"You understand this one?"
"You're very clear on this one?"

Pharmacist's use of rephrasals to communicate
across cultural and language barriers in a
South African antiretroviral clinic.

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Masterthesis Communication Studies

Utrecht University, the Netherlands
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Abstract

This study provides an in-depth analysis of the use of rephrasals and their interactional functions in pharmacist-patient interactions in a South African HIV/Aids context. Eighteen video recorded interactions were analysed using conversation analysis. By distinguishing between different categories of repetition and focusing on the use of rephrasals in one type of repetition (pharmacist's self-repetition), it was shown that rephrasals perform different interactional work. *Contingent rephrasals* solve interactional trouble in the interaction, for example by recovering a mistake or solving problems in understanding. *Contextual rephrasals* do not solve interactional trouble; in stead, I argue that this type of rephrasal is an interactional way to make the multilingual and multicultural contexts relevant. More specifically, two aspects of the context were made relevant by the contextual rephrasals: communication across language barriers and answering out of politeness. In conclusion, this study shows how conversation analysis can be used to analyse conversations in a complex context as the one in this study, showing not only *that* the context influences the conversation, but also *which parts* of the context influence the conversation.

Keywords:
Pharmacist-patient interactions – HIV/Aids – Conversation Analysis – Repetition - Rephrasing

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Preface

When I started doing my Master's degree in Communication Studies at Utrecht University, I was looking forward to learning about all the things this degree had to offer: learning new theories and research strategies, putting my knowledge into practice in solving communication problems, and doing an internship. However, there was one thing that I was absolutely not looking forward to, and that was to writing my MA thesis. Now, eight months later, I have made a fantastic trip to South Africa, had the chance to live and study in Johannesburg for two months and even had the chance to meet new people, travel around and finish a thesis that I am very proud of.

When I started orienting towards a thesis subject in September, I initially started working on emergency phone call conversations. I had been working on that subject before and it seemed like an interesting project to further investigate in my thesis. However, as the weeks passed by, I still hadn't found a suitable research question. As I was slightly starting to panic, I suddenly realised that my supervisor has been working with people at the University of the Witwatersrand in South Africa on a very interesting research project. After asking him about it, he contacted the professor and PhD researchers responsible for the project, and before I knew it, I was on my way to Johannesburg writing my thesis on pharmacist-patient interactions in a South African HIV/Aids clinic.

Looking back, living and studying in Johannesburg has been a great experience that I will cherish for the rest of my life. Living there wasn't always easy, but despite the setbacks I had, I have also learned a lot about myself, about participating in a great research project and about South Africa as a country. Claire Penn and Jennifer Watermeyer's Health Communication project is a very special and important project, aiming to make health care accessible to everyone, overcoming linguistic and cultural barriers. Although Claire and Jenny are attending conferences all over the world to talk about their project, they certainly do not get the recognition they deserve. It has been an honor to work with such skilled and committed academics, and hopefully we will be able to publish this thesis.

Contents

1. Introduction

By the end of 2010, an estimated 34 million people were living with HIV worldwide; an increase of 17% since 2001. Of all these people, a majority of 68% live in sub-Saharan Africa. In South Africa the epidemic happens to be the most severe, with more people living with HIV (an estimated 5.6 million) than any other country in the world (UNAIDS, 2011).

When infected with HIV, patients will never be cured of this disease. The virus can only be suppressed using Anti Retrovirals (ARV's) [1] that have to be taken twice a day at strict set times. Standard Anti Retroviral Treatment (ART) consists of the use of at least three ARV's to maximally suppress the HIV virus and to allow the immune system to recover (World Health Organisation, 2011). When given in combination, this treatment is also known as Highly Active Anti Retroviral Treatment (HAART). For years, the South African government did not provide enough HAART to Aids patients because of a lack of political will (Nattrass, 2006), but changed their policy from 2003 onwards, making HAART available for more people. Now more people in South Africa receive HAART, but still less than needed.

Because ARV's work as antibiotics to fight the HIV virus, they have to be taken every twelve hours. When starting the treatment, patients have to choose the times they want to take the ARV's and take them twice a day at this time for the rest of their lives. The patient's adherence level has to be 80-95% in order to prevent the virus from becoming immune (Watermeyer, 2008). Therefore, clear instructions and full understanding by the patient are essential in order for the treatment to succeed (Penn et al, 2011). However, when providing instructions to the patient, South African pharmacists are facing some challenges.

South Africa has a strong multilingual heritage (Watermeyer & Penn, 2009a). English and Afrikaans exist, as national languages, next to nine other official African languages such as Xhosa or Setswana. Public interactions such as healthcare encounters are, for the most part, conducted in English or Afrikaans. In ART instructions, the pharmacist and patient speak English while patients often only speak an African language. The patient having poor knowledge of English or Afrikaans, and the pharmacist having poor knowledge of the other African languages, makes it hard for both parties to achieve mutual understanding in the use of ARV's. Research has shown that such language barriers cause trouble in adherence (Murphy et al, 2003) and cause patient dissatisfaction (David, 1998). Cross-linguistic communication is therefore a very important skill for South African health care professionals (Watermeyer & Penn, 2009a).

Considering the fact that health care professionals have to deliver a complex instruction while facing cross-linguistic challenges, it would be expected that they will be provided with information, instructions, or training on how to do this. However, it appears that this is not available. The FIP International Network for Pharmacists on HIV/Aids (2004) provides information on different means to communicate (such as attending or organizing information meetings), and information on the tools a pharmacist can use to instruct the patient (such as posters or leaflets), but no information on how to perform the actual communication itself. Other research shows that education for medical professionals "remains predominantly science-based and generally does not include communication or counselling modules" (Watermeyer, 2008).

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[1] This paper contains abbreviations and words that might be unfamiliar to non-South African readers. For a list of abbreviations used in this study, I would like to refer to Appendix 1. For a list of key words and their definitions, I would like to refer to Appendix 2.

Because of the lack of information on cross-linguistic communication, research is needed to see how health care professionals are dealing with the challenges I have just mentioned. How do they communicate, and which strategies do they use to deliver instructions and verify understanding in multilingual constellations?

Watermeyer (2008) recorded and transcribed 26 interactions between pharmacists and patients in an HIV/Aids clinic in South Africa, in which the patients received information on ART and instructions on how to use ARV's. The results of this study have been published by Watermeyer & Penn (2009a, 2009b, 2009c) and Penn et al (2011), and will be discussed in more detail in the 'theoretical background' section (section 2). Important for this study is that the researchers have shown that pharmacists use different strategies to verify understanding of dosage instructions (Watermeyer & Penn, 2009a). Pharmacists also use repetition when checking understanding (Watermeyer & Penn 2009b), but in their 2009a study, Watermeyer & Penn have not investigated this phenomenon further. This result surprised me; when communicating in a cross-linguistic context, repetitions seem to me to provide the perfect strategy to improve comprehension of instructions and to make sure the patient understands. This idea is confirmed by Seidlhofer in her study on lingua franca communication, who states that "[o]ne obvious way of making what one says more accessible is to repeat, or to paraphrase, or a combination of the two." (Seidlhofer, 2011: 99)

Because (1) instruction and verification of understanding form the most important part of the pharmacist-patient interactions, (2) repetition occurs in this part of the conversation, and (3) despite the fact that it might have an important function, the use of repetitions has never been further investigated. In view of this, I decided to analyse Watermeyer's (2008) research material again in this study in order to find out why a pharmacist repeats her utterances and what interactional work she performs by doing this. Interactional work is a concept used in conversation analysis, and means acting with language to achieve something in reality, such as achieving comprehension or confirming something.

As I will show in the results section, it turned out that studying the interactional work that was being done by 'repetition' in general was too broad and extensive to research, especially when it turned out that there are different types of repetition each performing different interactional work as well. In order to provide the in-depth analysis that I aimed for in this study, it was necessary to choose between one of these different types of repetition and to further investigate this type in this study. Because rephrasals occurred a lot in the research data and because they seemed to fulfil many different interactional functions, it seemed that this type of repetition would be the most interesting to further investigate. This paper will therefore provide an in-depth analysis of the use of rephrasals in pharmacist-patient interactions in a South African HIV/Aids context, using Watermeyer's (2008) research material, answering the following research question:

What interactional work is being performed by rephrasals when used by a pharmacist in interaction with a patient in a South African HIV/Aids clinic?

In order to answer the research question above, the data will be analysed using conversation analysis. Important to mention is that this study's starting point is that it is not a *given fact* that the interactional behaviour by the participants is caused by the multilingual and multicultural context in which the interactions take place. By performing a bottom-up analysis using conversation analysis, I aim to find out *if* and *how* the external context is relevant in the interactions. By doing a top-down analysis in the end, explaining the results in light of the external context, I am aiming to avoid the pitfall of the minimum object and the pitfall of the maximum interpretation (Koole & ten Thije, 1994: see section 3).

The structure of this paper is as follows. In section 2, I will provide more information on the literature on medical communication and pharmacist-patient interactions. I will also describe the work of Watermeyer & Penn in more detail and present an overview of the literature on repetition, leading to additional research questions. In section 3, I will explain how this study relates to Watermeyer's study (2008) and how the use of rephrasals has been analysed using conversation analysis. In section 4, I will show which categories of repetition I have found in Watermeyer's pharmacist-patient interactions and how the pharmacist uses rephrasals to perform interactional work. In section 5 I will discuss the results and in section 6, this study's conclusions are presented.

2. Theoretical background

2.1 Introduction, definitions and context

In this study, I use the term cross-linguistic communication to refer to the fact that the pharmacist and patient both do not speak their first language when interacting with each other. They speak English and do not understand each other's first language, which means that they use English as a Lingua Franca (ELF, see Seidlhofer, 2011) to communicate. As I briefly mentioned in the introduction, and will discuss in more detail later in this section, the pharmacist and patient have to deal with cross-linguistic barriers, meaning "the often-encountered lack of language understanding between doctors and patients belonging to different ethnic/cultural groups" (Schouten & Meeuwesen, 2006: 22). The level of English (speaking and understanding) of the patients is mostly 'ok' (see section 3), meaning that the patients are able to speak and understand a little English, but not enough to communicate fluently. The pharmacist's English is much better in comparison, and therefore the conversations could also be compared to (literature on) conversations between native/non-native speakers, in which the pharmacist can be seen as the native speaker and the patient as the non-native speaker.

An important difference between ELF and native/non-native conversations is that in ELF conversations, none of the participants has the spoken language as a first language, while in native/non-native (N/NN) interactions, at least one of the participants does have the spoken language as a first language. However, both contexts require effort from both participants to ensure mutual understanding. In ELF, Seidlhofer (2011) argues that the most important thing is that both participants understand each other, and if that means that the use of English is not entirely correct, the participants take that for granted. In N/NN interactions this is a little more complicated; in these conversations, an asymmetry exists in which both native an non-native speaker are aware of the superiority (language wise) of the native speaker (Ciliberti, 1996).

This chapter will contain an overview of some[2] literature on medical communication, pharmacist-patient communication (PH-PA communication), HIV counselling, PH-PA conversations in an HIV/Aids context and repetition in these (and other relevant) contexts. First I will discuss medical communication (in an HIV/Aids context) and PH-PA conversations. Then, I will pay special attention to Watermeyer & Penn's (2009a, 2009b, 2009c) and Penn et al's (2011) work on PH-PA conversations in an HIV/Aids context and on the verification of information in these contexts. Lastly, I will discuss some literature on repetition, and will show which research questions were raised by the literature in this section.

2.2 Research in medical communication

For years, research into medical care has focused mainly on the quality of medical care in stead of on the interaction between physician and patient (Chapple 2002, Roter & Hall 2006). Only within the last thirty years has research started to focus on the interactions between physician and patient, recognising the significance of communication in the interaction.

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[2] I am aware of the fact that the amount of literature on medical communication comprises much more than I have mentioned in this study. The literature presented in this section is therefore an overview of work that I think describes best what factors are relevant in medical and pharmacist-patient interactions and of these interactions in an HIV/Aids setting.

The significance of talk

In medical care there are two fundamental ingredients that form the heart of the interaction: talk and expert knowledge (Roter & Hall, 2006). Talk - meaning both the verbal and non-verbal communication between doctor and patient - fulfils a central role in the conversation, since it is the main activity that the doctor and patient perform. With expert knowledge, Roter & Hall (2006) refer to information that both patient and physician have in their own field of knowledge. The patient is an expert in relation to his own complaints, beliefs, medical history and for example his cultural beliefs; the physician is expert in how to recognise, treat and cure diseases. In treating a patient, talk is an essential instrument in successfully exchanging the expert knowledge of both parties.

Research by Silverman (1997) and Peräkylä (1995) has shown that in HIV/Aids counselling, 'talk' consists of asking questions and making informative and advisory statements. The counsellor spends most of the time asking questions and making informative and advisory statements, while the patient spends most of the time answering questions and listening to the counsellor's information and advice (Peräkylä 1995). In this way, interactional roles arise from each participant as questioner, answerer, speaker or recipient. Peräkylä (1995) showed that in medical HIV/Aids counselling two formats dominate: the interview format, in which the counsellor is the questioner and the patient the answerer, and the information delivery format, in which the counsellor is the speaker and the patient the hearer.

Asymmetry in medical interactions

Because of the nature of the conversation, in which the counsellor is taking care of 80% of the talk and structuring the interaction, the conversation is structured asymmetrically (Peräkylä 1995, Silverman 1997, Pilnick 1998 and 2011). Peräkylä (1995) mentions that in normal institutional conversations, the unequal distribution of turns is set up by a set of norms and rules that are implicitly present in the conversation, and known of by both participants. However, in HIV/Aids counselling conversations, there are no norms or rules that would prescribe that only the counsellor may ask questions and make statements during the counselling session. Still, the conversation is organised asymmetrically: this creates a paradox.

The paradox can be explained by the fact that in HIV/Aids counselling conversations, patient and counsellor each have different tasks, causing each of them to contribute to the conversation in another way. The patient's task is to listen and to answer questions; the counsellor's task is to explore the patient's feelings, beliefs and perceptions, to advise and to provide information. Performing the different tasks requires different interactional behaviour from both participants. In order to listen carefully, a passive and responsive attitude is required from the patient; in order to find out the patient's beliefs, feelings and perceptions, and to provide them with the right information and advice, an active and talkative attitude is required from the counsellor.

