoff on choices among New Guinea languages, and among American form of address [16, 17]. Myers-Scotton therefore proposes the 'Markedness' model which states that speakers have a sense of markedness regarding available linguistic codes for any interaction, but choose their codes based on the persona and/or relation with others which they wish to have in place [10]. The model accounts for speakers' socio-psychological motivations when they engage in code-switching. This she proposes in order to fill the gap that exists between the psychological and socio-pragmatic status of contact phenomena.

As observed by her this has to do with the fact that analyst cannot assume that there is always a match between a speaker's motivation and the addressee's interpretation in bilingual discourse [10]. Obviously, the argument here is that all speakers have a 'markedness metric', an innate, internalized model which enables them to recognise that all code choices are more or less 'unmarked' or 'marked'. 'unmarked is used to mean that the choice of a particular linguistic variety is expected as the medium for a talk exchange, given the norms of the society regarding the salient of specific situational factors present while 'marked' choices are the choices that are not usual or unexpected.

While examining the effectiveness of code switching and code-mixing linguistic mechanism in doctor-patient clinic session using Obafemi Awolowo University Teaching Hospital as a case study, he observes that Dr. Tosin, the subject doctor, is a balanced bilingual who could employ both intimate and emblematic code-switching [1]. This agrees with the description of Poplack [15]. According to Bamigbade, this was obvious in the conformity of her code-switched segments and other segments around it to the underlying syntactic rules of the two languages as she was able to successfully use to bridge constituents to link them together grammatically. However, a close look at Faith's mother's speech pattern revealed that her code-switched segments consist more of individual items such as nouns, adverbs, conjunctions and verbs [1]. The following extract from is relevant here [1]:

Mother: Mo se ni *last week* (I did it last week)
Mother: Mó gba *number* ẹn ìyẹn, *but* wọn o tí fun mi ni *reply*. Mo *plan* ki n ṣétàn k ń pe won. (I collected the person's [attendant] [phone] number, but they [the attendant] have not given me reply. I am planning to call them [the attendant] as soon as I am through.)
Mother: Beeni, ko si *problem*. (Yes, there was no problem)
Mother: E o fun wa ni *form* o. (You didn't give us any form)
Mother:... Se mo pe ko soro dada tele *but* ati igba to ti n lo *drugs* yen lo ti n *improve* si. Oro yen ti nwa *okay* nsin. (...You know she was not talking before, until she started to take the drugs that her condition started to improve. The speech is now getting better).
Mother: Speech test lo wa put wa fun, so won wa ni ka pada wa. (No. We did speech test and we were told to come back.)

He also made reference to the 2nd and the 5th items in the ten commandments of the communication between the doctor and his/her patients proposed by Harlen which state that speakers [6];

1) Use simple, well-known words
2) Pay attention to feedback signals to ensure that communication is actually taking place

Making reference to [13], he opines that Doctors should avoid the use of medical jargons to avoid confusing the patients or scare them [1]. This is necessary because in a good doctor-patient interaction, linguistic ethics is significant. He therefore asserts that; this may account for why Dr. Tosin consciously switched and mixed codes to cater for the linguistic deficiency of Faith's mother. This combined with the doctor's consciousness of Faith mother's age and level of education. And also, which may account for the doctor's choice of simple words. More so, when she could not find appropriate equivalents to the words in Yoruba, she switched to English which was most convenient for her at such instances. The doctor was

only very careful to be sure that she did not confuse generalization with specifics in the process of her switching.

While recalling [20], he maintains that the listener, the setting and the topic remain unchanged in conversational code-switching contrary to the claims in situational code-switching, it was obvious that in the interaction between Dr. Tosin, Faith and her mother, the listener, the setting and the topic did not change, however codes were switched [1]. This was a clear case of conversational code-switching.

He further observed that there exist communicative conventions of closed network, in the interaction among the three interlocutors. In other words, the strategies used for their code-switching shed light on their shared background knowledge and cultural values of the particular speech community where they were located.

