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Question-answer sequences between doctors and patients in a South African HIV/AIDS day clinic

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1. Introduction

It is widely acknowledged that HIV and AIDS infection rates are exceptionally high in South Africa (cf. Whiteside 2005). Although the figures[1] that reflect infection in the Western Cape are slightly lower than in other parts of the country the situation is nevertheless alarming and worrying. The nature of the condition and of currently available medication is such that successful verbal communication is an essential precondition to effective treatment. Against such a background it appears to be even more important than with other pathologies that misunderstanding or lack of understanding between doctors and patients should, as far as possible, be addressed and minimized. However, observation and analysis of a small number of consultations between doctors and patients in an HIV day clinic in the Western Cape has given some impression of the communicative dilemmas and difficulties of doctors and patients in consultations related to anti-retroviral (ARV) treatment. Such communicative problems arise from the variety of disparate matters that need to be attended to, specifically the need to monitor constantly not only the physical condition of patients, but also their

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understanding of essential aspects of the disease and their ability to follow the rigid treatment procedures in order to take responsibility themselves for managing their condition.

This paper will focus on a particular generic feature of medical consultations, namely question-answer sequences. Our interest is particularly in the functions of certain kinds of questions and the interactive demands that arise from them. The method chosen is sequential analysis, which means that we study these sequences not in isolation, but within their discursive and institutional context (Johnstone 2002; Bührig 2005). By doing so we aim to reconstruct the underlying communicative purposes which shape the linguistic actions of physicians in ARV therapies. This may not only help us to better understand why communication is organized as it is in this context, but could also allow us to identify inadequate communicative strategies. Thus, thorough reflection on what actually happens in these interactions may be helpful in deciding what works, what does not work and what may be best practice in the given circumstances.

We will first give a general description of the distribution of languages used in the HIV clinic (section 2), the particular communicative purposes of the discourses investigated in this research project (section 3), and the ways in which participants use their linguistic resources to secure proper and sufficient understanding of pertinent matters (section 4). In section 5, we will present data recorded during authentic consultations[2] that will illustrate the particular dilemmas found in the ARV treatment context. In section 6, we will draw conclusions about what the communicative dilemmas are, how they are generally handled and what can be suggested from an applied linguistic point of view.

2. Multilingualism in the HIV clinic

Even before the 1994 introduction of a new, democratic constitution that allows for 11 official languages, multilingualism was the rule rather than the exception in medical institutions in South Africa. With two official languages since 1910, and with limited provision for use of other South African languages in the early years of schooling, language policy in the country at least minimally recognized the multilingualism of the population. The 11 languages are not equally represented in each of the different regions of the country. In the Western Cape where the research project introduced in this paper is situated, three languages account for the first language of about 97.5%[3] of the population of the region. These languages - English, Afrikaans and Xhosa - are mutually unintelligible, and speakers generally exhibit varying levels of proficiency in the different languages that they have learnt as first/home languages (L1s) and second/additional languages (L2s). This, in part, explains the fact that in spite of being a multilingual community, many individually bilingual and even multilingual persons, find cross-cultural or intercultural communication hazardous and burdensome.

Although English is an L1 for only 20.1% of the inhabitants in the Western Cape, it is (as in the rest of the country) an L2 for the large majority of speakers of other languages. Such large numbers of L2 speakers of the language assure that English is securely established as a *lingua franca*. For many speakers of indigenous African languages, such as Xhosa, Afrikaans also forms part of their linguistic repertoire. In the Western Cape Xhosa (L1 for 18.9% of the residents) is minimally established as an L2 for L1 speakers of English and Afrikaans.

As in most public service institutions, the setting in most South African HIV clinics, and certainly in the clinics in the Western Cape where this research is situated, is multilingual and multicultural. In many clinical meetings between doctors and patients from different language and cultural groups, it is possible to treat ailments successfully even if there are minimal shared communicative resources. However, this is not the case in doctor-patient meetings in an HIV clinic. Successful treatment of HIV-related illnesses, and particularly gaining desirable results from ARV treatment, appears to be dependant on successful communication between clinic staff and patients. Considering that in many cases doctors and patients belong to different language, culture and race groups, communicative success is not easily achieved.

The HIV clinic that is run at a day hospital in a town in the Western Cape is a state-funded facility used by patients whose L1 is, in the majority of cases, either Xhosa or Afrikaans. None of the patients observed over a period, in all, of three months reported English as L1; only two of the patients reported Sotho as L1. The patients all reported English as an L2. The Afrikaans L1 patients indicated no or minimal knowledge of Xhosa; however, the Xhosa L1 patients often indicated that they know Afrikaans – in some cases minimally, in other cases with a slightly better proficiency than in English. Although no language proficiency tests were administered, it was clear that patients' L2 skills were not as well developed as their L1 skills. In their communication with the doctors it appeared that, with respect to their L2s, most patients had limited vocabularies, made grammatical errors typical of the interlanguages of language learners, and often found it difficult to articulate even quite straightforward matters. From time to time they were not sufficiently proficient in the *lingua franca* (English in most cases; Afrikaans in some cases) to follow completely what the doctor was saying or asking. However, on close investigation it appeared that, although fragile language proficiency may account for some misunderstanding between doctors and patients, this was not the only source of misunderstanding. In fact, it may not even be the most significant source of communicative failure in this context.

The five doctors intermittently working at the clinic during the period of recording had Afrikaans as L1. Their L2 English skills gave the impression of near-L1 proficiency. None of them reported any significant knowledge of Xhosa, although one would from time to time, when she was not certain that she had been well understood, use Xhosa words in reference to certain symptoms of illness.

In the case of Afrikaans L1 patients, the consultations were conducted in Afrikaans. Mostly the doctors and patients speak different, though mutually intelligible, dialects of Afrikaans. It became clear that with the use of such different sociolects there could be misunderstanding of a similar kind to that occurring with the use of a *lingua franca* when speakers have different L1s.

In the case of Xhosa L1 patients, the consultations were mostly conducted in English. In some instances, however, when patients were proficient in English and Afrikaans as L2s (or as L2 and L3), the consultation was conducted in Afrikaans. Patients would be asked whether they preferred to talk in English or in Afrikaans. On some occasions it was clear that the choice for Afrikaans was due to the patient's better proficiency in Afrikaans; on other occasions it appeared as if the patient chose to communicate in Afrikaans in an attempt to accommodate the (Afrikaans L1) doctor.

No official translating or interpreting services are available. However, in the clinic that took part in this study two of the support staff[4], although not formally qualified or specifically employed as translators, were proficient in all three of the local languages. They were primarily required to explain the intricacies of using ARV medicine to patients entering into the treatment program, and then to assist with checking patients' compliance by counting the pills when they came to the clinic for regular follow-up consultations. The consultations between these health workers and the patients were conducted in the L1 of the patients, thus in these conversations much more Xhosa was used than in the doctors' rooms. From time to time in the doctor's consultation with a Xhosa L1 patient, at the request of either the doctor or the patient, one of these officers would be called on to interpret. Nevertheless, throughout, patients appeared to prefer using an L2 and communicating directly with the doctors, rather than making use of interpreting assistance.

3. Purposes of doctor-patient consultations in the context of South African HIV clinics

The practice of running HIV clinics was introduced in 2003 as part of a state funded plan to "roll-out" ARV treatment in the care of HIV-positive patients who do not have access to private medical aid. The patients who are treated in these day clinics are all people who have been tested for HIV, have been informed by the testing agency where this was detected that they do have the virus, and have often been referred to the clinic for care when some kind of illness has signaled the onset of AIDS.

The most basic knowledge of what HIV entails, assures that a person who has tested positive for the virus, is confronted with a range of choices about how to respond. The response could be to ignore the fact until the presence of the virus becomes manifest in some associated illness, to become withdrawn, depressed and despondent, or to confront the fact and make definite choices regarding lifestyle, disclosure, measures of monitoring and managing the condition, and so on. At the HIV clinics patients present who, regardless of their personal response, know their status and require some form of health care. To date there is no known cure for the condition, though the progression of AIDS and the devastation of the illness can be contained by the use of ARV therapy (ART). Although ART can dramatically improve patients' quality of life and life expectation, there are well-documented hazards to using this treatment.[5]

The flow chart given in figure 1 shows that during the course of an HIV-infection distinct phases in the development of and response to illness and treatment can be identified. During the post-infection phase, patients may adopt different stances towards their condition. Whereas some deny the fact that they are HIV-positive, others face up to the infection and, supported by continuous counseling and self-help from activist groups and NGO's as well as medical institutions, they manage to live with HIV.

