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University of Tlemcen

Faculty of Letters and Languages
Department of English
Section of English

Navigating Multilingualism: Patterns of Language Choice and Code-Switching in Algerian Healthcare Settings.

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Presented by

Ms. Dounia FATMI

Supervised by

Dr. Sarra Menal FERKACHE

Board of Examiners

Prof	**Ilhem ELOUCHDI**	**Prof**	**President**
Dr	**Sarra Menal FERKACHE**	**MCA**	**Supervisor**
Dr	**Lamia BENADLA**	**MCA**	**Examiner**

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DECLARATION

I, **Fatmi Dounia**, hereby declare that this thesis, entitled *"Navigating Multilingualism: Patterns of Language Choice and Code-Switching in Algerian Healthcare Settings,"* is the result of my own original work and has been composed solely by me, except where explicitly stated. All quoted, paraphrased, or referenced sources have been appropriately acknowledged in the references section. I also confirm that the research findings and analysis presented herein are derived from my own fieldwork and have not been submitted previously for any academic degree or qualification at this or any other institution.

Fatmi Dounia

Signature:

Dedication

To my beloved parents your endless love, sacrifices, and faith in me have been the foundation of this journey. Every page of this work carries your strength and your prayers.

To my maternal grandparents your presence, kindness, and warm encouragement have been a quiet strength in my life. I am deeply grateful to have you by my side.

To my paternal grandparents though no longer with us, your memory lives on in my heart. I dedicate this work to you with love and longing, for your role in shaping the roots of who I am.

To my only sister, Sarah your quiet support, kindness, and companionship have lifted me more than you know.

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Abstract

Language is more than a medium of communication in healthcare; it is central to building trust, understanding, and effective treatment. This study explores how healthcare providers in Algerian hospitals navigate multilingualism, focusing on patterns of language choice and code-switching during patient consultations. Conducted across both private clinics and public healthcare centres in Tlemcen , the research adopts a purely qualitative approach, gathering data through observations, semi-structured interviews, and focus group discussions. Analysis combined thematic and discourse frameworks to uncover the nuanced ways in which doctors adapt their language practices. The results demonstrate that language choice is rarely arbitrary: doctors shift between Algerian Arabic and French based on the patient's linguistic comfort, emotional cues, and the demands of the clinical situation. Code-switching served diverse communicative functions, from enhancing clarity and empathy to maintaining professional authority. Patients' non-verbal responses and explicit requests for clarification significantly influenced doctors' linguistic strategies. Ultimately, the study reveals the rich sociolinguistic complexity of healthcare interactions in Algeria and highlights the importance of language sensitivity for improving patient-centred care. These findings offer deeper insight into communication practices in multilingual medical settings and suggest future pathways for strengthening healthcare delivery through culturally and linguistically responsive approaches.

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List of Abbreviations and Acronyms

AA: Algerian Arabic

MSA: Modern Standard Arabic

CS : Code switching

GENERAL INTRODUCTION

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Language is not merely a tool for exchanging information; it is a cornerstone of effective communication, particularly within the delicate context of healthcare interactions. In multilingual societies like Algeria, communication becomes even more layered, shaped by the coexistence of Algerian Arabic, Berber (Tamazight), Modern Standard Arabic, and French. These languages intersect daily in Algerian healthcare centres, where patients and providers must negotiate meaning across linguistic and cultural lines. This linguistic diversity rooted in Algeria's complex colonial legacy and post-independence language policy has profound implications for healthcare delivery, especially in doctor–patient communication.

This research explores how multilingualism is navigated in Algerian healthcare settings, focusing on the language practices of healthcare providers during medical consultations in both public and private healthcare facilities across different locations in Tlemcen. It examines how language choice and code-switching strategies reflect the sociolinguistic dynamics of hospitals, where multiple languages interact in highly functional and context-sensitive ways.

In Algeria, French remains the primary language of medical education, whereas Algerian Arabic predominates in everyday communication. This contrast creates a unique communicative challenge in clinical encounters, where language use can both build rapport and unintentionally reinforce barriers. Understanding when, why, and how healthcare providers code-switch or adapt their language use is essential for improving clarity, empathy, and the overall quality of care in a linguistically diverse environment.

This study is guided by the following research questions:

1. How do healthcare providers in Algerian hospitals navigate multilingualism through specific language patterns and code-switching strategies during consultations?
2. What language choice patterns and code-switching strategies are commonly used by healthcare providers in Algerian hospitals?
3. Why do healthcare providers in Algerian hospitals code-switch during consultations?

In light of these questions, the study sets the following objectives:

- To explore the reasons behind healthcare providers' use of specific language patterns and code-switching strategies during consultations in Algerian hospitals

- To identify and describe the most common language choice patterns and code-switching strategies employed
- To investigate the factors influencing healthcare providers' decisions to code-switch during clinical interactions

To address these objectives, the study adopts a qualitative research approach. Data were collected using three complementary methods: participant observation of live consultations, semi-structured interviews with healthcare professionals, and focus group discussions with patients. These methods were applied across both public and private healthcare centres in urban Tlemcen. Data were analysed through a dual framework combining thematic analysis and discourse analysis, enabling a detailed examination of both the content and function of multilingual clinical communication.

This dissertation is structured into two main chapters. Chapter One presents the theoretical framework underpinning the study. It outlines Algeria's sociolinguistic landscape, introduces key concepts such as multilingualism, language choice, and code-switching, and reviews relevant literature on doctor–patient communication in multilingual contexts. Chapter Two presents the methodological design, including data collection procedures and analytical strategies. The dissertation concludes with a synthesis of the main findings and practical recommendations for improving communication in Algeria's multilingual healthcare environment.

By shedding light on the linguistic strategies used by healthcare professionals in Algeria, this research contributes to the sociolinguistic understanding of code-switching in institutional settings and offers insights for enhancing patient-centred care in a linguistically diverse society.

CHAPTER ONE

Algeria's Sociolinguistic Landscape

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1.1 Introduction

Algeria's rich linguistic diversity is no coincidence; rather, it is the result of centuries of historical, social, and political developments. Shaped by indigenous roots and successive periods of external influence, including the early Arab-Islamic expansion, Ottoman administration, and French colonial domination, the Algerian linguistic landscape has evolved into a complex mosaic where multiple languages coexist (Austin, 2019). Today, Algerians navigate between Algerian Arabic, Modern Standard Arabic, Berber, and French, each serving distinct roles across various domains of daily life. In the realm of healthcare, this multilingual reality is especially apparent, as medical professionals and patients often shift between languages to ensure effective communication. While French has historically maintained its status as the dominant language of medicine and scientific discourse, healthcare providers frequently engage in code-switching seamlessly alternating between languages depending on context and the patient's linguistic background.

1.2 Algeria's Sociolinguistic Situation

Algeria exhibits a complex multilingual profile characterised by a dynamic and heterogeneous linguistic landscape. This diversity emerges from the nation's intricate historical, cultural, and ethnic heritage. The linguistic environment is principally shaped by Arabic and Berber as the mother tongues. While this study does not propose to conduct an in-depth examination of Algeria's sociolinguistic configuration, it remains imperative to outline the fundamental parameters of its linguistic framework as contextual foundation for the present investigation.

To provide a concise overview of how the major languages function across various societal domains, the following table synthesizes general patterns of language use in Algeria, as reported in sociolinguistic studies by Mostari,(2004), Sadouki (2023), and Benguedda (2018).

Domain	High Variety (MSA)	Low Variety (AA/Darja)	French	Tamazight
Education	Language of formal instruction, especially in the humanities (Mostari, 2004)	Commonly spoken among students in informal settings (Sadouki, 2023)	Commonly used in STEM and technical subjects, especially in higher education (general knowledge)	Used regionally in localised educational programmes (Sadouki, 2023)
Administration	Used in official documents, legislation, and formalised communication	Spoken in the office	Widely used in legal communication (Benguedda, 2018)	More commonly used in administrative contexts in eastern Algeria (general knowledge)
Religion	Primary language for Qur'anic recitation and formal sermons	Used in informal religious discussions and everyday expressions	Rarely used in religious contexts (general knowledge)	Present in religious contexts in some Berber-speaking communities (Sadouki, 2023)
Media	Standard for news broadcasts and official media outlets	Common in talk shows, entertainment, and popular programming	Frequently used in advertising, print media, and magazines and even Tv channels (general knowledge)	Found in regional radio and cultural content (general knowledge)
Home/Informal Speech	Rarely used in domestic settings	Primary spoken variety in everyday life	Often used in code-switching with Arabic (general knowledge)	Varies by region and household (general knowledge)

Table 1.1: Language Use Across Domains in Algeria

1.2.1 Algerian Arabic (AA) In Healthcare

Algerian Arabic (AA) constitutes a distinct vernacular variety of Arabic primarily used for daily communication in Algeria (Boucherit, 2002). As a low-prestige dialect, it coexists in a diglossic relationship with Modern Standard Arabic (MSA), exhibiting significant phonological, lexical, and syntactic differences from both MSA and other Arabic dialects

(Benrabah, 2013). Its linguistic features reflect historical contact with Berber, French, and Ottoman Turkish, resulting in substantial borrowing and code-mixing phenomena (Sayahi, 2014). In healthcare contexts, AA serves as the primary spoken medium between practitioners and patients, often alternating with French for technical terminology (Taleb Ibrahimi, 1995).

1.2.2 Modern Standard Arabic (MSA)

Modern Standard Arabic (MSA), or /al.ʕa.ra.bij.ja al.fusˤ.ħaː/, is the formal version of Arabic used in writing, media, education, and government across the Arab world. While it shares grammar and structure with Classical Arabic, the language of the Qur'an and early Islamic texts, MSA has evolved to include modern vocabulary from science, technology, and global culture (Ryding, 2005).

In countries like Algeria, Modern Standard Arabic (MSA) was promoted after independence through Arabisation policies aimed at reducing the influence of French, particularly in education and formal state communication (Benrabah, 2007). However, this objective has not been fully realised. Algerian Arabic and French continue to dominate informal and everyday communication, while MSA remains largely confined to formal domains such as education, media, and official discourse (Mostari, 2004). MSA is primarily acquired through schooling and is not spoken as a native language. Although it holds symbolic and institutional importance, speakers typically revert to local dialects in daily life a sociolinguistic pattern common in diglossic Arab societies, where functional separation between language varieties and frequent code-switching are widespread (Nassif, 2021).

1.2.3 Berber

Tamazight, commonly known as the Berber language, is spoken by multiple ethnic communities in Algeria, including the Kabyle, Chaoui, and Mozabite populations, each of whom speaks a distinct variation of the language. This language encompasses a variety of dialects, and recent years have witnessed significant initiatives to support its development and institutional presence. A notable milestone occurred in 2016 when Tamazight was officially recognised as Algeria's second national and official language, alongside Arabic, through Article 4 of the constitutional amendment enacted by Law No. 16-01 on March 6, 2016. In his work *"Competition between Four World Languages in Algeria"* published in 2014, Benrabah notes that the substantial presence of Arabic-derived vocabulary in Berber can be attributed to

their shared Afro-Asiatic linguistic roots, which facilitate "the mutual adoption of structural and lexical elements." He also observes that native Berber speakers typically possess proficiency in Algerian Arabic, whereas the reverse is generally not true, illustrating an asymmetry in bilingual competence (Benrabah, 2014, pp. 48–49).

1.2.4 French in Algerian Medical Education and Institutions

French has long served as the primary language of instruction in Algerian medical education, a legacy of the colonial period that has persisted despite national efforts to promote Arabic. Following independence, Arabisation policies sought to reestablish Arabic as the language of public life. However, these policies had limited impact in scientific and technical fields such as medicine, where French remained dominant due to the availability of materials, faculty training, and institutional inertia (Mostari, 2004). This situation has produced a significant language gap for students. Most complete their secondary education in Arabic, only to encounter French as the medium of instruction upon entering university medical programs. The sudden shift to French imposes cognitive and academic strain, particularly on students with limited proficiency in the language. As Dendane (2015) notes, this linguistic mismatch often results in lower performance and disengagement, while students fluent in French typically adapt more successfully and achieve better academic outcomes.

French is also the language of choice in medical institutions across Algeria. It is used extensively in hospital administration, medical records, prescriptions, and internal communication among healthcare professionals. This continued institutional reliance reflects both historical continuity and a lack of comprehensive language policy reform in healthcare (Benrabah, 2007). However, in April 2025, Algeria took a significant step by announcing a reform to replace French with English as the medium of instruction in medical and scientific university programs, beginning with the 2025–2026 academic year. The directive, endorsed by President Abdelmadjid Tebboune, reflects a strategic move to reduce dependency on French and to position Algeria within the global academic and scientific community. While this shift marks a new era in language policy, its impact on institutional practices and clinical environments remains to be seen.

1.3 Linguistic Diversity in Algerian Healthcare

In Algeria's healthcare system, linguistic diversity is not merely a background feature; it is central to how care is experienced, understood, and delivered. While French continues to dominate medical education, official documentation, and institutional discourse due to its colonial legacy, Algerian Arabic /ˈdæɾ.ʒæ/ (Darja) is widely used in clinical interactions. Darja serves as a powerful tool for emotional connection, empathy, and cultural alignment, especially in sensitive patient-provider communication. As Belaskri and Drew (2023) demonstrate, this code-switching between French and Darja enables healthcare professionals to navigate both technical precision and emotional resonance, reflecting the centrality of linguistic diversity in clinical practice. Many patients feel more secure and understood when using their native dialect, while health professionals navigate a complex linguistic space shaped by historical and policy-driven influences (Belmihoub, 2018). In hospitals, this results in a dual-language system with French used for formal procedures and Darja for interpersonal interactions.

Meanwhile, Tamazight, although officially recognised since 2016, remains underutilized in healthcare because of limited standardization of medical terminology and a shortage of fluent speakers among healthcare providers (Aitsiselmi, 2006). These linguistic dynamics reflect broader sociolinguistic tensions between institutional norms and the linguistic identities of the population. Language in this context is not just a means of communication; it is intimately connected to access, dignity, and representation. As such, Algeria's healthcare system faces the challenge of balancing national language policies with the need for culturally responsive and patient-centered care (Bessaid, 2020).

1.4 Language Contact Phenomena

Winford (2003, p. 11) identifies language contact phenomena as the various modifications that occur when distinct language systems interact, ranging from vocabulary adoption to grammatical alignment. These interactions may produce hybrid speech patterns through code-mixing or lead to the gradual replacement of one language by another. The author emphasizes that such transformations frequently occur in culturally diverse or historically complex societies, where linguistic boundaries naturally blur. Notably, these changes do not presuppose equal proficiency in both languages among speakers. Rather, they reflect the inherent flexibility of human communication systems when faced with intercultural exchange. The study of these phenomena provides crucial insights into how languages evolve through social interaction .