He therefore concludes that the two clinic sessions used as sample data in this study revealed two different situations which he explains below [1]:

The first session did not show obvious evidence of code-switching. This was because the doctor and his clients communicated in English throughout since the patient and her family members who came with her were all educated, despite their ethnic differences the clients are from Warri and the doctor is a Yoruba man. Hence; only two instances of code-switching were observed. However, the second clinic session (Subject III) revealed that code-switching aided the effectiveness of the interaction. This is because the doctor made virtually all her conversations either by code-switching or code-mixing. It was therefore pertinent to conclude that code-switching and code-mixing played a vital role in effective interaction between doctor and patient.

4.2. Barriers to Communication

One of the weaknesses of western medicine is communication skills [19] He asserts that medical education does not involve training and developing the communicative skills of the practitioners [19]. The focus is mainly on the training of their professional skills such as diagnosis and surgical procedures. He therefore observes that it is now clear to people, including the professionals, that skillful communication is primary to medical education [19]. Despite this, he further notes that professionals are yet to be equipped with requisite communication skills. According to him, teaching communication skills to medical students started only recently in Britain. Though, the teaching efforts are usually scattered about the curriculum, fairly limited in scope and do not include formal assessment" [12].

Oloruntoba-Oju states that communicative challenge between medical practitioners and patients is worse in Nigeria [13]. This communication challenge also presents itself in form of communication barrier in terms of code differences and code selection in a mixed or heterogenous society especially when the medical practitioners and the patients do not belong to the same speech community. This is a common situation in Nigeria, being a heterogenous country, and quite obvious in Ile-Ife, which is our study locale. Many times, the communication gap between the practitioners and the patients in the course of their interaction with each other are usually responsible for wrong diagnosis, wrong interpretation of prescription and other complications. This may arise as a result of inadequate supply of information from the patient to the doctor while describing the symptoms of his/her ailments or health conditions. On the other way round, it arises from the doctor to the patient while prescribing drugs/treatments.

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Patients with Limited English Proficiency (LEP) or those who live with hearing impairment may require interpreters or other services to help them communicate effectively with healthcare providers. Many hospitals are actively taking steps to improve effective communication; however, hospitals face increasing challenges to meet the communication needs of an increasingly diverse population in Nigeria. He therefore identifies the following barriers to communication [13]:

1) Psychological Barriers: The psychological condition of the receiver will power how the message is received. Stress management is a significant personal skill that affects our interpersonal relationships. For example, anger is a psychological barrier to communication. When we are angry, it is easy to say things we will regret later, and also misunderstand what others are saying. Also, people with low self-esteem may be less self-assured and therefore may not feel comfortable communicating.
2) Physical Barriers**:** communication is usually easier over shorter distances as more communication channels are obtainable, and less technology is obligatory. Although modern technology often serves to decrease the crash of physical barriers, the advantages and disadvantages of each communication channel should be unspoken so that a suitable channel can be used to overcome physical barriers.
3) Physiological Barriers**:** Physiological barriers may affect the receiver's physical condition. For example, a receiver with condensed hearing may not grab the sum of a spoken conversation, especially if there is significant surroundings noise.
4) Language Barriers: Language and linguistic aptitude may act as a barrier to communication. However, even

when communicating in a similar language, the terms used in a message may act as a barrier if it is not easy to understand by the receiver.

5) Attitudinal Barriers: Attitudinal barriers are perceptions that stop people from communicating well. Attitudinal barriers to communication may affects from poor management, personality conflicts, and battle to change, or a lack of motivation. Active receivers of messages should challenge to overcome their attitudinal barriers to assist effective communication.