This picture changes when the CD4 of the patient drops and first manifestations of AIDS appear. Then, the patient's clinical, personal, and contextual "readiness" will be checked to determine whether ARV will be prescribed and dispensed by the ARV clinic or not. For various reasons not every HIV-positive patient can or should be on ARV. Once ART has become advisable on the basis of a patient's physical condition, which is generally measured in terms of the CD4-count[6] and viral load, a number of other conditions have to be considered before the treatment can actually proceed.[7] The Western Cape Antiretroviral Treatment Protocol[8] (Cohen et al. 2004: 4) refers to the various conditions as "medical and psychosocial criteria" that need to be met before ART can commence. Psychosocial criteria are defined as "factors that place the patient at risk of poor adherence".[9]

Patient compliance is an important aspect of ART: a person who does not use the medication according to strict prescription, is at risk of suffering more from the medication than from the illness it is intended to control. Therefore a clinic that prescribes and administers ARV medicine has a necessary interest in whether patients are able to meet the required psychosocial criteria. The patients' capacity to deal with the psycho-physical demands of the treatment is crucial for the outcome of the treatment. The communicative problems that we will discuss later on in this paper are related to this general requirement that is addressed in the medical consultation relatively late in the course of the infection.

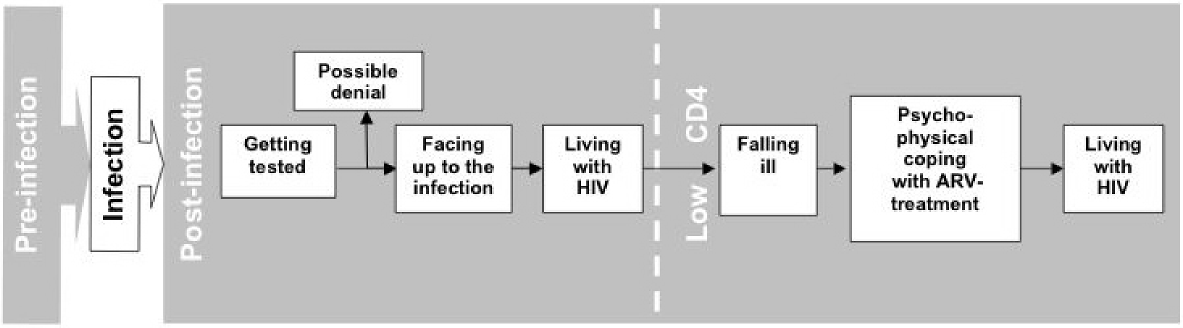

Fig. 1. Bio-psycho-social matters during the course of an HIV-infection

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Systematic, rigid checking of psychosocial conditions of the patient is probably not standard practice in countries with lower infection rates and better supplies in public medical services. Elsewhere it is likely that the patient's readiness for ART and the availability of the medication can be presupposed. However, in the context of most South African ARV clinics, checking the preparedness of patients and actually also facilitating their readiness are generic and important features of the consultation. Thus, communicative demands for doctors and patients increase significantly in the time directly before and after ARV prescription. The doctor's role is then no longer that of a merely clinical professional. Rather, he or she partly acts as a social worker or counsellor, in order to find out what the patient's social circumstances are and to check whether it is necessary and possible to improve the patient's readiness before the medication is provided. Although there are supportive health workers such as qualified nursing staff and adherence officers at the ARV clinics, doctors do not delegate and distance themselves from this responsibility in the process of providing treatment.

The flow chart in figure 2 is a schematic representation of a section of the time events schedule provided by the Western Cape Antiretroviral Treatment Protocol (Cohen et al. 2004: 10). The comprehensive schedule in the protocol is a synopsis of all the activities carried out by the clinic team before and after putting the patient on ARV. Our figure 2 only refers to two types of consultations that are included in this schedule during the first four months of contact between the patient and the health professionals in the ARV clinic, namely (1) educative/therapeutic visits with counsellors, and (2) treatment readiness assessments which are carried out by physicians, and in which counsellors may or may not participate. As the flow chart shows, the first contact between the patients and the clinic is with a counsellor four weeks before the beginning of the treatment. Two and four weeks later, two distinct consultations will be carried out, one educative and one that serves to assess the patient's readiness. Four weeks after putting the patient on ARV, the counsellors will continuously have educative sessions with the patient.[10]

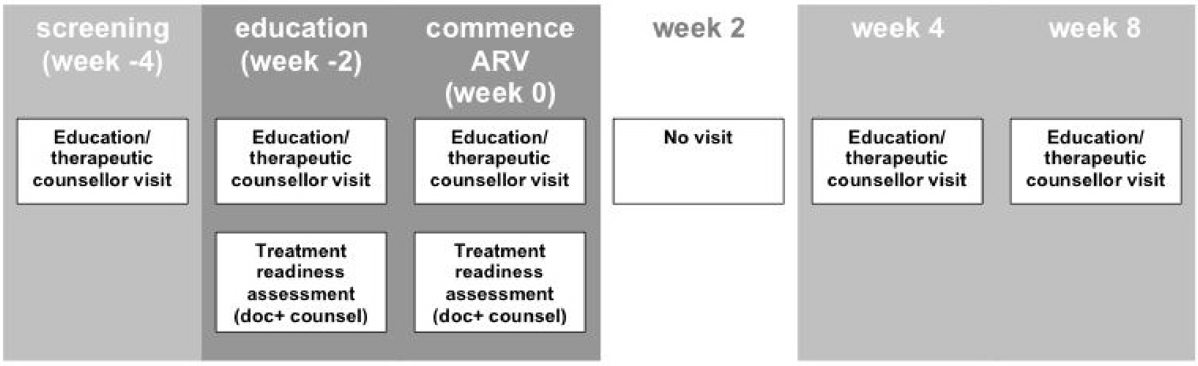


Fig. 2. Consultation types during the weeks preceding and following the beginning of ARV medication

Although week -2 and week 0 are the phases of intensive communication before the onset of the treatment, the communicative demands do not decrease once the patient is on ARV. Even after the patient is put on ARV, doctors and/or counsellors constantly monitor not only his or her physical response to the medication, but also cognitive and behavioural aspects relevant to the use of the treatment. The reason for this lies in the fact that the patients' social conditions usually do not facilitate adherence. Lack of housing, food, transport, income, as well as rejection, shame and lack of family support may hinder their proper participation in the treatment so that, in some cases, it cannot be continued without additional measures and support.

In this investigation, we will focus on data from consultations that occur directly before and after ARV medication has been prescribed to the patient (cf. week -2 to week 4 in figure 2). This means that the patients in our data at the time of entering the ARV program do not show up for the first time. Rather, they have already been in contact with the ARV clinic and/or with other medical institutions for at least a couple of months. We are interested specifically in the communicative function of certain types of questions asked by doctors. Although questions are a generic and typical feature of medical consultations, we believe that in these consultations different kinds of questions occur that highlight particular dilemmas attached to the prescription of ARV medication in the Western Cape. Besides questions about physical conditions, doctors also use questions related to non-clinical issues, such as the patient's understanding of the illness and the medication, and the patient's personal and social conditions. We discuss particularly the manner in which these questions are articulated and what purposes they are intended to serve.

4. Towards the communicative potential of question/answer sequences

Before we analyse the data it is necessary to discuss some general findings about question/answer sequences and their communicative functions in other scholarly work. Beside philosophical and logical traditions, two discourse-oriented perspectives can be found in the literature: an interactional perspective and a pragmatic perspective. The first one highlights the fact that questions are very often "part of a complex communicative project" (Linell, Hofvendahl and Lindholm 2003: 540). According to this perspective, questions are often non-initial follow-up initiatives related to preceding discourse sections. Also, turns containing a question are often composed of several utterances (interrogative and assertive ones), which in combination serve to widen or narrow the range of possible answers. Thus, the interactional perspective perceives questions as devices that link disparate sections of discourse, allowing the addresser to steer the course of interaction and its content (Auer 2005).

