Post-colonial Appropriation of English Language: Case of ELF and L1 features in HIV/AIDS Consultations in South Africa

Diana B. Njweipi-Kongor
St Jerome's Catholic University Institute, Douala, Cameroon.
University of Bamenda, Cameroon

Abstract
This study addresses a gap in medical research, especially in the field of HIV/AIDS, namely, a lack of sufficient data-driven analytical investigation into the linguistic and conversational nature of doctor-patient communication in English as lingua franca (ELF) in a multilingual setting in South Africa. It is a qualitative analytical study that investigates the features of ELF and L1 between doctors and patients with different L1s during HIV/AIDS consultations in a postcolonial medical setting in the Western Cape Province. The data consist of transcribed audio-recording of HIV/AIDS consultations conducted in ELF. Discourse analysis (DA) was used to decipher the discursive features through which interactants mark their appropriation of English as a socio-cultural tool with the use of their regional ELF. From this perspective, the results reveal characteristic linguistic features of ELF usage like borrowing, linguistic transference from L1, the use of analogy, code-switching and local metaphors, all resulting from processes of indigenization and hybridization. The study therefore shows that there are some linguistic and socio-cultural specificities of HIV/AIDS consultations that show that South Africans use ELF during this discourse not just to include interactants who would otherwise have been excluded or who would have been just minimally involved but also to put their stamp of ownership and appropriation of the English they use.

Key words: ELF, Appropriation, indigenisation, hybridisation, code-switching, Discourse analysis.

Introduction

Health communication discourse research has expanded to cover a wide range of areas including the relationship and communication between participants of different professional and linguistic backgrounds. Mostly, such research is motivated by concerns for the quality of health care provided when there is cultural and linguistic discordance between the service providers and the patients (Orr 1996; Ohtaki, Ohtaki & Fetters 2003; Moa 2005; Schouten & Meeuwesen 2006). HIV/AIDS is part of this and the foci on HIV/AIDS discourse itself range from blame allocation, malevolence, stigma and social distance (Pittam & Gallois 2000), to identifying and suggesting care for groups that are most vulnerable to the infection (Fiscella et al. 2000). Many studies on this subject have centred on aspects such as education regarding transmission, prevention, counselling and treatment of those affected and infected (Dube 2006), who often have to deal with the stigma associated with HIV/AIDS (Campbell, Nair & Maimane 2006; Campbell, Nair, Maimane et al. 2007). Other studies have focused on lessons learnt by those who have made contributions to HIV/AIDS research (Ellison, Parker & Campbell 2003). These studies rarely refer to the specificities of the actual doctor-patient interaction, which could be critical to the management of the pandemic especially in a cross-cultural and multilingual context. This paper focusses on ELF as a local variant of English that is not necessarily sub-standard, but which reflects a distinct cultural outlook through local usage. The paper explores English as a language that bears the scars of the political history, the different cultures which have robbed shoulders with it over time and the different contexts which result in linguistic features and practices that are evidence of appropriation and accommodation. These are processes by which, Ashcroft, Griffiths and Tiffin (1989, *38-39)* say, the language (English) is made to "bear the burden" of one's own cultural experience … and is adopted as a tool and utilized to express widely differing cultural experiences such as the HIV consultation. This echoes the opinion of writers like (Rushdi, 1992) who think that postcolonial users of English which was an imperial language, can't simply use the language and I dare to add, do not have to use it the way the British did ; but need remake it

using the linguistic resources available to them, to suit their own purposes.