Challenges in medical communication

Even though counsellor and patient collaborate in enabling each other to perform their tasks within the agreed format, the successful exchange of expert knowledge still remains a difficult task. Britten et al (2000) found that in a group of 20 GP's and 35 patients, misunderstanding occurred among 4 out of 5 patients. For the most part, this was caused by the fact that the patient and/or doctor was unaware of certain parts of the other person's expert knowledge (e.g. if the patient did not tell all the complaints, the doctor made assumptions, or the doctor did not provide all the information needed), causing misunderstandings, insecurity or problems in adherence.

Next to this, the nature of the doctor-patient interaction may also contribute to misunderstandings. Doctors generally have more power than patients to structure and organise the interaction (Charles et al, 2000). In HIV/Aids counselling conversations, interactional organisation by the counsellor is a necessary means, since the counsellor has a huge agenda with (delicate) topics that have to be covered; it is therefore easier if the counsellor is in control of the agenda (Silverman, 1997). However, the difference in power relations that is being created in this way may - on the other hand - cause patients to feel that their voice is overridden, which makes them more passive in the conversation, leading to misunderstandings and eventually even to non-adherence to the medications (Britten et al, 2000). Because most of the interaction is routine and scripted, most of the talk that is being exchanged is taken for granted, causing parts of the talk (mostly the non-verbal parts) to remain unnoticed by the doctor, leading to miscommunication as well (Roter & Hall, 2006).

2.3 Research in pharmacist-patient communication

In studying pharmacist-patient communication, Alison Pilnick (1997, 1998, 2001, 2003, 2011) has performed research in an oncology clinic in the UK, providing a good addition to the existing curriculum of literature in medical communication. In her 2001 article, Pilnick discusses the structure of pharmacist conversations, as compared to other institutional conversations such as troubles talk (Jefferson, 1988) and emergency phone call conversations (Zimmerman, 1992).

By presenting a structure for pharmacist-patient interactions and comparing this to structures in troubles talk and emergency phone call conversations as presented by Jefferson and Zimmerman, Pilnick shows that in institutional conversations, participants each have different goals when entering the conversation. In some institutional conversations, such as Zimmerman's emergency phone call conversations, the goals of each participant are clear. The caller needs an ambulance, the police or the fire department, and the operator needs to find out where the caller is, and what has happened. In other institutional conversations such as pharmacist-patient conversations, the goals of the participants may be less clear, due to many reasons such as cultural differences, assumptions or expectations. By proper communication and successful exchange of talk, the goals of each participant will become clear and the conversation will be a success. Pilnick mentions that in some institutional conversations, this requires more effort than in other institutional conversations, because it is not always clear which goals each participant has.

In her 2003 study, Pilnick distinguished between four different approaches to the delivery of counselling sequences. The fact that pharmacists use different approaches in different situations shows that dealing with and approaching patients is complicated and that different aspects influence the conversation. For example, Pilnick showed that interactional contingencies exist when patients are approached in a way that does not correspond to their (acquired) knowledge. Expectations and assumptions considering patient's knowledge cause some aspects of the conversation to become delicate subjects. Next to this, Pilnick found a frequent use of pre-sequences (sequences in interactions that can be seen as a 'preparation' for the actual topic that has to be discussed) in her pharmacist-patient conversations. She speculates that this extended use is caused by a role extension of the pharmacist, of which the patient is unaware. Traditionally, the patient has an idea of the pharmacist as a 'glorified shopkeeper', but nowadays, this role has extended and a more advisory role can be expected from the pharmacist. Patients or carers may not expect extended advising or informing sequences from pharmacists, so by using pre-sequence type formulations (announcements and offers), the pharmacist found a way to deal with possible resistance by the patient.

2.4 Pharmacist-patient conversations in an HIV/Aids context

Jennifer Watermeyer and Claire Penn have done ground breaking research in studying pharmacist-patient conversations in an HIV/Aids context in South Africa. In her (unpublished) PhD study, Watermeyer (2008) has studied 26 recorded conversations between pharmacists and HIV positive patients in an HIV/Aids clinic in South Africa, providing a very important addition to the existing curriculum of literature on pharmacist-patient interactions, adding the context of a complex treatment in a multicultural, multilinguistic environment. The results of her study show that pharmacist-patient interactions can be successful, even when facing cultural or language barriers.

Watermeyer and Penn have published parts of Watermeyer's PhD study, each time focusing on one aspect of the pharmacist-patient interactions and describing this in detail. Publications have been made on the impact of context and culture on patient's adherence to the ART (Penn et al, 2011); pharmacist's strategies to verify patient's understanding (Penn & Watermeyer, 2009a); the way that the pharmacist-patient conversation in an HIV/Aids context is structured (Penn & Watermeyer, 2009b); and the strategies a pharmacist uses to successfully communicate dosage instructions (Penn & Watermeyer, 2009c).

The South African HIV/Aids pharmacist's challenges
When compared to pharmacists, counsellors or other medical health care professionals as described in the studies of Peräkylä (1995), Silverman (1997) and Pilnick (1997, 1998, 2001, 2003, 2011), it turns out that South African pharmacists have a complex task in instructing patients, because they have to provide complex medicine instructions while facing cultural and language barriers.

Pharmacists in South Africa have a big responsibility in instructing the patient. "Providing pharmaceutical services to a patient with HIV/Aids involves dispensing ARVs and other drugs, monitoring drug interactions and toxicities, optimising regimes, educating patients about HIV therapy and adherence, following up on management issues, and planning strategies to improve patient adherence. (…) Aside from these tasks, pharmacists are also expected to provide counselling and advice to patients; however, they are rarely trained in these skills." (Watermeyer & Penn 2009b, 2053-2054). Next to this, the pharmacist is under a huge pressure to deliver a comprehensible instruction; if the patient fails to adhere to the medicines, he will not survive.

South African HIV/Aids pharmacists are also facing language barriers (communication issues) that make the conversation more difficult. As mentioned in the introduction, the conversation is conducted in English, while both pharmacist and patient often do not have English as their first language. Pharmacists and patients use English as a Lingua Franca, which means that they need "(…) crucial adaptive accommodation skills along with appreciation and acceptance of diversity" (Cogo, 2009: 270 in Seidlhofer, 2011: 99). In other words: in order to communicate successfully, both pharmacist and patient need to be flexible and creative in achieving mutual understanding.

Most black South Africans do not speak English at all, which makes it very hard for the pharmacist to provide difficult instructions in a clear way, which are essential in enabling the patient to use the ARV's correctly. Interpreters are not always available and are also not preferred by pharmacists because of the chance of terminology issues and cultural differences in meaning (Watermeyer & Penn, 2009a). Also, communication issues are being caused by the difficult terminology that is linked to the disease (Watermeyer & Penn, 2009b).

Taking ARV's is a complex task; many different medicines have to be taken at strict set times. A high level of adherence is required for the treatment to succeed, and ARV's can cause severe side effects as well. Taking ARV's is therefore not a very pleasant task, and especially because of the severe side effects it is difficult for patients to maintain high adherence levels (Watermeyer & Penn 2009b). Explaining this complex matter and feeling the pressure to make the treatment a success both have an impact on the pharmacist, whilst having to deal with complicated medicines for the rest of their lives and enduring severe side effects has an impact on the patient. Other illness, drug and treatment factors that are mentioned in Watermeyer & Penn (2009b) that might influence the patient's adherence have to do with confusion caused by change and (political) unrest. Medicine packages, drug regiments and the place where the patients have to collect their medicines change over time, causing confusion; patients might be insecure about the efficacy of the treatment and political unrest and hospital strikes cause general unrest as well.

Finally, pharmacists are facing life, world and culture factors when instructing patients. Traditional beliefs about the illness, alternative treatment or stigma might influence the patient in successfully undergoing ART. Disclosure by family and friends may also happen, making it hard for the patient to adhere to the medicines and for the pharmacist to provide a successful treatment (Watermeyer & Penn 2009b).

Verification of understanding
In their article on comprehension, Watermeyer & Penn (2009a) have found that South African pharmacists use four strategies to check whether patients have understood instructions on taking ARV's. These strategies are (1) the use of response solicitations, (2) carefully monitoring the patient's responses, (3) asking the patients for a demonstration of understanding, and (4) asking specific questions. I will first explain more about these strategies individually, and then I will show which research questions were raised after reading Watermeyer & Penn's (2009a) article.

A first strategy that the pharmacist may use to verify understanding is to add 'ok?', 'isnt't it?' or 'nè?' (meaning 'ok?' or 'isn't it?' in Afrikaans) to the end of an utterance. By adding one of these items to the sentence, the pharmacist invites the patient to respond, which is a method for the pharmacist to check if the patient has understood what she has just said. Thereby, response solicitations can be used in order to prompt a response to the instruction or information that has just been provided, to check if the patient is following the information, or to invite the patient to ask for more explanation if some of the information is not understood.

A second strategy that pharmacists use to check if patients have understood their instruction is to carefully monitor the patient's responses. In interviews with the participating pharmacists in Watermeyer's (2008) study, the pharmacists mentioned that when dealing with patients in a cross cultural and cross linguistic context, a higher awareness of the patient's non-verbal behaviour is necessary to reveal subtle misunderstandings as well. By routinely verifying if the patient is still following the instruction and closely monitoring the question and answer sequences, the pharmacist is able to notice subtle misunderstandings and solve these as well.

A third strategy is a very common strategy used by the pharmacists. When the pharmacist asks the patient for a demonstration of understanding, she usually does this by using an open-ended request to "tell" or "show" the patient how to take the medicines. In this way, misunderstandings can be identified, and the pharmacist will provide a new explanation right away. This process of providing information and verifying understanding might be repeated several times, until the pharmacist is convinced or satisfied that the patient has understood the instructions.

Fourth, when verifying understanding of specific information, pharmacists also ask specific questions, such as "what time do you take the medicine?" or "how many pills do you take?" These questions are meant to check specific knowledge on one specific topic. If the patient is unable to give the right answer, the pharmacist will know immediately and will provide a new instruction right away.

Watermeyer & Penn state that asking for a demonstration of understanding is preferred over direct questions to find out if the patient understands. However, in their article, they mention that this request for a demonstration of understanding might be repeated several times. This phenomenon has until so far not been investigated any further. If a demonstration of understanding is indeed the best way to verify understanding, why does it have to be repeated several times? And, what is the function of repetition in this context? Before answering these questions by looking at the data, I will first say more about repetition in the literature.

2.5 Repetition in conversation

In describing the different purposes and functions of repetition in conversation, Deborah Tannen (2007) studied the use of repetition in social conversations (friends talking during a dinner party). She discovers that in these conversations, repetitions have different functions. For example, it enables the speaker to hold the floor while thinking about what to say next, it is a means to show appreciation of a good line or joke, or it can be used to include someone that did not hear the previous utterance(s). Repetition is also a good way of making the conversation less dense: when repeating something, no new information is added, giving the listener more time to process the information and is therefore also used as a means to improve comprehension.

Tannen (2007) mentions that there are different forms of repetition. First of all, there is the (obvious) difference between self-repetition and allo-repetition (other repetition). Next to this, she also distinguishes between how literally something is being repeated: the utterance can be repeated the exact same way (exact repetition), or, on the other end of the scale, can be paraphrased. Paraphrasing is the opposite of exact repetition, but is still referred to as a category of repetition by Tannen. Between exact repetition and paraphrasing, there are other forms of repetition to be distinguished as well, such as questions that are transformed into statements, repetition with a single word or phrase changed, or repetition with a change of person or tense.

In her definition of repetition, Tannen also includes patterned rhythm, "in which completely different words are uttered in the same syntactic and rhythmic paradigm as the preceding utterance" (Tannen 2007: 63). Tannen does not provide a clear definition of repetition and the distance between utterances: how far may the utterance and repeated utterance be separated from each other in the conversation, for it to be a repetition? The use of repetition by native and non-native speakers has been studied by Ciliberti (1996) in interactions between a native German speaker and a native Italian speaker who help each other learning their native language. The study provides interesting insights that are useful for this study as well. In both Ciliberti's study as well as in the pharmacist-patient interactions investigated in this study, language barriers have to be overcome, and participants are not equal language wise, creating difficulties that have to be dealt with in the conversation. Because the native speaker is much more capable of expressing himself through the language than the non-native speaker, the native speaker adopts a sort of 'natural didactic' towards the non-native speaker in order to help him to understand, but also to give him the opportunity to learn the language.

Repetition in native/non-native interactions

Ciliberti found that in native versus non-native speaker conversations, there are two types of repetition: comprehension-oriented repetition and production-oriented repetition. Comprehension-oriented repetition is repetition that is being used to improve comprehension, and is especially used by the native speaker by repeating the sentence while replacing a (difficult) word, or by re-structuring the sentence in a different way. Difficult words may also be replaced by words in the native speaker's mother tongue; when the native speaker predicts that a word is difficult for the non-native speaker, he might say the word in the non-native speaker's language and then repeat it in the native speaker's language (his own language). In the pharmacist-patient conversations investigated in this study, this phenomenon occurs a lot too, where the pharmacist (who is superior to the patient, language wise) repeats a difficult word or an important instruction in Setswana, the native language of the patient (Watermeyer, 2008).

Production-oriented repetition is a type of repetition that is used by both native and non-native speakers, with the main purpose of showing understanding and involvement. When the non-native speaker uses production-oriented repetition, he repeats the last words of the native speaker's utterance to show that he understood. Because this process can take several turns, a lot of utterances are produced; that is why this type of repetition is called production-oriented repetition. The native speaker, on the other hand, uses this type of repetition to correct the non-native speaker, or to confirm the correctness of the utterance when the non-native speaker is unsure about it.

Lastly, repetition in native and non-native speaker interactions functions as a strategy to establish intimacy and to build rapport. In contexts like this, building rapport (building a relationship) is very important, because the difference in language makes both participants unequal in their ability to express themselves. Misunderstandings occur and in order to make the conversation a success, both parties have to make sure that they are allowed to make mistakes and that they will not understand each other right away. Establishing this bond of intimacy takes the following form:

The non-native speaker points out a communication problem;
The native speaker helps to solve the problem;
Both participants celebrate the successful outcome by repeating the correct utterance.

Repetition in English as a Lingua Franca

As mentioned above, both pharmacist and patient speak English during the interaction, while English is not their first language: they use English as a lingua franca (Seidlhofer, 2011). Participants who choose to speak through a lingua franca make efforts to achieve mutual understanding, or a so called "pragmatic clarity" (Kecskes, 2007 in Seidlhofer, 2011: 99). There are many ways in which the speakers try to achieve this pragmatic clarity. One of the means mentioned by Seidlhofer (2011) is to repeat or to paraphrase, or a combination of the two. Other-repetition and code-switching (talking in one language, quickly switching to another language and then switching back to the first language again) are also mentioned as common strategies to enhance mutual understanding. As will turn out from the analysis, all of the just mentioned strategies are used by the pharmacist and patient in the interactions in this study.