In a study of seven PHCs in Obot Akara, Akwa Ibom State, he found that 43.9% of respondents identified language barrier as a factor that could affect their compliance with medications, and 19.3% cited their ability to understand the language used at a health facility as a reason for choosing it [11]. These findings suggest that patients are acutely aware of language as a determinant of care quality and actively factor it into their healthcare-seeking behavior. Equally, patients often report feelings of anxiety, frustration, and powerlessness when they cannot communicate effectively with their providers, and that this emotional distress can itself hinder the healing process and erode trust in the healthcare system [18].

In a similar study, Mba asserts that increasing the doctors' awareness of the communicative differences and empowering patients to express concerns and preferences could serve as a springboard to establishing a more effective clinician-patient communication [9]. The study suggests that at both national and organization levels, policies should be in place to integrate cultural competence into health care services. Based on cultural differences also, he suggests that physicians have to encourage patients to discuss their concerns and to ask questions, and they should listen actively [9].

5. Methodology

The sample for this study includes two doctor-patient clinic sessions taken from General hospital in Ìkàré Akoko Town, Ondo State. The sampling technique employed to arrive at the samples was spontaneous sampling. This is because the such doctor-patient clinic session in the health sector is not open to the public hence as a result of the need for confidentiality of the clinic session to keep the identity and information of the patient safe the researcher is restricted to certain spontaneous cases. Informed consent was gotten from the doctors and the patient. The purpose of the study was explained to them and since their identity will be anonymous, they gave their consent. The two patients are native speakers of Ìkàré Akoko, while Doctor 1 is from Benin city, hence he understands very little of Yoruba while Doctor 2 is Yoruba but not from Ìkàré Akoko.

The researchers personally visited the General hospital in Ìkàré Akoko Town, Ondo State to collect the data. The researchers sought the permission of the management of the hospital and was allowed to take a recording of some selected non-sensitive doctor-patient clinic sessions in the hospital. The researchers also elicited relevant personal information that relates to the linguistic and educational background of the subjects for the purpose of the research. The data for this research was collected through audio recordings in the office of the doctors. Due to ethical reason, we were restricted from recording some particular conversations termed 'confidential'.

The qualitative data were transcribed and translated to English for the sake of proper understanding, and further subjected to descriptive analysis. The implication of the use of code switching as a linguistic tool in bridging communication gap in a doctor- patient clinic session and other health professional communication to foster effective delivery was discussed from the findings of the study. The study is not quantitative and the focus is not to determine the type of codeswitching, hence, the limitation of the investigation.

6. Data Presentation

DATUM 1

DOCTOR: Good morning madam.

PATIENT: Good morning sir

DOCTOR: Ki lo se yin?

(what happen to you?)

PATIENT: Ori nfo mi ni, so gbogbo orun tun dun mi

(I have headache and neck pain)

DOCTOR: Okay, ori fifo

(Headache?)

PATIENT: So mi de jeun, taste enu mi koro sa. Ebi de tun ma gbee mi ni ekan kan (And I am not eating, my taste bud is sour, and once a while I feel nauseating)

DOCTOR: Okay, ni eyin nko?

(How about your back?)

PATIENT: Hmmmm isale inu ma dun mi.

(I feel sharp pain below my abdomen)

DOCTOR: Isale inu ni side ibo, Isale inu gangan.

(Below the abdomen on which side, precisely below the abdomen?)

PATIENT: Beeni.

(Yes)

DOCTOR: Epele, ni eyin nko? Eni ori nfo yin, ara nro yin, e le jeun, e lose appetite yin, ebi man le yin, hmmm Isale ikun di ja o?

(Sorry, how about you? You said that you always have headache, you don't have appetite, you feel nauseating, and you have lower abdominal pain?)

PATIENT: Beeni, Isale inu yen a kan kan mi.

(Yes, I feel abdominal pain)

DOCTOR: Ibe bere?

(When did it start?)

PATIENT: Hmmmm, bi ati ijerin si ibe.

(Since about four days ago)

DOCTOR: Ijerin sun be, 4 days ago?

(Four days ago?)

DOCTOR: Oka lo si?

(What medication did you take?)