1.4.1 Diglossic Situation Between AA And MSA

The concept of *diglossia*, first introduced by Ferguson (1959), refers to a linguistic situation in which two distinct varieties of the same language coexist within a speech community. Typically, a "high" (H) variety is used in formal, institutional, or literary settings, while a "low" (L) variety is reserved for everyday, informal communication. In the Arab world, and in Algeria in particular, this duality is manifested in the relationship between Modern Standard Arabic (MSA) as the H variety and Algerian Arabic (AA), or *Darja*, as the L variety. Ferguson's framework has served as a foundational model; however, subsequent scholars such as Fishman (1967) and Badawi (1973) have extended and critiqued it, noting that language use in real contexts often transcends the binary distinction between H and L.

In the Algerian context, diglossia is further complicated by the country's colonial past, national identity, and language policy. French, a lingering legacy of colonial rule, continues to dominate sectors such as science, medicine, and higher education prompting some scholars to refer to this as "extended diglossia" or even societal bilingualism (Rahmoun-Mrabet, 2017, p. 985). Additionally, Tamazight, the language of the indigenous Berber population, was granted official status in 2016, further enriching the country's multilingual landscape (Aitsiselmi, 2006). While Ferguson (1959) emphasised the functional complementarity between H and L varieties, recent scholarship suggests that these roles are increasingly fluid. For instance, Djennane (2014) observes that Algeria's diglossic dynamics are evolving in response to educational reforms, urbanisation, and the influence of digital communication. In an empirical study conducted in Tlemcen, Hamzaoui (2019) found that while both teachers and pupils hold MSA in high esteem for its prestige and religious connotations, they continue to favour AA for daily interpersonal interactions.

Divergent perspectives also appear in the literature. For example, Mostari (2004) argues that Arabisation policies have largely failed to displace French from elite and technical domains, thereby creating a sociolinguistic tension between ideological aspirations and practical necessity. Conversely, Abbassia (2021) highlights the growing prevalence of multilingualism and the gradual normalisation of linguistic hybridity in Algeria's public and private spheres. These linguistic and sociopolitical developments collectively establish Algeria as a representative example of complex diglossia. The Algerian case illustrates how historical processes, institutional language planning, and evolving societal attitudes interact to shape language use. A comprehensive understanding of this situation necessitates moving beyond

rigid high–low dichotomies and instead adopting a multidimensional framework that considers the intersecting influences of power, identity, and sociocultural context.

1.4.2 Bilingualism (Arabic-French)

Bilingualism, in its broadest sense, refers to the ability to understand and use two languages with varying degrees of fluency. It is a widespread and historically rooted phenomenon influenced by factors such as colonization, migration, education, and globalization. According to Weinreich (1968), bilingualism can be categorised into compound, coordinate, and subordinate types, depending on how individuals store and access the two linguistic systems cognitively. Compound bilinguals develop a single semantic system for both languages, coordinate bilinguals maintain distinct systems, and subordinate bilinguals rely on translation through their dominant language.

This framework was expanded by Hamers (2000)**,** who introduced a sociocognitive model that considers the dynamic relationship between cognitive development, linguistic input, and social interaction. They also distinguished between individual bilingualism, where one person is proficient in two languages, and societal bilingualism, where two languages function across communities or nations. Adding to this complexity, Romaine (1995) proposed a model based on seven types of bilingualism, highlighting factors such as age of acquisition, context of use, and degree of fluency.

Bilingualism is not a fixed state but exists on a continuum of proficiency and functionality. It can be additive, where the second language enhances cognitive and social resources, or subtractive, where it potentially erodes the first language due to lack of institutional or cultural reinforcement. The social value of bilingualism varies across contexts: while it is a sign of prestige and mobility in some societies, in others it may be associated with marginalisation or linguistic insecurity (Romaine, 1995; Gumperz, 1982).

1.4.2 .1 Classification of Bilingualism

People can become bilingual in different ways, depending on when they learn their languages, how well they know them, and how they use them. Some grow up speaking two languages at the same time from early childhood (simultaneous bilingualism), while others learn a second language after mastering their first (sequential bilingualism). Bilinguals might be equally skilled in both languages (balanced) or stronger in one (dominant). In some cases,

learning a second language strengthens both (additive bilingualism), but in others, the first language may weaken as the second takes over (subtractive bilingualism). These differences help researchers understand how bilingualism affects thinking, education, and social life (Baker, 2011; Grosjean, 2010).

Type	Description
Compound	Two languages learned simultaneously; single semantic system
Coordinate	Languages learned in separate contexts; distinct semantic systems
Subordinate	Second language interpreted through the dominant language
Balanced	Equal proficiency in both languages
Dominant	Greater fluency and preference for one language over the other
Passive (Receptive)	Understanding but limited or no production in second language
Additive	Acquisition of second language enriches first language skills
Subtractive	Second language acquisition interferes with maintenance of first language

Adapted from (Hamers, 2000); (Romaine, 1995)

Table 1.2: Description of Different Classes of Bilingualism

1.4.2.2 Arabic-French Bilingualism in Algeria

Bilingualism is also influenced by sociopolitical structures. In Algeria, the dominant bilingual pairing is Arabic and French, a result of over 130 years of French colonial rule. This Arabic-French bilingualism is deeply embedded in the fabric of Algerian society and constitutes a prime example of societal bilingualism. Arabic, particularly in its Modern Standard and colloquial forms, is central to cultural, religious, and national identity, while French holds strong institutional power, particularly in domains such as higher education, science, medicine, technology, and administration. Despite multiple waves of Arabization policies since

independence in 1962, French has retained its influence and continues to be perceived as a language of modernity, upward mobility, and global access (Belazreg, 2016; Rahmoun-Mrabet, 2017).The coexistence of Arabic and French often results in code-switching, diglossic interaction, and linguistic stratification, reflecting broader tensions between national identity and post-colonial pragmatism.

Region	Bilingual Population (%)
North America	30%
Europe	56%
Sub-Saharan Africa	69%
MENA (incl. Algeria)	61%
South Asia	41%
East Asia	23%

Adapted from UNESCO Linguistic Diversity Report (2021) (UNESCO., 2021), cited in (Sadouki, 2023)

Table 1.3: Estimated Exposure to Bilingualism by Region (% of population regularly using two languages)

In summary, bilingualism is a complex and dynamic phenomenon shaped by cognitive, social, and political factors. While theoretical models provide a framework to classify bilingual types, real-world usage reflects a fluid interaction between language proficiency, identity, and power. In contexts like Algeria, bilingualism serves as both a communicative tool and a marker of historical continuity and cultural tension.

1.4.3 Code-Switching Types

Code-switching is a linguistically and socially intricate phenomenon that occurs when speakers alternate between two or more languages or dialects within a single discourse. Rooted in multilingual environments, it has attracted significant attention from sociolinguists and psycholinguists alike. Gumperz (1982) defines code-switching as the juxtaposition of different grammatical systems within the same conversational exchange. Myers-Scotton (1993), through her Matrix Language Frame (MLF) model, contends that one language typically provides the grammatical framework (the matrix language), while the other contributes content elements.

Appel (2005) further emphasises the pragmatic dimensions of code-switching, recognising it as a strategic act used to achieve communicative purposes such as emphasis, clarification, quotation, or expressing solidarity. Poplack (1980) proposed a widely cited typology of code-switching based on syntactic positioning and frequency of occurrence. These classifications remain central to both theoretical and applied research. Accordingly, the following subsections outline the main types of code-switching namely, intersentential, intrasentential, and extra-sentential drawing on Poplack's framework and subsequent developments in the literature.

1.4.3.1 Intersentential Code Switching

Intersentential code-switching (CS) represents a typologically distinct form of bilingual speech occurring at clause or sentence boundaries (Poplack, 1980). This phenomenon is characterized by the alternation between two linguistic systems across syntactically complete units while maintaining each language's internal grammatical integrity (Myers-Scotton, 1993). As evidenced across institutional bilingual settings, the structural independence of intersentential CS facilitates discourse-management functions including topic-shifting, register adjustment, and participant-role negotiation (Gumperz, 1982). Crucially, this CS type imposes minimal syntactic integration demands, making it accessible to speakers across the bilingual proficiency spectrum (Muysken, 2000).

The clause-bound nature of intersentential CS reduces cognitive processing load by avoiding the morphological integration challenges characteristic of intrasentential switching (Poplack, 1980). Empirical studies across healthcare contexts confirm this structural autonomy through systematic utterance-level language alternation (Muysken, 2000; Myers-Scotton, 1993). However, contemporary sociolinguistic scholarship (Auer, 1999; Li, 2018) challenges purely competence-based explanations, framing such switches as strategic interactional resources rather than grammatical limitations. This theoretical tension between psycholinguistic and sociolinguistic accounts underscores the need for contextual analysis when examining intersentential CS patterns, particularly in institutional settings where power dynamics and communicative efficacy intersect.

1.4.3.2 Intrasentential Code Switching

Intrasentential code-switching (CS) involves language alternation within a single sentence or utterance, requiring advanced bilingual fluency to navigate syntactic integration across linguistic systems (Poplack, 1980). This form of CS demonstrates the highest degree of structural complexity, as speakers must reconcile morphological and syntactic constraints from both languages within a unified grammatical framework (Myers-Scotton, 1993). Research indicates that successful intrasentential CS depends on shared typological features between languages (Muysken, 2000), such as congruent clause structures or compatible inflectional systems. The cognitive demands of this integration process distinguish intrasentential CS from other switching types, positioning it as a marker of high bilingual proficiency (Poplack, 1980).

Linguistic scholarship remains divided on the mechanisms governing intrasentential CS. While Poplack's (1980) *Equivalence Constraint* posits that switches occur only at points where surface structures align across languages, Myers-Scotton's (1993) *Matrix Language Frame Model* argues for asymmetric domination by one grammatical system. These theoretical tensions reflect broader disciplinary debates about whether intrasentential CS represents (1) a rule-governed linguistic phenomenon or (2) a dynamic, speaker-driven negotiation of grammatical resources (Auer, 1999). In institutional settings like healthcare, such structural complexity may serve specialized communicative functions for instance, embedding precise medical terminology (often in a prestige language) within a patient's dominant language for explanatory purposes (Li, 2018). This functional versatility underscores the need for theoretically informed analysis when examining intrasentential patterns in your data.

1.4.3.3 Extra-Sentential Code switching

Extra-sentential code-switching (CS) involves the insertion of syntactically autonomous elements - such as tags, fillers, or discourse markers - into an utterance primarily structured in another language (Muysken, 2000). These switches differ fundamentally from inter- and intra-sentential CS, as they typically occur at utterance boundaries or as parenthetical elements without requiring grammatical integration (Myers-Scotton, 1993). Common examples include discourse markers (e.g., "you know" in English-dominant

utterances), interjections, or formulaic expressions that serve primarily pragmatic rather than syntactic functions. This type of switching is particularly prevalent in bilingual speech as it imposes minimal grammatical constraints while offering significant communicative flexibility (Poplack, 1980).

From a functional perspective, extra-sentential CS often serves important interactional purposes in bilingual discourse, including emphasis, emotional expression, or the management of conversational flow (Auer, 1999). The relative syntactic independence of these elements makes them accessible to speakers across the bilingual proficiency spectrum, from balanced bilinguals to those with limited L2 competence (Muysken, 2000). In institutional settings like healthcare, such switching patterns may fulfill specific communicative needs - for instance, using culturally salient markers of empathy or attention-getting devices that transcend strict language boundaries (Li, 2018). This functional versatility raises important theoretical questions about the relationship between linguistic form and communicative intent in bilingual speech, particularly in high-stakes professional contexts where precise understanding is crucial.

In Algeria, code-switching is a widespread communicative practice shaped by historical bilingualism and postcolonial language politics. Algerian Arabic and French are alternated fluidly in everyday interactions, classrooms, media, and commerce. (Benguedda, 2018) observed that code-switching in Tlemcen, Algeria serves pragmatic goals like humor, status-marking, and solidarity. In commercial contexts like Facebook Live sales, vendors blend French for its prestige and Algerian Arabic for accessibility (Belaidouni, 2024). The linguistic repertoire in Algeria features frequent use of all three structural types. In fact, Amazouz (2017) shows that intersentential switching is the most dominant, followed by intrasentential and extra-sentential forms.

Code-Switching Type	Percentage of Occurrence (%)
Intersentential	52%
Intrasentential	33%
Extra-Sentential	15%

Adapted from (Djegdjiga Amazouz, 2017)

Table 1.4: Frequency of Code-Switching Types in Algerian Speech Communities

1.4.4 Reasons for Code-Switching

Code-switching among bilinguals is a deliberate and multifunctional linguistic strategy rather than a random act or sign of linguistic deficiency. It arises from the bilingual speaker's need to navigate linguistic limitations, fulfill pragmatic goals, and respond to sociocultural contexts. Grosjean (1982) observes that bilinguals frequently code-switch when unable to retrieve a specific word or when an exact translation is unavailable in their primary language, highlighting lexical necessity as a key motivation. In other cases, speakers may shift languages to report speech or to emphasise cultural identity, with Gumperz (1982, p. 131) referring to such instances as "contextualisation cues" that signal a change in role, tone, or stance. A third common reason is addressee specification when the speaker uses the language typically associated with the individual being addressed.

Grosjean (1982) notes that bilinguals intuitively adapt their language use to align with their interlocutors' linguistic preferences or identities, often code-switching more freely with peers than with elders or authority figures. Bhatia (2004) further argues that discourse structuring plays a critical role: switching may occur to introduce direct quotations, emphasise rhetorical elements like hedging, or to demarcate thematic shifts within a conversation. Another key motivation lies in social positioning. Through her Markedness Model, Myers-Scotton (1993) explains that bilinguals code-switch to construct social meanings and signal status, solidarity, or power relations within an interaction. Lastly, language dominance and emotional state are also important triggers.

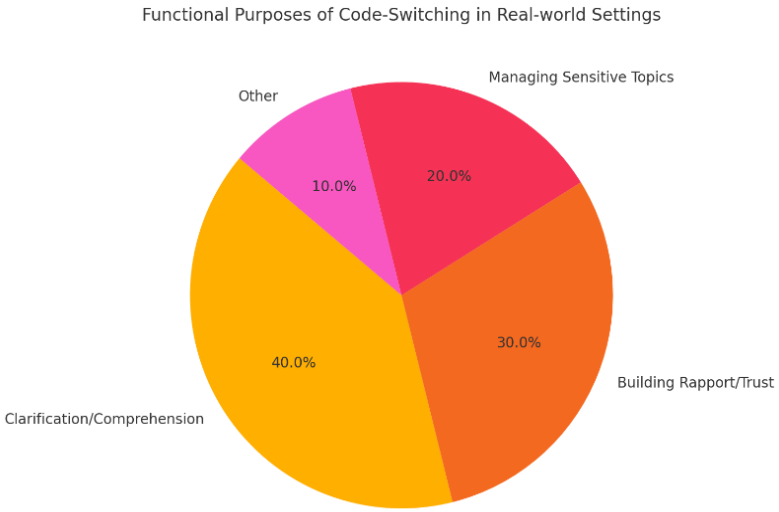
Genesee (1995) observed that children and adults alike are more likely to insert elements from their dominant language when operating in their weaker code. Emotional conditions such as fatigue, stress, or excitement may lower a speaker's linguistic monitoring, resulting in more spontaneous code-switching (Grosjean, 1982). These motivations highlight the deeply embedded psychological, social, and cognitive roots of code-switching, framing it as a dynamic resource for meaning-making, alignment, and linguistic adaptability in bilingual discourse.