The pragmatic perspective emphasizes the fact that questions are used to impinge upon mental activities of the addressee. By asking a question, the addresser triggers a search procedure in the addressee, thus causing specific knowledge elements to be highlighted or foregrounded. This search is guided by the syntactic format of the question and its propositional content. According to this perspective, a question does not only invoke what is unknown to the addresser, but also what he or she assumes to be common knowledge of speaker and listener. Furthermore, questions already outline the answer or at least delineate the scope of answers preferred by the addresser (Rehbein 1984; Ehlich and Rehbein 1986; Rehbein 1993; Bührig 2005). Thus, the pragmatic perspective emphasizes the specific syntactic format of questions and question type (yes/no-questions vs. wh-questions, rhetorical questions (Ilie 1994)), whereas the interactional perspective emphasizes the sequential order of question turns and how they are related to preceding and subsequent units of discourse. The two approaches do, however, complement each other. From both perspectives, it has been argued that communicative functions of questions can only be established by taking into account the discursive context, and, similarly, both approaches agree that institutional contexts generate certain phenomena, like question cascades (Clayman and Heritage 2002; Ehlich and Rehbein 1977) or question paraphrases.

In relating the above to the analyses presented in this article, general features and functions of question/answer sequences that we in fact also traced in our data, can be summarized as follows:

- Complexity - it is often not possible to achieve the intended interactional or pragmatic function with one interrogative act alone. Rather, several acts are needed, very often combinations of assertions and questions or questions of different types (open vs. particularizing ones).
- Intrusiveness - questions are intrusive by nature, as they force the addressee to direct his/her attention towards a specific area of knowledge. Therefore, questions can successfully be used to highlight or topicalize knowledge elements, even if they do not lead to an adjacent and/or overt response.
- Institutionally shaped – question-answer sequences are constitutive in many institutional settings (police, court, health care, classroom, politics, media), yet to identify their specific functions it is necessary to take the specific institutional context into consideration.

As the data will show, physicians in ARV clinics use the communicative potential of questions to monitor psychosocial conditions of the patients, but also to steer their attention towards issues that are related to the treatment procedure, such as the course of the treatment or the development of certain clinical conditions. In this sense, their questions are not always requests for information, but may also serve to provide information and to assess and educate patients. However, as the analyses given below will illustrate, it is sometimes arguable whether the ultimate goal of supporting or encouraging adherence can be achieved by means of this.

5. Discussion of data from five consultations

The Antiretroviral Treatment Protocol developed in the Western Cape is based on national treatment guidelines, and is circulated as the main guide to health professionals who are engaged in the treatment of HIV-positive patients with ARV drugs. This protocol specifically refers to the fact that doctors need to consider more than merely the clinical condition of patients referred to the clinic for possible ART. In the discussion of our data we will indicate how guidelines set out in the protocol direct the various ways in which the consultations are conducted. We will also indicate how patients' responses to some of the questions reflect the differences in the positions of doctors and patients and the associated communicative dilemmas of these particular medical encounters.

5.1 "What is a CD4?" - Insisting on a show of knowledge

In this consultation Inneke, a female physician, (DOC) talks to Adriaan, a male patient (PAT) who has already been monitored by the ARV clinic for some months. During the consultation Adriaan speaks Afrikaans and English, although from the data we got the impression that neither of these languages is his L1. The consultation starts in English but after a while Adriaan switches to Afrikaans, seemingly because he is not fluent enough to answer the questions in English. On a medical level, in terms of his physical condition, he could not have been placed on ART earlier, because he had TB. Now that the TB is cured, his CD4-count remains so low that it indicates that the ART should proceed. During the consultation Inneke, the physician, mainly pages through the file and asks the patient about details of his medical history and his living conditions, much of which is already mentioned in the file. In the section directly preceding the excerpt given below, she asks about how and when his HIV-positive status was determined. The patient tells the physician that he had TB and went to the hospital for that. There it became clear that he was HIV-positive.

Excerpt 1. "Wat is dit?" (*What is it?*)

DOC	Oh, okay.	Orrait.	((2s))	En jou CD-vier telling is gedoen in
	Oh, okay.	*Allright.*		*And your CD-four count was done in August.*

DOC	Augustus.	En dit was seventy-one, né? • •	Kan jy onthou wat is'n
		And that was seventy-one, right?	*Can you remenber what a*

PAT		CD-four?		Jaa.		CD-four is nou die •
		CD-four?		*Yes.*		*CD-four is now that,*
DOC	CD-vier telling?		Hm̌.		Wat is dit?	
	CD-four count is?				*What is it?*	

PAT	• • hoe dat dat hulle nou toets om/ ((2s)) dat hulle/ die, die/ (hoe)
	how they test it, to/ that they/ the, the/ how further the illness goes on, the…

PAT	verder die siekte aangaan, die…	
DOC		So om te kyk hoe ver die siekte is, *So to look how far the illness is, right?*

PAT	Hoe ver die siekte is. *How far the illness is.*	
DOC	né?	Dis mos nou jou soldate-selletijes, né? *These are now your little soldier-cells, right?*

PAT	Ja. *Yes.*	Ja. *Yes.*
DOC	(Hulle) noem dit ook jou/ sommer jou bodyguards, né? *They also call it your/ simply your bodyguards, right?*	

PAT		Is, ja. *Right, yes.*
DOC	Dit baklei teen ander siektes. *It fights the other illnesses.*	

At the beginning of this excerpt, Inneke switches the topic from the patient's HIV-infection to his last CD4-count taken 3 months prior to the consultation: "And your CD4-count was done in August. Do you remember what a CD4-count is?" In this utterance, she uses the Afrikaans expression "CD-vier" to refer to the medical measure of the progress of the infection. Adriaan responds by using the English expression "CD-four". Inneke encouragingly confirms ("Hm"), and the patient then answers the question with a lengthened "Jaa" (*Yes*), indicating that he remembers what the term refers to. The physician follows up by insisting on a more detailed answer by asking "Wat is dit?" (*What is it?*). In attempting to answer, Adriaan starts a longer utterance containing several instances of self-repair, hesitations and pauses. When he finally comes to a relatively good definition of the goals underlying the CD4-count ("hoe verder die siekte aangaan", *how further the illness goes*), Inneke takes over and provides the answer in correct, but colloquial Afrikaans: "So om te kyk hoe ver die siekte is, né?" (*So to look how far the illness is, right?*). Adriaan echoes her definition ("Hoe ver die siekte is", *how far the illness is*) and then she continues with explanations concerning the immune system by introducing typical metaphors such as the one of the "soldate-selletjes" (*soldier cells*). He accompanies these explanations with several hearer signals ("Ja", *Yes*).

In this example the physician raises the issue of the CD4-count by referring to the last date this count was done, which she gets from the file. She then asks a question that does not necessarily call for a detailed answer ("Kan jy onthou", *do you remember*). It can actually be answered simply with "yes" or "no". By calling on the patient's memory she does not explicitly refer to medical aspects of the CD4-count as such; rather, her interest is in those aspects the patient might be able to talk about because he received the results of the test without necessarily understanding all of its technical aspects. Finally, the question as to whether the patient remembers, is one about something that the doctor cannot know and the patient surely can. However, despite the fact that the patient by simply saying "Jaa" (*Yes*) provides an answer that fits the question, and although by lengthening the "Jaa" he signals that he is not quite sure about the details of what the CD4-count is, the doctor insists on a detailed answer: "Wat is dit?" (*What is it?*). This obliges the patient to expose his rather fragmented knowledge about the particular method of checking the effect of the HIV at a given time.

In our view there is a remarkable shift between the doctor's first and second question related to the CD4-count (*Do you remember?* vs. *What is it?*). The first question is a relatively open one that allows several types of answers, even the short and evasive one the patient actually provides. Furthermore, the question makes sense from a patient's point of view: the doctor has just established the CD4-count as a discourse topic, and if she wants to continue this topic she might want to be sure that the patient is able to follow her. Therefore, the question (*Do you remember...*) and the answer (*Yes*) fit well together and would allow a continuation of the consultation. The doctor's second question (*What is it?*), however, refers to a subject the doctor already knows. The question is not intended to elicit information due to a knowledge deficit the physician has on the CD4-count itself. Rather, she wants to hear what the patient knows about this measure. Thus, it is a question that serves to test the patient's knowledge about ARV-related matters. We would argue that specifically this second question goes beyond what one would normally expect in a medical consultation. Taking on the professional perspective and so explaining the CD4-count to a medical doctor, is definitely a tough task for someone who is affected by the virus and presumably has neither the medical-technical knowledge nor the necessary linguistic skills to do that.