In English as a lingua franca (ELF), repetition and paraphrase (or rephrase) are used to clarify or emphasise something. In order to achieve this, the repeated or rephrased utterance takes a more and more explicit form. Seidlhofer illustrates this with a conversation between a Greek and German person, in which the German makes the utterances more explicit: *"you have to move, you have to move out totally, you have to take your things out of your room"* (Seidlhofer, 2011: 100). Seidlhofer explains this

'explicitness' as a means for the German speaker "to make absolutely sure that her message comes across" (Seidlhofer, 2011:100).

Research on other-repetition in ELF shows that participants might use a 'represent', which is a literal repetition of the interpreter's utterance, to help them process the information, to show this to the other participants, or to request information (House, 2003 in Seidlhofer, 2011). Another important goal for using other-repetition is to achieve convergence of the intended and received message, also to improve comprehensibility.

Repetition in pharmacist-patient conversations in a South African HIV/Aids context
In pharmacist-patient interactions in a South African HIV/Aids context, Watermeyer (2008) found that pharmacists and patients repeat or summarize the information that is being exchanged, e.g. the names of the drugs, the dosage instructions or other information. She found that when a pharmacist repeats something, it is mostly after the patient has indicated (verbally or non-verbally) that he or she did not understand the instruction the first time. By repeating the instruction, the pharmacist presents the information in a slightly different way, mostly by making the instructions more explicit, thereby trying to improve the patient's understanding. Another type of repetition mentioned by Watermeyer is the patient's repetition of a pharmacist's utterance. In this context, Watermeyer suggests that the patient repeats the pharmacist's utterances or instructions as a question to check whether he or she has understood the instruction correctly. A patient might also simply repeat the utterance or instruction; in that case, Watermeyer explains that the patient uses repetition as a means to show the pharmacist that he is making an effort to remember the utterance or instruction.

Interestingly, in her study, Watermeyer (2008) only mentions allo-repetition (other-repetition), but does not discuss self-repetition. In my analysis, I will show that in pharmacist-patient conversations, both types of repetition occur. It would therefore be interesting to see what the interactional function of self-repetition in these conversations is.

A definition of repetition used in this study
In this study, the definition of repetition as described by Tannen (2007) is used for the most part to decide which utterances are repetitions and which ones are not. Just like Tannen, I will differentiate between self-repetition and other repetition. As for the types of repetition, I will adopt Tannen's broad definition of repetition and will therefore not only count literal repetition as repetition, but also questions that are transformed into statements, repetitions with a single word or phrase changed, repetition with a change of person or tense, and paraphrasing (rephrasing). Important to estimate as well is the fact that I see rephrasing as a *type* of repetition, and not as something *different* than repetition.

Tannen did not have any restrictions regarding the distance between the first utterance and the repeated utterance; even if there were several turns between the first utterance and the repeated utterance, Tannen would still see it as a repetition. In this study, a restriction on this aspect has been made; the repeated utterance had to be close to the original utterance. One or two utterances in between was allowed; a small insertion-sequence (of 2 or 3 turns) before the repetition occurred was allowed as well.

2.6 Research questions

While studying the literature, research questions appeared along the way. Some of them could be answered while studying more literature; others remained unanswered, and can only be answered by analysing the research material. I will first discuss the research questions that appeared along the way, and end with the questions that will be answered after the analysis.

As we have seen in Roter & Hall (2006), there are two fundamental ingredients that make the heart of the medical interaction: talk and expert knowledge. In the interactions studied in Peräkylä (1995), Silverman (1997) and Pilnick (1997, 1998, 2001, 2003 and 2011), the participants face challenges, but they do not face a language barrier as we have seen in South African pharmacist-patient interactions. A question that arises is: how do South African pharmacists deal with these language barriers in order to be able to exchange expert knowledge? Watermeyer & Penn (2009c) have shown that SA pharmacists have many ways to deal with these barriers, for example by using props to show which medicine has to be used when and how. Also, the SA pharmacists check regularly if the patient still understands, using different techniques as well (Watermeyer & Penn 2009a).

A factor that complicates the exchange of knowledge through talk in both South African contexts and in the other contexts mentioned in Peräkylä (1995), Silverman (1997) and Pilnick (1997, 1998, 2001, 2003 and 2011), is caused by the structure of the interaction in an asymmetrical way through the information delivery format (Peräkylä, 1995). On the one hand, this structure facilitates the exchange of information since it makes it easier for the pharmacist to control the agenda, to deliver a large amount of information and for the patient to be responsive, in order to receive and understand the provided information. On the other hand, the structure could be causing the patient to feel that their voice is overridden, which makes the patient more passive than they should be, causing misunderstandings (Britten et al, 2000).

A question that arises is: is the situation as described above, also applicable to South African pharmacist-patient interactions? The answer is yes. When looking at the interactions, we can see that they are also structured as described in the information delivery format. The pharmacist is the one that asks the questions and provides information and instructions; the patient listens and receives the information. Watermeyer & Penn (2009a) add to this that using the right methods to verify understanding "(…) is especially important in a cross-cultural context because of cultural attitudes towards authority, patients' reluctance to initiate clarification requests, and their unwillingness to reveal a lack of understanding" (Watermeyer & Penn 2009a: 211). By asking the patient for a demonstration of knowledge or understanding, to use response solicitations and by closely monitoring the non-verbal behaviour of the patient, the South African pharmacist has found a method to deal with this attitude, reluctance and unwillingness.

Pilnick (2003) mentions that the role of the pharmacist has extended over the years, and that patients are mostly unaware of this role extension. Patients still see the pharmacist as a passive 'glorified shopkeeper', but are mostly unaware of the fact that the pharmacist has nowadays evolved towards a healthcare professional with a more extended and advisory role. Patients or carers may not expect extended advising or informing sequences from pharmacists; this might cause uncomfortable situations or confusion. Because Pilnick studied interactions in a Western context, the question arose: what do the South African patients think of the role of the pharmacist, and if this view does not match with the role that the pharmacist has nowadays, will this influence the conversation? Watermeyer & Penn (2009b) asked the same question as well, and unfortunately had to

conclude that it is unknown how the South African patients think about the role of the pharmacist.

In Ciliberti's (1996) study on native versus non-native speaker interactions, different types of repetition were mentioned, namely comprehension-oriented repetition and production-oriented repetition. After reading this, the question arose whether in this study, the different types of repetition are noticeable as well. From Watermeyer's (2008) study it can be concluded that the pharmacist and patient use comprehension-oriented repetition, because difficult words or important (parts of the) sentences are being repeated in Setswana, the native language of the patients. When looking at the data, it turned out that the production-oriented repetition was hardly used.

As mentioned in the introduction and in this section, important research questions arose after reading Watermeyer & Penn's (2009a) article on techniques to verify understanding. The fact that they did not mention repetition as a verification strategy and the fact that they have not investigated the use of repetition in the studied pharmacist-patient conversations any further, made me wonder how the pharmacist and patient use repetition in their conversations in this context, and more importantly: what interactional work is being performed by using repetition in this context?

After reading Tannen's (2007) work on repetition, in which she briefly explains different forms of repetition, I have defined my definition of repetition that I will use to analyse the research material. Since there are different types of repetition that could occur in my data, I added the following questions to the research question above:

What types of repetition can be found in my data?
And if it turns out that there are many types of repetition: would it then be wise to continue analysing the interactional function of just one type? And which type would that be?

In the results section, the answer to these questions will be provided. In the next section, I will first explain how I have analysed the research data.

3. Methodology

In this study, video material and transcripts from Watermeyer's (2008) study have been used to answer new research questions. I will first introduce the research data; then, I will explain how I have used this data to answer the research questions in my study.

3.1 Research data

In 2007, Jennifer Watermeyer started to research pharmacist-patient interactions in an HIV/Aids clinic at a hospital in Rustenburg, South Africa. The aims of her study were to describe and understand how the interactions are structured, and how communication helps in providing and understanding ARV and HIV/Aids related instructions and information. As a result, she published a PhD thesis and many publications (see section 2). In order to get a more detailed understanding of the use of repetition and rephrasals by the pharmacists, she made her research data available for this study.

Setting
The pharmacy where the interactions were recorded is located at the RPH Wellness Clinic in the North West Province of South Africa, in the centre of a town called Rustenburg. The hospital, as well as the clinic, struggles with an overwhelming amount of patients, and experiences many difficulties trying to help all of the patients with the limited staff they have available. During the time of data collection (January 2007), the clinic provided care to 4567 adult patients who started with the ARV programme, 3333 adult patients who were currently on ART, and 528 paediatric patients who started with ART. Only two pharmacists work at the pharmacy; one permanent HIV pharmacist and one community service pharmacist. They are assisted by a pharmacy assistant who normally works at the OPD (outpatient pharmacy) but can be called upon when the pharmacists need assistance or require an interpreter.

Participants
Since Watermeyer worked in quite an unexplored field by studying pharmacist-patient interactions in a South African context, she aimed for a target group as broad as possible. The characteristics of the participants were therefore not very specific. They were HIV positive, and were referred to the pharmacy by a doctor to collect their ARV medicines. If they were also willing to participate in the study, they had met the participation-criteria. A total of two pharmacists, one pharmacy assistant, 24 patients, 4 caregivers and 2 mothers of children with HIV/Aids participated in the study.

The first and second (and sometimes third or fourth) language of the patients was mentioned by Watermeyer (2008) at the beginning of every transcript. In the interactions used in this study, a majority of sixteen patients were first-language Setswana speakers; one patient was first language Sesotho speaker and the other patient was a first language IsiXhosa speaker. Only three patients were second language English speakers; among the other patients there were eight patients whose English was "ok", two patients who "understand English", one "who struggles to understand", one who had Afrikaans as a second language and one who had English as a fourth language. The estimation of the level of English was done by Watermeyer (2008). Because Watermeyer has a background as a speech pathologist, I trust that she is able to provide reliable judgments on this aspect; I will therefore use these levels in this study as well.

In two cases (patient 10 and 20), the pharmacist interacted with a caregiver in stead of with the patient, because the patient was unable to speak or understand English, and the caregivers were. Patients were also sometimes accompanied by a family member, but they

were mostly just supporting the patient and did not participate in the conversation as much as the patient did.

Procedure
Due to logistical reasons, it was only possible to record the participating patients once, and not to follow them for multiple visits or even for a few years (as done by Tannen, 2007). After ethical permission from patients and the health care clinic, data was collected during one week at the RPH Wellness Clinic. During this week, Watermeyer recorded 26 interactions, in which the above mentioned participants participated. Next to this, an ethnographic description of the pharmacy and interviews with the participants were performed.

The pharmacy itself consists of one large room, containing a few desks, a computer, fridges to store the medicines, medicine cupboards and a sitting room (see Watermeyer 2008: 138-144 for a more detailed (ethnographic) description of the pharmacy).

When the pharmacist instructs the patient on the use of ARV's, the pharmacist and patient each sit at the opposite side of a desk. The researcher was positioned at the other side of the room and recorded the interactions using a video camera. Afterwards, the patients were interviewed by a research assistant to find out whether the patient really understood the provided instructions and what he or she thought of the conversation in general. The pharmacists were interviewed as well in order to explore their experiences with instructing the patients. Before and during the data collection period, the researcher made descriptive observations of the research environment, which have been discussed above. In the current study, only the video recordings and transcripts have been used to answer the research questions.

Video material and transcripts
After making video recordings of the interactions, transcripts have been made of the verbal elements in the interactions. This was done by Watermeyer and her research assistant by looking at the videos and transcribing from there, following transcription conventions as described by Jefferson (2004) (see appendix 3).

Watermeyer also transcribed some of the non-verbals that occurred in the interaction, because of the significance of the non-verbal communication in these interactions. Only the non-verbals that were necessary or essential for the understanding of the interactions were transcribed, for instance when a patient answered by nodding only, or by pointing at a pill bottle, in order to keep the transcripts simple and organised. When utterances were performed in Setswana or Afrikaans, Watermeyer added translations in English to make these utterances comprehensible as well.

Structure of the pharmacist-patient interaction
In her 2008 study, and later also in her 2009b article, Watermeyer explains how the pharmacist-patient interactions are organised. Her results can be found in table 1 and figure 1. In this section, I will first show how Watermeyer describes the structure of the pharmacist-patient interactions.

The content of the pharmacist-patient interaction consists of many topics that differ between first-visit conversations and multiple-visit conversations (table 1). Since the use of ARV's is complicated and the patient receives a lot of information during the first-visit conversation, there is a difference in structure between the first-visit conversations and the multiple-visit conversations.

During the first visit, the pharmacist pays a lot of attention to the explanation of the disease, instruction on the medication and the patient's registration into the computer system. During a subsequent (second or later) visit, the focus is more on completing the file and on evaluating the patient's usage of the medicines. In the first-visit interaction, there is an instruction part in which the patient gets a very detailed explanation on how to use the medicines. During the subsequent visit conversation, this only happens after the patient has explained how he or she uses the medicines. Then, in both conversations, the pharmacist checks if the patient understands the provided instruction. After that, in the first-visit conversations, there is a part where the pharmacist provides instructions considering the usage of the medicines. In the subsequent visit conversations, the pharmacist skips this part and checks if the patient has any side-effects and provides him/her with a new yellow card (a card that helps them remember to take their medicines). Finally, in both conversations, there is a closure in which the patient and pharmacist talk about the next visit and where they pack the medicines.

The structure and content as explained above is made visible in table 1.