PATIENT: Mo sha lo paracetamol ati flagyl

(I took paracetamol and flagyl)
DOCTOR: Owo nu, o su?
(Are you stooling?)
PATIENT: Oti oo, mo sa su normal imi.
(No, I defecate normal)
DOCTOR: Igba melo le ti bi?
(How many times have you vomited?)
PATIENT: Mo sha ka ebi yen, bi igba meta.
(I counted it, like three times)
DOCTOR: Mayin e kede se e?
PATIENT: Mi sun dada ni, Irom.
(I don't sleep well at all)
DOCTOR: E to omo lowo ni?
(Are you a nursing mother?)
PATIENT: o ti oo.
(Not at all)
DOCTOR: Okay, omo yin te bi dani how old ni?
(How old is the child you are carrying?)
PATIENT: Hmmmm ka so wipe bi odun kan abo
(Let's say one and a half years old)
DOCTOR: Igba wo le se nkan osu last?
(When was your last menstrual circle?)
PATIENT: Ati inu osu karun, May.
(Since the fifth month of the year, May)
DOCTOR: May this year? Any other thing aside that?
PATIENT: Nothing
DOCTOR: ok, epele
(Sorry)
PATIENT: yes, eshey sir
(Thank you sir)

DATUM 2

DOCTOR: grandma ekaro
(Good morning)
PATIENT: Ekaro sir
(Good morning sir)
DOCTOR: se eyin ni Hafusat?
(Is you name Hafusat?)
PATIENT: Benni sir
(Yes sir)
DOCTOR: Epele, (sorry) what happened to you?
PATIENT: my chest is paining me to my back
DOCTOR: ok your chest is paining you radiating to the back. Igba wo lo bere?
(When did it start?)
PATIENT: lati bi (since) two weeks ago
DOCTOR: ki leti wa lo si?
(What medication have you taken?)
PATIENT: mo sa so fun brother mi kan, o sa fun mi ni ogun kan bi brown and yellow baii.
(I told a brother of mine and he gave me one drug like brown and yellow)
DOCTOR: ki se omeprazole?
(IS it omeprazole?)
PATIENT: uhn uhn eniyen ni o sha shey typhoid, pe amoxil ekeji pe amipiclox
(He said it is for typhoid, one is Amoxil and the second one is Ampiclox)
DOCTOR: ok, but aya ja ehn, o ja ehn kanyin, egbe e si re?
(but are you feeling palpitation, is that side aching you?)
PATIENT: egbe yen si gbe Kankan, but aya yen o ja mi ju a de ma ra mi.
(that side is dry, but I am not feeling much palpitation)
DOCTOR: ok, shey e bi?
(Do you vomit?)
PATIENT: Rara me bi
(No I didn't vomit)
DOCTOR: ke lo?
(What medication did you take?)
PATIENT: ogun bi mo sha ran brother mi, e ogun i o hun mi ni.
(It is the drug that I sent my brother that I took)
DOCTOR: ko to di pe e bere si ni ma fili peeni yen, ki lawon ogun ti e ti ma nlo tele?
(Before you started feeling this pain what are the drugs that you used to take?)
PATIENT: boya tara ba kan ro mi abi ori kan fo mi, ma sa lo paracetamol
(When I have headache or body pain I take paracetamol)
DOCTOR: ok o ni e n lo tele. ko de si anybody to ni, boya bi daddy yin abi mummy yin to ma complain pe inu yen ma n ta oun, o ma ra oun?
(That is what you use before, and there is nobody may be your father or mother that have ever complained of such stomach pain or ache?)
PATIENT: rara
(Not at all)
DOCTOR: e si? Egbon e, aburo e, a soro e naa
(None? Not your elder ones or younger ones ever had such complaint?)
PATIENT: rara, boya ara riro sha
(Not at all, probably just body ache)
DOCTOR: leyin amoxil te lo yen, e si pada tun lo nikan mi
(Aside the Amoxil that you took did you take any other medication?)
PATIENT: ati paracetamol o pari
(With paracetamol and that is all)
DOCTOR: Iya o je, shey e jeun? Boya bi ke je ewa, ke je agbado
(What did you eat, do you have appetite? Did you eat anything like beans and corn?)
PATIENT: ti n ba je ewa, isun or sometimes ti mo ba mu ogi na, o ma ta mi
(If I eat beans I will feel it, even if I take pap, I it will pain me)
DOCTOR: ok o ma n ta yin. Ko wa si anything ti o je pe te ba je o ma fi relief yin.
(So it pains you, and is there nothing that when you eat, it will relieve you?)
PATIENT: boya ti n ba je…, igba mi gan boya ti ba je okele, mo ma ri pe o ma ta mi.