1.4.5 Functions of Code-Switching

In bilingual and multilingual communities, code-switching the alternating use of two or more languages within the same conversation is increasingly recognized not as linguistic interference, but as a sophisticated communicative resource. Rather than being arbitrary or flawed language use, researchers emphasize that code-switching follows social, cognitive, and grammatical rules**.** Auer (2000), for instance, frames code-switching as a discourse tool that speakers use to manage conversational structure and negotiate identity. Meanwhile, Poplack (2001) demonstrated that code-switching tends to respect syntactic boundaries, revealing bilingual speakers' grammatical competence rather than linguistic deficiency. Heredia (2001) further proposes that bilinguals switch languages to reduce cognitive load, facilitating faster access to lexical items based on contextual needs. These foundational studies underscore that code-switching is not a random mix of languages but a deliberate, often strategic process governed by linguistic knowledge and interactional goals.

Beyond structural and cognitive functions, code-switching serves interpersonal and pragmatic purposes in real-world contexts. In educational settings, it aids comprehension, bridges vocabulary gaps, and fosters inclusivity, especially in bilingual classrooms (Sagala, 2019). Similarly, in Algeria's healthcare system where French is dominant in medical discourse, but patients may be more comfortable in Arabic doctors often switch between languages to improve understanding and reduce anxiety. For example, during consultations, physicians use French for technical terms but revert to Algerian Arabic or Modern Standard Arabic when explaining diagnoses, thus ensuring patient clarity and emotional comfort (Belaskri, 2023). This illustrates how code-switching operates as a functional, culturally responsive tool, especially in environments where language proficiency varies widely. Researchers like Lovrić (2012) and Ariffin (2009) also highlight key sociolinguistic functions such as expressing identity, managing discourse, and maintaining rapport, making code-switching a vital asset in both formal and informal communication.

As discussed in the literature, code-switching is not random but serves various communicative functions such as clarification, topic management, and emotional emphasis. These functions are particularly relevant in healthcare contexts where linguistic negotiation is essential. The following figure summarizes the primary purposes of code-switching as observed in Algerian bilingual settings.



Synthesized from academic literature (Auer, 2000) (Heredia, 2001) (Lovrić, 2012); (Belaskri, 2023)

Figure 1.1: Functional Purposes of Code-Switching in Real-world Settings

1.4.6 Borrowing

Languages have always been shaped by contact with others, and borrowing is one of the most enduring outcomes of that interaction. It refers to the process of adopting words, sounds, or other linguistic features from one language into another often as a result of social, political, or cultural exchange. Early linguists like Whitney (1981), Sapir (1921), and Bloomfield (1933) all recognised borrowing as a key part of how languages evolve. Sapir (1921, p. 193) famously pointed out that "languages influence one another" through this process. Later on, Haugen (1950) introduced a more systematic model of borrowing, outlining how speakers adopt foreign elements and adapt them to fit the structure of their own language. Weinreich (1953) added to this by focusing on how bilingualism facilitates borrowing, showing that speakers often carry features from one language into another, sometimes unconsciously. Together, these scholars laid the foundation for understanding borrowing not as corruption or interference, but as a natural outcome of multilingual societies.

In academic discussions, the terms *borrowing* and *loanwords* are often used interchangeably, although, as Thomason (1988) noted, the metaphor is misleading in fact, nothing is returned. Instead, they defined borrowing as the lasting incorporation of foreign elements into a native language. More recently, Researchers like Clyne (2003, p. 76) have argued for using alternative

terms such as *transfer* to more accurately reflect the permanence and integration involved in the borrowing process. Borrowing doesn't stop at vocabulary; it can involve changes in pronunciation, grammar, or even sentence structure. Typically, the language that provides the borrowed form is known as the donor or source language, while the receiving language is called the recipient. According to Appel (2005), borrowed items are rarely adopted as-is. Instead, speakers absorb them in a general form and reshape them to align with the patterns of their own language. This shows that borrowing is not passive it reflects choice, adaptation, and social context.

In Algeria, borrowing is especially visible in fields like healthcare, where French terms are commonly used in Arabic speech. This is partly due to colonial history, but also because French still dominates in medical education and professional training. For example, words like *pompe* (pump) and *tracteur* (tractor) were not just adopted they were reshaped to match local speech patterns and filled a real need for describing new technologies. Interestingly, the adaptation of *pompe* into a locally pronounced form even led to the introduction of the /p/ sound into Algerian Arabic, which previously lacked it a rare case where borrowing changed the phonemic system of a language (Belaskri, 2023). These terms, often called "cultural borrowings" by Myers-Scotton (1993, pp. 168–169), entered the language out of necessity, and despite Arabisation campaigns following independence, they have remained in use. They show that borrowing is not just about language it's about identity, practicality, and how people navigate everyday life in multilingual settings.

1.4.7 Code-Switching vs. Mixing

While code-switching and code-mixing are both common practices among bilingual speakers, they refer to distinct patterns of multilingual language use. Code-switching typically happens when someone alternates between two languages depending on who they are talking to, what they are discussing, or the tone they want to set. Poplack (2001) explains that this type of switching typically occurs at logical points in speech, particularly between sentences or clauses, and serves identifiable communicative functions. In contrast, code-mixing tends to be more spontaneous and less structured. According to Muysken (2000), code-mixing involves blending elements from different languages within the same sentence or phrase, without necessarily changing the topic or the speaker's intent. Mahootian (2019) notes that mixing can take various forms, such as inserting foreign words or combining grammatical rules from

different languages, and it usually reflects the speaker's ease and familiarity with both languages. Code-mixing is particularly common in casual settings like peer conversations or online chats, where language use is more fluid. Researchers such as Faraj and Abdulla (2018) also highlight that while both forms emerge from bilingual competence, code-switching is often more deliberate, whereas code-mixing reveals the natural interaction between languages in a speaker's thought process. Recognizing the difference helps us better understand how bilingual individuals use language not only to communicate clearly but also to express identity and maintain social bonds.

1.4.8 Code-Switching vs. Borrowing

The academic discourse surrounding code-switching and lexical borrowing presents a complex theoretical landscape that continues to challenge linguists' understanding of language contact phenomena. Myers-Scotton (1993), through her *Matrix Language Frame* model, establishes a foundational distinction by proposing that code-switching occurs when two linguistic systems alternate within a single discourse, with one language providing the grammatical framework while the other contributes lexical items. This perspective emphasizes the structural constraints governing such alternations and the cognitive processes underlying bilingual speech production. In contrast, borrowing represents a more permanent linguistic integration, where foreign lexemes become fully incorporated into the recipient language's lexicon, undergoing necessary phonological and morphological adaptations to conform to the host language's structural patterns**.** Poplack (2018) emphasises that this process involves deep grammatical assimilation within the speech community.

The theoretical boundary between these phenomena remains contested within contemporary linguistic scholarship. Muysken (2000, p. 122) challenges binary classifications by introducing the concept of *congruent lexicalisation*, which accounts for contact situations where languages share sufficient structural similarity to permit seamless blending that defies traditional categorisation .This perspective highlights the gradient nature of language contact outcomes and questions the validity of discrete typologies**.** Sankoff (2001) further complicates the theoretical framework by demonstrating how frequently code-switched items may gradually transition into borrowed status through increased community usage and linguistic conventionalisation.

In summary, the distinction between code-switching and borrowing, while foundational in language contact theory, cannot be reduced to rigid categories. Instead, as the evolving

research suggests, these phenomena exist along a continuum shaped by structural integration, frequency of use, and sociolinguistic context. Theoretical models such as the *Matrix Language Frame* proposed by Myers-Scotton (1993) and frameworks like *congruent lexicalisation* introduced by Muysken (2000) reveal the fluid and dynamic nature of bilingual speech, where boundaries between linguistic systems are often porous. Sankoff's (2001) diachronic perspective further reinforces this view by showing that items initially used in code-switching can, over time, become fully lexicalised borrowings. Such findings underscore the importance of adopting flexible, gradient approaches when analysing language contact, particularly in multilingual communities where patterns of usage are continuously negotiated and redefined.

1.4.9 Language Accommodation

Language accommodation is the process through which speakers adjust their language use to reduce social distance, enhance understanding, and foster connection. In healthcare settings, this phenomenon is especially critical, as the effectiveness of clinical communication can directly impact patient outcomes, adherence, and satisfaction. Rooted in Communication Accommodation Theory (Giles et al., 1991), the concept extends beyond vocabulary to encompass shifts in accent, tone, pace, and even non-verbal cues, all tailored to the perceived needs of the listener. When providers accommodate patients' linguistic needs whether by simplifying language, adopting culturally familiar expressions, or switching dialects they create more inclusive and effective care environments (Hudon et al., 2012).Conversely, failure to accommodate can reinforce power imbalances and contribute to health disparities, especially for linguistically marginalized groups (Piller, 2016).

1.4.9.1 Theoretical Frames

At the core of healthcare communication lies Communication Accommodation Theory (CAT), which explains how people naturally adjust their speech either to connect better with others or maintain social distance (Giles et al., 1991). In medical settings, healthcare providers typically aim to adapt communication by simplifying terms, using familiar language, or switching codes to match patients' comfort levels. As Watson and Gallois (1998) found, getting this right builds trust and strengthens healing relationships. But there is a catch overdoing it through excessive simplification or stereotyped speech can backfire, creating misunderstandings or making patients feel talked down to. The real skill lies in balancing professional clarity with genuine connection, where subtle language choices significantly

impact care quality. It's not just about sharing medical facts, but how we communicate them that truly matters where every word choice can either bridge gaps or create barriers in patient-provider relationships.

1.4.9.2 The Algerian Case

Algeria presents a compelling case of linguistic accommodation shaped by postcolonial identity, institutional legacy, and everyday pragmatism. French remains dominant in medical training and documentation, while patients often speak in Darja, Tamazight, or Modern Standard Arabic, depending on region and background (Mostari, 2004). This creates a multilingual maze where physicians frequently shift codes or rely on informal interpreters to bridge linguistic gaps strategies that reflect on-the-ground accommodation rather than formal policy . In the absence of systematic language planning in healthcare, linguistic choices often mirror social hierarchies and colonial residues, with French sometimes signaling authority and Arabic aligning with patient familiarity. Thus, in Algeria, language accommodation is not merely a communicative tool, but a mirror of broader cultural negotiations within care.

1.5 Language Variation in Healthcare

In healthcare, the way people speak the words they choose, the accents they carry, and the languages they navigate can be just as critical as the medical care itself. Communication is not merely about transmitting information; it is shaped by layers of social meaning, linguistic variation, and cultural nuance. As (Munson, 2006, p. 201) puts it, "variation is not simply noise in the system it is a socially meaningful phenomenon that influences both perception and interaction." In multilingual healthcare environments, such as hospitals in North Africa or urban Europe, language variation can emerge from regional dialects, professional terminology, or alternation between official and minority languages**.** Ravindranath (2015) emphasizes that understanding sociolinguistic variation in healthcare requires more than observing surface-level differences. It involves examining how social factors such as ethnicity, education, and power relationships influence language choices in clinical settings. Effective communication between patients and practitioners often depends on aligning language use with the cultural and linguistic expectations of those involved. When this alignment breaks down, the risk of misdiagnosis or reduced trust increases. In Algeria, for example, medical terms with French origins are often embedded within Algerian Arabic consultations. Words such as ordonnance or radio are used interchangeably with Arabic expressions, a reflection of the country's colonial history and its bilingual medical training. These interactions are especially common in public hospitals, where

health professionals trained in French interact with patients who primarily speak colloquial Arabic or Berber. As Ball (2006) explains in *Clinical Sociolinguistics*, medical professionals must be "linguistically aware" to ensure successful communication in such environments, where language variation often conveys more than just information, it communicates identity, confidence, and cultural connection (Ball, 2006). Understanding these dynamics is essential in providing effective care in linguistically diverse communities like those found across Algeria.

1.5.1 Regional Dialects

Regional dialects are not merely linguistic differences they embody the social, historical, and geographical identities of their speakers. Chambers (2000) argues that dialectal diversity persists as one of language's most resilient features, enduring even under the influence of standardisation. These variations do more than indicate a speaker's origin; they also shape perceptions in both professional and everyday interactions. In medical settings, such perceptions carry significant weight. As Clopper and Wagner (2012) note, even among speakers of the same language, dialectal differences can hinder comprehension and affect assumptions about a person's education, trustworthiness, or approachability factors that directly impact patient–provider relationships.

This issue is particularly evident in Algeria, where physicians often trained in French or Modern Standard Arabic frequently encounter patients from rural or Amazigh-speaking backgrounds. Miscommunication may occur not due to a complete language barrier, but because of subtle dialectal variations**.** Barbu, Martin, and Chevrot (2014) highlight that individuals retain their local speech patterns throughout life, underscoring how deeply dialects are tied to social identity.Thus, acknowledging and adapting to these linguistic differences is not just a matter of cultural sensitivity but a crucial component of effective healthcare delivery in multilingual societies.

1.5.2 Register Shifting

The ability to modify language formality and style known as register shifting represents an essential skill for effective healthcare communication. Shaw (1987) conceptualises register as a flexible linguistic tool shaped by speaker intent, audience needs, and situational demands, arguing that adept register modulation helps professionals balance precision with approachability. A physician, for instance, might employ technical terminology when consulting with fellow specialists but transition to simplified explanations for patient

interactions. Gardner (2010) expands this view, demonstrating how such adaptations serve not just informational purposes but also social functions whether to project competence or foster therapeutic rapport.

These linguistic adjustments carry profound implications, influencing patients' perceptions of both medical credibility and provider empathy. As Gumperz (1982) established, successful register shifting frequently dictates communication outcomes, particularly in cross-cultural encounters where linguistic norms and expectations diverge. When healthcare providers fail to adapt their register appropriately, it may lead to misunderstandings, reduced compliance, or even compromised care quality.

1.5.3 Medical Jargon

Medical jargon plays a dual role in healthcare communication: while it enables precision and efficiency among medical professionals, it can simultaneously create significant barriers to patient understanding. Research has shown that patients generally respond more positively to physicians who use clear, non-technical language, particularly during emotionally and cognitively demanding encounters such as surgical consultations (Tran & Sweeny, 2019, p. 1252). Despite the broad consensus on the importance of plain speech, many clinicians continue to use technical language unintentionally. This phenomenon, referred to as "jargon oblivion," describes the tendency of healthcare providers to overestimate patients' comprehension of medical terms (Pitt & Hendrickson, 2019, p. 986).