Table 1. Comparison of content for first visits versus subsequent visits. (Watermeyer, 2008)

Greets patient	Greets patient
Obtains patient details: name, address, telephone number, date of birth, etc.	(Obtains patient details: name, address, telephone number, date of birth, etc.)
Enquires whether patient is treatment-naïve or treatment-experienced, i.e. has patient taken ARVs prior to this visit to the pharmacy	Checks pharmacy records to ensure that patient is correctly entered in record system
(Explains how ARVs work against the virus, specifically that they do not kill the AIDS virus)	Enquires how patient is doing
Discusses patient's preferred times in a 24-h period to take ARVs	(Enquires generally whether patient has had problems with ARVs)
Emphasizes importance of good adherence behaviours	(Checks whether patient is naïve—has patient taken ARVs before)
Encourages patient to learn names of drugs	Checks whether patient brought left-over pills; if not, encourages patient to bring pills to each visit
Provides information about each drug: name, purpose, or how it works	Asks patient to finish old pills before starting new ones
Provides dosage instructions for each drug	Checks when patient is taking ARVs
Checks patient's understanding, usually through eliciting a demonstration of understanding	Checks how patient is taking pills, usually through eliciting a demonstration of understanding
Gives an adherence diary card to patient and demonstrates how to use it	Corrects any errors in patient's understanding of how to take ARVs
Emphasizes that no fatty foods should be taken with Stocrin at night	(Revises information about each drug: name, purpose, or how it works)
Emphasizes that no alcohol should be taken with ARVs	Clarifies any confusions due to generic drugs or different containers; explains that drugs are the same but containers are different
(Explains CD4, viral load measures)	Revises and repeats dosage instructions for each drug
(Mentions the possibility of side effects during the first 2 weeks on ARVs; emphasizes that patient should not stop taking the ARVs should side effects arise)	Discusses patient's adherence behaviours, or reminds patient of importance of good adherence behaviours
Discusses patient's next appointment date or agenda for next visit	Asks whether patient has experienced any side effects; these are discussed and a solution is suggested if necessary, or patient is referred to doctor
Sticks instruction labels onto each medicine container	Gives a new adherence diary card to patient
Packs drugs into a brown paper bag (enough tablets are given for 1 month, plus a surplus supply should the patient be unable to collect his/her next prescription)	Discusses patient's next appointment date or agenda for next visit (e.g. patient can go straight to OPD pharmacy)
	Packs drugs into a brown paper bag (enough tablets are given for 1 month, plus a surplus supply should the patient be unable to collect his/her next prescription)

The content of the conversations as shown in table 1 are simplified by Watermeyer (2008) to the structure that we see in figure 1. The important aspects of the conversations are being magnified, showing that in all the conversations there is an agenda-setting part, then the delivery of instruction, a part where the pharmacist checks understanding and to which the patient responds.

Figure 1. Distinct cycle in the pharmacist-patient interaction (Watermeyer, 2008).
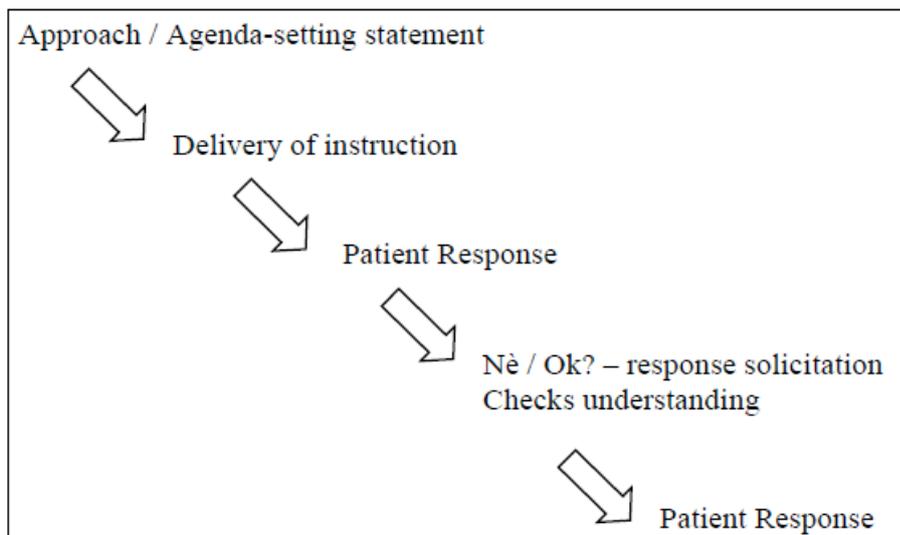
Because I think the structure in table 1 is too extensive to work with, and because the structure in figure 1 does not cover the conversation as a whole, I will now show how I have merged Watermeyer's table 1 and figure 1 into one model, which I will use in this study. The structure I would like to suggest is the following:

Opening sequence
First part: Registering / introducing / checking / evaluating
Main part: Instruction & checking of understanding (as presented in figure 1)
Last part: Last instructions considering usage or side-effects / next appointment
Closure

3.2 Analysis of the research data

Not all of Watermeyer's research data was used. In this study, 18 out of 26 interactions have been analysed; the interactions that were interpreted, performed by the research assistant or performed in Afrikaans, were left out[3].

I chose to exclude the interactions that were performed by the pharmacy assistant because there were only two interactions available in which the pharmacy assistant appeared. In most of the interactions, the permanent pharmacists were involved; these transcripts would therefore provide me with a better view of how the interactions normally take place. Interactions with the pharmacy assistant are exceptions, because they only appeared 2 out of 26 times. For this reason it seemed safer to exclude them from the research material.

The interactions with an interpreter were left out because repetitions in these conversations do not have the same function because of the presence of a third party. The pharmacist does not directly interact with the patient, so repetition is often being used as a means to translate, and it is difficult to see for what purpose a rephrasal is used in this sense. In this study, I focus on the interactions between pharmacists and patients who interact directly without interpreter, and in interactions where the participants *both*

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[3] The interactions that were excluded from the research material were numbers 3, 4, 9, 13, 16, 17, 24 and 25.

speak a language that is not their first language (English). For this reason, I decided to exclude the interactions performed in Afrikaans as well. Also because it is not a language I understand (even though translations were provided) and I therefore experienced difficulties in analysing these interactions.

Conversation analysis

In this study, I have used Conversation Analysis (CA) to analyse the research data. Before I get to the detail of explaining how I analysed the material using CA, I will first explain the method itself.

CA is a method that is used to study people's interactions through talk. It starts from the idea that people use unwritten rules when interacting, enabling them to interact in an orderly and structured way. CA's aim is to reveal these unwritten rules and to find out how we interact in different settings that might have different rules on their own. For instance, a conversation analyst can be interested to find out if people use different rules when interacting with their dentist, compared to when they are interacting with a close friend. Important to mention is that CA believes that interactional roles of the participants are actively constructed *within* the conversation. As Hutchby and Wooffitt (1998) put it: "CA seeks to uncover the organization of talk not from any exterior, but from the perspective of how the participants display for one another their understanding of 'what is going on'".

As opposed to what the name suggests, conversation analysts prefer to say that they study 'talk-in-interaction' rather than 'conversations' (Hutchby & Wooffitt, 1998), because conversation analysts do not study the content of the interactions, but the way the participants act with language. Talk is not just delivering a message that is being understood by the listener; it is a process of sending and delivering, in which participants actively construct meaning and understanding. By looking at the sequential organisation of the interactions (see Sacks, Schegloff and Jefferson, 1974 and Schegloff and Sacks 1973), CA enables us to reveal the unwritten rules that are used by the participants to structure the interactions. This provides us with insight in the way participants construct meaning and how they act with language, for example to complain, request, propose, accuse and so on (Hutchby & Wooffitt, 1998).

In order to get reliable research material, it is essential that the recorded conversations are 'naturally occurring' interactions (Hutchby & Wooffitt 1998). The interactions are as far as possible real conversations that can occur in people's lives, rather than conversations that are being set up and recorded in a non-natural environment such as a research lab. Only by recording and studying naturally occurring data, the researcher will get a true sense of the unwritten rules that people use to structure their interactions. In the report, fragments of the analysed research material are used to show how the observations in the data led to the conclusions. Herewith, the reader will be able to examine researcher's analysis.

Conversation analysis and context

When analysing interactions in a context such as the South African one, one cannot deny that the context must, somehow, play a role in the interactions. However, when using CA to study the interactions, it is important to notice that one cannot in advance say that the context or parts of the context influence the conversation. Therefore, it is first important to notice that conversation analysts differentiate between two types of contexts. The first context is the sequential context (Hutchby & Wooffitt, 1998). This is a context that is actively built by the participants at the time of the interaction, so we can also refer to this context as a local, micro-context. Then, there is the other, broader context in which the interactions take place, because "talk does not occur in a vacuum. It is always,

somehow, situated" (Hutchby & Wooffitt, 1998: 146). I will refer to this type of context as the 'external context'. This external context is first of all determined by the institutional situation in which the interaction takes place, such as the court room or a friend's house; second of all, it is determined by the cultural knowledge and beliefs that the participants have and take with them to the conversation.

However, when analysing interactions that take place in a complicated external context as the one in this study, one needs to make sure that the interpretation of the events in the interactions is being done correctly. In his article 'Whose text? Whose context?', Schegloff (1997) mentions that when describing interactions in light of the context, a distinction should be made between the aspects that are *true* and the aspects that are *relevant* in the conversation.

There are many ways to describe a context in which an interaction takes place. It is not said that one description is better than the other – there are many ways to describe something and there are many aspects applicable to a person, setting, interaction and so forth, depending on the angle from which you look at it. For example, I can be described as female, but also as student, daughter, Dutch, brown-eyed and so forth. These observations are all *true*. However, when describing an interaction in which I take part, all these *true* observations do not necessarily have to be *relevant*. "It is one thing to register that there are many ways to characterize a person, a stretch of conduct, or a setting or context in which the person enacts that conduct. It is quite another to claim that they are all equally warranted, equally legitimate, entitled to identical uptake and weight. But how should one discriminate?" (Schegloff, 1997: 166).

As an answer to this question, Schegloff suggests that a researcher can only discriminate between the relevant contextual aspects by looking at the ones that are being *made* relevant by the participants. If the researcher would describe and explain the events in the interaction based on his own ideas of 'the relevant context', which might happen when using a method such as Critical Discourse Analysis (CDA), he might as well be in danger of basing these ideas on the aspects to which he turns his attention in his study. This is something that should be avoided.

Margareth Wetherell (1998) writes a response to Schegloff's article, in which she argues that not only in CDA, but also in CA, a chance exists that the researcher describes the events from his own point of view. She argues that because CA analysts only focus on fragments, and not on the conversation as a whole, earlier conversations and even earlier utterances are not (enough) being taken in consideration. This makes her doubt if CA analysts are able to decide which parts of the context are being made relevant by the participants; the analyst does not take the whole conversation in consideration, so what does he actually base his suggestions on?

However, in a reply to Wetherell's article and as a conclusion to the discussion, Schegloff (1998) notes that there is a difference in the research questions used by him and Wetherell, which might explain the usual differences that exist between CA and CDA analysts as well. Schegloff mentions that they both ask themselves the question 'why that now?', but each approached it in a different way. CA analysts see it as a question that the *participants* in the interaction are concerned with, while CDA analysts such as Wetherell see it as a question that the *researcher* is concerned with. Of course, the question is also of consideration for the CA analyst, but more in a second order – "prompted by, made relevant by, and grounded in the participants' conduct in each case" (Schegloff, 1998: 414).

An important lesson that can be learned from these articles is that CA analysts ask themselves *how* something happens, and *what* interactional work is being done by an utterance or event in the interaction, while CDA analysts like Wetherell are more concerned with *why* things happen the way they do. For example, in her article, Wetherell asked herself the question "*Why* in this community, among these members, might this [argument] possibly work as an adequate justification?" (Wetherell, 1998: 404). A CA analyst would probably formulate this question as: *What* interactional work is being performed by this [argument], and *how* do the participants make the context relevant by doing it this way? In this way, it is avoided that the researcher thinks *for* the participants, and bases his descriptions on assumptions. Assumptions have to be avoided, because it is impossible to look inside someone's head. Only by looking at the context that is being *made* relevant by the participants, an objective conclusion on the relevant context can be obtained.

Studying a different culture

Another aspect considering CA and context is being put forward by de Kok (2008). When someone from one particular culture studies a foreign culture, de Kok warns that it might be difficult to see which parts of the external context are made relevant in the conversation. When the researcher studies interactions performed by participants that have the same cultural background as he has, there is no need to collect extra knowledge on the cultural background of the participants. However, "when dealing with (…) foreign interactions, it would seem that remedying a likely lack of cultural knowledge on behalf of the analyst necessitates acquiring information about, and paying attention to, the external cultural context" (de Kok, 2008: 890).

As explained above, the interactions analysed in this study have quite a complicated context – for me, as a Dutch analyst, I was unfamiliar with this context. If I would have studied the interactions without any knowledge of the external context whatsoever, I am seriously doubting if I would have been able to make a good analysis. I would not have understood why the participants would use code-switching, why pharmacists say 'ne?' at the end of a sentence, why the pharmacists need to repeat the instruction so many times or why the explanation and instruction on ARV's are so complicated.

The pitfall of the minimum object and the maximum interpretation

Next to the problems that might appear when studying a culture different from my own, there were other possible problems that I had to take in consideration. Studying one particular phenomenon (rephrasals) as part of a general phenomenon (pharmacist-patient interactions in a South African HIV/Aids clinic) requires me to study the phenomena in a circular movement, in which the particular phenomenon is studied as part of the general phenomenon, and the general phenomenon is regarded as a particular phenomenon in terms of other phenomena (Koole & ten Thije, 1994). If the researcher fails to study the phenomena in this circular movement, and would for instance study the material bottom-up or top-down only, there are two methodological pitfalls that the researcher might fall into: the pitfall of the minimum object, and the pitfall of the maximum interpretation (Koole & ten Thije, 1994). I will first explain more about the pitfalls; then I will explain how I have analysed the research material in this study to avoid them.

The pitfall of the minimum object occurs "when we fail to account for the choices we make, that is, when we fail to consider the particular in terms of the general" (Koole & ten Thije, 1994: 51). In other words: if we focus too much on the particular, we might start to see the general in light of this particular phenomenon, and even present the general as identical to the particular phenomenon. As an example, Koole & ten Thije mention a mistake that is often made in intercultural communication, namely the

reduction of intercultural communication (a general phenomenon) to studying misunderstandings (a particular phenomenon).

The pitfall of maximum interpretation refers to "the failure to recognize that not all particular phenomena are representatives of a certain general phenomenon" (Koole & ten Thije, 1994: 51). In other words: the danger of subscribing all observations to a particular aspect, for example your observations to the fact that the participants speak different languages or have a different race or culture, while there may be other (general) things that might explain the observations as well. Koole & ten Thije (1994) argue that we have to ask ourselves the following question if we wish to avoid this pitfall: "how is our object of research related to the reality of which it is part?" (Koole & ten Thije, 1994: 52).