In the South African context, there are cultural and linguistic peculiarities which engender communicative challenges in public domains (Pennycook 1994; Ellis 2004), especially considering how linguistically complex public spaces have become in the post-colonial times. The 1996 Constitution of the Republic of South Africa recognises eleven official languages, providing the possibility for members of the different ethnic groups to use their first language to conduct interpersonal and official business (Mesthrie 2002). Medical consultations between doctors and patients in general and in HIV/AIDS clinics in particular present instances where this provision of service in the client's language choice should be honoured. Unfortunately, most post-colonial language policies still struggle with the hegemony of the colonial languages (English and Afrikaans in the case of South African) that they do not sufficiently provide for planning, linguistic, structural or financial resources to implement such intentions (Anthonissen 2010). Research has shown that not many health workers in South Africa share the same mother tongue with their patients (Penn 2007; Watermeyer 2008; Deumert 2010), with as little as 5% of doctors being able to conduct interactions in their patient's mother tongue (Schwartz 2004). This implies that a majority of consultations are still carried out in English, even though the interactants have limited proficiency in the language. Interestingly, the population of patients who require medical services (HIV/AIDS treatment) and who are not L1 users of English keeps increasing due to easier migration of people across national boundaries .This necessarily puts a lot of strain on the health workers who must meet the health needs of the patients that come along, in a common language that is understood by both them and the patients. Such a language is a lingua franca and in the four HIV/AIDS clinics in which this study was carried out in South Africa, the lingua franca was English (ELF).

Thus using a language that both health workers and patients understand, even if they both have limited proficiency in it, is in line with some research that has revealed that good communication in consultations should be patient-centered and should guarantee patient satisfaction (Beisecker 1990; Elwyn, Edwards & Kinnersley 1999). So,

health workers and patients in these HIV/AIDS clinics show some ingenuity in the use of the linguistic resources available to them to try to resolve the language problem. They do this by adapting and adjusting the ELF through processes of hybridization, indigenisation, code-switching and the use of local metaphors and analogy, which are all linguistic processes that resulted from the post-colonial linguistic set up.

Primary data on doctor-patient interactions on the use of ELF in HIV/AIDS consultations within South Africa is generally lacking since the role of language and communication during such consultations is rarely addressed. This study addresses this gap, by providing data from which features that mark communication practices in health care consultations between an expert (the doctor) and a lay person (the patient) could be deduced. The study focuses on cases where the speakers have a variety of different first languages (L1s), and where patients who mostly have low levels of proficiency in English and quite often limited knowledge of the illness they are being treated for, have to explain symptoms as well as receive diagnosis and prescription in a language which is not their L1. The study investigates salient aspects of participants' knowledge and use of ELF as a post-colonial linguistic tool to navigate the complex topic of HIV/AIDS.

Methods

Data wwere collected through audio-recording of doctor-patient HIV/AIDS consultations, conducted in ELF in four public clinics in the Western Cape Province, South Africa. These were transcribed using transcription symbols adapted from Ten Have (1999: 213-214, 2004: 183-184). A total of 19 consultations were recorded over a period of six weeks. The sample specifically consists of four doctors (1 male and 3 female) who had each been involved with the treatment of HIV-positive patients for at least 2 years. They were selected by default because they were working in the four selected clinics. All the 19 patients were HIV-positive adults who were on or to be put on anti-retroviral (ARVs). Only people who did not share a common L1 and used ELF for consultation were eligible for the study. Due to ethical considerations that were made for the participants, all of them signed consent forms. The patients were initially contacted by a nursing Sister, who followed the language and age

criteria prescribed by the researcher. The doctors are coded as Drs. A, B, C and D, with Drs A, C and D being Afrikaans L1 speakers and Dr B being Xhosa but also able to speak Mosotho. The data are analysed from a macro i.e. DA perspective, to investigate the impact of the socio-cultural environment on ELF as it is used in the context of HIV/AIDS consultations to highlight the form it takes in terms of discursive features.

Data presentation, analysis and discussion of results

The data presented here constitutes part of the research work on a doctoral dissertation. In this light, only data patches from the corpus that reveal characteristic South African ELF and L1 interactive features and strategies from the local indigenous languages that are used to facilitate the doctor-patient HIV/AIDS consultation are presented and discussed. The discussion is intended to paint a picture of the form the language takes in this context and present its strength even in post-colonial times.

Specific L1 discursive features in HIV/AIDS consultations in ELF

Linguistic hybridity and indigenization (metaphors and analogy)

The doctor uses local metaphors and analogy that the patient understands, to explain HIV and related concepts such as CD4 count and viral load. The use of these features in a South African setting is a confirmation of (Meierkord 2002: 124)'s opinion that the heterogeneity of ELF users creates "communicative hybridity" i.e. English marked by influences and incorporations of other languages and influences relevant to the participants. In the present study, they not only add local colour, they can be seen as markers of ELF-communication by people in the Western Cape and a clear indication that these people have appropriated the language.