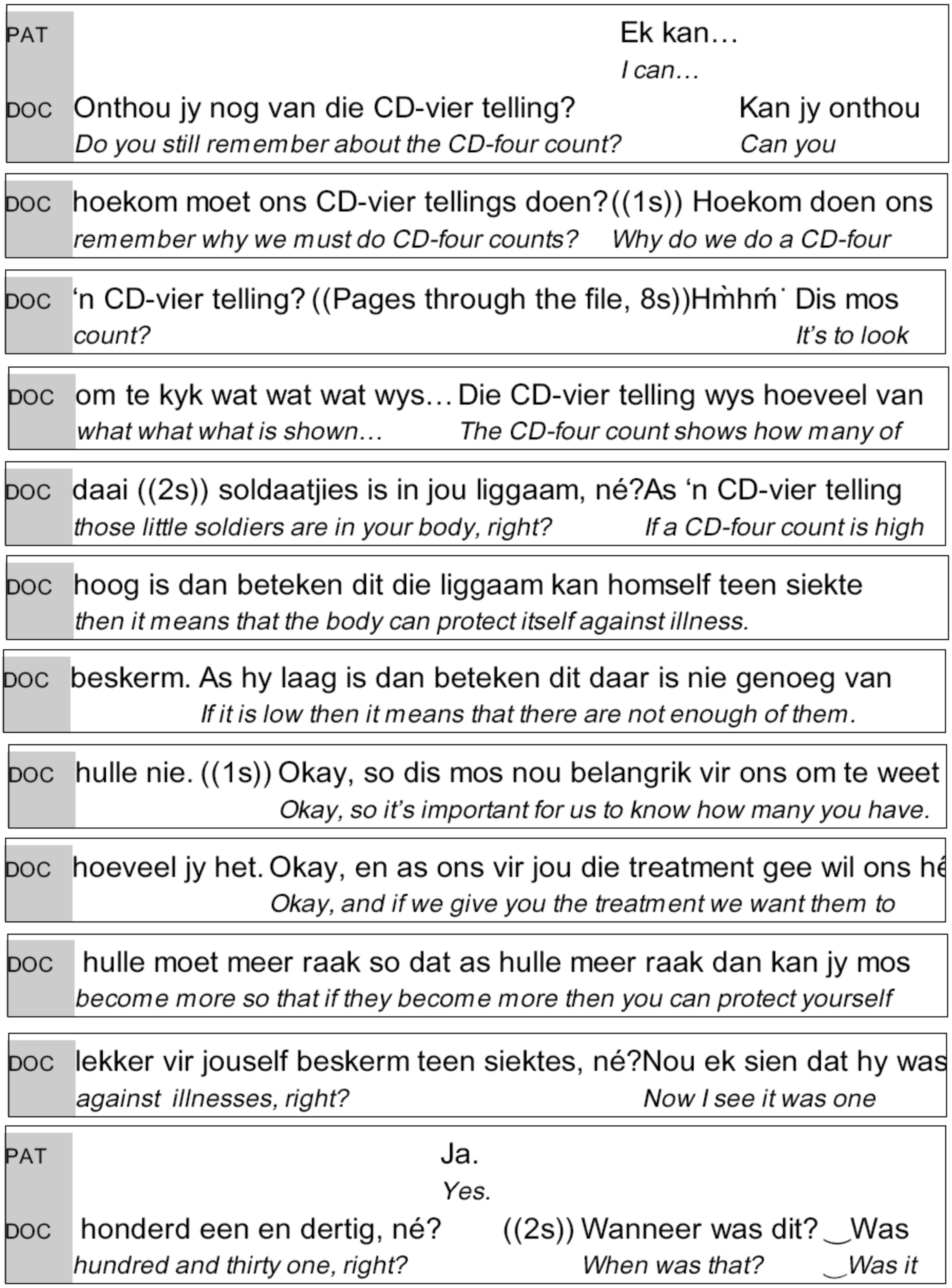
The fact that the physician eventually takes the turn and provides the correct answer after the patient tried to do so, clearly indicates that she does not use this strategy to talk down the patient. Rather, she follows the protocol according to which only informed patients can successfully adhere to the ART and this informedness or "readiness" has to be monitored and enhanced constantly in the same way as the patient's clinical conditions.

5.2 "And what is happening at home?" – Checking on behaviour that may compromise adherence

In this consultation Piet, a male physician, (DOC) talks to Josie, a young, female patient (PAT) that has been on ARV treatment for only two weeks. Josie has Sotho as L1, and both Afrikaans and English as L2s learnt at a young age. Her Afrikaans proficiency appears to be slightly better than her proficiency in English. Further, in the couple of years in this region, she has acquired Xhosa as an additional language. So Josie is a multilingual patient with good receptive skills, and fair oral communicative ability in at least 3 South African languages other than her mother tongue. During the consultation Piet speaks Afrikaans, which is his L1. Josie does not talk much during the whole consultation, but her contributions are all in Afrikaans. She was diagnosed HIV-positive when she went to hospital for care after she fell pregnant. She was successfully treated with the necessary medication to prevent mother-to-child transfer. After the birth of her daughter she visited a mobile clinic near the farm where she lives for various ailments, but her general physical condition did not immediately require the use of ARV drugs. An injury that would not heal apparently preceded a drop in her CD4-count to below 150, thus she was referred to the ARV clinic. Here, as in the first case, there is no doubt about a clinical condition that indicates readiness to start on ARV drugs. However, it has to be established that the patient understands what her clinical condition is and what the treatment entails; it also has to be established that her social circumstances will support her compliance with the prescribed treatment.

As in the previous example, the physician mainly pages through the file and asks the patient about her medical history and how she experienced the first two weeks on treatment. In the section preceding the excerpt below he refers to her last two CD4-counts, taken before and after initiating the treatment.

Excerpt 2. "En wat gebeur by die huis?" (*And what is happening at home?*)



PAT	Ek kan…
	I can…
DOC	Onthou jy nog van die CD-vier telling? Kan jy onthou
	Do you still remember about the CD-four count? Can you
DOC	hoekom moet ons CD-vier tellings doen?((1s)) Hoekom doen ons
	remember why we must do CD-four counts? Why do we do a CD-four
DOC	‘n CD-vier telling? ((Pages through the file, 8s))Hm̀hḿ ˙ Dis mos
	count? It’s to look
DOC	om te kyk wat wat wat wys… Die CD-vier telling wys hoeveel van
	what what what is shown… The CD-four count shows how many of
DOC	daai ((2s)) soldaatjies is in jou liggaam, né?As ‘n CD-vier telling
	those little soldiers are in your body, right? If a CD-four count is high
DOC	hoog is dan beteken dit die liggaam kan homself teen siekte
	then it means that the body can protect itself against illness.
DOC	beskerm. As hy laag is dan beteken dit daar is nie genoeg van
	If it is low then it means that there are not enough of them.
DOC	hulle nie. ((1s)) Okay, so dis mos nou belangrik vir ons om te weet
	Okay, so it’s important for us to know how many you have.
DOC	hoeveel jy het. Okay, en as ons vir jou die treatment gee wil ons h
	Okay, and if we give you the treatment we want them to
DOC	hulle moet meer raak so dat as hulle meer raak dan kan jy mos
	become more so that if they become more then you can protect yourself
DOC	lekker vir jouself beskerm teen siektes, né?Nou ek sien dat hy was
	against illnesses, right? Now I see it was one
PAT	Ja.
	Yes.
DOC	honderd een en dertig, né? ((2s)) Wanneer was dit? ‿Was
	hundred and thirty one, right? When was that? ‿Was it

PAT	Ja.
	Yes.
DOC	dit laas jaar, né? En nou/ toe ons hom nou gedoen het was hy
	last year, right? And now/ when we did it now it was one hundred

DOC	honderd en nege en sestig. Okay, so ons sien hy't al klaar begin
	and sixty nine. Okay, so we see it has already started to get

DOC	beter raak, né? As ons hierdie treatment mooi gaan neem dan gat
	better, right? If we take this treatment nicely then it will get even better.