In this study, I have tried to avoid the pitfalls by studying the research material in a circular movement, starting bottom-up by using conversation analysis, and ending top-down by going back to the general phenomenon (the external context of pharmacist-patient interactions in a South African HIV/Aids clinic) in which I studied a particular phenomenon (rephrasals). In the next paragraph, I will explain how I have analysed the research material exactly, combining both bottom-up and top-down methods, eventually using a circular method.

Analysing this study's research data
The above mentioned discussion on CA and context raised the following question: how will I be able to analyse the research material in a way that is valid for conversation analysis and that will still enable me to explain why certain interactional work is being done, in light of the external context?

Because I was about to study interactions in a country and culture that was totally different from my own, there was a 'gap' that needed to be filled with knowledge of this context. Taking de Kok's (2008) warning in consideration that I might not be able to explain the results in light of the external context if this 'gap' was not filled, I consulted Watermeyer's (2008) PhD thesis in which she provided an overview of all the contextually relevant factors that need to be considered when studying interactions in a South African HIV/Aids clinic. I also looked up recent information on the HIV/Aids status, and consulted literature on medical interactions and pharmacist-patient interactions, in general as well as in an HIV/Aids context.

Then, I started the bottom-up analysis and analysed the research material using CA in order to reveal the sequential context and to find out how pharmacists use rephrasals when interacting with the patients (section 4). I used the video recordings and transcripts only, left the ethnographic observations out and focused on the sequential context only.

After the analysis was done and the results were presented, I did a top-down analysis in which I explained the results in this study by using the external context (section 5). I made sure I took Koole & ten Thije's question in consideration, by asking how rephrasals (my object of research) are related to the reality of which they are part. In this way, I did not only provide insight into how pharmacists use rephrasals in interaction with patients, but also why pharmacists in this context choose to perform this kind of interactional work, and which aspects of the external context are made relevant in the interaction.

In the next section, I will present the results of the bottom-up analysis. In section 5 I will explain these results in light of the external context, doing a top-down analysis.

4. Results

4.1 Four categories of repetition

The dataset has been analysed first by exploring it and by looking at repetition in general. A total of 261 repetitions were found in the research data. These repetitions were divided in four different repetition categories. These categories are:

1. Pharmacist (PH) repeats what the patient (PA) said   PA - PH repetition
2. Pharmacist repeats her own utterance   PH - PH repetition
3. Patient repeats what the pharmacist said   PH - PA repetition
4. Patient repeats his/her own utterance   PA - PA repetition

The distribution of repetition categories in the research material is presented in figure 2.
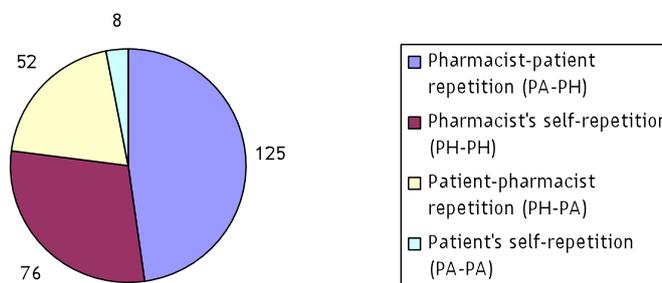
Figure 2. Repetition categories with the number of repetitions per category

As we can see, the type of repetition that was most used in the interactions was the pharmacist-patient repetition followed by the pharmacist's self-repetition. This shows that the pharmacist is responsible for most of the repetitions in the interactions (77%), which shows that also the use of repetitions is asymmetrically distributed in the interactions.

I will explain each category separately in the next part and provide them with examples from the data, thereby showing the interactional work that is performed by the repetition.

Pharmacist - patient repetition (PA - PH repetition)
In fragment 1, an example of a PA – PH repetition is shown [4]. In this fragment, the PA – PH repetition functions as a response initiator. The pharmacist asks the patient when she is going to take her medicines; the patient answers that she will take them at "Eight o'clock" (line 75). In line 76 the repetition occurs, when the pharmacist repeats the patient's answer by asking "Eight o'clock?". As we can see, PH repeats PA's utterance as a question; PA answers in line 77 with 'yes', which shows that she treats PH's utterance as a question as well. By repeating 'Eight o'clock' and turning it into a question, PH's question functions as a response initiator, asking for confirmation from PA. Remaining silent in line 78 shows that PH treats PA's response as sufficient, and writes the answer in her file.

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[4] In appendix 3, an overview of the transcription conventions used in this study is provided.

Fragment 1 (patient 11)
PH = pharmacist
PA = patient

74	PH	What <u>time</u> are you going to take your ARV's?
75	PA →	Eight o'clock.
76	PH →	Eight o'clock? ((sits down at desk))
77	PA	↑Yes
78	PH	((writes in file))
79	PA	((coughs))

Pharmacist's self-repetition (PH - PH repetition)
In fragment 2, the PH – PH repetition occurs in line 91, and also functions as a response initiator. In line 87, we see that PH asks a question followed by "ne↑"; the patient responds with "mm" in line 88. In line 89, the pharmacist tells the patient to take two tablets in the morning. Then there is a silence of 3.08 seconds, and then the pharmacist repeats her utterance, adding '↑ne'. The patient answers with 'ok'. By remaining silent after PH's utterance in line 89, PA treats PH's utterance as a remark that needs no response to it. Then, in line 91, PH repeats the utterance literally, adding '↑ne'. By doing this, PH treats her previous utterance as insufficient, and treats PA's silence as an insufficient response. By responding with 'ok', PA treats PH's utterance as an invitation to respond. Then, PH continues with the next question, which shows that she treats PA's answer as sufficient.

Fragment 2 (patient 11)
PH = pharmacist
PA = patient

87	PH	this is just a vitamin↑ to make you stronger, ↑ne
88	PA	mm.
89	PH →	Two tablets in the morning.
90		(3.08) ((wites on packet))
91	→	Two tablets in the morning, ↑ne
92	PA	Ok.
93	PH	Then we have your Bactrim. It's to protect the chest from infections. °It is an
94		antibiotic.° These three sachets is the same, ↑ne
95	PA	Ok.

Patient - pharmacist repetition (PH - PA repetition)
In fragment 3, we see an example of a PH – PA repetition. Compared to fragments 1 and 2, the repetition in this fragment is used as a confirmation.

Fragment 3 (patient 11)
PH = pharmacist
PA = patient

231	PH	And next morning you going to take them-
232	PA	On the fifth

233   PH →   Of July.

234   PA →   Of July.

235   PH   ↑Mm

In line 232, we see that PA's utterance completes PH's utterance in line 231, which served as a question to PA. Then, in line 233, PH completes PA's utterance in line 232; by doing this, PH treats PA's answer as incomplete, or not specific enough. In line 234, we see that PA repeats 'of July'. By doing this, she confirms that 'the fifth' in line 232 indeed means 'the fifth of July', and treats PH's 'of July' as correct.

Patient's self-repetition (PA - PA repetition)
In fragment 4, the PA – PA repetition occurs in line 171. In line 167, the patient asks a question: "This is only (.) one (.) once a day?" The pharmacist answers with "eight o'clock" and "In the morning only". Nevertheless, this is not a direct answer to the patient's question. Therefore, the patient draws her own conclusion, and concludes that she was correct and that she has to take this pill only once a day. This is also shown by the fact that the patient adds "Ja" before she repeats "Once a day". So here we see a different function of rephrasing, namely the patient drawing his or her own conclusion from what the pharmacist just said.

Fragment 4 (patient 11)
PH = pharmacist
PA = patient

167   PA →   Alright. This is only (.) one (.) once a day?

168   PH   Ja. ↑ (injama) eight o'↑clock=

169   PA   =mm.=

170   PH   =phakela fela.
                In the morning only

171   PA →   mm. Ja. Once a day.

4.2 Interactional functions of repetition

After dividing the repetitions into the four categories that I have just described, a case study was performed using just one transcript, to find out what interactional work is being performed by each repetition category. It turned out that in each category, repetition can perform different interactional work. The case study can be found in Appendix 4.

In the case study I found several functions for different categories of repetition, as well as different forms of repetition within the categories. As shown in appendix 4, PH - PH repetitions turned out to have the most interactional functions. A more detailed examination of this category in the transcript used in the case study showed that there are different forms of repetition as well, such as literal repetition, partial repetition, repeating in a different language (code-switching) and rephrasing.

In PH-PH repetition, there were lots of examples on rephrasing, all performing different interactional work such as self-correction by the pharmacist and obtaining certainty about something, e.g. checking if the patient really understood everything. Because there were so many functions of rephrasing in the one transcript used in the case study, and because not all of the repetition categories could be analysed in depth, only the use of rephrasals in PH-PH repetition will be analysed in depth in this study.

I will first discuss why it is interesting to analyse the use of rephrasals, and then in paragraph 4.3 I will provide an in-depth analysis on the interactional work performed by rephrasals, using all 18 transcripts mentioned in section 3.

From an interactional point of view, the fact that the pharmacist uses rephrasals quite often compared to other types of repetition is quite interesting. The action of rephrasing itself takes more effort than literally repeating an utterance, since in the first situation, the speaker will have to perform cognitive work in putting the same utterance into other words. A possible explanation for the use of rephrasals could therefore be, that someone who takes the effort of rephrasing something in stead of literally repeating it, must have a good reason to do so. Otherwise, why would he not go for the easy option of repeating the utterance literally? Rephrasals seem the most interesting category of PH – PH repetition to further investigate, in order to find out why a pharmacist chooses to rephrase and not to (literally) repeat the utterance.

A question that arises as well is: *when* does a pharmacist use rephrasals? Does she use them throughout the whole conversation, or does she only use them in certain parts of the conversation? It would also be interesting to know what interactional work is being done by the pharmacist when using a rephrasal, and what the rephrasal responds to, because then we will get an insight into how rephrasals are being used by the pharmacist in a cross-linguistic context, and what interactional work is being done by the pharmacist when using them. In the next paragraph, an answer to these questions will be provided.

4.3 Rephrasing

In this paragraph, an in-depth analysis of the interactional work done by rephrasals in this context will be presented. By choosing the fragments that contained rephrasals, looking at the place in the conversation that they occurred, and the question or utterance that they responded to, I found that rephrasals can fulfil different roles in the conversation. In the PH-PH repetitions, I found 24 fragments that contained rephrasals.

Rephrasing a question or other utterance is an act that requires effort from the pharmacist. It makes sense to think that this effort is done only to solve interactional trouble in the interaction. For example, in my dataset, rephrasals recovered a mistake (fragment 5), were used as self-correction (fragment 6), solved problems in understanding (fragment 7) or showed the pharmacists' involvement with the patient (fragment 8).

Interesting enough, in 12 cases, the rephrasal was not used to solve interactional trouble, and therefore did not have a very clear interactional reason. Mostly during what I called the main part of the conversation (where the instruction and verification take place), rephrasals seem to occur without adding new content and asking for the same type of response (fragment 9, 10 and 11). Incidentally, this occurred during other parts of the conversation as well (fragment 12). The fact that the pharmacist makes a lot of effort when rephrasing something, while the rephrasal does not add new information and asks for the same type of response, makes these rephrasals very interesting to research.

I will first show how rephrasals can be used to solve interactional trouble. I will call these rephrasals *contingent rephrasals,* because their appearance is dependent on the presence of interactional trouble; there does not necessarily have to be interactional trouble, so their presence is conditional, and therefore contingent. Then, I will show that the rephrasals that do not solve interactional trouble, fulfil a different function, namely showing the patient that the repeated utterance is important. I will call these rephrasals *contextual rephrasals,* because the participants make certain parts of the external context relevant by using these rephrasals.

Contingent rephrasals

In fragment 5, we see an example where the rephrasal solves interactional trouble by repairing a mistake.

Fragment 5 (patient 8)
PH = pharmacist
PA = patient

63	PH	You've only been on it now for two week- for two weeks ne?
64	PA	Yes.
65	PH	For two weeks.
66	PA	°Eh°.
67	PH →	From now on it will start feeling (more) ((picks up bag next to desk))
68	PA	↑Ok
69	PH →	°It will° start feeling better.
70	PA	mm.

In fragment 5, the pharmacist and the patient have reached the last part of the conversation (see section 3 for a more detailed description of the structure of the interactions). They are talking about side-effects, and the patient mentions that she experiences dizziness while using the medicines. In line 67, the pharmacist does a first attempt to explain that it will start to feel better from now on, but does this while picking up a brown, paper bag. She then rephrases 'more' in line 67 to 'better' in line 69, which shows that she treats 'more' as incorrect. The rephrasal also functions as a self-initiated self-repair (Schegloff, Jefferson & Sacks, 1977), because the pharmacist repairs her previous utterance by herself without initiation by PA. By rephrasing her first utterance, the rephrasal recovers the mistake, and the interactional trouble is being solved.

In fragment 6 an example of a rephrasal that corrects a part of the first utterance is provided.

Fragment 6 (patient 20)
PH = pharmacist
C = caregiver

229	PH →	And then we'll see you on the sixth of the seventh.
230	C	O[k ((nods))
231	PH →	[Sixth of July.
232	C	°Ok.°=
233	PH	=°Ok.°
234		(2 secs)

Just as in fragment 5, the pharmacist and caregiver have reached the end of the conversation, but are now talking about the next visit. In line 229, PH mentions the date of the next visit, but does not call the month by name, but by number. Then, instead of waiting for C to answer, PH interrupts her and rephrases 'the sixth of the seventh' in line 229 to 'Sixth of July' in line 231. By doing this, PH treats her previous utterance as insufficient, also because PH does not wait for C to answer, but interrupts her and starts rephrasing before C has finished with her 'ok' (line 230). Again, we see that the rephrasal

functions as a self-initiated self-repair. The rephrasal recovers a part of the sentence that PH treats as insufficient; possible interactional trouble is thereby being avoided.

In fragment 7, we see how the rephrasal solves interactional trouble by repairing a question that was not understood by the caregiver.

Fragment 7 (patient 20)
PH = pharmacist
C = caregiver

201	PH	>Ok and then the ↑Bactrim< (.) do you remember that one? She got that
202		before [also?
203	C	[↑Yes
204	PH →	When does she take them?
205		(3 secs) ((C looks at medicines))
206	C	°Sorry? °
207	PH →	When? Ka nako mang?
		At what time?
208	C	Let me see this one.
209	PH	Here, °this is what it looks like°.
210	C	The one th th they are
211		(2 secs)
212		Ke eng ka na (.) two times a day.
		What is this at the hour of

In this fragment, the pharmacist and caregiver are talking about the patient's medicines. In line 204, PH asks when PA takes the medicines, but in stead of an answer, there is a silence (line 205) followed by a question ('sorry?') in line 206. PA's 'sorry?' functions as a repair initiator, and leads to other-initiated self-repair by PH in line 207. PH rephrases the question, which shows that she treats C's silence and 'sorry?' as signs that C did not understand the question, and that it needs to be repaired. By rephrasing the problematic question, PH's interactional work accomplishes that C eventually does understand the question and provides an answer. PH's rephrasal repairs a question and improves comprehension, thereby solving interactional trouble.