(May be if I eat…, even sometimes when I eat swallow food I still feel the pain)

DOCTOR: o ma ta yin, ko si boya any ounje te ba je to je pe oma relief yin dada.

(So it pains you, and is there nothing that when you eat, it will relieve you?)

PATIENT: kosi

(None)

DOCTOR: kosi? Ok mo fi ti ayo ti ayo so fun n yin pe…,

(None? I put it to you that…)

PATIENT: even gan ti mo ba je iyan nigba mi, awa okay

(Even if I eat pounded yam sometimes it will be okay)

DOCTOR: ati to how many days bayi?

(Since about how many days now?)

PATIENT: a ti to boya bi two weeks

(It should be about two weeks ago now)

DOCTOR: to ti bere, e ma worry you'll be fine, segbo

(Don't worry, you will be fine, do you understand?)

PATIENT: thank you

DOCTOR: epele

(Sorry)

7. Data Analysis and Discussions of Findings

Datum 1 is a clinic session between the Doctor and a patient who came to complain of headache and neck pain. The patient further complains of loss of appetite, sour taste bud and feeling of nauseating. In the course of further interrogation by the doctor the patient also complains of abdominal pain and insomnia; all of these has been on for like three days. It is observed that the Doctor started the clinic session in English language with greetings 'good morning madam' with the patient responding also in English saying 'good morning sir' before the doctor introduce Yoruba language immediately after the greetings.

Obviously, both the doctor and the patient understand and speak English communicatively. One would wonder why the doctor decided to switch from English to Yoruba since the patient did not show any sign that she does not understand English or that she is not comfortable with English. It will be expected that the doctor should have asked the woman if she would prefer to continue the clinic session in English with which he started or she would prefer him to switch to Yoruba or Akoko dialect but that was not the case. The doctor switched spontaneously to Yoruba without any notice.

It would have been expected that the Doctor should have started the clinic session by greeting the woman in Yoruba or Akoko dialect since he knew he would want the clinic session to hold in Yoruba instead of introducing English and the switching to Yoruba immediately. This is an unsolicited switching, however, the patient also followed suit which indicated that the patient herself seems more comfortable to engage the conversation in Yoruba rather than English. In the course of the interaction, the doctor had to insert English item into the Yoruba conversation.

For instance, the dialogue:

Epele, ni eyin nko? Eni ori nfo yin, ara nro yin, e le jeun, e lose appetite yin, ebi man le yin, hmmm Isale ikun di ja o?

Obviously, finding a perfect Yoruba equivalent for the phrase 'lose appetite' seems pretty difficult at the instance, hence the doctor had to switch code for linguistic incompetence in Yoruba. Meanwhile the patient had earlier expressed the same feeling using the Yoruba sentence '*So mi de jeun, taste enu mi koro sa*' also with the insertion of the English item 'taste' which is another dimension of linguistic incompetence.