PAT	Ja.
	Yes.
DOC	hy nog beter raak. Okay. Goed! Sê vir my jy't nie probleme
	Good! Tell me you didn't have problems

PAT	Ja.
	Yes.
DOC	gehad om by ons te beg/ te kom nie? Niks nie. Okay. ((3s))
	start/ getting to us? Nothing.

DOC	En wat gebeur by die huis? ((3s)) Enige problems daar? ‿ Is die
	And what is happening at home? Any problems there? Are the

PAT	((unintelligible, 2s))
DOC	mense bly jy't begin? Het jy vir niemand
	people glad that you've started? Didn't you tell

PAT	((1s)) Uuh uuh.
DOC	gesê nie? ((1s)) Weet niemand dat jy die pille drink
	anyone? Doesn't anyone know that you are

PAT	Hm̌.
DOC	nie? Is dit? Jy't nog nie met mense by die huis
	taking the pills? Really? You haven't spoken to the people at home?

PAT	Ja.
	Yes.
DOC	gepraat of so nie? En die kliniek? Was jy ooit by die kliniek?
	And the clinic? Have you ever been to the

DOC	
	clinic?

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The excerpt can be divided into three sections. In the first section the physician asks three questions regarding the CD4-count. Just like the physician in example 1, he starts with an open question ("Onthou jy...", *Do you remember*). He does not wait for the answer, but continues to ask two more detailed questions about why these counts are carried out. The patient does not respond, so after a fairly long pause in which he goes through the file, the physician answers his own question by explaining why CD4-counts are carried out.

In the second section he refers to the CD4-count of this particular patient ("Nou ek sien dat hy was honderd een en dertig, né?" *Now I see that it was one hundred and thirty, right?*). The patient confirms this statement with "Ja". The formulation "Ek sien" (*I see*) refers here to the fact that the physician gets the clinical information from the file. Then he asks her about the date of this CD4-count: "Wanneer was dit? Was dit laas jaar, né?" (*When was it? Was it last year, right?*). Again the patient confirms with "Ja" (*Yes*). The physician then explains that her CD4-count has gone up and that this indicates that the treatment is working well.

In the third section the physician unexpectedly introduces the topic of transport problems and then asks the patient about her family situation. He starts with an open question (*What is happening at home?)* and then narrows the issue down: "Is die mense bly jy't begin?" (*Are the people glad that you have started?*). Her answer is unintelligible, but from the video we got the impression that she is actually confessing that she did not tell anyone. The physician picks this up, after which the patient audibly confirms that she has not spoken to anybody about her condition. This is repeated one more time, followed by a conventional expression, "Is dit?" (*Really?),* with which Piet shows polite disagreement. A third time he requests confirmation that she has not spoken to the people she is living with. Piet finally stops when Josie explicitly confirms this fact with "Ja" (Yes). Then he switches to another topic, Josie's contact with the local clinic.

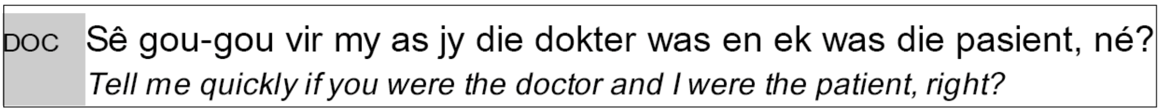
In this excerpt, questions refer mainly to three topics: to technical aspects of the treatment (the CD4-count), to the individual medical history (When was your last CD4-count?), and to the patient's social context. The initial questions about the CD4-count seem to be used primarily to introduce a new topic and to check whether the patient already knows enough about the CD4 as a monitoring device or whether she needs further explanation. With his question about the date of the last CD4-count before the consultation, however, the physician seems to be checking whether the patient is consciously following the treatment. As physicians later confirmed to us, knowledge about the course of the treatment is taken as an indicator of active participation. The physicians themselves call this the "activation" of the patient and consider it to be an important purpose of the consultation. The questions then serve to check for this, but also to foreground the issue and to direct the patient's attention towards it.

The final questions about the family context serve a similar purpose. With such questions the doctor checks to which extent activation has already taken place or not. The patient's "information standing" is considered to be an important indicator for adherence and successful treatment. As the medication requires storage of quite a number of pills and punctuality regarding their intake, it is hardly possible to hide that one is on treatment without putting the effect of the treatment at risk. Furthermore, individuals may find it difficult to follow the procedures without the support of others. Therefore, it is strongly recommended to all patients that they find at least one other person with whom they can share that they are on ART. If patients for whatever reason do not share this information with someone in their family or circle of friends, doctors will probably doubt the patient's ability to adhere to the treatment and they will monitor the patient more strictly.

5.3 "What does the HIV do?" – Using a battery of questions to elicit a response

The next excerpt is from Piet's (DOC) interview with Josie (PAT) when he first saw her at the clinic. It was carried out some weeks before the previous example. Josie was not yet on medication at that time. The interview was carried out to check whether she was ready for treatment.

Excerpt 3. "As jy die dokter was" - (*If you were the doctor*)



DOC Sê gou-gou vir my as jy die dokter was en ek was die pasient, né?
Tell me quickly if you were the doctor and I were the patient, right?

DOC	Jy moet vir my nou verduidelik wat is HIV. Hoe sou jy dit doen?
	Now you must explain to me what HIV is. How would you do that?

DOC	Wat is dit? Alet het met jou daaroor gepraat. Wat het sy gesê?
	What is it? Alet has spoken to you about it. What did she say?

DOC	((unintelligible, 2s)) Dis nie verkeerd nie. Net wat jy dink kan jy vir
	It is not wrong. Whatever you think you can

DOC	my sê. Hoe verstaan jy dit? ((unintelligible, 1s)) Hulle sê dis 'n
	tell me. How do you understand it? They say it's a virus.

DOC	virus. Weet jy wat's 'n virus? • • • Of nie? Wat maak die HIV?
	Do you know what a virus is? Or not? What does the HIV do?

PAT	Hy maak mense dood.
	It kills people.
DOC	Jaa? Het jy al gesien dat hy dit aan iemand
	Yees? Have you seen that it does that to

PAT	Hm̌. Ek het gesien daar by die
	I saw there at the hospital.
DOC	doen? Wie het jy gesien?
	somebody? Who have you seen?

PAT	hospitaal. Ja. En daar by Klapmuts.
	Yes. And there at Klapmuts.
DOC	Is dit? Eh maak dit jou
	Really? Uh, does it make you

PAT	Ja.
	Yes.
DOC	bang?
	scared?

In order to check Josie's grasp of what untreated HIV can do to the body, Piet suggests a kind of role-play. He asks her to pretend that she is a doctor who has to explain HIV to a patient. Josie seems timid and is hesitant in answering. Piet, contrastively, speaks easily. His tone of voice is gentle, though his coaxing to get an answer is unrelenting. When Josie shows no sign of immediately being ready to follow Piet's instruction, three more questions follow on the cue that Josie should explain what HIV is: "Hoe sou jy dit doen? Wat is dit? Alet het met jou

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daaroor gepraat. Wat het sy gesê?" (*How would you do it? What is it? Alet [an adherence officer] has spoken to you about it. What did she say?*). In rephrasing, Piet is apparently trying to make it easier for Josie. In line with the protocol that patients should be properly informed and, for entrance into the ARV programme, should show insight into the consequences of the infection (cf. p. 4 of protocol), he wants her to talk, to articulate her own understanding.

In observing this exchange, it was clear that the patient did not find it easy to respond. She needed time to find her words, and when she actually responded she talked so softly that she was almost inaudible. Sensing her insecurity, Piet tried to help her by saying there were no right or wrong answers; Josie should simply say what she thought, how she understood things. Eventually, when no clear answer as to what HIV is, was forthcoming, he provided the answer: "Hulle sê dis 'n virus" (*They say it's a virus*). The answer is immediately followed by yet another question by him, another request for information that he has, but that he wants to ensure the patient has as well: "Weet jy wat's 'n virus … of nie? Wat maak die HIV?" (*Do you know what a virus is, or not? What does the HIV do?*)

To the full battery of about eight questions intended to elicit the patient's participation in this process of checking that the required cognitive criteria are met, Josie does not volunteer information on technical aspects of what a virus is, what the HI-virus is or what effects the HI-virus may have on a person's health. She answers only the final question.