In fragment 8, we see an example where the pharmacist rephrases her utterance twice. Here, the rephrasal does not solve interactional trouble, but shows the patient that the pharmacist is registering the patient's answer and that she is still communicating with him.

Fragment 8 (patient 18)
PH = pharmacist
PA = patient
F = father

99	PH	Will you <u>see</u> that eight o'clock he <u>drinks</u> this medicine?
100	F	((nods)) °Ok°.
101	PH	Ok? Alright, >I'm going to show you now<. Let me just write your name down
102	→	in the ↑file, you've <u>never</u> had this ARV medicine before, [↑ne G***,

103	PA		[((shakes head))
104	PH →	((looks at file)) this is the first time you're getting it.	
105	→	((writes in file)) °Ok so you're na↑ïve°	
106		(2 secs)	

In this fragment, the pharmacist, patient and father are in the first part of the conversation, where PH is taking the basic details from PA. In line 102, PH asks PA if he never had the medicines before. In response, PA shakes his head, thereby showing PH that the answer to her question is 'no'. Then, in line 104 and 105, PH rephrases PA's answer by saying that this is the first time that PA is getting his medicines, and that he is naïve.

When looking at PH's non-verbal behaviour, we see that she looks and writes in her file while she rephrases her question in lines 104 and 105. At first sight, it does not seem as if the rephrasals have a direct interactional function in the conversation; PH received an answer from PA, so why would she rephrase them? However, the fact that PH looks in her file while she rephrases, shows that the rephrasals *do* have a direct interactional function. The rephrasals show PA that PH is still communicating with him, and that she is registering his answer in her file.

Contextual rephrasals
Now that I have shown how rephrasals can solve interactional trouble, I will now pay attention to the cases where rephrasals do not solve interactional trouble, but perform other interactional work.

Fragment 9 (patient 11)
PH = pharmacist
PA = patient

170	PH	=phakela fela.
		in the morning only
171	PA	mm. Ja. Once a day.
172	PH	Ok? Until the fourth of July.
173	→	And then?
174		(.)
175	→	What then?
176		(.)
177	→	What are you going to do then?
178	PA	I come back ((D starts laughing))
179		I'll come back and tell you about this ((laughs)).
180	PH	M******, no. Wag, let me tell you. ((opens pill bottle with her teeth))
		Wait
181		I'm going to show you, ↑ne

This fragment differs in two different ways from the other four fragments I have shown before.

First of all, the questions that the rephrasals respond to are different. In fragment 9 the rephrased utterance is a verification question, meant to check understanding. In

fragments 5 to 8, the rephrased utterances were doing something else, such as taking details or talking about the next appointment. Secondly, rephrasing without solving interactional trouble occurs most of the times during the instruction and checking understanding part, while contingent rephrasals occurred in other parts of the conversation.

The fact that fragment 9 takes place in the instruction and checking understanding part of the conversation, influences the interactional work that is being done by the rephrasals. When we look at the whole transcript, we see that PH has done several attempts to tell the patient that she has to take her pills differently after the fourth of July. In line 173, PH checks if PA understood her last instruction by asking what PA is going to do after the fourth of July ('and then?'). PH thereby asks for PA's knowledge on that part of the instruction, and checks if PA has acquired the knowledge yet.

Asking for someone's knowledge creates a sequential environment in which an answer in the form of a demonstration of understanding is preferred (Koole, 2010). But, as we see in line 174 and 176, PA does not answer, and in lines 175 and 177, PH rephrases the question. It could be argued that by rephrasing her question after a silence, PH treats the silence as a sign that PA did not understand the question. However, when looking at the video recordings and listening to the fragment, we see that the silences are very short – almost too short for PA to answer. I would therefore like to suggest that the rephrasal performs other interactional work than 'making the question more comprehensible'.

First of all, it is interesting to notice that PH rephrases the question twice; this requires effort, and by doing this, PH does not only show how she treats PA's silences; it also shows that she treats the question as an important question. If the question was not worth the effort of rephrasing, PH could have just waited a bit longer to give PA the chance to answer. Now, by rephrasing the question instead of waiting for an answer, PH makes a lot of effort without having to solve interactional trouble. Apparently, the question is worth the effort of rephrasing; and by rephrasing it, PH treats the question as important, which in its turn functions as a means to show the patient as well that the question is important. By this means, the rephrasals create a context brought about (a context created *in situ)*, used to distinguish between important and less important questions.

In fragment 10, we see another example of a rephrasal that seems to have no direct interactional reason at first sight, but at a closer look, also contributes to a context brought about, making the question important and showing the patient that the question *is* important as well.

Fragment 10 (patient 14)
PH = pharmacist
PA = patient

164	PH	Then you pull it up to two again.
165	PA	Ok.
166	PH	Seven o'clock ↑phakela and seven o'clock °bosigo.°
		in the morning *at night*
167	PA	Ok.=
168	PH →	=Ok? You understand this [one?
169	PA	[Yes.
170	PH →	You're very clear on this [one?
171	PA	[Yes

172	PH	°Ok. Let me go onto the next one.°
173		((P starts writing on paper))

In fragment 9, PH asked for a claim of understanding, and rephrased her question until PA was able to provide this. In fragment 10, something else happens: here, PH asks PA if he understands, thereby orienting towards a different type of 'epistemic access', namely understanding, in which a claim of understanding is preferred (Koole, 2010).

In line 166, we see that PH provides the last part of the instruction; PA responds with 'ok'. In line 168, PH asks if PA understands. As just mentioned, a preferred answer to this question would be a claim of understanding, and in line 169, we see that PA indeed responds with a claim of understanding. PH now has two options: accept PA's claim of understanding, or continue and ask for an additional demonstration of understanding (which we often see in classroom interactions, see Koole 2010). However, PH does neither of the two options and in stead, rephrases her question in line 170, asking again for a claim of understanding. The rephrasal in line 170 could thereby as well function as an other-initiated self-repair (Schegloff, Jefferson & Sacks, 1977); PH creates an opportunity for PA to repair his claim of understanding, in case he said 'yes' while he actually didn't understand the question. However, after the rephrasal, PA answers with 'yes' in line 171 and thereby again provides a claim of understanding, and does not repair his first claim. In line 172, D accepts this claim of understanding and goes to the next instruction.

Considering the fact that the literature describes that accepting a claim of understanding, or asking for a demonstration of understanding, are common responses after receiving a claim of understanding when asked for it, and that in fragment 10 PH does neither of the two, I would like to suggest a different explanation for the interactional work that is being performed by the rephrasal in line 170. Because the rephrasal does not solve any interactional trouble and because it asks for the same response, thereby not adding any new information for the pharmacist, I suggest that the rephrasal creates a context brought about in which the rephrasal functions as a means to show the patient that the question is important. Namely, all this effort is being done to rephrase the question, asking for the exact same claim as given the first time. Rephrasing thereby adds weight to the question and weight to the answer, and thereby functions as a means by the pharmacist to show the patient that the rephrased question is important.

Lastly, The rephrasal in fragment 10 could also be seen as a repair, initiated by PH, to provide PA with an opportunity to repair his claim of understanding, and to give him another opportunity to tell PH in case he *claimed* to have understood, but actually did not understand the instruction.

In fragment 11, we see another example of a question that is being rephrased with the same purposes as in fragment 10. Only in this fragment, the question is being rephrased three times in stead of once, as we saw in fragment 10.

Fragment 11 (patient 11)
PH = pharmacist
PA = patient

268	PH	Eight in the ↑morning and one tablet at exactly eight pm at night.
269	PA	Ok.
270	PH →	Ok? You sharp now?
271	PA	Yes.

272	PH →	You sure?
273	PA	Yes.
274	PH →	I don't want you to leave here if you're not sure.
275	PA	I'm ok.
276	PH →	You're very sure?
277	PA	Yes.
278	PH	Ok. Then I'm very happy [↑n:e ((reaches down to get a brown paper bag))
279	PA	[↑Yes (.) thank ↑you

In this fragment there has just been an instruction from PH (the last part of the instruction is shown in line 268) and as an answer to the instruction, PA says 'ok'; thereby claiming that she understands. However, in stead of accepting the claim and moving on to the next topic or closing the conversation, PH asks 'ok?' and 'You sharp now?' in line 270, asking for (another) claim of understanding. PH then asks three times if PA is sure (lines 272, 274, 276), thereby rephrasing her question in line 270.

Again, we see that these rephrasals ask for the same response. PA provides a claim of understanding, but PH rephrases the question and asks for other claims of understanding. Eventually, PH accepts PA's claim of understanding, but when we look at the content of the questions and PA's claims, the rephrasals add no new information to the conversation, meaning that PH knows as many after the three rephrasals as she knew after the first question. The rephrasals make the question important, and rephrasing is thereby used by the pharmacist to show this importance to the patient as well.

However, the fact that the question is being rephrased multiple times shows something else as well. When asking for more than one claim of understanding, the responsibility for the claim increases: claiming that you understand three times, adds more weight to the claims compared to claiming that you understand just once. Just like in fragment 10, the rephrasals could be seen as repair initiators to provide the PA with opportunities to repair his claim of understanding. However, as we have seen in fragment 10 as well, PA does not repair himself and keeps on claiming that he understands. Eventually PH accepts the claims and moves on to the next topic. The fact that PA has been given opportunities to correct his claims and the fact that PH rephrases multiple times all contribute to a context brought about in which the rephrased utterance is being made important.

Although the rephrasals as described above, mostly occur during the main part of the conversation, they also occur in other parts of the conversation.

Fragment 12 (patient 6)
PH = pharmacist
PA = patient

14		((D types on computer, P chews gum))
15	PH →	Is this the first time you're going to take the ↑ARV's=
16	PA	=Yes=
17	PH →	=You've never had them from another doctor?
18	PA	No. ((shakes head))
19	PH →	No never?
20		(8 sec)

Fragment 12 takes place at the first part of the conversation, where the pharmacist takes details from the patient to complete the file. As part of this procedure, PH asks if PA ever had ARV's before (line 15). PA responds with 'yes' in the proceding line, thereby answering PH's question. Since PH didn't pose a verification question, PA's 'yes' is not a claim of understanding but a confirmation. Still, it is a valid answer. Then, as in the fragments before, PH rephrases the question in line 17, even though she received a valid answer from PA, again providing a repair initiation for PA to repair his answer. Again, PA does not repair himself and confirms that he never took ARV's before (line 18).

So, in the previous fragments, we saw that the use of contextual rephrasals mostly occurs in the main part of the conversation; fragment 12 shows, however, that contextual rephrasals can also occur in other parts of the conversation, for example in the first part of the conversation, to show PA that the question is important. Only in fragment 12, PH does not ask for another claim of understanding by rephrasing the question, but for another confirmation.

However, this fragment shows something else as well, namely that the patient in this case understands that the pharmacist tries to show the importance of the question to her. In line 19, we see that PH asks 'no never?' but does not receive an answer from PA. By remaining silent, PA does not treat PH's utterance as a question that needs to be answered. This shows that PA understands that PH is showing her that the question is important, and that she understands that the questions have this purpose, instead of asking for the third time if PA never had ARV's before.

4.4 Reflection

Analysing the fragments in the paragraph above showed that different interactional work is performed when rephrasing an utterance. Most of the times, rephrasals solve interactional trouble, or try to prevent interactional trouble by repairing the previous utterance. However, I have shown that rephrasals in pharmacist-patient interactions in an HIV/Aids context also perform other interactional work, by constructing a context brought about that enables the pharmacist to show the patient the importance of an utterance.

As a researcher, I was able to distinguish between the fragments by looking at the place in the conversation where the rephrasals occurred, and the utterance that the rephrasal responded to. The fragments that contained a contingent rephrasal occurred in the first and last part of the conversation, and the interactional work that was done, was for example to repair a mistake. The fragments that contained contextual rephrasals occurred in the instruction and verification part of the conversation. The utterance that was being rephrased was meant to check understanding, and was asking for a demonstration or a claim of understanding by the patient. The interactional work that was done by rephrasing the utterance, was creating a context brought about, in which the pharmacist made the utterance important, and which enabled her to show this importance to the patient as well.

When taking these findings to a level that transcends the context of pharmacist-patient interactions, I will be able to answer the following question:

In what way are rephrasals being done that make an utterance important, and in what way are rephrasals being done that do not make an utterance important?

As I have found in my analysis, a question is being made important by rephrasing it while there is no interactional trouble to be solved. When someone poses a question, receives

the answer he asked for, and then asks again for the same type of answer, a context brought about is created in which the question is being brought to the attention of the receiver in a different way, more weight is being added to the question and the answers, and in which the question is being made important.

Rephrasals by which the utterance is not being made important perform different interactional work, namely solving interactional trouble. In those cases, the conversation continues right after the rephrasal is done, and the rephrased utterance is not being repeated again. Therefore, the sender does not construct a context brought about, and does not make the question important. The reason to rephrase is being solved, and this is more important than the question itself.

5. Discussion

5.1 Explanation of the results using the external context

In the previous section, I have shown that a rephrasal can be used in two ways: as a contingent rephrasal, to solve interactional trouble, and as a contextual rephrasal, to show the patient that a question or utterance is important.

I would like to suggest that the presence of contingent rephrasals in these interactions is quite obvious; it is used to repair something or to solve interactional trouble and could therefore occur in any conversation. In other words, it is not 'special' that this type of rephrasal occurs in these interactions, since it might occur in any other interaction in any other context as well. However, I would like to suggest that the presence of contextual rephrasals in these interactions might be specific for this context, and I will now discuss this suggestion further.

Distinguishing between important and less important questions
When a pharmacist makes a question important, she actually makes an effort and performs an act *for* the patient: she distinguishes between the important and less important questions. What I would like to suggest now is that the pharmacist, by doing this, treats the patient as someone who is not capable of making this distinction by himself. Otherwise, if the pharmacist would think the patient *is* capable of making this distinction, she wouldn't have made the effort of making this distinction for him.