Lazzaro-Salazar (2022) notes that jargon is also a tool for performing professional identity, signalling membership in the medical community. However, this identity-marking can come at the cost of alienating patients. In Algeria, where French medical terminology is deeply embedded in the training of healthcare workers, terms like *prescription* or *échographie* may be used even when patients are more comfortable with simplified or Arabic alternatives. Kumar (2023) shows that excessive use of jargon not only reduces understanding but can also compromise treatment outcomes, especially when no clarification is offered. A balance between professional precision and patient-*centred* clarity is essential in fostering trust and achieving effective communication.

1.6 Language Choice Patterns in Healthcare Settings

In healthcare settings where multiple languages are spoken, the choice of language significantly impacts patient care and communication. It's not just about words it reflects social dynamics, power imbalances, and the intent behind the conversation. Gallego-Balsà (2018) points out that the language professionals use can signal solidarity, authority, or compassion, shaping how identities are perceived. In healthcare, this choice is often limited by institutional rules and the language skills of those involved. For example, Rodríguez Tembrás (2024) found that in Galicia, doctors and patients switch between Spanish and Galician based on their goals sometimes for clarity, other times to build rapport. These decisions depend on practical factors like fluency and tone, as well as symbolic ones, such as maintaining professionalism or creating a friendly atmosphere. Essentially, language choice isn't just about understanding it's about navigating power and expectations in unequal relationships.

Language choice in healthcare is not merely a matter of communication, but a reflection of broader sociocultural dynamics. Studies have shown that patients' language preferences often signal perceived social status, accessibility, and trust in medical professionals (Piller, 2016; Hudon et al., 2012). In Dubai, for instance, English is frequently preferred in institutional contexts, despite Arabic being the official language. This preference is shaped by factors such as educational background, familiarity with technology, and the perceived prestige of English (Al-Issa & Sulieman, 2024). Similarly, Genemo (2021) argues that language use in hospitals, schools, and government offices reflects broader patterns of social influence and communicative effectiveness. In these environments, speakers often switch between languages navigating between technical terminology and more emotionally resonant expressions depending on the demands of the interaction.

Research consistently highlights that language choice in medical settings is strategic, shaped by power relations, cultural affiliations, and the participants' communicative goals (Piller, 2016; Lazzaro-Salazar, 2022). These insights offer a valuable framework for examining linguistic practices in Algeria's healthcare system, where French, Modern Standard Arabic, and Darja interact in complex and ever-evolving ways.

1.7 Doctor-Patient Communication

Doctor–patient communication is more than the exchange of medical facts; it is a complex sociolinguistic act that directly influences the effectiveness of diagnosis, treatment, and trust. According to Waitzkin (1984), this communication is often hindered by structural barriers such as unequal access to language, professional hierarchies, and assumptions about what patients

want or need to know. One of the key challenges is the asymmetry in turn-taking and speech control. Simmons (1998) found that doctors frequently dominate consultations through directive questioning styles, limiting the patient's ability to express concerns or clarify doubts. These speech dynamics can unintentionally silence patients and reinforce institutional authority, especially in systems where patients lack the medical literacy or confidence to assert themselves. Wodak (2006) further observes that patients may refrain from asking questions due to fear of judgment or the perception that their input is unwelcome, which can reduce satisfaction and impact care outcomes.

In Algeria, where doctors often switch between French and Arabic depending on the topic or the patient's education level, this linguistic alternation may enhance or hinder clarity. For instance, a physician might explain a procedure using formal French terms but then soften the message in colloquial Arabic to make it more relatable. While this strategy can personalize care, it also requires careful balance to avoid misinterpretation. Cerný (2008) emphasizes that sociolinguistic sensitivity such as recognising politeness strategies, speech acts, and cultural expectations is essential for clinicians who aim to engage patients effectively and ethically. Ultimately, effective doctor–patient communication demands more than medical expertise; it requires cultural awareness, linguistic flexibility, and an ability to manage interpersonal dynamics sensitively and transparently.

1.7.1 Language in Clinical Talk

Language in clinical talk does far more than convey medical facts it organizes the entire interaction between doctor and patient. From the way questions are posed to how information is clarified, language structures not only the delivery of care but also the patient's sense of agency and involvement. Gumperz (1982) emphasised that conversational inference or the ability to interpret meaning based on subtle contextual cues plays a central role in how communication succeeds or fails in diverse social settings.These cues, such as intonation, pacing, or lexical choice, often go unnoticed by speakers but carry critical implications in clinical encounters. Heritage & Maynard, (2006) highlight this explicitly by saying: "medical talk is institutionally shaped: it prioritizes diagnostic goals, frames patient input within clinician agendas, and follows interactional structures that often restrict open dialogue" (p. 3).

This observation reveals that clinical dialogue is influenced not only by medical necessity but also by institutional patterns and power dynamics. In multilingual environments

like Algeria, such dynamics are further shaped by code-switching between French and Algerian Arabic. Physicians often begin with French medical terms, switching to Arabic to clarify or soften the delivery. These shifts serve as more than translation they reflect strategic adaptations to social roles, patient familiarity, and cultural expectations. Viewed through a linguistic lens, clinical talk becomes a site where language performs the dual roles of transmitting care and negotiating human connection.

1.7.2 Code-Switching in Clinical Encounters

Code-switching in clinical encounters is a nuanced linguistic strategy that plays a central role in shaping how medical information is conveyed and understood in multilingual contexts. It involves the deliberate or subconscious alternation between two or more languages within a single interaction, often guided by social, cognitive, or communicative motivations**.** As Appel and Muysken (1987) note**,** code-switching is not a random phenomenon but rather a purposeful act tied to discourse functions such as clarification, emphasis, or alignment with the listener.In healthcare settings, these functions take on heightened importance, as patient comprehension, emotional comfort, and trust are directly influenced by how language is used.

According to Myers-Scotton (1993), the Matrix Language Frame model provides a useful framework for analysing such bilingual exchanges.This model suggests that one language provides the grammatical foundation of the sentence, while elements from another language are inserted to enrich meaning or express subtle shifts in tone or identity. Wood (2018, p. 465) refers to this as "linguistic alignment," where healthcare providers adjust their speech to meet the perceived needs of their patients. Far from being a linguistic distraction, this type of flexible code usage can serve to bridge knowledge gaps, foster empathy, and reinforce professional credibility. Singo (2014) argues that analysing code-switching in medical contexts is essential for enhancing patient-centred communication and promoting equity in linguistically diverse healthcare settings.

1.7.3 Challenges in Medical Dialogue

Medical conversations involve more than just the exchange of words they are shaped by imbalances in authority, expertise, and conversational dynamics. As Candlin (2003) points out, clinical interactions are fundamentally unequal, with healthcare providers typically steering discussions while patients respond, sometimes leading to gaps in comprehension. Roberts

(2010) adds that miscommunication often stems not from a lack of knowledge but from differing interpretations of how information is presented.

These challenges become even more pronounced in multilingual or cross-cultural healthcare encounters, where differences in language, tone, and social norms can influence understanding. Subtle conversational cues such as phrasing, pauses, or nonverbal signals can significantly impact patient responses. Sarangi (2005) argues that awareness of these linguistic and cultural nuances is crucial for fostering trust and ensuring clear, respectful communication. Adopting a more adaptive, patient-centred dialogue can help overcome these barriers and enhance the quality of care.

1.7.3.1 Language Gaps

Language gaps occur when patients and healthcare providers differ in language proficiency, dialect, or familiarity with medical terminology. Even when both parties technically share a language, differences in register, jargon, or cultural references can lead to serious misunderstandings. Sarangi (2005) emphasizes that successful medical communication depends on navigating subtle discourse features such as how information is sequenced, how questions are framed, and what cultural assumptions underlie word choice. Without this awareness, a clinician's well-intended explanation may confuse rather than clarify. Gumperz (1982) notes that misinterpretations often stem not from content itself but from cues that are lost or misread due to linguistic mismatches.

These gaps are particularly acute in multilingual environments, where the choice of language can affect both the clarity of information and the emotional tone of the interaction. One observed strategy used to overcome such gaps is repetition or reformulation of key information. Doctors often repeated or rephrased statements especially when discussing complex diagnoses or treatments to ensure patient comprehension. This communicative behaviour aligns with Tannen's (1989, pp. 45–46) notion of "talk as interaction," where repetition serves not merely as redundancy, but as a tool to facilitate connection, confirm understanding, and reinforce key messages in interpersonal discourse. Bridging language gaps therefore requires sensitivity, simplification without condescension, and occasionally, the use of interpreters or culturally adapted materials to support true understanding.

1.7.3.2 Power Gaps

Power gaps in medical dialogue arise from the inherently unequal roles between doctors and patients. Healthcare professionals are positioned as knowledge-holders and decision-makers, while patients are often expected to follow instructions without question. This imbalance can unintentionally suppress patient voice and hinder open communication. Candlin (2003) highlights how clinical communication is shaped by institutional norms that grant physicians significant control over both the flow and structure of interaction, limiting patients' opportunities to contribute meaningfully. This dynamic reflects Foucault's (1972) concept of discourse as a vehicle of institutional power, where language not only communicates knowledge but also constructs and reinforces authority. In medical encounters, discourse governs who may speak, what may be said, and how knowledge is legitimised reinforcing the hierarchical nature of the doctor–patient relationship.

The asymmetry in medical talk is further reinforced by Bourdieu's (1991) notion of linguistic capital, where control over prestigious codes such as French in the Algerian healthcare context helps sustain professional dominance and institutional boundaries. Such control over language can reduce the opportunity for patients to express concerns, seek clarification, or participate in decision-making. Roberts (2010) adds that when patients feel unable to ask questions or interrupt, they may withdraw or withhold important information, further weakening the communicative exchange. Addressing these power gaps requires a shift towards a more dialogic approach one that views patients as active participants in their care, rather than passive recipients of professional authority.

1.7.3.3 Cultural Gaps

Cultural gaps in medical dialogue emerge when doctors and patients bring different belief systems, communication styles, or expectations into the consultation. These differences can influence how symptoms are described, how illness is understood, and what kind of treatment is considered acceptable. As Kleinman and Benson (2006, p. 530) explain, culture is not simply ethnicity or tradition; it encompasses "the values, behaviors, and beliefs that guide how people make sense of the world, especially in times of vulnerability like illness."When healthcare professionals are unaware of these frameworks, even well-meaning communication can come across as dismissive or confusing. For example, patients from collectivist cultures may avoid direct disagreement with authority figures, which could be misinterpreted as agreement or

understanding. Gumperz (1982) notes that without shared cultural cues, clinicians may misread patient intentions, leading to diagnostic or relational breakdowns. Bridging cultural gaps requires cultural humility, active listening, and an openness to multiple ways of interpreting health and care.

1.7.4 Narratives of Illness: Language, Identity, and Healing

Illness isn't just a biological experience it is also shaped by language, interpretation, and storytelling. In healthcare, patients don't merely describe symptoms; they weave narratives that give meaning to their suffering, identity, and healing process**.** Frank (1995, p. 56) describes this as a shift from being a passive "body in distress" to an active storyteller, using narrative to reclaim agency.These illness stories take different forms some are chaotic and fragmented, overwhelmed by pain, while others follow structures of recovery or personal growth, reflecting hope or transformation.

Charon (2006, p. 4) argues that listening deeply to these stories is itself a clinical skill, which she calls "narrative competence."By engaging with patients' narratives, healthcare providers can cultivate greater empathy and understanding. Language here is more than a diagnostic tool it bridges medical facts and lived experience. Kleinman (1988) warns that when clinicians focus solely on disease, they often miss the patient's full story, overlooking the moral and social dimensions of illness. The way patients speak about their condition through metaphor, memory, or cultural lens shapes how they perceive their bodies, engage with treatment, and imagine recovery. Recognizing these narratives transforms healthcare from a transactional exchange into a meaningful human connection, centred on voice, understanding, and healing.

1.8 Lexicons of care

In healthcare, language extends far beyond mere information exchange it serves as the foundation for building empathy, trust, and healing. Within multilingual settings such as Algeria and other linguistically diverse communities, patients and healthcare providers frequently navigate complex linguistic dynamics, including code-switching, real-time translation, and mutual adaptation in communication. These nuanced interactions have a direct influence on the quality of care delivered. As Hymes (1972) emphasised, effective healthcare requires more than clinical proficiency; it demands meaningful connection through the patient's language, both linguistically and culturally. Research by Flores (2006) further substantiates that language barriers contribute to misdiagnoses, reduced treatment adherence, and exacerbated

health disparities. Similarly, Spolsky (2004) underscores how healthcare language policies can either mitigate or perpetuate inequities, contingent upon their support for multilingual inclusion. Given the increasing globalization of healthcare, understanding these "lexicons of care" the intricate and evolving role of language in medical contexts is not merely beneficial but essential for ensuring ethical, equitable, and patient-centred care.

1.9 Conclusion

This chapter has presented a theoretical and contextual framework for examining multilingualism and language practices in Algeria, with a particular focus on healthcare communication. It began by outlining the historical and sociopolitical factors that shaped Algeria's rich linguistic repertoire, where Modern Standard Arabic, Algerian Arabic, Tamazight, and French coexist in layered and often overlapping ways. Through an exploration of key concepts such as bilingualism, diglossia, and language borrowing, the chapter has illustrated how language in Algeria functions not only as a communicative tool and a marker of identity and status, but also as a means of exercising power within social and institutional contexts.The discussion also highlighted the sociolinguistic complexities brought about by Arabic-French bilingualism, a legacy of colonial history, and its ongoing influence on domains like education, administration, and health.

In parallel, the chapter introduced foundational perspectives on code-switching and language choice, outlining both structural classifications and functional motivations. Code-switching was analysed not simply as a linguistic occurrence but as a dynamic social strategy shaped by context, speaker intention, and power relations. Particular attention was given to its relevance in healthcare settings, where shifts in language may serve to express empathy, manage asymmetry, or increase clarity between professionals and patients. The interplay of language dominance, communicative roles, and emotional tone was also shown to impact language choice significantly. Together, these insights provide a comprehensive base for the next stages of this research, which aim to empirically investigate how multilingual speakers in Algeria's healthcare environment navigate their linguistic options to achieve effective and meaningful interaction.

CHAPTER TWO

Methodology and Data Analysis

CHAPTER TWO: METHODOLOGY AND DATA ANALYSIS

2.1 Introduction

The previous chapter discussed Algeria's multilingual landscape and introduced key sociolinguistic concepts such as bilingualism, diglossia, and code-switching, with a particular emphasis on healthcare communication. These theoretical foundations set the stage for examining how language is used in real-world clinical settings. Given Algeria's rich multilingual landscape and the constant interplay between Algerian Arabic, French, and Modern Standard Arabic, the study of language use in institutional domains has garnered significant attention from sociolinguists. In healthcare context, this linguistic diversity becomes particularly salient, where the effectiveness of communication can directly influence patient outcomes. This chapter presents the methodological framework adopted to explore how healthcare professionals in urban Algerian public and private healthcare centres navigate multilingualism through language choice and code-switching during medical consultations. The study aims to investigate real communicative practices and uncover both the strategies and motivations behind these linguistic behaviours.