Lack of access to a Yoruba equivalent for the word 'taste' forced a switch at a seemingly wrong trigger point. The use of the word 'taste' in the context of the latter extract above seems like a qualifier for the noun *enu* whereas Yoruba is a post modifying language unlike pre-modifying English. This transposition violates the Noun-Adjective relationship in Yoruba which made the trigger point abnormal. The use of 'normal' to qualify the Yoruba noun *imi* in the expression *mo sa su normal imi* to indicate normalcy in her defecate as against the insinuation of the doctor asking if she was stooling is another example of intra-sentential lexical mix as a result of finding equivalent word in Yoruba in the context.

It may be said that the patient by reflex decided to mention 'May' after indicating in Yoruba *osu karun* in apposition to her response to the doctors question about when she had her last menstrual circle; to this she said '*ati inu osun karun*, May'. This may be to create emphasis or to prevent the doctor from getting confused as per which month is meant by *osu karun*, whereas she should have mentioned the name of the *osun karun* 'fifth month' in Yoruba as *osu ebibi*, however, lexical attrition may have eroded such level of month counting from her lexical as a result of modernization. Interestingly, the doctor decided to close the discussion in English like he started it by the question; 'May this year? Any other thing aside that? The patient also responded; 'nothing'. It is quite clear that the patient follow the linguistic pattern of the doctor, hence the doctor maintains the power position linguistically to decide the linguistic pattern of the conversation.

The reason for this sudden switch is unknown since the doctor has maintained Yoruba and Akoko in the clinic session. He should have just concluded the session in Yoruba but he chose to switch to English.

It is further observed that the discussion gradually switched on and off Standard Yoruba and Akoko dialect. For instance, the expression *ebi ma nle yin* does not represent Standard Yoruba as Standard Yoruba will rather use *ebi ma npa yin* using *pa* and not *le*. This is also attested in the question *Ibe bere?* This will rather be expressed in Standard Yoruba as *Igbawo lo bere?* Akoko switch also has *bi ati ijerin si ibe* which contradict Standard Yoruba of *bi ati ijerin si isinyin*. In a similar argument, the question *Oka lo si?* is represented in Standard Yoruba as *Kini o lo si?*

The pattern of code switching and code mixing in datum 2 is a little different from the pattern in datum 1. Here, the doctor introduced the conversation with greetings in Yoruba which was followed by the patient a grandma who came for treatment. After the introduction and confirmation of the patient's name, the doctor immediately switched to English to ask about her complaint; 'what happened to you'? The patient also followed the switch to English by responding in English language thus: 'my chest is paining me to my back'.

To this the doctor proceeded in English by reiterating her response with additional clarification and switched to Yoruba at question tag point: 'ok your chest is paining you radiating to the back. *Igba wo lo bere*'? This is tag switch and inter-sentential switch. From the patient's response we observe intra-sentential switch '*lati bi* (since) two weeks ago'. Also, the patient is observed to comfortably code-switch intra-sentential in her further response: '*mo sa so fun* brother *mi kan, o sa fun mi ni ogun kan bi* brown and yellow *baii*. The insertion of 'brother' in the expression is ambiguous as to whether the brother is younger or elder; also in Yoruba context any male close to someone may be referred to as relative in terms of brother which is not so in English.

Finding appropriate Yoruba equivalent for the colour brown and yellow seems quite elusive for the patient who finds English colour names convenient. Lack of linguistic equivalent due to disuse of such colour name in Yoruba or even non availability of such metalanguage in Yoruba is a significant trigger for such switch.

Predictably, the use of names for orthodox drugs such as Omeprazole, Amoxil, Paracetamol and Ampiclox is undebatable. Instances of lexical borrowing is also observed in the doctor's conversation when he said: '*ko to di pe e bere si ni ma fili peeni yen'.* The word fili and peeni are borrowed from English and adapted into the structure of Yoruba.

Certain lexical items has already become fossilized from English in Yoruba language which are unconsciously used as part of normal Yoruba conversation. Such is as used in the extract below by the doctor: '*ko de si* anybody *to ni, boya bi* daddy *yin abi* mummy *yin to ma complain pe inu yen ma n ta oun'*. The word Daddy and Mummy, anybody, anything nobody etc have become part and parcel of everyday use amongst Yoruba speakers both the elite and the uneducated, hence it is predictable that conveniently Yoruba speakers will comfortably code mixed them at trigger points. Other examples of fossilized expressions as these are further found in the data which include the use of 'even' in 'even *gan ti mo ba je iyan nigba mi*' and '*e ma* worry you'll be fine'.