By treating the patient as someone who is incapable of making a distinction like this, the language barrier is made relevant in the conversation. Most of the patients have little knowledge of English or Afrikaans, and the pharmacist have even less knowledge of the other African languages, which makes it hard for both parties to achieve mutual understanding. The patient might not understand everything the pharmacist says; he therefore needs some help in distinguishing between important and less important questions.

The repeated request for a claim of understanding
As we have seen in fragment 10 and 11, the pharmacist provides an instruction on the use of ARV's, and then asks if the patient understands, thereby asking for a claim of understanding. However, when the patient answers with a claim of understanding, the pharmacist does not accept this right away, and rephrases her question one or two times. By this means, PH provides an opportunity for PA to repair his claim of understanding, in case he didn't understand but did claim to do so. As I have suggested in my results section, the pharmacist hereby creates a context brought about, and shows the patient that the question is important. However, I would like to suggest another possible reason for the pharmacist to ask for a second or third claim of understanding, by looking at the external context.

Watermeyer & Penn mention that "In both same-culture and cross-cultural interactions, patients may respond positively to a question such as 'Do you understand?' out of politeness or deference to the health professional's authority, even if they have not understood." (Watermeyer & Penn, 2009a: 206). It could therefore be possible that this 'politeness-problem' is made relevant in the conversation by rephrasing the question, not accepting the patient's claim of understanding right away, and initiating PA's self-repair, because the pharmacist tries to figure out whether the patient is telling the truth or that he is just being polite.

I would like to suggest that by rephrasing the question, the pharmacist deals with the problem of politeness in three ways. First, making the question important suggests that the answer to the question is important as well. This might make the patient realise that it is important to tell the truth, in stead of answering out of politeness. Second, a claim of understanding that is being given three times, carries more 'responsibility' than a claim of understanding that is being given once. In other words: by rephrasing the question, more weight is added to the claim, which might explain why a pharmacist mostly does not accept a claim of understanding the first time, but only after a few times. Thirdly, I have shown that the rephrasals function as other-initiated self-repairs, giving PA the chance to repair his claim of understanding; the fact that PA does not repair himself but keeps on claiming that he understands (and chooses not to correct himself), also shows that the pharmacist makes an effort to avoid the patient to answer out of politeness.

Comparing these explanations to a similar study in intercultural communication
Meeuwesen et al (2006) also found that the existence of a linguistic barrier and the presence of power relations can explain results in conversations comparable to the ones in this study. In their study, in which the communication between Dutch doctors and Dutch patients vs. Dutch doctors and ethnic minority patients was researched, they have shown that a significant difference exists in communication patterns between the doctor and the different patients. The main result was that the doctors were able to create a closer relationship with their Dutch patients than with their ethnic minority patients, due to the fact that with the ethnic minority patients, most of the conversation was spent trying to understand each other, while with Dutch patients, this was not necessary and the doctor could therefore show more empathy (reflection of feelings) and involvement (agreeing and social behaviour) (Meeuwesen et al, 2006).

As in this study, Meeuwesen et al associated the above mentioned results with the existence of a language barrier. The language barrier made it difficult for the doctor and ethnic minority patients to build a relationship, since they were mostly occupied with trying to understand each other. In this study, the pharmacist and patient were also mostly occupied with trying to understand each other, which might also be caused by the fact that they were talking through a lingua franca and because the pharmacist was a better English speaker than the patient. In this study, I have explained the influence of the language barrier in more detail by arguing that the linguistic barrier caused the use of contextual rephrasals and the distinction between important and unimportant questions.

The other explanation for the different communication patterns and differences in relationship building between doctor and patients is explained by Meeuwesen et al by the existence of a power distance. As the researchers explain, the ethnic minority patients have a traditional view on power distance, and the difference between these patients and the Dutch patients was that the Dutch patients were more assertive and discussed more with the doctor than the ethnic minority patients. In this study, I have also explained the results in light of the presence of a power distance, but was also able to explain that one aspect of the existing power distance, namely being polite to a higher authority, might be particularly relevant in the use of contextual rephrasals.

5.2 Reflection on the methods

Looking back, I was afraid that it would be quite a challenge for me to study interactions that took place in a foreign country and culture. I did not know much about the South African culture or the context in which the pharmacist-patient interactions took place. By learning, reading and talking to other people about it while I was in Africa, I think I have managed to make this cultural 'gap' a bit smaller and still managed to deliver a solid analysis.

In the preceding paragraph, I have tried to explain why certain interactional work might be done, using the external context. By showing which parts of the context were being made relevant while using contextual rephrasals, I was able to show that not the 'whole' context, but parts of the context, were made relevant. By using my acquired knowledge of the external context and by arguing what seemed to me a logical explanation of the results, I have tried to explain the results as clearly as possible. However, I do not claim to have 'the' right explanation for the use of rephrasals in this context; rather it is my knowledge and my analysis which brought me to this conclusion.

By analysing the research material in a circular way, doing a bottom-up analysis using conversation analysis first, and doing the top-down explanation of the results (using the external context) second, I have avoided falling into the pitfalls mentioned by Koole & ten Thije (1994).

By doing a bottom-up analysis first, using conversation analysis, I was able to make a distinction between the context that was *true* and the context that was being made *relevant* by the participants. By doing this, I avoided the pitfall of maximum interpretation by not taking for granted beforehand that all the context that was *true* would necessarily also be *relevant* or influential in the interactions.

By doing a top-down analysis in the end, using the external context, I was able to avoid the pitfall of the minimum object. I have first studied the use of rephrasals in the conversation itself; then I explained their appearance in light of the external context. Because I considered them in terms of the general context in which they took place, I avoided generalisation and was able to perform the analysis in a circular way, in stead of performing the analysis in one direction.

5.3 Practice implications

The results of this study made me think about the efficiency of the question 'do you understand?' – a question that occurs quite often in the interactions. Watermeyer & Penn (2009b) have shown that of all the techniques that pharmacists have available to verify understanding, the question for a demonstration of understanding is by far the most effective. When a pharmacist asks if the patient has understood the instruction, she asks for a claim of understanding, but as we have seen in the results of this study, the pharmacist has to perform a lot of interactional work to make the question important. Next to this, the pharmacist asks for a claim of understanding; but when she receives it, the pharmacist does not accept it and rephrases her question in order to get another claim of understanding.

Even though this technique is effective in showing the patient that the question is important, I am not sure if this technique is as effective as simply asking for a demonstration of understanding, if the pharmacist is really trying to find out if the patient understood the instruction. Namely, by asking for another claim of understanding, weight is added to the claim, but no new information is added. The patient might still answer out of politeness, even when he realises that it is an important question. Making a question important by rephrasing it might therefore be a good technique for other important questions, but when asking if the patient has understood, asking for a demonstration of understanding might still be preferred.

5.4 Future research

As with most studies, this study answered a lot of research questions, but also raised new research questions. In this paragraph I will show which questions were raised for me while doing this study, and I will make some suggestions for future research.

First of all, the fact that only the interactional work of rephrasals has been investigated can be seen as a limitation to this study. It would be interesting to analyse the other repetition categories as well, to see which sub-categories can be distinguished and what interactional work is being performed by these categories. Analysing this might reveal other strategies that the pharmacist uses to achieve comprehension or to communicate across language or cultural barriers.

In paragraph 5.1, I have explained why I think that the use of contextual rephrasals might be something that occurs specifically in this context. By looking at the external context this seems plausible, but it would be interesting to find out if the pharmacist also feels the need to distinguish between important and unimportant questions when interacting with a patient with the same cultural background and on the same language level as the pharmacist. Would the pharmacist still use the same techniques when interacting with a patient from the same culture, meaning that she does not have to deal with language or cultural barriers? Comparing verification techniques between different cultures might provide the researchers with more detailed information on which techniques are specifically used when dealing with cultural and language barriers, and which ones are used when interacting in an HIV/Aids context.

By showing that pharmacists use two types of rephrasals, I have shown how a pharmacist or other professional can use rephrasals as a strategy to show the patient that a question is important. When communicating across languages or cultures, this might be an effective strategy; it might therefore be interesting for future researchers to find out if it is also successful in other contexts, for example in Western clinics when the physician interacts with a foreign patient, or in interactions without the HIV/Aids context.

6. Conclusion

In this study, I have analysed 18 out of 26 pharmacist-patient interactions in an HIV/Aids clinic in South Africa, which were originally recorded and transcribed by Watermeyer (2008). By analysing the research material using Conversation Analysis, focusing on repetition and then on the use of rephrasals by the pharmacist, I was able to answer this study's research question.

What interactional work is being performed by rephrasals when used by a pharmacist in interaction with a patient in a South African HIV/Aids clinic?

I have shown that rephrasals used by South African pharmacists in an HIV/Aids clinic can perform different interactional work. When the pharmacist makes a mistake, when she corrects herself, when the patient doesn't understand an utterance or when the pharmacist rephrases her utterance to show the patient that she is registering something in her file, *contingent rephrasals* are used to solve interactional trouble.

However, a pharmacist can also rephrase an utterance while there is no interactional trouble to be solved. *Contextual rephrasals* show the patient that the repeated utterance is important. In the discussion, I have suggested that the interactional function of this type of rephrasal is contextual, because the reason for the pharmacist to distinguish between important and less important questions can be explained by the multilingual and multicultural context in which the interactions took place. I have suggested that the rephrasals distinguish for the patient between important and less important questions, making the language barrier relevant; secondly, I have suggested that the rephrasals, by asking for the same type of response, make the politeness problem relevant.

Analysing the use of rephrasals in the interactions in this study has not only enabled me to see how and why South African pharmacists use rephrasals to make a question important; it also provided insight into how questions in general can be made important. The study made me realise that it might not be as efficient to use this strategy with regards to the question 'do you understand?' compared to asking for a demonstration of understanding, but it can certainly help to use the strategy in respect of other important questions in an interaction. However, in order to find out if this study's results can be generalised to other contexts as well, other research is needed, for which I have made suggestions in the discussion part of this thesis.

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Appendixes

Appendix 1 – List of abbreviations

ART	Anti Retroviral Treatment
ARV	Anti Retroviral
CA	Conversation Analysis
CDA	Critical Discourse Analysis
ELF	English as a Lingua Franca
HAART	Highly Active Anti Retroviral Treatment
HIV	Human immunodeficiency virus
N/NN	Native/ Non-Native (interactions)
PA	Patient
PH	Pharmacist

Appendix 2 – Key words and definitions

Adherence
: In the HIV/Aids context of this study, adherence means sticking to the ARV regimen and taking the ARV's on time, every day (see Watermeyer, 2008 for more information on adherence)

Afrikaans
: National language of South Africa, together with English

AIDS
: Acquired immune deficiency syndrome. An infectious disease of the immune system caused by the human immunodeficiency virus (HIV)

Allo-repetition
: The repetition of the other participant's utterance (see Tannen, 2007 for more information on repetition)

ART
: Anti Retroviral Treatment: the treatment of Aids or the HIV virus using medicines (ARV's)

ARV
: Anti Retrovirals: the medicines an HIV/Aids patients has to take to suppress the virus

Asymmetry
: The unequal distribution of turns in a conversation – in medical interactions this means that the doctor takes more turns than the patient, and that the doctor structures the conversation

Claim of understanding
: Saying (claiming) that you understand something

Code-switching
: Talking in one language, switching to another language and then switching back to the first language again

Context brought about
: A context created *in situ*

Contextual rephrasals
: Rephrasals that do not have a direct reason to rephrase, and are meant to show the patient that an utterance is important

Contingent rephrasals
: Rephrasals that have a direct interactional reason to rephrase, meant for example to correct the previous utterance

Cross-linguistic barriers
: "the often-encountered lack of language understanding between doctors and patients belonging to different ethnic/cultural groups" (Schouten & Meeuwesen, 2006: 22)

Cross-linguistic communication
: With cross-linguistic communication I refer to the fact that the pharmacist and patient both do not speak their first language when interacting with each other and that they have to find other means to achieve mutual understanding, overcoming cross-linguistic barriers

Demonstration of understanding
: Showing that you understand something

English as a Lingua Franca	"any use of English among speakers of different first languages for whom English is the communicative medium of choice, and often the only option" (Seidlhofer, 2011: 7).
Expert knowledge	Information that both patient and physician have on their own field of knowledge. The patient is expert on his own complaints, beliefs, medical history and for example his cultural beliefs; the physician is expert on how to recognise, treat and cure diseases
External context	The context in which the interaction takes place, such as the place, country or culture
HIV	Human immunodeficiency virus, the virus that causes AIDS.
Information delivery format	A way in which institutional conversations can be structured: the counsellor is the speaker and the patient the hearer
Interactional work	A concept used in conversation analysis, which means acting with language to achieve something in reality, such as achieving comprehension or confirming something.
Interview format	A way in which institutional conversations can be structured: the counsellor is the questioner and the patient the answerer
Native/non-native interactions	Interactions conducted in a language between at least one person who is a native speaker of the chosen language, and one person who is not a native speaker of the chosen language (see Ciliberti, 1996 for more information on this subject)
Other-initiated self-repair	Repair of the speaker's own utterance, performed after initiation by the other speaker (see Schegloff, Jefferson & Sacks, 1977 for more information on repair)
Paraphrasing	Other definition of rephrasing
Participant	Person that participates in the conversation
Pitfall of the minimum object	"We encounter the pitfall of the minimum object when we fail to account for the choices we make, that is, when we fail to consider the particular in terms of the general" (Koole & ten Thije, 1994: 51)
Pitfall of the maximum interpretation	"The pitfall of the maximum interpretation refers to the failure to recognize that not all particular phenomena are representatives of a certain general phenomenon." (Koole & ten Thije, 1994: 52)
Repetition	The act of repeating an utterance
Rephrasing	To say something in other words

Rephrasal	Utterance by which a previous utterance is said in other words
Self-initiated self-repair	Repair of the speaker's own utterance, performed on his own initiative (see Schegloff, Jefferson & Sacks, 1977 for more information on repair)
Sequential context	The context that is being constructed by the participants in the interaction
Setswana	One of the official South African languages, and the first language of most of the patients in this study
Talk	The verbal and non-verbal communication between doctor and patient
(Isi)Xhosa	One of the ten official South African languages

Appendix 3 – Conversation Analysis transcription conventions

Jefferson (2004) in Watermeyer (2008).