This chapter cites the research design opted for in this study. Then, it displays the results obtained from the collected data in order to analyse and interpret them. Finally, some suggestions and recommendations are made for future investigations.

2.2 Research Setting and Context

This study was conducted in Tlemcen, Algeria. Data were collected from three healthcare settings: a private medical practice in Remchi, a public healthcare centre in Abu Tachfin, and a public healthcare centre in Imama. Fieldwork took place between December 2024 and February 2025. Each site was visited multiple times over several days to conduct focused observations and in-depth interviews, and focus group discussions. Participants included both doctors and patients, providing a comprehensive perspective on the communicative dynamics during medical consultations. The sociolinguistic context of these interactions was shaped by the coexistence of Algerian Arabic and French as the main languages used in clinical communication. These multilingual settings offered a valuable context for examining how healthcare providers and patients manage language choice and code-switching in response to various communicative and institutional demands.

2.3 Research Design

Any rigorous scientific enquiry requires a clear methodological orientation to ensure coherence and credibility. This research adopts a qualitative approach to explore the sociolinguistic dimensions of language use in Algerian healthcare settings, particularly within multilingual and culturally layered environments such as hospitals and clinics. The qualitative paradigm was chosen for its capacity to prioritise meaning, context, and participants' lived experiences over numerical generalisation. Data were collected through three complementary methods: observation, semi-structured interviews, and focus group discussions. The use of these tools was not intended to serve triangulation in a positivist or statistical sense. Rather, it was a deliberate methodological choice aimed at deepening the interpretive scope of the study. As Flick (2018) notes, in qualitative research, employing multiple methods enhances contextual understanding rather than confirming validity through convergence. In this exploratory investigation, the combination of tools enabled a nuanced examination of how language practices unfold in real clinical settings, capturing diverse perspectives and interactional realities.

The research does not seek to produce generalisable findings, but instead aims to uncover how healthcare professionals and patients navigate language choice and code-switching in situated encounters. Observing natural consultations, eliciting individual narratives, and facilitating group reflections allowed for a multi-faceted analysis of language use grounded in everyday clinical practice. Analytically, the study draws on thematic analysis to identify patterns across the data, and discourse analysis to investigate how language signals social roles, intent, and interpersonal positioning. The theoretical grounding rests on Gumperz's interactional sociolinguistics and Myers-Scotton's code-switching theory, ensuring that the research is both interpretively rich and conceptually anchored.

2.4 Sampling Strategy and Participant Selection

According to Creswell (2014), sampling involves selecting individuals who can best help the researcher understand the central phenomenon under study. In this research, a non-random purposive sampling technique was employed to select participants who actively engage in multilingual communication within healthcare contexts. Purposive sampling is a non-probability technique in which participants are deliberately selected based on specific

characteristics that align with the objectives of the study (Palinkas et al., 2015). This approach allows the researcher to focus on individuals who are most likely to provide relevant and rich information related to language choice and code-switching in clinical interactions. The study included both doctors and patients from urban medical centers in Tlemcen, specifically in Remchi, Abu Tachfin , and Imama. A total of five doctors participated in individual interviews, and 64 patients were observed during live consultations across the three medical centres (see Table 7).In addition, 25 patients participated in four focus group discussions, providing collective insights on language use and doctor-patient interactions.The sample was demographically rich and diverse, encompassing male and female participants across a wide age spectrum from elderly patients to adults, and even a few interactions involving children. This intentional diversity in participant backgrounds was essential for capturing key variables, such as language behaviours and communicative preferences, that characterise Algeria's multilingual clinical environments.

2.4.1 Doctor Participant Profile

The following table presents the demographic and professional details of the five doctors who participated in the study. It includes their gender, age range, area of specialty, workplace type, years of experience, and the languages used during consultations.

Code	Gender	Age Range	Specialty	Workplace	Years of Experience	Languages Used in Consultations
D1	Male	30–50	Dentistry	Public	>10 years	Based on patient profile
D2	Female	30–50	Internal Medicine	Private	>10 years	Based on patient profile
D3	Female	30–50	General Practitioner	Public	>10 years	Based on patient profile
D4	Female	20–30	Anaesthesia & Resuscitation	Public	1 year	Based on patient profile
D5	Female	30–50	General Practitioner	Public	>10 years	Based on patient profile

Table 2.1: Doctor Participant Profile

2.4.2 Patient Participant Profile

The characteristics of the patient participants involved in this study are summarized below, including demographic diversity, educational background, reason for consultation, and the type of healthcare facility attended.

Category	Details
Total Patients	89 (64 observed, 25 in focus group discussions)
Gender	Both male and female
Age Range	Children to elderly (approx. 10 to 75+ years)
Education	Educated and non-educated individuals
Consultation Type	Routine consultations and serious medical cases
Healthcare Setting	Public and private centres in Tlemcen city

Table 2.2: Patient Participant Profile

2.5 Research Instruments

According to Cohen, Manion, and Morrison (2018), research instruments are tools purposefully designed to collect relevant data, allowing researchers to generate, interpret, and analyse evidence in relation to their research questions. In qualitative research, selecting appropriate instruments is crucial for ensuring depth, authenticity, and contextual sensitivity in data collection (Creswell, 2014). For this study, research tools were selected in direct alignment with the research objectives and qualitative design, which sought to uncover how healthcare providers and patients in Algeria navigate multilingualism during clinical consultations. Accordingly, the present research employed three key tools: non-participatory observation, semi-structured interviews, and focus group discussions. Each instrument was used not only to gather linguistic data but also to explore the social, cultural, and emotional dimensions of language choice and code-switching in real-time doctor–patient interactions.

2.5.1 Observations

Observation served as a core data collection method for documenting authentic doctor-patient communication during medical consultations. The researcher conducted five days of naturalistic, non-participant observations across three healthcare facilities in Tlemcen: Remchi, Abu Tachfin, and Imama.

This methodological approach involved the researcher being physically present in clinical settings without participating in or influencing interactions, allowing communication to unfold naturally (Cohen et al., 2018). With prior participant consent, the researcher observed real-time medical consultations to analyse language shifts, patterns of language choice, and functional code-switching. This design captured spontaneous, context-driven discourse, generating rich qualitative data on multilingual healthcare communication. While limitations included time constraints and ambient noise, the observations yielded valuable insights into sociolinguistic dynamics in Algerian clinical contexts.

The following table presents the distribution of observation sessions across the three healthcare facilities, including dates and patient consultation numbers:

Facility	**Observation Date**	**Patients Observed**
Imama	29/12/2024	15
	31/12/2024	11
Abu Tachfin	12/02/2025	8
	15/02/2025	10
Remchi	21/11/2024	20
Total	5 days	64

Table 2.3: Observation Sessions by Facility, Date, and Patient Numbers

2.5.2 Semi-Structured Interviews

To gain a deeper understanding of language behaviour and motivations behind code-switching, five semi-structured interviews were conducted with doctors practicing in Remchi, Abu Tachfin ,and Imama. These interviews were designed to elicit reflective, detailed responses from participants regarding their language use during patient interactions. The interview was originally prepared in English and then translated into Arabic to facilitate understanding and ensure effective communication with the participating doctors. It consisted of 14 open-ended questions designed to elicit detailed responses about language use and communication practices in clinical settings. A portion of the interviews was audio recorded with participants' permission, while the remainder relied on note-taking. Some interviewees declined audio recording due to concerns about confidentiality and personal comfort, preferring instead to respond off the record. The semi-structured format allowed the researcher to guide the conversation while giving doctors freedom to elaborate on their perspectives, making this tool particularly useful for capturing professional insights into language choice, communicative

preferences, and the impact of sociolinguistic context on medical discourse. As Dörnyei (2007) notes, semi-structured interviews are effective in language-related research, as they allow for flexible exploration of individual experience while maintaining consistency across participants.

2.5.3 Focus Group Discussions

In addition to interviews and observations, four focus group discussions were conducted as the final stage of data collection, with 25 patients representing diverse age groups and social backgrounds. Krueger and Casey (2015) define focus group discussions as moderated group interactions that examine collective experiences, perceptions, and opinions through guided dialogue.This method was intentionally positioned after the observation and interview phases in order to validate emerging patterns, encourage reflection on previously observed behaviours, and allow participants to engage with each other's views in a more dynamic, collaborative setting. Conducted primarily in Remchi and Abu Tachfin, the sessions included both male and female participants and offered a diverse range of perspectives on doctor–patient interaction, language preference, and reactions to code-switching practices. Note-taking was the primary mode of data collection, as audio recording was not always feasible or preferred by participants. These discussions offered a richer, socially contextualised understanding of multilingual communication as experienced by patients in Algerian healthcare settings.

2.6 Ethical Considerations

Ethical considerations were a fundamental component of this study, particularly due to the sensitivity of its setting, namely healthcare environments where patient well-being, confidentiality, and professional ethics are paramount. This research involved interactions with vulnerable individuals in clinical spaces, including doctors and patients, making it imperative to uphold the highest standards of ethical conduct throughout the investigation. Prior to commencing the fieldwork, the researcher obtained official approval and verbal authorization from the administrative bodies governing the selected healthcare centers in Tlemcen, specifically in Remchi, Imama, and Abu Tachfine . These clearances were vital to ensure institutional accountability and legal compliance. Using information sheets, all participants were clearly informed about the study's aims, the types of data to be collected, and their expected contributions.Participation was entirely voluntary, and individuals were assured of their right to refuse or withdraw at any time without providing justification or facing any

negative consequences. Informed consent was secured from all participants, either verbally or in writing, depending on the participants' literacy level and comfort.

Special attention was given to the ethical complexities of observing live medical consultations. In each case, permission was obtained from both the healthcare provider and the patient. The researcher maintained a passive, non-intrusive role during observations to minimise any disruption to the natural flow of interaction and to respect the privacy and dignity of those involved. During interviews and focus group discussions, participant anonymity was strictly preserved; names and identifying information were removed from all notes, transcripts, and final reports. Importantly, the data reported and analysed in this study did not include any medical records or personal health information. The focus remained solely on language use within clinical communication, ensuring that ethical standards related to confidentiality and participant protection were fully upheld.

All data, including audio recordings, field notes, and interview transcripts, were stored securely and accessed only by the researcher. This approach ensured full compliance with data protection standards and ethical guidelines. As Flick (2018) notes, confidentiality is a foundational principle in qualitative research, requiring researchers to safeguard participants' identities and ensure that sensitive information is not disclosed or misused. Moreover, the linguistic and cultural comfort of participants was respected throughout the study. Participants were free to use the language of their choice primarily Algerian Arabic or French which facilitated a more natural and authentic exchange of ideas . Overall, this research adhered to core ethical principles including respect, integrity, autonomy, and confidentiality, ensuring the protection and dignity of all participants throughout the study.These measures contributed to building trust with participants and ensured that the findings were obtained in a respectful, culturally aware, and ethically sound manner.

2.7 Data Analysis Procedure

This study examined the linguistic and social intricacies of multilingual communication in Algerian hospital settings using two qualitative frameworks: thematic analysis and discourse analysis. Thematic analysis followed Braun and Clarke's (2006, p. 87) six-phase model, which involves familiarising oneself with the data, generating initial codes, identifying and reviewing themes, defining and naming them, and producing the final report. This structured process provided a consistent foundation for analysing patterns in language use, communicative

behaviours, and interactional dynamics derived from focus groups, semi-structured interviews, and observational data. For discourse analysis, an interactional sociolinguistic approach, as conceptualised by Gumperz (1982), was adopted. This method emphasises how meaning is co-constructed in real-time interactions, especially through features such as code-switching, lexical selection, turn-taking, and the negotiation of social roles within the institutional context of healthcare. The integration of both analytical frameworks enabled the study to uncover not only recurring thematic patterns but also the sociocultural meanings and power dynamics embedded in clinical discourse.

After transcribing all audio recordings and thoroughly reviewing field notes, the researcher manually developed descriptive codes to capture significant meaning units. These were refined into broader categories, eventually forming key themes such as emotional reassurance, linguistic accommodation, and the negotiation of power and professional identity. Manual coding allowed for a close engagement with the data, ensuring a context-sensitive interpretation. Simultaneously, discourse analysis focused on the form and function of multilingual interactions, drawing on the work of Myers-Scotton (1993) and Gumperz (1982) to examine pragmatic strategies like tone modulation, code alternation, and turn-taking. This approach offered insights into how participants conveyed authority or empathy, constructed meaning, and adjusted their speech in response to contextual and social cues.

Given the trilingual environment of Algerian Arabic, French, and Modern Standard Arabic, transcription and translation were conducted with attention to preserving sociocultural nuances. Following Temple and Young's (2004) recommendations, translations retained both linguistic form and contextual relevance to ensure interpretive accuracy. Thematic analysis traced recurring patterns of language use across the dataset, while discourse analysis revealed how language was strategically employed during doctor–patient interactions. Together, these methods provided a comprehensive understanding of both the content and the communicative strategies shaping multilingual exchanges in clinical settings.

2.8 Thematic and Discourse Analysis of Data

The integration of thematic and discourse approaches enables a deeper understanding of not only what is said during clinical encounters but also how it is said, why certain language choices are made, and what these choices reveal about empathy, comprehension, professional authority, and identity in the healthcare setting. The following themes were derived from the

data through thematic analysis, and their interpretation draws on discourse analysis to explore how language was used within clinical interactions.

2.8.1 Language Adaptation to Patient Profile

One of the most salient patterns observed during consultations was the tendency of doctors to adapt their language based on the patient's age, educational background, and perceived level of comprehension. This linguistic flexibility was particularly evident when doctors initially addressed patients in French but quickly switched to Algerian Arabic after noticing signs of misunderstanding. In several interviews, healthcare providers explained that elderly patients or those with limited formal education were often more comfortable in Arabic. As one doctor noted, "I start in French, but if the patient looks confused or doesn't reply, I shift immediately to Arabic especially for elderly people."

In terms of discourse, this theme was characterised by pragmatic strategies such as repetition, simplification, and shifts in register. During observations, doctors were seen paraphrasing medical instructions in both languages or reiterating key terms in Algerian Arabic to ensure comprehension. The switch was not random but responsive triggered by patients' facial expressions, silence, or hesitancy. This aligns with interactional sociolinguistics, where meaning is co-constructed based on immediate social cues.

An illustrative example was recorded during one consultation:

Doctor: **"***Tu dois prendre ce médicament deux fois par jour... ok ?"*
Patient: *(silent)*
Doctor: *"تشربيه مرتين في النهار، الصباح والمساء، فهمتيني؟"*
Translation: "You have to take this medicine twice a day... do you understand?" → "Take it twice a day, morning and evening. Did you get that?"