The use of locally developed and easily accessed metaphors and analogies, help the interactants understand and communicate with each other better as they can relate to the figures of speech used. This is crucial to yielding a positive medical outcome. For example in Extract 1 (taken from Consultation 14), the doctor discusses the CD4 count, the viral load and the ARVs and the outcome of their combined work, using the

metaphors of 'good people' and 'skollies' in a 'township'. In this way he likens the destructive effect of the viruses to that of the "skollies in the road" who are "killing and chasing the good people" (lines 140-146).

Extract 1: Analogy and local metaphors

123	Patient:	Yes she told me my CD4 count is 344
124	Doctor C:	That's great and the viral load?
125	Patient:	She didn't tell me about the viral load
126	Doctor C:	The viral load is beyond detectable levels
127	Patient:	Why?
128	Doctor C:	How do you understand that? Do you understand that?
129	Patient:	That is the problem. I know my CD4 count but the viral load I don't understand about the viral load
130	Doctor C:	Ok I'm going to try to explain to you
131	Patient:	Yes please
132	Doctor C:	We take some of your blood ok,
133	Patient:	Hmm
134	Doctor C:	And then we take some of the blood and we take one drop of blood and then we put it and we take a photo of it and we in that photo we can see how many of the good CD4s are in your blood
135	Patient:	Ok
136	Doctor C:	It's like when you are taking a photo of the township?
137	Patient:	Uhmm, uhmm
138	Doctor C:	then you would see what's happening on the streets.
139	Patient:	Uhmm
140	Doctor C:	In this streets you would see all of these good people going to work
141	Patient:	Uhmm
142	Doctor C:	And they are doing fine
143	Patient:	Uhmm
144	Doctor C:	That's the CD4s. Now if everything is good in the town there would be a lot of people going to work. But if there is a lot of skollies in the road they will start killing and chasing the good people away

145	Patient:	Of course
146	Doctor C:	now what we do is when we take the photo we see how many of the good people is there and we also see how many of the viruses are there
147	Patient:	Ok
148	Doctor C:	Now if we say it is lower than detectable it means that on this photo that we have taken we don't see any viruses
149	Patient:	Ok
150	Doctor C	So that means that the medication is killing all the viruses in your blood
151	Patient:	Is it?
152	Doctor C:	So it is important to remember that the medication is not taking the virus out of your body but it is taking the virus out of your blood
153	Patient:	Ok

The same doctor in another consultation says, "And now, this one is the combination of ARVs ok? So they are like a team, they work together. They are like a 'rugby' or 'soccer' team. You can't play without this one. You need to play with all of them together, ok?" (line 103, Consultation 15). Through this strategy, the doctor makes the point that; none of the drugs is to be taken in isolation. He insists, "So that is the first rule. If one of them gets lost you must come back and get the rest of them ok?" These analogies would not be understood in a context in which these games are not played or enthusiastically supported.

Linguistic transference and borrowing

The interactants in these consultations display what has been referred to as pragmatic knowledge of their linguistic resources when they introduce linguistic elements from local languages into the English they use in that environment (Stockinger 2003: 14). Their communicative competence allows them to opt for both lexical and syntactic simplicity as it enhances their intelligibility during the consultation. There is evidence from the data of transference and hybridization as defined by House (2003: 573) and Bhabha (1994); who see it as border-crossing, taking alien items into