From the findings of this work, and in tandem to the objectives of the study code mixing and code switching are a veritable tool to bridging communicative gap in a bi/multilingual society. This is especially so in cases where misunderstanding and misinterpretation of utterances can have far reaching consequences such as in a case of health care dialogue.

There are a number of observable patterns of code mixing and code switching attested in the present study. The data underscore inter-sentential switching, intra-sentential switching, tag switching, lexical insertion and lexical borrowings. It could also be assumed that the doctor intends to bridge communicative gap between himself and the patients by switching between Yoruba and English trying to find suitable linguistic equilibrium in the conversation.

Equally, the need to show dialectal identity in other to provide comfortability and make the patients be at ease in the course of the clinic session must have motivated the doctor to switch from Standard Yoruba to Ikare Akoko dialect at intervals for the sake of ethnic solidarity and accommodation.

From the two clinic sessions used as data in this study, the two patients obviously understand and speaks English and Yoruba languages well enough to be able to navigate the two conveniently at intervals. It also suffices to say that both patients also speak Ikare Akoko dialect well enough to afford them switch codes from Standard Yoruba to Ikare Akoko with little or no effort at all. In other words, even when we say that some of the lexical borrowings and lexical switch may be due to lack if linguistic competence in finding appropriate Yoruba equivalent for the words that triggered the switch to English as a result of erosion in their Yoruba mental lexicon, it will not be out of place to equally score that their ability to switch at intervals effortlessly may be accounted for as a skillful use of the three speech forms – English, Standard Yoruba and Ikare Akoko dialect.

8. Conclusion

From the findings of this work, and in tandem to the objectives of the study code mixing and code switching are a veritable tool to bridging communicative gap in a bi/multilingual society. This is especially so in cases where misunderstanding and misinterpretation of utterances can have far reaching consequences such as in a case of health care dialogue. There are a number of observable patterns of code mixing and code switching attested in the present study.

The data underscore inter-sentential switching, intra-sentential switching, tag switching, lexical insertion and lexical borrowings. The pattern of code switching and code mixing in datum 2 is a little different from the pattern in datum 1. Here, the doctor introduced the conversation with greetings in Yoruba which was followed by the patient a grandma who came for treatment. After the introduction and confirmation of the patient's name, the doctor immediately switched to English to ask about her complaint; 'what happened to you'? The patient also followed the switch to English by responding in English language thus: 'my chest is paining me to my back'.

It therefore suffices to draw from the data and the analysis of this study and the discussions so far that effective communication is sequel to efficient health care delivery. And to achieve effective communication, the participant in a discourse, especially a crucial discourse such as in the case of

health care delivery must be afforded the opportunity to express themselves in the most convenient linguistic code for them to explain best their health signs and symptoms and at the same time such linguistic code has to be at equilibrium with the health care giver at the particular speech time and event. This supports the recommendation of Otaigboria highlighting that challenges posed by language barriers are not abstract; they resonate deeply within diverse communities [14]. For example, families of immigrant backgrounds often rely on fragmented communication methods to navigate healthcare systems. Such experiences emphasize the critical role that clear communication plays in fostering trust, ensuring dignity, and improving care delivery [14]. By addressing these barriers, healthcare systems can work toward creating inclusive environments that prioritize patient safety and equitable access to care.

Author Contributions

Odediran Deborah Olusayo: Conceptualization, Data curation, Formal Analysis, Writing – original draft

Bamigbade Oluwafemi Emmanuel: Data curation, Methodology, Writing – review & editing

Conflicts of Interest

The authors declare no conflicts of interest.

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