The code-switch from French to Algerian Arabic was accompanied by clearer time markers and a softer tone. This shift was not just a repetition, but a discursive strategy to check comprehension and reinforce meaning in a more familiar linguistic register. The change of code also introduced a more personal, empathetic interactional stance, suggesting care and reassurance. Furthermore During the observation phase, it was confirmed that younger or more educated patients were often addressed in French, sometimes for the entire duration of the consultation.This selective adaptation underlines a form of audience design, where the doctor

adjusts speech not merely to transfer information, but to build rapport, ensure clarity, and navigate the linguistic diversity of the Algerian clinical setting. The use of Algerian Arabic for clarification was not limited to medical explanations; it also occurred when doctors gave instructions about prescriptions, appointment dates, or aftercare procedures. In such moments, clear, familiar language was prioritised over professional or technical terminology, reinforcing the importance of patient-centred communication in multilingual healthcare environments.

2.8.2 Emotional Framing Through Language Choice

A distinct and recurrent theme emerging from the data was the emotional function of language, particularly the deliberate use of Algerian Arabic to convey empathy, reassurance, and sensitivity in moments of heightened emotional intensity. Unlike instances where doctors adjusted their language for reasons of comprehension, this theme highlights how language was employed to create emotional proximity, manage delicate topics, or deliver distressing information in a culturally resonant manner. Across interviews, focus group discussions, and observations, it was noted that doctors frequently shifted from French typically used for diagnosis and treatment plans to Algerian Arabic when discussing emotionally sensitive issues such as chronic illness, pain, or uncertainty. This choice often occurred even with patients who were proficient in French. For example, in one observed consultation, a doctor discussing a long-term treatment said:

Doctor: *"Il faut du temps, c'est une maladie chronique."*
(Pause, then gently in Arabic) *"يصح ما تخافش، بالدواء تقدر تعيش بيه عادي"*
Translation: "It will take time; it's a chronic illness." → "But don't worry, with medication, you can live normally."

The tone softened notably in the Arabic portion, and the shift was clearly intended to soothe the patient. In discourse terms, this reflects what is known as affective alignment the use of language to emotionally mirror the listener's state or to reduce anxiety.Such emotionally charged code-switches were observed to occur at pivotal moments in consultations: when breaking bad news, calming a distressed patient, or showing solidarity. Focus group participants confirmed that Arabic felt more "real" or "closer to the heart," especially in difficult conversations. The cultural salience of Algerian Arabic its idioms, intimacy, and emotional nuance made it the preferred code for relational connection. This theme reveals that language in healthcare is not merely transactional but is imbued with affective and symbolic weight. The

strategic use of Arabic in these moments reflects doctors' awareness of linguistic intimacy and the need to build trust through culturally attuned discourse. Far from being incidental, such choices are an essential part of empathetic, patient-centred care.

2.8.3 Repetition as a Communicative Strategy

In healthcare consultations, repetition frequently emerged as a communicative strategy used by doctors to enhance patient understanding, confirm message clarity, and emphasise critical information. Data collected from interviews, observations, and focus group discussions consistently demonstrated how repetition served to bridge linguistic and cognitive gaps, particularly in emotionally charged or complex scenarios. Doctors often repeated medical instructions or diagnostic information, especially when dealing with elderly patients or those with limited literacy or language proficiency. This repetition was not mere redundancy; rather, it was a strategic response to perceived or actual communicative barriers. For instance, some healthcare providers repeated statements in both French and Algerian Arabic to ensure clarity:

Doctor: "Combien ta trouvé mesure du sucre ce matin ?"
Then immediately repeated:
"L'hadj, ki 3abert sekour sba7, chhal sabtou ?"

In this example, the doctor initially asked the question in French, followed by an immediate reiteration in Algerian Arabic. This dual-language repetition ensured that the elderly patient likely more comfortable in dialect clearly understood the query about their morning blood sugar measurement. Thematic analysis revealed that repetition was commonly employed in scenarios involving critical diagnoses, complex treatment plans, or emotionally fragile patients. For instance, one doctor explained that repeating instructions slowly and clearly was essential when a patient appeared anxious or disoriented. This pattern was supported by field observations showing that patients often responded more confidently or expressed gratitude after hearing critical information more than once. Discursively analysed, data revealed that, repetition can also be understood as a tool for managing the interaction. It serves to maintain the flow of conversation, emphasise important points, and signal empathy or attentiveness. In emotionally intense moments, such as delivering bad news or discussing treatment failure, repetition helped doctors project reassurance and authority, often softening the tone of their communication. This theme highlights how repetition is not simply a fallback strategy but a purposeful linguistic

choice embedded within the socio-cultural and emotional dynamics of clinical consultations in multilingual Algerian settings.

2.8.4 Using Indirect Language and Metaphors to Ease Patient Anxiety

Another communicative pattern observed across interviews, observations, and focus group discussions involved the strategic use of indirect language, metaphors, and simplified comparisons to reduce stress and promote understanding during consultations. Particularly with elderly or anxious patients, doctors often avoided using technical or clinical terminology in either French or Arabic. Instead, they relied on metaphorical expressions, analogies, or visual demonstrations to make complex medical ideas accessible.

This strategy was most evident when dealing with unfamiliar medical tools or procedures. For example, one doctor, referring to an electrocardiogram (ECG), used the phrase "radio taʿ sbet" (/ˈʁa.dju tæʕ es.bɛt/)instead of the French abbreviation “ECG.” Another example involved a reference to an abdominal ultrasound as "radio taʿ l-kerch" (/ˈʁa.dju tæʕ el.keʁʃ/, translation: “stomach ultrasound”), a term that felt more familiar and less intimidating for the patient. In other cases, pills were described by their colour or shape for example, *hādāk ed-dwā ellī kī lobya* (/ħaː.dak əd.dwaː ʔil.liː kiː ˈlʊb.jæ/, meaning “the one that looks like a bean”) to check the patient’s understanding without relying on pharmacological or technical terminology. Such expressions not only served informational purposes but also helped ease anxiety. Many of the observed patients nodded in response or repeated the doctor’s metaphor, indicating both comprehension and relief. In some instances, this indirectness was further accompanied by gestures, like pointing to the medicine box or mimicking how to take the treatment.

This form of metaphoric substitution reflects both cultural familiarity and relational sensitivity, as it draws on shared everyday imagery to reinforce understanding and interpersonal connection. It allowed doctors to maintain professional authority while reducing the psychological burden of confronting technical medical topics. This practice demonstrates how linguistic strategies are deeply intertwined with emotional and cognitive aspects of patient care, particularly in multilingual and diglossic settings like Algeria’s healthcare system.

2.8.5 Asserting Medical Authority

While much of the communicative behaviour observed in Algerian healthcare settings reveals doctors adapting to patients' profiles through code-switching, a contrasting pattern emerged in which some doctors deliberately maintained French during particular moments of the consultation. This consistent use of French was especially apparent during the delivery of medical diagnoses, treatment plans, or procedural instructions. Even when patients showed signs of limited French comprehension, such as hesitant nodding or verbal uncertainty, the doctor sometimes refrained from switching to Algerian Arabic. In such cases, French appeared to serve as a symbol of medical precision and institutional gravity.

This behaviour was noted across several consultations and further discussed with interviewees.For example, one physician stated that in serious cases, "je préfère rester en français pour qu'ils comprennent que c'est quelque chose de médical, pas ordinaire." In the field, one doctor told a patient, "Vous allez suivre ce protocole pendant quinze jours, et vous revenez avec les résultats," without rephrasing in Arabic, despite the patient's visible confusion. The intentional non-switching suggests that language here is not only a medium for information delivery, but also a marker of professional identity and epistemic authority. French, as the historical language of medicine in Algeria, carries institutional legitimacy and distinguishes the doctor from the patient in terms of roles and expertise.

Thus, in contrast to previous themes that highlighted accommodation, this behaviour reflects a hierarchically anchored strategy, where linguistic choices reinforce boundaries rather than dissolve them. The use of French in these contexts asserts the doctor's authority, aligns with the formal nature of biomedical discourse, and communicates the seriousness of the moment. Not switching codes becomes discursively significant particularly when it serves to maintain power dynamics and institutional identity within the clinical interaction. In this way, language functions not only as a communicative tool but also as a means of exercising institutional power, as Foucault (1972) argued, where discourse operates as a mechanism for producing, sustaining, and legitimising authority in structured social environments such as healthcare.

2.8.6 Pharmacists as Mediators in Communication Gaps

A recurrent finding from the focus group discussions was the critical role pharmacists play in bridging communication gaps between patients and healthcare providers. When medical consultations were conducted exclusively in French or used technical codes unfamiliar to the

patient, participants often reported avoiding immediate clarification with the doctor. Instead, they turned to pharmacists, particularly those from the same neighbourhood or local area, who could explain prescriptions and clarify ambiguous medical advice in more accessible language.

This practice reflects the development of an informal communication chain that enhances understanding outside the clinical encounter. Pharmacists, sharing a linguistic and social familiarity with patients through Algerian Arabic, provided not only translation but emotional reassurance. Their language was less formal and more empathetic, adapting professional information into a form more easily understood by patients. This recontextualisation of medical discourse highlights the crucial intermediary role pharmacists play in sustaining continuity of care, particularly in multilingual healthcare environments such as Algeria. Thus, pharmacists act as essential linguistic and cultural brokers, filling a critical gap left by the structural limitations of the doctor–patient interaction.

2.8.7 Patients' Non-Verbal Responses as Triggers for Language Adaptation

An important pattern emerging from the triangulation of observational data, interviews, and focus group discussions was the role of non-verbal communication in shaping language choice during doctor–patient interactions. Rather than relying solely on explicit verbal requests for clarification, doctors often interpreted patients' facial expressions, body language, and emotional cues as indirect signals of comprehension difficulties. This phenomenon underscores how multilingual communication in healthcare settings is not only a matter of linguistic competence but also of relational sensitivity and perceptual awareness. Doctors interviewed during the fieldwork repeatedly emphasised that patients seldom verbalised their confusion when unfamiliar terminology or French expressions were used. Instead, physicians reported detecting subtle indicators such as furrowed brows, prolonged silence, nervous fidgeting, or visible hesitation. One doctor noted, *"Tqdar tḥess blli l-mrīd ma fhem walou, ḥattā ila ma qāl walou;f wajhou ybān kolchi"* (/tˤqdar tˤħess bəlli l-mriːd ma fəhem waːlu, ħattaː ʔila ma ʔqaːl waːlu; wʒhuː ybaːn kulʃi/), which translates as *"You can immediately sense when a patient is lost, even if they say nothing; their face shows everything."*prompting an immediate shift to Algerian Arabic or a more simplified, hybrid code to regain communicative alignment.

Observational data further confirmed that language shifts were frequently initiated not after patient complaints, but following perceptible non-verbal reactions. For instance, in a recorded consultation, a physician initially explained a treatment plan in French but, upon noticing the

patient's puzzled expression, rephrased the instructions in clear Algerian Arabic without any explicit request from the patient. These spontaneous adaptations reflect a highly dynamic interactional environment where responsiveness to unspoken signals is as critical as linguistic competence itself. Focus group participants corroborated this finding by acknowledging that many felt reluctant or too embarrassed to admit when they did not understand medical explanations, particularly in formal healthcare contexts where asymmetrical power dynamics are present. Several patients recounted situations where they were grateful that the doctor "understood without them needing to ask," avoiding the potential loss of face or social discomfort associated with openly admitting linguistic limitations.

From a discourse-analytic perspective, these shifts demonstrate an acute sensitivity to interactional cues that go beyond language itself. Non-verbal behaviour, operating alongside spoken discourse, acts as an indexical resource through which communicative needs are negotiated and addressed in real time. In multilingual healthcare contexts like Algeria, where language choice carries heavy social and emotional weight, the ability to decode non-verbal feedback becomes a crucial communicative competence for medical practitioners. Thus, non-verbal responses act as silent yet powerful triggers for language adaptation, reinforcing the inherently multimodal and relational nature of healthcare communication. Doctors' capacity to perceive and respond to these signals not only facilitates better understanding but also strengthens relational trust, patient comfort, and overall healthcare quality.

2.9 Interpretation and Discussion of Findings

The data revealed several recurring communicative patterns in Algerian healthcare interactions, particularly regarding language choice and code-switching. In qualitative research, interpretation transcends simple description; it seeks to situate the findings within broader theoretical and empirical frameworks (Creswell, 2014). Accordingly, this discussion endeavours to connect the extracted themes to the established body of literature concerning multilingualism, language choice, and code-switching, as explored in Chapter One. Special attention will be paid to the extent to which the current study's findings either corroborate or challenge existing scholarship, particularly within the sociolinguistic and healthcare communication fields. In doing so, the discussion will not only validate the significance of the observed communicative patterns but also uncover the nuanced ways in which linguistic and sociocultural factors intersect in Algerian clinical encounters. The themes are discussed

sequentially, with each theme analysed individually before presenting a broader synthesis of their collective implications.

Through a critical lens, the analysis highlights how multilingual communication practices in Algerian healthcare contexts correspond to, extend, or challenge previous theoretical discussions. Each theme will be examined individually, offering an in-depth reflection on its significance in light of sociolinguistic and healthcare communication research.

2.9.1.Language Accommodation Strategies in Multilingual Consultations

The findings reveal that healthcare providers in both public and private healthcare settings in Algeria frequently accommodate their language choice according to the linguistic needs of their patients. Doctors demonstrated awareness of patients' preferred languages, particularly switching between Algerian Arabic and French to ensure mutual comprehension and comfort. This pattern supports Gumperz's (1982) theory of interactional sociolinguistics, which stresses that language choice in conversations serves to negotiate social relationships, build solidarity, and reduce social distance. Similarly, Holmes (2013) contends that speakers adjust their linguistic behaviour based on their interlocutors' social identity and communicative needs, which directly echoes the behaviours observed in the present study.

Moreover, Myers-Scotton's (1993) Markedness Model posits that speakers consciously select a code to signal desired social meanings, including authority, solidarity, or politeness. In this context, Algerian doctors used language accommodation not only to foster rapport but also to maintain professional authority when necessary. Notably, patients' linguistic preferences were accommodated more visibly during sensitive consultations, such as discussions involving complex diagnoses or treatment plans, aligning with Hymes' (1972) emphasis on the role of contextual appropriateness in communication. Thus, the observed language accommodation strategies not only reinforce but also enrich the established theoretical frameworks, illustrating how multilingual competence is dynamically employed in healthcare interactions to balance empathy, clarity, and authority.

2.9.2 Strategic Use of Code-Switching to Manage Consultation Flow

Findings show that code-switching among Algerian healthcare providers is not random but strategically deployed to manage conversational flow, clarify concepts, or emphasise specific information. Such patterns serve as contextualisation cues that signal discourse boundaries or

shifts in footing, as illustrated in interactional models of code-switching (Auer, 1998).Additionally, Myers-Scotton (1993) argues that speakers engage in code-switching to project specific social identities or align themselves with the perceived linguistic preferences of their interlocutors. In Algerian hospitals, doctors used code-switching both to simplify medical explanations for patients with limited French proficiency and to maintain professional authority during formal procedures. This supports Gumperz's (1982) concept of code-switching as a conversational resource that fosters understanding and manages interactional dynamics.