It was our first impression that the battery of questions used here was a-typical for a medical consultation and that it in fact achieved the opposite of the intended effect. The patient appears to be inhibited by the suggestion that she take on the role of the doctor, that she attempt a medical-technical explanation. Even when she is encouraged to use lay terms, it is beyond any kind of interactive experience she is likely to have had before. Thus she finally responds by picking up on the multifunctionality of the word "maak" (*do*) in this linguistic context: "Wat <u>maak</u> die HIV?" (*What does the HIV <u>do</u>?*). Instead of explaining what the virus does to the immune system, she articulates what it ultimately does to people, what its eventual effect is. Instead of the most likely expected answer that the virus makes one ill, or that the virus destructs the immune system (that it "kills the soldier-cells"), her answer is: "Hy maak mense dood" - what the virus does, is that it kills people. However, this answer is not surprising, as the mortal effect of the virus probably bothers the patient more than the technical details.

Interestingly, the physician immediately reacts to this response and asks how she came to know about the mortal effect of the virus. Instead of insisting on answers to his previous questions, he starts asking about Josie's experiences regarding the virus and her feelings about it. When we discussed this excerpt with Piet later, he stated that he asked all the previous questions just to get any response from Josie. The moment she responded he was satisfied, he said, because that gave him an anchor for further conversation.

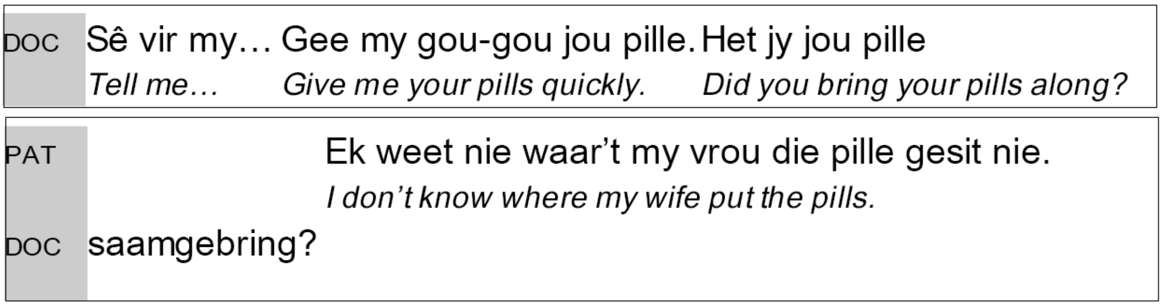
5.4 "How do you know that it is seven o'clock?" – Checking on adherence conditions

The next excerpt to be analysed is taken from an unscheduled follow-up consultation between Inneke (DOC), the physician from example 1, and John (PAT), a male patient with Xhosa as L1 and good Afrikaans L2 fluency. John has been on ART for five weeks, had kept his appointment with the clinic after two weeks when his compliance in the use of the medication was checked by a pill-count, and his physical response was found to be within the reasonably expected parameters and so of no special concern. He was scheduled to come again for a check-up after a month, but in the meantime suffered from persistent diarrhoea. Taking responsibility for his own well-being, he came to the ARV clinic for advice and assistance.

Inneke asks, as is to be expected in any such medical consultation, whether this is a condition the patient has experienced before and what kind of treatment he used then. She enquires as to whether he used the same medication with this renewed bout of the infirmity, and his answer is that he had not taken any medicine for the particular condition as (quite sensibly) he was not certain whether it was good to take other drugs in combination with the ARV drugs he had started with. Inneke acknowledges John's answers with "oh" and "ok". She then changes the topic from the diarrhoea complaint to the HIV condition of the patient and starts to handle the consultation as a regular ART follow-up. If a patient recently started treatment and is not doing well, it may be due to side-effects of the medication, but it may also be due to erroneous use of the drugs. Thus an important question in a consultation would refer to the practice of pill-counting in the clinic. It is a standard instruction that patients are to bring along their ARV medication when they come to the clinic for follow-up visits. The patient's record mostly has a note entered by an adherence officer who checks and enters comments regarding proper compliance after counting how many pills the patient still has and calculating good use of the medication on the basis of how many pills had been dispensed. If the patient gets to see the doctor before such a count has been done, the doctor will check herself. This explains her questions: "Gee gou-gou vir my jou pille. Het jy jou pille saamgebring?" (*Give me your pills. Have you brought them along?*)

Here a completely normal kind of misunderstanding occurs. The patient is still dwelling on the reference to diarrhoea pills, while the doctor has already moved on to a new topic and is referring to ARV pills. When the patient's answer is that he does not know where his wife has put the pills he had used some time ago for intestinal difficulties and that he would have to ask her about it, the doctor infers that he does not know where his ARV pills are and so responds with audible shock: "Jou ARV pille?" (*Your ARV pills?*). The patient immediately recognises the misunderstanding and responds, repairing the miscommunication by providing a better answer: "Hy's by die huis. Ek het nie saamgebring nie." (*They're at home. I didn't bring them along*). As the visit was unscheduled, John had not thought that the regular procedure would apply. Inneke shows her relief by repeating John's words, indicating that she understands that the pills were left at home. Her concern about compliance and her familiarity with the protocol, dictates the next question: "Het jy vanoggend ge/ gedrink?" (*Did you take [your pills] this morning*?) Anticipating Inneke's concern, John starts answering before she has finished her question. He confirms not only that he had taken his pills that morning, but that he had not interrupted his taking of the ARV medication.

Excerpt 4. "Hoe onthou jy?" (*How do you remember?*)



DOC Sê vir my… Gee my gou-gou jou pille. Het jy jou pille
Tell me… Give me your pills quickly. Did you bring your pills along?

PAT Ek weet nie waar't my vrou die pille gesit nie.
I don't know where my wife put the pills.
DOC saamgebring?

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PAT ((unintelligible, 1s))Ek sal gan hoor waar't sy die pille gesit het.
I'll find out where that she put thepills.
DOC [Jou ARV-pille?
Your ARV-pills?
[astonished

PAT Ja/ nee. Is/ hy is by die huis. Ek het nie saamgebring nie.
Yes/ no. Is/ they are at home. I didn't bring them along.
DOC Hy is by die,
They are at, at

PAT Ek het hom ge/ het hom vanoggend gedrink, ja.
I did/ did drink them this morning, yes.
DOC is by die huis. Het jy vanoggend ge/ gedrink?
home. Did you drink them this morning?

PAT Ek het nie, ek het nie opgehou drink nieEn
I haven't, haven't stopped drinking it. And
DOC Okay.Het jy…
Did you…

PAT ((unintelligible)). Nooit nie.
((unintelligible)). Never.
DOC Jy't nie een keer vergeet nie? Hoe onthou
You haven't forgotten even once? How do you

PAT Eh van seven o'clock saans en seven o'clock soggens.
Eh at seven in the morning and at seven in the evening.
DOC jy?
remember?

PAT Nee, ek wiet.
No, I know.
DOC Nou hoe onthou jy dat dit seven/ eh seven o'clock is?
Now how do you know that it is seven/ eh seven o'clock?

PAT Ek kyk na die TV en die dinges eh saans en• • •
I look at the TV and things, eh, in the evening and
DOC Jy weet wanner…
You know when…

doi: 10.5842/36-0-37

PAT	Ek kyk na die TV en die dinges eh saans en• • •
	I look at the TV and things, eh, in the evening and
DOC	Jy weet wanner…
	You know when…

PAT	Sewende Laan/ as Sewende Laan klaar is. Want ek moet my
	Sewende Laan/ when Sewende Laan is finished. Because I have to
DOC	Okay. Okay.

PAT	pille drink. Soggens, my kind gaan mos altyd skool toe. Dan sien
	drink my pills. In the morning my child always goes to school. Then I see:

PAT	ek: "Nee, dis seven o'clock.
	"Oh, it's seven o'clock."
DOC	Okay. Sê vir my jy't nooit TB gehad
	So tell me you never had TB, don't

DOC	nie, né?
	you?

Generally speaking, questions and answers about whether a patient has been using medication according to the prescription, are typical of any medical consultation. However, in this encounter the doctor seems to move a step further. According to protocol she needs to check the pill-count as this is a recognised factor in assuring adherence. If the patient cannot show pills to be counted, the next step is to check whether there are adverse events that have affected his adherence. In this case the explanation that the pills were left at home, is acceptable; yet, Inneke double-checks: *Are you sure you haven't forgotten even once?* John's answer is firm: *Never*.