B:	speaker identification
<u>word</u>	some form of stress, via pitch or amplitude
WORD	especially loud speech relative to surrounding talk
((laugh))	transcriber's descriptions, e.g. laughter or head nod
?	rising intonation
.	falling or terminal intonation
,	continuing intonation
(.)	short pause
(0.0)	elapsed time in silence (in seconds)
(word)	especially dubious hearings or speaker identifications
˚word˚	softly spoken, quieter than the surrounding talk
[ ]	onset and offset of overlapping talk
…………	omitted text
=	latching (no gap between lines)
:	prolongation of the immediately prior sound
-	cut-off
↑	shift into higher pitch in the utterance immediately following the arrow
↓	shift into lower pitch in the utterance immediately following the arrow
hhh	out breath or sigh
***	text omitted to protect participant's confidentiality
< >	decrease in speed of speech, relative to surrounding speech
> <	increase in speed of speech, relative to surrounding speech
bold	boldface is used to indicate specific phenomena or points of interest in an extract

Appendix 4 – Case study

Repetition in pharmacist-patient interactions in an HIV/Aids clinic
November 9th, 2011.

Introduction

Repetition is a common phenomenon in conversation. From our own experience, we know that it sometimes occurs while we do not even notice it, and that we sometimes do notice when it happens. But what purpose do repetitions have in conversation? While answering this question, I will focus on one kind of interaction only: namely, pharmacist-patient interactions. When looking at a big dataset of 26 recorded and transcribed conversations, it occurred to me that a lot of repetition occurs in these conversations. Why do the participants of these conversations repeat themselves or others? Is there a certain interactional purpose that these repetitions try to fulfil? With these questions in mind, I started analysing the data. In this case study I will present the results of this analysis, according to one particular case (patient 11). I performed the analysis by using Conversation Analysis. First I will show how I started analysing the data, then I will show the results of this (exploring) analysis and finally I will explain how I will continue analysing from here on.

Procedure

The first step in my analysis was to look at the dataset and mark all the repetitions I saw. Soon after I started doing this, I found that there were four kinds of repetition. I started marking each different kind of repetition with a different colour. At the end of every transcript, I wrote down which kind of repetition occurred in which part of the transcript, so that I would be able to see which kind of repetition occurs the most, which kind occurs the least, and that I would be able to recover where in the transcript the specific kinds of repetition occur. When I was done doing that, I looked for one specific case that contained all four types of repetition, and that could serve as an example to show my results.

Results

While analysing the data, I discovered four categories of repetition:

  5. Pharmacist (Ph) repeats what the patient (Pt) said   Ph-Pt repetition
  6. Ph repeats her own utterance   Ph-Ph repetition
  7. Pt repeats what Ph said   Pt-Ph repetition
  8. Pt repeats his/her own utterance   Pt-Pt repetition

By making a list of all the places where a specific kind of repetition occurred per transcript, I can tell that Ph-Pt repetition occurred the most, followed by Ph-Ph repetition and Pt-Ph repetition. Pt-Pt repetition hardly ever occurred.

Ph-Pt repetition

Ph-Pt repetition occurs when, as I said before, the pharmacist repeats what the patient just said. Fragment 1 is an example of a Ph-Pt repetition.

74	D	What <u>time</u> are you going to take your ARVs?
75	P	Eight o'clock.
76	D	Eight o'clock? ((sits down at desk))
77	P	↑Yes

Fragment 1. An example of Ph-Pt repetition

In this fragment, the pharmacist asks the patient when she is going to take her medicines. The patient answers that she will take them at "Eight o'clock". In line 76 the repetition occurs, when the pharmacist repeats the patient's answer by asking "Eight o'clock?" So here we see that the pharmacist repeats the patient's answer, and puts it into a question. The patient answers the question by saying "yes". By repeating the patient's answer as a question, it seems that the pharmacist's repetition functions as a verification, which she uses to make sure that the patient is confident about the time she is going to take her medication (eight o'clock). When looking at the context of the pharmacist-patient interaction, it makes sense that the pharmacist uses this strategy. The patient has to take the medicines twice a day at exactly the same time for the rest of her life; therefore, she must be confident about the time, and the pharmacist needs to check this.

There are two other ways in which Ph-Pt repetitions can be used. I will show that by using fragment 2.

14	D	Mommy are you pregnant?
15	P	((nods head)) ↑mm
16	D	↑Congratulations
17	P	Yoo
18	D	How [far are you?
19	P	[Whoo huh ((laughs)) seven months.
20 21	D	Seven months? You so small, ↑huh (.) you so small. °Ag shame, man.° Is it the <u>first</u> baby?
22	P	((holds up three fingers))
23	D	<u>Third</u> one?
24	P	↑Mm

Fragment 2. Two other examples of Ph-Pt repetitions.

In this fragment, the first repetition occurs in lines 20 and 23. The pharmacist asks the patient how far her pregnancy is; the patient answers that she is in her seventh month. The pharmacist repeats this and again, puts it into a question: "seven months?". When looking at the rest of the sentence, we can tell that she repeats "seven months" as a question because she is surprised: "You so small, huh, you so small". The patient is still

small and her pregnancy doesn't show that she is already in her seventh month. So here, the repetition functions as a way for the pharmacist to express that she is surprised.

In line 23, the second repetition occurs. Here, the pharmacist first asked the patient if it is her first baby. The patient answers by holding up three fingers. The pharmacist asks "Third one?" and the patient confirms this by saying "Mm". Again, a similar thing occurs, namely that the patient answers a question and the pharmacist repeats this answer by putting it into a question. Here, the answer of the patient is non-verbal. By repeating the patients answer (showing three fingers), the pharmacist puts into words what she sees. By formulating it into a question, and getting an answer from the patient, we can tell that the pharmacist posed the question to confirm that the patient means that this is her third child. We know that this repetition is different from the one I described before, because in line 25, we see that the pharmacist types on the computer. She does not say anything that shows she was surprised that it is the patient's third child, so we know the repetition of the patient answer was meant as verification.

Ph-Ph repetition

Ph-Ph repetition occurs when the pharmacist repeats her own utterance. As with the Ph-Pt repetitions, I found different types of Ph-Ph repetitions.

The first type of Ph-Ph repetition is shown in fragment 3.

89	D	Two tablets in the morning.
90		((writes on packet)) (3.08)
91	D	Two tablets in the morning. ↑ne
92	P	Ok.

Fragment 3. An example of a Ph-Ph repetition

Here, the repetition occurs in line 91. The pharmacist tells the patient to take two tablets in the morning. Then there is a silence of 3.08 seconds, and then the pharmacist repeats her sentence, adding ↑ne. The patient answers with "ok".

There are a few things we can tell from this fragment. The fact that the pharmacist says "Two tablets in the morning" and repeats this after a silence means that she was expecting something from the patient after her first utterance. But in contrast with her expectations, nothing happened: there was a silence. By repeating her sentence and adding ↑ne, she shows that the instruction has to be understood as a verification question: she needs the patient to verify that she understood that she has to take two tablets in the morning. After the first time (line 89) the patient does not understand the pharmacist's intentions, and remains silent in line 90. But during the second time the patient does understand the pharmacist's intentions, because she answers with "Ok" in line 92, showing that she understood the fact that line 91 was a verification question, and that she understands that she has to take two tablets in the morning. All in all, we see that a Ph-Ph repetition can function as a way to show the patient that the first utterance should be understood in a different way.

Another type of Ph-Ph repetition involves code-switching. This is shown in fragment 4.

162	D	One ↑pillie <u>eight</u> o'clock in the morning, only.
163	P	[Oh.
164	D	[Phakela fela. *In the morning only*
165	P	Only in- ok.
166	D	Morning. For fifteen days.

Fragment 4. An example of Ph-Ph repetition that involves code-switching.

We can see that the pharmacist repeats her sentence three times: she says "One pillie eight o'clock in the morning, only." In line 146 she repeats "in the morning only", but then in Setswana. Then in line 166 she repeats "morning" again.

After the instruction in line 162, the patient says "Oh." Apparently the pharmacist takes that as a signal that the patient hasn't understood her utterance in line 162, so she repeats her sentence, *but* she does so in another language. This shows that the pharmacist not only thought that the patient didn't understand her instruction in line 162, but that the reason that the patient did not understood, is caused by the fact that English is not the patient's first language. So we see that Ph-Ph repetitions that involve code-switching occur after the pharmacist has concluded two things: first of all, that the patient hasn't understood her first utterance, and second of all, that this is caused by the fact that the patient does not have English as a first language, and therefore does not understand what the pharmacist is saying.

The third repetition of "morning" in line 166 shows that the pharmacist wants to estimate the fact that the patient has to take the pill in the morning. She does so because she probably isn't satisfied with the patient's answer in line 165: "Only in- ok." So here we see that pharmacists can use Ph-Ph repetition as a means to estimate something when they are not sure that the patient has understood it correctly.

Another type of Ph-Ph repetition that I have seen, is rephrasing. This comes in different forms:

Rephrasing the same question (fragment 5)

172 173	D	Ok? Until the fourth of July. And then? What then? What are you going to do then?

Fragment 5. Example of Ph-Ph repetition where the pharmacist rephrases the same question

Self-correction (fragment 6)

178 179	D	You'll get it <u>now</u>, don't worry. ((opens pill boxes, cuts up pill sheets)) So now you see <u>also</u> how your tablets looks. How your tablets look like, ↑ne (.)

Fragment 6. Example of Ph-Ph repetition where the pharmacist corrects herself

Obtain certainty about something, e.g. if the patient really understood everything (fragment 7).

270 D   Ok? You sharp now?

271 P   Yes.

272 D   You sure?

273 P   Yes.

274 D   I don't want you to leave here if you're not sure.

275 P   I'm ok.

276 D   You're very sure?

277 P   Yes.

278 D   Ok. Then I'm very happy. [↑ne ((reaches down to get a brown paper bag))

Fragment 7. Example of Ph-Ph repetition where the pharmacist tries to obtain certainty about something

Pt-Ph repetition

Pt-Ph repetition occurs when the patient repeats something that the pharmacist said. The first type of Pt-Ph repetition is shown in fragment 8.

120 P   I'm going to start to drink this one?

121 D   Ev- all of ↑this

122 P   (all [of this).

123 D   [all of this. Ja. Let me try and explain differently. For the first fifteen days,
124   [↑ne

Fragment 8. Example of a Pt-Ph repetition

Here, we see that the patient asks a question ("I'm going to start to drink this one?") and the pharmacist replies with "Ev- all of this". The patient repeats the pharmacists answer by saying "all of this". It is not really clear what the patient does by repeating the pharmacist's sentence: it could mean that she does not understand, and repeats the sentence to try and grasp the meaning of it. But, the fact that that there is a dot at the end of her utterance, shows that the pronounces it quite confident, and this could mean that she repeats the pharmacists sentence to show that she understood. However, the pharmacist repeats her sentence again in line 123 ("all of this"), and hereby shows that she understands the patients utterance in line 121 as a sign that the patient didn't understood her utterance in line 120. Her "let me try and explain differently" in line 123 estimates this assumption, that the pharmacist thinks that the patient hasn't understood it yet. So, Pt-Ph repetition can be a sign that the patient hasn't understood what the pharmacist said.

Pt-Ph repetition can also be an expression of the patient to the pharmacist, saying: "that's right, you are correct". An example is shown in fragment 9.

231　D　And next morning you going to take them-

232　P　[On the fifth

233　D　Of July.

234　P　Of July.

235　D　↑Mm

Fragment 9. Example of Pt-Ph repetition where the patient shows that the pharmacist is right.

When looking at the intonation of the patient's utterance in line 232, we can see that there is no dot at the end of her utterance: this means that her utterance is not finished yet. However, there are no = marks so the pharmacist overtakes the turn and finishes the patient's sentence by saying "Of July". The patient repeats this in line 234 by saying "Of July." According to the dot at the end, her voice goes down and this means that the utterance "Of July." can be seen as a confirmation of the pharmacist's utterance in line 233. Therefore, this Pt-Ph repetition shows that it can mean that the patient is trying to show that the pharmacist is right about something.

Pt-Pt repetition

Pt-Pt repetition occurs when the patient repeats his or her own utterance. There are not many cases of Pt-Pt present in the dataset. In the transcript that I use for this case study, I have found one interesting Pt-Pt repetition. This is shown in fragment 10.

167　P　Alright. This is only (.) one (.) once a day?

168　D　Ja. ↑ (injama) eight o'↑clock=

169　P　=mm.=

170　D　=phakela fela.
　　　　In the morning only

171　P　mm. Ja. Once a day.

Fragment 10. Example of a Pt-Pt repetition.

Here, the repetition occurs in line 171. In line 167, the patient asks a question: "This is only (.) one (.) once a day?" The pharmacist answers with "eight o'clock" and "In the morning only". Nevertheless, this is not a direct answer to the patient's question. Therefore, the patient draws her own conclusion, and concludes that she was correct and that she has to take this pill only once a day. This is also shown by the fact that the patient adds "Ja" before she repeats "Once a day". In conclusion, this fragment shows that Pt-Pt repetition can be a sign of the patient drawing his of her own conclusion from what the pharmacist just said.

Conclusion

When analysing the dataset, I have found four categories of repetition:

1. Pharmacist (Ph) repeats what the patient (Pt) said   Ph-Pt repetition
2. Ph repeats her own utterance   Ph-Ph repetition
3. Pt repeats what Ph said   Pt-Ph repetition
4. Pt repeats his/her own utterance   Pt-Pt repetition

While having a closer look at the different types of repetition, it occurred to me that I could distinguish different types of repetition *within* the above mentioned categories:

In Ph-Pt repetition, repetition can function as…
1. A way to verify of the patient is confident or absolutely sure about something
2. A way for the pharmacist to express that she is surprised
3. A way to verify if the pharmacist has understood the utterance of the patient (for example, when the patient uses non-verbal communication)

In Ph-Ph repetition, repetition can function as…
1. A way to show the patient that the first utterance should be understood in a different way
2. A way of showing (using code-switching) that the pharmacist has concluded two things, namely that the patient hasn't understood the pharmacist's first utterance, and that this is caused by the fact that the patient does not have English as a first language, and therefore does not understand what the pharmacist is saying
3. A way to estimate something when the pharmacist is not sure that the patient has understood it correctly.
4. A means to rephrase something. This rephrasing comes in different forms:
   - Rephrasing the same question
   - Self-correction
   - Obtain certainty about something, e.g. if the patient really understood everything

In Pt-Ph repetition, repetition can function as…
1. A sign that the patient hasn't understood what the pharmacist said
2. A strategy for the patient to show that he thinks the pharmacist is right about something

In Pt-Pt repetition, repetition can function as a sign that patient is drawing his of her own conclusion from what the pharmacist just said.