2.9.3 Repetition and Reformulation as Clarification Strategies

Doctors often repeated or reformulated statements during consultations to ensure patient comprehension, particularly when explaining complex diagnoses or treatments. Rather than being merely redundant, such repetition serves as a communicative tool that facilitates shared understanding and reinforces clarity. As Tannen (1989) highlights, repetition in conversational interaction supports the co-construction of meaning and helps maintain engagement between speakers.In addition, Ferguson (1994) highlights that in multilingual settings, reformulation serves a pedagogical function, helping bridge gaps in linguistic or medical knowledge between speaker and listener. The use of repetition and reformulation in Algerian healthcare reflects the necessity to negotiate meaning in linguistically diverse contexts, emphasising that clarity often requires dynamic and adaptive discourse strategies.

2.9.4 Figurative Language and Metaphors to Simplify Medical Concepts

Doctors employed figurative language, likening medicines to everyday objects (e.g., 'this pill is like a bean'), which corresponds with Lakoff and Johnson's (1980) conceptual metaphor theory, which posits that metaphors are essential for human understanding of abstract concepts. In healthcare, as Charteris-Black (2003) discusses, metaphors serve not merely rhetorical functions but cognitive and emotional ones, enabling patients to grasp complex medical phenomena through familiar imagery. Algerian doctors' reliance on metaphorical expressions thus reflects a culturally sensitive communication strategy, aligning clinical discourse with patients' lived realities and cognitive frameworks.

2.9.5 Authority Maintenance through Code Choice

The tendency of some doctors to maintain French or resist switching into Arabic, even when patients seemed linguistically uncomfortable, suggests a deliberate effort to reinforce

professional authority. This finding is consistent with Bourdieu's (1991) notion of linguistic capital, where control over prestigious codes (such as French in Algeria) reinforces social hierarchies within institutional settings. Holmes (2013) also notes that language choice can serve to emphasise status and expertise in professional encounters. Hence, in the Algerian context, the use of French can symbolically reaffirm the doctor's expert identity, though it may risk alienating certain patient groups.

2.9.6 Pharmacists as Mediators in Post-Consultation Communication

The focus group findings revealed that patients often sought clarification from pharmacists after medical consultations, especially when linguistic barriers remained unresolved. This phenomenon mirrors the findings of Shohamy (2006), who explores how multilingual intermediaries often act as informal translators and cultural brokers in healthcare settings. Furthermore, research by Pöchhacker (2000) on community interpreting highlights the crucial role played by non-official actors in bridging communicative gaps. In the Algerian healthcare landscape, pharmacists emerge as pivotal figures who facilitate comprehension and provide patients with reassurance when doctor-patient communication falls short.

2.9.7 Patients' Non-Verbal Responses as Triggers for Language Adaptation

The data indicated that doctors frequently adjusted their language choice based on patients' non-verbal cues confusion, hesitation, facial expressions even when patients did not verbally request clarification. This aligns with Gumperz's (1982) work on contextualisation cues, where non-verbal behaviours inform conversational inferences and adjustments. Similarly, Goodwin (1981) underscores the role of embodied cues in conversation management, arguing that understanding extends beyond verbal content to include gestures, gaze, and body language. In Algerian hospitals, sensitivity to non-verbal feedback demonstrates doctors' reliance on interactional competence to adapt dynamically to their patients' communicative needs.

2.10 Study Limitations

Although the goal of this study was to give a thorough grasp of multilingual practices in Algerian healthcare settings, it should be noted that there are a number of limitations. First and foremost, The fieldwork was influenced by time restrictions. Access to medical facilities was provided for different lengths of time; in some situations, administrative approval permitted observation for no more than two days, while in others, the researcher was only permitted to

observe for one week. Doctor collaboration during observations and interviews was generally favourable and uniform among the chosen clinics in terms of participant engagement. Even after being thoroughly informed about the purpose of the study and their rights, several patients still showed a reluctance to participate. Given the sensitive nature of medical consultations, some participants were initially cautious in their responses. However, through the use of trust-building strategies and ethical assurance, the researcher was able to collect meaningful and contextually rich data that offered valuable insights into the communicative dynamics under study.

The linguistic requirements of data processing constituted another constraint. A significant portion of the data, particularly from observations and interviews, was collected in Algerian Arabic, necessitating rigorous transcription and context-sensitive translation into scholarly English. Although translation from Algerian Arabic into English may not always perfectly convey culturally embedded expressions, great care was taken to preserve the original intent and meaning of all participant responses. No data was falsified or distorted during the transcription and translation process. For clarity and authenticity, original utterances are occasionally included in Arabic alongside their English translations when culturally specific meanings were at stake. Every attempt was taken to guarantee that the translated content adhered faithfully to the original intent and meaning. Finally, the results are context-bound, as is typical in qualitative research. This study focused on selected healthcare settings in the urban areas of Tlemcen province, aiming to gain a deeper understanding of how multilingual communication unfolds in real clinical contexts. Through purposive sampling, the research prioritised the richness and depth of participant experiences over broad representativeness, allowing for an in-depth exploration of language practices, particularly code-switching and language choice, within doctor–patient interactions. However, the patterns found provide important information about language use and interactional tactics in multilingual clinical settings.

2.11 Recommendations

Building on the results and observations of the present study, several recommendations for future research and practice are proposed. Firstly, while the current research focused on multilingual practices in general healthcare contexts, future investigations could explore the dynamics of multilingualism within a specific medical specialty ,such as oncology, paediatrics, or emergency medicine, where emotional and linguistic demands are even higher. Additionally, studies could examine interprofessional communication between doctors, nurses, and

administrative staff, to uncover how language choice operates beyond doctor–patient consultations. Another promising area would involve patients with chronic illnesses, analysing how long-term treatment relationships influence patterns of code-switching and language accommodation over time. Methodologically, future research could benefit from incorporating ethnographic longitudinal designs to capture changes in language use across multiple consultations. Finally, greater attention could be given to the impact of health literacy levels on language negotiation, exploring how patients' ability to understand medical discourse shapes communicative strategies and outcomes.

2.12 Conclusion

This chapter presented the methodological framework and analytical strategies employed to investigate language choice patterns and code-switching in Algerian healthcare settings. Through a qualitative approach, supported by observation, interviews, and focus group discussions, rich linguistic and interactional data were collected. Thematic analysis, supplemented by discourse analysis, enabled the identification of key communication behaviours and sociolinguistic practices shaping doctor–patient exchanges. Themes such as language accommodation, repetition for clarification, and non-verbal cues for adaptation emerged as central to understanding multilingual communication dynamics in clinical encounters. Each theme was subsequently interpreted in light of relevant sociolinguistic literature, reinforcing the study's theoretical grounding and offering broader insights into how language reflects and constructs social relations in medical contexts. The findings highlighted the intricate balance between historical language hierarchies, professional identity, patient needs, and cultural expectations. Overall, this chapter laid the foundation for a deeper discussion of the implications of multilingual interaction in healthcare and set the stage for the forthcoming analysis of the broader sociocultural meanings behind the observed communicative patterns.

GENERAL CONCLUSION

General Conclusion

This research set out to explore the complex linguistic realities of healthcare communication within Algeria's multilingual environment. It aimed to shed light on how doctors and patients manage language choice, engage in code-switching, and negotiate meaning in clinical interactions. Through a qualitative lens, the investigation focused on uncovering the dynamic communicative strategies that emerge where Algerian Arabic, French, and occasionally Modern Standard Arabic intertwine in medical consultations.

The dissertation was structured across two major chapters. Chapter One provided the theoretical foundation, engaging critically with key sociolinguistic concepts such as multilingualism, diglossia, language choice, and code-switching. It contextualised the aforementioned phenomena within both the wider Arab world and Algeria specifically, drawing on major scholarly works to establish a nuanced framework for the study. In turn, Chapter Two presented the methodological approach and detailed the processes of data collection, analysis, and interpretation. By combining observation, semi-structured interviews, and focus group discussions, the research ensured a robust triangulation of perspectives and captured the everyday linguistic practices of healthcare providers and their patients.

The analysis revealed several important findings. Language choice in healthcare settings was shown to be highly adaptive, shaped by factors such as the patient's age, education level, emotional state, and perceived authority dynamics. Code-switching emerged as a flexible strategy serving multiple functions: ensuring comprehension, building rapport, reinforcing authority, and accommodating emotional needs. Moreover, non-verbal cues played a critical role in prompting doctors to shift codes when confusion or discomfort was detected. These results confirm the centrality of linguistic negotiation in clinical communication and highlight the sensitivity with which healthcare providers must navigate Algeria's multilingual landscape. Despite these hurdles, the study offers valuable insights into real-world language practices and contributes to the growing body of sociolinguistic research in healthcare contexts.

Importantly, this dissertation offers both theoretical and practical contributions. Theoretically, it enriches the understanding of how multilingualism operates in high-stakes environments., supporting the idea that code-switching is not merely linguistic fluctuation but a sophisticated

communicative tool. Practically, the findings have implications for medical training in Algeria, suggesting the need for heightened linguistic awareness and sensitivity among healthcare providers to ensure more equitable and effective patient care.

Looking ahead, future research could expand this study by adopting longitudinal ethnographic designs, examining specialised medical domains (such as psychiatry or paediatrics), or focusing on patient outcomes relative to language practices. Comparative studies across rural and urban contexts could also offer deeper insights into regional linguistic variations within Algerian healthcare settings. In conclusion, this study reaffirms that language is not a neutral conduit in healthcare; it is an active agent that shapes, enables, and sometimes constrains the healing process. In a society as richly multilingual as Algeria, understanding and respecting these communicative intricacies is not merely an academic pursuit it is a vital step towards more humane and effective healthcare delivery.

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APPENDICES

Appendix A

The Interview

Interview template

Applicant's name:
Interview date:
Position: Doctor either public/ private healthcare setting
Interviewer: Fatmi Dounia
Duration : 1h30

Language Choice in Doctor-Patient Interactions

1. How does the patient's age influence your choice of language during consultations?
2. Does the gender of the patient affect how you decide which language to use?
3. How do you adapt your language choice based on the patient's emotional state (e.g., anxious, calm, distressed)?
4. To what extent does the patient's social profile (e.g., job, educational background) impact your language choice?
5. How does the type of illness influence the language you use with patients?
6. Are your language choices different in normal consultations compared to emergency situations?

Code-Switching Strategies

7. Do you adjust your code-switching based on a patient's emotional state or level of distress?
8. How does the patient's social profile (e.g., job or education) influence your code-switching behavior?
9. Are there specific medical contexts (e.g., technical explanations or emergencies) where code-switching becomes more frequent or necessary?

Impact of Code-Switching on Communication

10. Have you encountered any misunderstandings due to code-switching, particularly with patients of different ages or social profiles?
11. Do patients in emotional distress respond differently to code-switching? How so?
12. How do emergency settings shape the effectiveness of code-switching in improving communication?

Additional Insights

13. Are there strategies you use to improve communication with patients in emergency settings or with different social profiles?
14. How could healthcare providers be better trained to manage multilingual communication in routine and emergency settings?

Translation into Arabic :

اختيار اللغة في تواصل الطبيب مع المريض

1. كيف يؤثر عمر المريض على اختيارك للغة أثناء الاستشارة؟
2. هل جنس المريض يؤثر على اختيارك للغة؟
3. كيف تتكيف مع اختيارك للغة بناءً على الحالة النفسية للمريض (مثل القلق، الهدوء، أو التوتر)؟
4. إلى أي مدى يؤثر المستوى الاجتماعي للمريض (مثل العمل أو المستوى التعليمي) على اختيارك للغة؟
5. كيف يؤثر نوع المرض على اختيارك للغة؟
6. هل تختلف اختياراتك للغة بين الاستشارات العادية والحالات الطارئة؟

استراتيجيات تغيير اللغة (Code-Switching)

7. هل تقوم بتغيير اللغة بشكل مختلف بناءً على الحالة النفسية أو مستوى توتر المريض؟
8. كيف يؤثر المستوى الاجتماعي للمريض (مثل العمل أو التعليم) على سلوكك في تغيير اللغة؟
9. هل هناك مواقف طبية محددة (مثل شرح الأمور التقنية أو الطوارئ) تجعل تغيير اللغة أكثر تكرارًا أو ضرورة؟

تأثير تغيير اللغة على التواصل

10. هل واجهت أي سوء تفاهم بسبب تغيير اللغة، خاصة مع مرضى مختلفي العمر أو المستويات الاجتماعية؟
11. كيف يتفاعل المرضى في حالة التوتر أو الضيق مع تغيير اللغة؟
12. كيف تؤثر الحالات الطارئة على فعالية تغيير اللغة لتحسين التواصل؟

أفكار إضافية

13. هل لديك استراتيجيات لتحسين التواصل مع المرضى في الحالات الطارئة أو من خلفيات اجتماعية مختلفة؟
14. كيف يمكن تحسين تدريب العاملين في الرعاية الصحية على إدارة التواصل متعدد اللغات في الاستشارات العادية والطوارئ؟

Appendix B

CONSULTATION OBSERVATION template

Observer:	Fatmi Dounia
Observation Date:	
Time:	
Location:	
Activity:	

Aspects Focused On:

• Code-switching

• Language choice patterns

ANTECEDENT	BEHAVIOR	CONSEQUENCE

Appendix C

Focus group disscussion

التركيز مجموعات مناقشة أسئلة

ةيفطاعلا ةلاحلا لوح ةلئسأ:

؟اذاملو ؟ةيمسر ةغلب مأ ةحضاوو ةطيسب ةغلب كعم بيبطلا ثدحتي نأ لضفت له ،اًفئاخ وأ اًقلق نوكت امدنع

؟كتلاح حرش ءانثأ كنم اًبرق َبرقأ نوكيل هتغل بيبطلا ريغ امدنع ربكأ ةحارب ترعش نأ قبس له

ةيضرملا ةلاحلا بسح ةلئسأ:

نع رظنلا ضغب ،كل ةبسنلاب ةموهفم ةقيرطب جلاعلا ةطخ بيبطلا حرشي له ،نمزم ضرم نم يناعت تنك اذإ

؟اهمدختسي يتلا ةغللا

داز وأ ءودهلاب روعشلا ىلع كدعاس تاغللا نيب بيبطلا طلخ نأ ترعش له ،ةئراط ةيبط ةلاح نم يناعت تنك اذإ

؟ككابترا نم

ةيعامتجلاا ةيفلخلا ىلع ًءانب ةلئسأ:

نأ اًنايحأ رعشت مأ ؟كميلعت وأ ةيعامتجلاا كتلاح بسانت يتلا ةغللا نومهفي ةيحصلا ةياعرلا يمدقم نأ دقتعت له

؟ةحضاو ريغ وأ ةدقعم نوكت دق ةمدختسملا تاملكلا

؟ةيعامتجلاا كتئيب بسانت بيبطلا ةغل نأ دقتعت له ،ةنيدم نم وأ ةيفير ةيفلخ نم تنك اذإ .