In moving beyond checking clinical indicators of adherence, the doctor follows a directive to routinely and in an open-ended way, discuss with or educate patients regarding the conditions that support adherence (cf. protocol, p. 28). In this discussion the doctor is apparently aware of the fact that few patients have a lifestyle that is regulated by the exact hours of the day; in fact, very few have watches. The most common time-keeping devices are probably cell phones and the regularity of radio or television programmes. This explains Inneke's question in response to a patient who says that he never forgets to take his pills: "Hoe onthou jy?" (*How do you remember?*). John indicates his knowledge of the nature of his treatment when he says that he takes the pills on exact hours of the day, at seven in the evening and at seven in the morning. The doctor persists: "Nou hoe onthou jy dat dit seven o'clock is?" (*Now how do you remember that it is seven o' clock?*). John's answer is a reinforcement of a pattern in his answers – he anticipates what the doctor may be worried about and gives a brief, clear answer: *I know*. To substantiate his answer he uses the kind of time-reminders that the adherence officers regularly suggest. In the evenings there is a TV-program ("Sewende Laan") that ends at seven and in the mornings his child leaves for school at seven. So in giving the required information, the patient satisfies the doctor, and the doctor moves on to the next question – back to clinical matters about former illness of the patient.

5.5 "Yes, it's in my blood" - Polite silence or stubborn refusal to answer?

The following excerpt is taken from a consultation between Piet (DOC) and Themba (PAT), a patient who fell seriously ill about ten months prior to the particular meeting recorded here. His clinical condition had for some time indicated that he needed to be started on ART. However, considering the particular psychosocial conditions, the multidisciplinary team at the ARV centre was not immediately comfortable with taking a final decision to start him on the treatment. Different doctors and various health workers had explained to the patient what the range of criteria were on which a decision to prescribe and administer the drugs turned. General care was given to immediate concerns, and a date for follow-up visits to the clinic was set. On the day of the recording it was established that Themba had kept all appointments over a period of months, thereby indicating his dedication to the programme even if other circumstances still left a certain amount of doubt as to the patient's ability to comply.

In this conversation the doctor used Afrikaans. The patient, although his L1 is Xhosa, had indicated adequate communicative proficiency in Afrikaans. After briefly checking the age of the patient, his family circumstances, the history of his illness and hospitalisation a couple of months before, the doctor turns to the regular testing of blood samples and the reason for such testing. At this point, he continues with a question-answer procedure already established as a typical pattern in these consultations. The patient mostly gives very brief responses, though he does voluntarily give his understanding that blood samples are tested for their ability to indicate the presence of diseases. Picking up on this, Piet, the physician, encourages Themba, the patient, by saying that indeed he had been tested for various diseases, specifically sexually transmitted diseases (STDs) and that he had tested negative for most of these. Then Piet continues with the battery of questions cited in excerpt 5.

In a series of four virtually synonymous, short questions he asks the patient to name the disease for which he had tested positive and was now visiting the clinic. It is clear that the doctor knows the answer to these questions. His intention is to check whether the patient has the necessary knowledge of his HIV-positive condition. The questions are met by seemingly puzzled silence. Themba gives no verbal response. Finally, Piet starts a fifth question: "Wat noem hulle dit?" (*What do they call it*), and then provides the answer he had hoped to get: "Dis HIV, né?" (*It's HIV, isn't it*?). Technically, HIV is a virus that lowers the body's ability to combat disease. It is not itself a disease. It is widely known that some people carry the virus for an extended period of time before disease that causes concern, sets in. Often the virus is only detected once a patient presents with a tell-tale illness such as TB or chronic diarrhoea. Thus it is possible that in this situation the patient is not certain which disease he is being asked (or told) about. After all, he had recovered from the very serious condition he had had when he was first brought to the clinic. When it is clear that the expected answer is "HIV", the patient simply confirms "Yes, HIV".

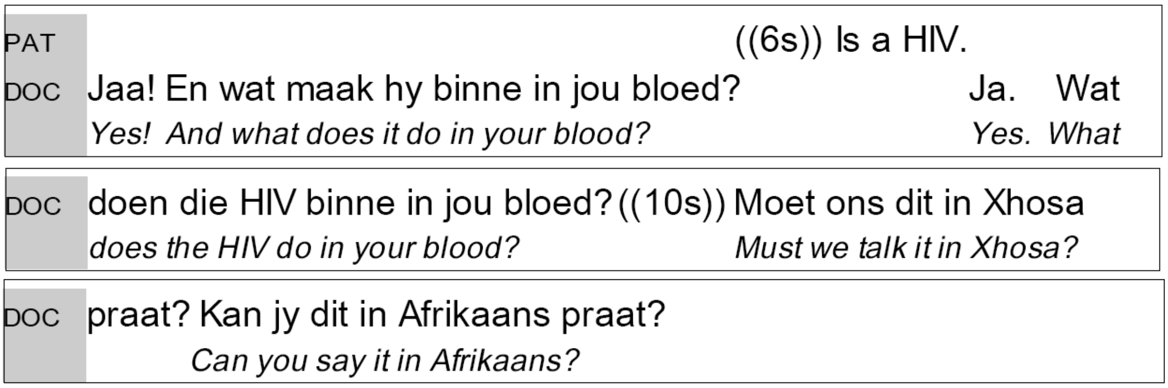
Excerpt 5. "Ja! Dis in my bloed." (*Yes! It's in my blood*)

DOC	Maar watter siekte het jy wel?((1,5s))	Wat is die siekte wat jy wel
	But which illness do you have?	*What is the illness that you do*

DOC	het? ((2s))	Watter siekte is daar? ((4s))	Die een waarvoor jy hier
	have?	*What illness is there?*	*The one that you are here*

PAT		((1s)) Ja, HIV.	
		Yes, HIV.	
DOC	is? ((3s)) Wat noem hulle dit? Dis HIV, né?		Waar is
	for? How do they call it? It's HIV, right?		*Where is*

PAT		Ja! Dis in my bloed.
		Yes! It's in my blood.
DOC	die HIV? ((6s)) HIV is mos in jou bloed, né?	
	the HIV? HIV is in your blood, right?	



PAT		((6s)) Is a HIV.	
DOC	Jaa! En wat maak hy binne in jou bloed?		Ja. Wat
	Yes! And what does it do in your blood?		*Yes. What*

DOC	doen die HIV binne in jou bloed? ((10s))	Moet ons dit in Xhosa
	does the HIV do in your blood?	*Must we talk it in Xhosa?*

DOC	praat? Kan jy dit in Afrikaans praat?
	Can you say it in Afrikaans?

Next, the doctor attempts to get a bit more evidence that the patient has the required cognitive grasp of what HIV entails. He asks where the HIV is, and when he gets no answer, refers back to the blood tests previously mentioned, stating and at the same time asking the patient's corroboration, that HIV is a virus found in the blood: "HIV is mos in jou bloed, né?" (*HIV is in your blood, isn't it*?) Here, similar to the previous response, the patient repeats Piet's words, "Ja, dis in my bloed" (*Yes, it's in my blood*), but with marked impatience: the "Ja" is pronounced with a hint of exasperation. But he is not let off the hook. He is encouraged to elaborate, to go on, to say more. Twice he is asked what the virus does in the blood. It seems that the patient does not know what the doctor is getting at. The doctor is asking to be told the obvious. The patient is being asked to repeat things that have been mentioned elaborately and often before. Surely the doctor should know better than he does what the answers to all these questions are. Unless of course these are trick questions intended to point at something more that the patient needs to know or say. Is the doctor indirectly trying to tell him something that he is not quite getting? And if he gives an inappropriate answer, will he be sent home once again without the drugs that he hopes they will prescribe? So Themba hesitates, he chooses silence as his best option in the circumstances.

Interestingly, Piet interprets Themba's silence not as a lack of clarity as to what precisely is required of him, but rather as a communicative problem linked to the fact that the conversation is in a language in which Themba has lesser (perhaps inadequate) proficiency.