:ةيبطلا ةراشتسلاا ءانثأ ةغللا لوح ةلئسأ

؟ترعش فيك ،كلذك نكي مل اذإ ؟اهلضفت يتلا ةغللاب كعم ثدحت له ،ةرم رخآ بيبطلا ترز امدنع .

ةبوعص تهجاو مأ ؟كتلاح نع هلاق ام لك تمهف له ،ةيغيزاملأا وأ ةيسنرفلاو ةيبرعلا نيب طلخي بيبطلا ناك اذإ .

؟مهفلا يف

لكشب مهفلا ىلع كدعاسيس كلذ نأ ترعش كنلأ ةددحم ةغلب ثدحتلا ضرمملا وأ بيبطلا نم تبلط نأ قبس له .

؟لضفأ

ةيرمعلا ةئفلا بسح ةلئسأ:

كجعزي له ،اًنس رغصأ تنك اذإو ؟ةحضاوو ةدحاو ةغلب بيبطلا ثدحتي نأ لضفت له ،نسلا رابك نم تنك اذإ

؟تاغللا نم جيزم مادختسا كحيري وأ

؟اذاملو ؟ةيمسر ةغل وأ ةثيدح ةغلب ةيبطلا روملأا حرشُت نأ لضفت له :بابشلل ةبسنلاب

لصاوتلا نيسحتل تاحارتقا:

،بولسلأا وأ ةغللا ةيحان نم ءاوس ،ىضرملا عم ءابطلأا ثيدح ةقيرط يف دحاو رييغت حارتقا كناكمإب ناك اذإ

؟نوكيس اذام

؟اًديفم نوكي اًنايحأ تاغللا طلخ نأ مأ لضفأ ةراشتسلاا للاخ ةدحاو ةغل مادختسا نأ ىرت له

Appendix D

Autorisation documents for field investigation

الجمهورية الجزائرية الديمقراطية الشعبية
وزارة الصـــحـــة

و لا يـــــــــة تلمســـان
المؤسسة العمومية للصحة الجوارية تلمسـان
رقم :94... /م.ف.م.ص/2025

مـقـــــرر

إنّ مـديـر المؤسسة العمومية للصحة الجوارية تلمسـان.

* بمقتضى الأمر رقم:06-03 المؤرخ في :15 يوليو 2006 و المتضمن القانون الأساسي العام للوظيفة العمومية؛
* و بمقتضى المرسوم التنفيذي رقم:90 -99 المؤرّخ في 1990.03.27 المتعلق بسلطة التعين،التسير الاداري لموظفي و اعوان الادارات المركزية،الولايات،البلديات و المؤسسات العمومية ذات الطابع الاداري،
* بمقتضى المرسوم التنفيذي رقم 11-357 المؤرخ في 17اكتوبر 2011 المعدل و المتمم للمرسوم التنفيذي رقم 07-140 المؤرخ في 2007.05.19 المتضمن انشاء المؤسسات العمومية الاستشفائية و المؤسسات العمومية للصحة الجوارية ،تنظيمها و سيرها.
* و بمقتضى المرسوم التنفيذي رقم :09-240 المؤرّخ في 2009.07.22 المتضمن القانون الاساسي الخاص بالموظفين المنتمين لأسلاك النفسانيين للصحة العمومية.
* تبعا لطلب المعنية بالأمر بتاريخ 2025/02/10

وباقتراح من السيدة المديرة الفرعية للمصالح الصحية

يـــقـــرر

المادة الأولى : يعين السيـــد(ة) الآنسة : **فاطمي دنيا .**
بصـــفتـــه (ـها) **لانجاز أطروحة الماستر السنة الثانية تخصص علم لسانيات اللغة (متربصة)**
ابتـــداء من : **2025/02/11 إلى 2025/02/19**
بمـصـلـــة **بالعيادة المتعددة الخدمات أبو تشفين .**

الـــمـادة 02: يكلف كل من السيد ة المديرة الفرعية للمصالح الصحية و رئيس المصلحة بتنفيذ ما جاء في هذا المقرر.

نسخة مخصصة لـ :

***رئيس المصلحة**
***المعني بالامر**
***الارشيف**

10 فيفري 2025
تلمسان في :.....
المديرة الفرعية للمصالح الصحية

الجمهورية الجزائرية الديمقراطية الشعبية
وزارة التعليم العالي والبحث العلمي
جامعة أبو بكر بلقايد تلمسان
كلية اللغات الأجنبية
قسم اللغة الإنجليزية

إلى السيد مدير قاعة العلاج ايمامة المحترم

الموضوع :طلب ترخيص لإجراء بحث علمي

تحية طيبة وبعد،

يشرفني أنا الطالبة الباحثة فاطمي دنيا ، المسجلة في السنة الثانية ماستر تخصص علم لسانيات اللغة، بجامعة أبو بكر بلقايد تلمسان، تحت إشراف الأستاذة فركاش سارة منال، أن أتقدم إلى سيادتكم بطلب ترخيص لإجراء دراسة ميدانية داخل مؤسستكم الصحية.

تهدف هذه الدراسة إلى البحث في موضوع: **"أنماط اختيار اللغة في التفاعل بين المرضى والأطباء في المؤسسات الصحية الجزائرية"**. يركز البحث على تحليل استخدام اللغات المختلفة (العربية، الفرنسية، واللهجة الجزائرية) وأثرها على جودة التواصل بين الأطراف المعنية.

أرجو من سيادتكم السماح لي بالدخول إلى المرافق الصحية التابعة للمؤسسة، وإجراء مقابلات ميدانية مع الأطباء والمرضى خلال الفترة الممتدة من 2024/12/10 الى غاية 2025/02/20 ، مع التعهد بالالتزام بكافة القوانين التنظيمية المعمول بها واحترام أخلاقيات البحث العلمي، بما في ذلك الحفاظ على سرية المعلومات وخصوصية المرضى.

وأحيطكم علمًا بأن رئيس قسم اللغة الإنجليزية بجامعة أبو بكر بلقايد تلمسان قد أطلع على هذا الطلب وصدّق عليه مع ختمه، لتأكيد معرفته وإشراف القسم على هذا البحث.

وفي انتظار ردكم الكريم، تقبلوا منا فائق الاحترام والتقدير.

إمضاء رئيس القسم:

Mme F.Z DIB Née DJAFOUR
Médecin Coordinatrice
Sous Secteur Kiffane

Avis favorable
pour séjour le 29/12/2024
au 31/12/2025.

السيد فريد داودي
رئيس قسم اللغة الإنجليزية
جامعة أبو بكر بلقايد تلمسان

إمضاء المشرفة:

السيدة فركاش سارة منال
مشرفة البحث العلمي

التاريخ: 14-12-2024

الجمهورية الجزائرية الديمقراطية الشعبية
وزارة التعليم العالي والبحث العلمي
جامعة أبو بكر بلقايد تلمسان
كلية اللغات الأجنبية
قسم اللغة الإنجليزية

إلى رئيسة وحدة الكشف و المتابعة (أبو تشفين) السيدة زناقي سمية

الموضوع :طلب ترخيص لإجراء بحث علمي

تحية طيبة وبعد،

يشرفني أنا الطالبة الباحثة فاطمي دنيا ، المسجلة في السنة الثانية ماستر تخصص علم لسانيات اللغة، بجامعة أبو بكر بلقايد تلمسان، تحت إشراف الأستاذة فركاش سارة منال، أن أتقدم إلى سيادتكم بطلب ترخيص لإجراء دراسة ميدانية داخل مؤسستكم الصحية.

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وفي انتظار ردكم الكريم، تقبلوا منا فائق الاحترام والتقدير.

إمضاء رئيس القسم:

جامعة ابي بكر بلقايد تلمسان
قسم اللغة الانجليزية
كلية الآداب واللغات

السيد فريد داودي
رئيس قسم اللغة الإنجليزية
جامعة أبو بكر بلقايد تلمسان

إمضاء المشرفة:

السيدة فركاش سارة منال
مشرفة البحث العلمي

التاريخ: 04-02-2025

Appendix E
Participant Information sheet

الجمهورية الجزائرية الديمقراطية الشعبية
وزارة التعليم العالي والبحث العلمي
جامعة أبو بكر بلقايد تلمسان
كلية اللغات الأجنبية
قسم اللغة الإنجليزية

Participant Information sheet

عنوان الدراسة: أنماط اختيار اللغة والتبديل اللغوي في مؤسسات الرعاية الصحية الجزائرية

اسم الباحثة: فاطمي دنيا
الجامعة: جامعة تلمسان أبو بكر بلقايد

مقدمة عن الدراسة:
في الجزائر، يعكس نظام الرعاية الصحية البيئة اللغوية المتعددة في البلاد، حيث يتنقل المرضى ومقدمو الرعاية الصحية بين العربية، الفرنسية، الأمازيغية، واللهجات المحلية. تسعى هذه الدراسة إلى استكشاف كيفية اختيار مقدمي الرعاية الصحية للغات واستخدامهم للتبديل اللغوي كوسيلة للتواصل. سيتم فحص أنماط اختيار اللغة واستراتيجيات التبديل اللغوي لتقييم فعاليتها في التغلب على حواجز التواصل وتعزيز الرعاية التي تركز على المريض.

الغرض من الدراسة:
تهدف الدراسة إلى:

1. استكشاف الأسباب التي تجعل مقدمي الرعاية الصحية يعتمدون على أنماط لغوية واستراتيجيات تبديل لغوي معينة أثناء الاستشارات الطبية.
2. وصف أنماط اختيار اللغة واستراتيجيات التبديل اللغوي الشائعة في المستشفيات الجزائرية
3. دراسة العوامل المؤثرة على قرارات مقدمي الرعاية الصحية بالتبديل بين اللغات أثناء الاستشارات.
4. تحليل تأثير التبديل اللغوي على جودة التواصل بين مقدمي الرعاية الصحية والمرضى.

ما الذي يتطلبه الأمر من المشاركين؟

- إذا وافقت على المشاركة في هذه الدراسة، سنطلب منك:
- السماح بملاحظتك أثناء الاستشارات الطبية.
- المشاركة في مقابلة شبه مُنظمة (قد يتم تسجيلها صوتياً بموافقتك).

حقوقك كمشارك:

- مشاركتك اختيارية تماماً، ويحق لك الانسحاب في أي وقت دون تقديم أي تفسير.
- سيتم التعامل مع جميع المعلومات التي تشاركها بسرية تامة ولن تُستخدم إلا لأغراض أكاديمية.
- ستُعرض النتائج بشكل مجهول الهوية، ولن تُكشف أي معلومات تحدد هويتك.

كيفية استخدام البيانات:

- سيتم استخدام البيانات المُجمعة لتحليل الأنماط اللغوية والتبديل اللغوي.
- قد تُعرض النتائج في مؤتمرات أو تُنشر في دراسات أكاديمية، مع ضمان الحفاظ على سرية المشاركين.

Appendix F
Consent form

الجمهورية الجزائرية الديمقراطية الشعبية
وزارة التعليم العالي والبحث العلمي
جامعة أبو بكر بلقايد تلمسان
كلية اللغات الأجنبية
قسم اللغة الإنجليزية

اذن اجراء المقابلة

عنوان الدراسة: أنماط اختيار اللغة والتبديل اللغوي في المجال الصحي الجزائري

اسم الباحث: فا طمي دنيا

1. أؤكد أنني قرأت وفهمت ورقة المعلومات المؤرخة في (يُدرج التاريخ) الخاصة بالدراسة المذكورة أعلاه. لقد أتيحت لي الفرصة للنظر في المعلومات، وطرح الأسئلة، والحصول على إجابات مرضية.
2. أدرك أن مشاركتي طوعية وأنه يحق لي الانسحاب في أي وقت دون إبداء أي سبب.
3. أدرك أن البيانات التي سيتم جمعها خلال هذه الدراسة قد يُطلب الاطلاع عليها من قبل السلطات التنظيمية. أمنح إذني لأي سلطة لديها الحق القانوني في الاطلاع على البيانات التي قد تحدد هويتي. سيتم احترام جميع وعود السرية التي يقدمها الباحث.
4. أدرك أن نتائج هذه الدراسة قد يتم نشرها و/أو تقديمها في اجتماعات أو مؤتمرات أكاديمية. أمنح إذني بنشر بياناتي المجهلة التي لا تكشف هويتي بهذه الطريقة.
5. أوافق على تسجيل المقابلة صوتيًا. سيتم تفريغ التسجيل وتحليله لأغراض البحث.
6. أوافق على استخدام اقتباسات حرفية في المنشورات؛ لن يتم ذكر اسمي ولكنني أدرك أن هناك خطر التعرف على هويتي.
7. أوافق على المشاركة في الدراسة المذكورة أعلاه.

اسم المشارك.....

التاريخ.....

التوقيع.....

اسم الشخص الآخذ للموافقة.....

التاريخ.....

التوقيع.....

Abstract:

This study examines how healthcare providers in Algerian hospitals manage multilingual communication, focusing on language choice and code-switching during patient consultations. Using qualitative methods, observations, interviews, and focus groups, conducted in Tlemcen's public and private healthcare settings, the research shows that doctors shift between Algerian Arabic and French depending on patient needs, emotional context, and clinical demands. Code-switching helps improve clarity, empathy, and authority. Patient cues play a major role in shaping doctors' language strategies. The study underscores the importance of linguistic sensitivity in delivering effective, patient-centered care in Algeria's multilingual healthcare environment.

Key words: Multilingualism, Code-switching, Healthcare communication, Algeria

Resumé:

Cette étude explore comment les médecins dans les hôpitaux algériens, notamment à Tlemcen, gèrent le multilinguisme lors des consultations. En alternant entre l'arabe algérien et le français, les praticiens adaptent leur langage selon les besoins et réactions des patients. Le code-switching permet d'améliorer la clarté, l'empathie et l'autorité professionnelle. Les résultats soulignent l'importance de la sensibilité linguistique pour une communication médicale efficace et centrée sur le patient.

Mots clés : Multilinguisme, Code-switching, Communication médicale, Algérie

ملخص:

تُسلّط هذه الدراسة الضوء على الممارسات اللغوية للأطباء في المؤسسات الصحية الجزائرية، مع التركيز على آليات اختيار اللغة وظاهرة التناوب اللغوي أثناء التفاعل مع المرضى. من خلال مقاربة نوعية أُجريت في مستشفيات وعيادات بمدينة تلمسان، تبيّن أن اختيار اللغة ليس عشوائيًا، بل يتحدد حسب راحة المريض اللغوية، وسياق التفاعل، والمؤشرات الانفعالية. يُؤدي التناوب بين العربية الجزائرية والفرنسية وظائف تواصلية متعددة، كتعزيز الفهم، وتيسير التعاطف، وتأكيد السلطة المهنية. وتؤكد النتائج على أهمية الوعي اللغوي في تحسين جودة الرعاية الطبية في بيئة متعددة اللغات.

الكلمات المفتاحية: التعدد اللغوي ,التناوب اللغوي , التواصل الطبي ,الجزائر