6. Summary and conclusions

Considering the general characteristics of medical consultations, it is to be expected that there will be a high incidence of question-answer sequences. Even so, our data confirm that in the particular doctor-patient consultations in the ARV clinic elaborate use is made of questions. In the excerpts analysed here, questions are given directly and indirectly, often in the form of a statement with a tag question attached as a means of requesting confirmation or agreement. Not every question is matched by an answer. Sometimes whole cascades of questions are used apparently to drive home an important point, or in rephrasing the same propositional content when a required response is not directly forthcoming.

Following the central assumptions of the pragmatic and interactional perspectives on question-answer sequences, it seems that indeed, the majority of these sequences are used to focus the attention of the patient on aspects of the illness and the treatment as the protocol requires.

In excerpt 1 attention is specifically drawn to the CD4-count and the patient's understanding of this. The patient's answer provides the doctor with an indication of whether the patient is sufficiently informed, or whether further explanation is required. Thus, the seemingly standard question about the CD4-count is both a measure to assess the patient's knowledge about ARV-related matters and an attempt to establish a starting point for further explanations, if needed.

In excerpt 2 the first questions relate similarly to the CD4-count. In the second part the focus shifts to social circumstances, when the doctor inquires relatively indirectly about indicators of support the patient has from her family or those living with her. Access to transport may indicate whether the requisite financial support is provided, and whether relatives know about her condition and will assist the treatment. The questions give the doctor insight into the patient's ability to comply and open the opportunity to emphasize the importance of supportive structures at home.

In excerpt 3, however, something slightly different happens. The doctor's questions are directed at the HIV and how it destroys immunity. The patient does not answer in the technical terms the doctor probably anticipated. Nevertheless, he is satisfied because his questions were in part intended to get the patient to talk about her own feelings regarding the illness. In a sense, he would have accepted any response from her.

In excerpt 4 the questions are directed at the topic of taking the medication at regular times. The doctor needs information on how the patient is managing to adhere, and she checks for this quite directly by insisting on a detailed answer to her questions. The patient in this case, however, seems to be very quick in giving the "right" answers. He presumably has already learnt what kind of response will satisfy the doctor, and clearly gives the necessary assurances.

In excerpt 5, as in excerpt 3, questions are directed at the nature of the HI-virus. However, in this case the patient appears to be irritated and therefore reluctant to answer. It is likely that the doctor had the same intention as before, namely to provoke the patient to talk about his condition, but his questions do not have the intended effect. One explanation that seems plausible to us is that it is not transparent why these questions are being asked. The patient has been visiting the clinic for quite some time, so it can be presupposed that he knows his condition. The doctor may know what he wants with these questions, but the long pauses and the abrupt, short answers of the patient show that he, the patient, is not as clear on why he has to answer on what is already obvious.

Table 1 below summarises the topics of the various questions that occurred in the data introduced in this paper and indicates what the functions of such questions were in each case.

	Excerpt 1	**Excerpt 2**	**Excerpt 3**	**Excerpt 4**	**Excerpt 5**
Participants	Inneke, Adriaan	Piet, Josie	Piet, Josie	Inneke, John	Piet, Themba
Topic	What is a CD4-count?	Is there a supportive social context?	What is HIV?	How does the patient manage to adhere?	Does the patient know his condition?
Purposes of questions	Checking knowledge, providing information	Checking behaviour and context, emphasizing need for support	Checking knowledge, activating the patient, bringing her to respond	Controlling adherence behaviour	Checking knowledge, activating the patient, bringing him to respond

Table 1. Synopsis of the main focus of excerpts 1-5

The question-answer sequences in the data analysed serve the following purposes:

- to check the patients' understanding of their condition and HIV-related matters,
- to check their social context as indicator of most likely adherence behaviour, and
- to elicit responses from the patients, to anchor and direct further conversation on aspects of the illness and treatment as directed in the medical protocol.

The first two purposes relate directly to common assumptions about cognitive and psychosocial indicators of good adherence. The third one, however, seems to relate to something less obvious, namely a conception of the kind of communicative behaviour typical of an optimally adherent patient. It seems that a patient who, in the relationship with the doctor, is able to articulate his/her understanding of HIV-related matters clearly, is constructed as more likely to comply with ARV prescriptions. It is of course possible that the use of questions to fulfil the latter purpose, namely to prompt explicit vocal response from the patient, is specific to the personal style of the doctor rather than generic. However, there are clear differences between doctors and patients on the level of language, culture, race, social position, formal schooling, personal experience of HIV-related illnesses, etc. These differences could account for the lack of ease in keeping a meaningful linguistic exchange going. Then it is likely that there is more to this communicative purpose than just the individual style of a particular doctor or patient.

Considering the insight gained from the analyses presented in this paper, the following emerges:

- Question-answer sequences in our data are used in a manner similar to those typical of medical consultations in general.
- A number of them, however, appear to have forms and functions which are specific to the HIV-context.
- Not all of the topics raised in the sequences investigated are articulated in the medical protocol set out for ART; although all doctors subscribe to the set protocol, they sometimes introduce their own topics either in addition to or instead of the prescribed ones.
- Although the aims of assessing and educating the patient seemingly have been achieved in most cases, there were awkward moments, when patients appeared to be at

a loss for words, even irritated and annoyed, while doctors appeared to be at a loss for how to get an authentic and useful response.

Although it is not within the scope of this article to make suggestions about how to communicate effectively with HIV-positive patients in the Western Cape, we think that some considerations nevertheless could be raised. It may be helpful to enrich what can be achieved in these consultations by bringing in greater awareness of

- culturally determined taboos that make communication about sexual aspects of HIV-transmission and management of the condition difficult,
- levels of education of the patients that make it difficult for them to articulate their understanding of HIV, the immune system, etc., in the sophisticated terms that the questions imply, and
- differences in perspective on a debilitating illness that interests physicians from the perspective of an epidemic that requires aggressive intervention, but interests patients from the perspective of personal experience of being ill and fearful of how the illness will affect their quality of life and life expectancy.

It is possible that with specific attention to these considerations, some of the awkwardness experienced by the doctors as well as the patients in question-answer sequences such as those analysed here, may actually be avoided.

Notes

1. Determining exact numbers of people infected with HIV is notoriously difficult. Antenatal surveillance is internationally recognised as the most useful way of estimating HIV prevalence.
2. Due to the sensitivity of the condition and the possibility of intruding in a very personal consultation process, proper ethical clearance in research such as this is imperative. The data were collected as part of an NRF-funded focus area research project by one of the researchers who was also present during the consultation. Before any recordings were made early in 2005, the project was given ethical clearance by Provincial Health Care authorities at the hospital in question and by the University of Stellenbosch Research Committee A. In each case, before audio-recording a consultation, informed consent was obtained from the patient as well as from the consulting doctor. In a small number

of cases video-recordings were made; however, to protect identities and to limit intrusion of the researcher, visual recording was not standard procedure.

3. Statistics from most recent official census taken in 2001 (http://www.statssa.gov.za/census01/html/WCPrimary.pdf).
4. These two officers are a "health officer" appointed by the local municipality, and an "adherence officer" appointed by an NGO that works closely with local community organisations informing and advising on HIV testing, counseling and prevention, as well as providing support of various kinds to HIV-positive patients.
5. The positive effect of ART on the quality of life of HIV-positive patients has been proven in numerous studies. See, for example, Abadía-Barrero and Castro 2006. However, the treatment may also cause side effects like stomach pain, headache, diarrhoea, or nausea that need to be monitored carefully.
6. A normal CD4 count is around 1000. HIV-positive patients generally present with a markedly reduced CD4 count. This is an indication that the patient is vulnerable to a variety of opportunistic diseases. In state clinics the policy is to prescribe ARV treatment when the count has dropped to below 200, even if the patient appears to be relatively healthy.
7. For example, infections like TB (tuberculosis) need to be treated first.
8. The protocol is inspired by World Health Organisation (WHO) guidelines for health workers working with HIV-positive patients, cf. WHO 2006.
9. Martini et al. 2000 and Martini, Parazzini and Agnoletto 2001 point out that adherence to ART is influenced by cognitive factors, such as the patients' attitudes towards the condition and the treatment, and by the doctor-patient relationship. See also Fong et al. 2003.
10. The counseling sessions may also be devoted to the patient's coping with his or her condition. However, they are not comparable to AIDS counseling encounters such as those investigated by Perakyla 1995, which have a therapeutic orientation.

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