one's native language and culture, going against conventional rules and standards. In this case, this involves the incorporation of linguistic items from the interactants' L1 into English in ELF interactions. It is an aspect of code-switching which involves the isolated use of lexical items from one language in another for various reasons (Gxilishe 1992: 94). For example, the expressions 'yho' and 'shoh' which are interjections that express astonishment, surprise and disbelief occur in the data and are quite common in normal South African every day interactions, and seem to be communication features whose roots are in the indigenous languages that are spoken in this area of the country. So in the phrase, "Yho, you are great hey" Doctor C is pleasantly surprised and impressed with the patient's multilingual ability. Meanwhile 'hey' is an affirmation which often functions as, and is usually placed in the position of a tag question. It appears in the data and is used quite liberally by all the doctors to engage the patient. For example, Doctor A says, "what we still need to do and the Sister took blood today hey?" *(line 24, Consultation 11*), and Doctor C says, "°°° (Let me see) °°°They did took your blood hey?" (*line 25,* Consultation 16). Then the word 'bietjie' and 'skollies' are Afrikaans words for 'a little' or 'a bit' and 'bad people' respectively. With "Not Afrikaans bietjie?" uttered by Doctor C (*line 7, Consultation 17),* the doctor wants to know if the patient speaks any Afrikaans and by choosing this word there is the insinuation that if the patient could speak any Afrikaans, then she ought to know the word 'bietjie'. But it seems that the doctor was deliberately playing on the word to lighten the mood because I would think that the doctor knew what English word he could use, in the place of 'bietjie' in this utterance.

Other instances of this type of lexical usage are evident in the use of 'vanag' and 'mos' as seen in, "It changed this vanag, it it changed mos" (Doctor D; *line 14, Consultation 19)* and "He is a Xhosa mos" (Consultation 14, line 156). 'Vanag' is an Afrikaans word for 'tonight', while the word 'mos' is a South African colloquialism for 'of course'. There is also the regular occurrence of a local token 'neh' which is unique to the South African context and used to acknowledge or re-inforce a situation. Doctor B says, "She must be tested. Ok so you're ready neh …" *(line 57, Consultation 12).* This is also to ascertain the

readiness of the patient to start his treatment. The linguistic feature 'neh' is used at all the phases of the consultation and by all the doctors.

It is also not uncommon to find conventionally ungrammatical sentences as is seen in most information-giving/-seeking and diagnostic sequences. This is evidence of levelling and simplification (Canagarajah 2006). Similarly, the uses of non-L1 strategies such as transference have been recorded as typical of ELF interactions (Meierkord 2006a). One of the characteristic strengths of ELF interactions is that the interactants are more concerned about their message than they are about respecting conventional grammatical rules. Consequently, they transfer syntactic structures from one language to the other as mentioned above or blatantly distort rules and ignore the conventional grammatical mistakes of their interlocutors. This is because in ELF situations, L2 varieties have different sets of often flexible grammatical rules, which gives rise to alternative linguistic forms that are typical of lingua franca use. For example, the sentences below do not disrupt the interaction and the interlocutors do not worry about them because from the ELF perspective, they are part and parcel of the language.

> Patient: "I'm not feel like eat so much all the time" (*line 16, Consultation 16*) instead of 'I don't always feel like eating much all the time', and
> Doctor C: "They did took your blood hey?" (line 25, Consultation 16), to mean, 'They did take your blood, didn't they?'

Meierkord (2002: 109-133) observes that in lingua franca situations sometimes, ordinary vocabulary items seem to take on new and/or additional meaning in the interaction and the meaning of some words is shown to shrink. For example the word 'sorry' in Native Speaker situations usually indicates an apology for wrong doing, but in this context, it signals a request for clarification. This transference is typical of South African English even though the same speaker can still use the word to convey its conventional meaning of indicating apology. Also the word 'blood' in, "Errhm then we can do the uhm bloods next month hey?" (line 83, consultation 3) is an uncountable noun which in this case

Doctor A has modified into an unconventional plural noun 'bloods' which semantically represents the different blood tests to be conducted.

Code-switching

During the consultations, the interactants occasionally switch from English to their L1 between themselves. Code-switching serves different functions such as a means of establishing intra-group solidarity, a means for identification and for referential purposes (Gxilishe 1992: 94). By language switching from English to Sotho (*Extract 2, lines 95-105, Consultation 6*), the interactants establish some sort of linguistic support and rapport for each other. This creates an atmosphere of camaraderie (House & Rehbein 2004: 135), that eases the tension and formality of the consultation. The referential function of code-switching is displayed when there is inadequacy of facility in one language on a certain topic or lack of vocabulary to name new things, concepts, persons and personal experiences. This is not evident in this study but is mentioned as it is a typical occurrence of congruence in code-switching (Myers-Scotton 2002: 101-102). Only one Xhosa patient uses the modified expression 'iviral load' to explain the concept of viral load. This can be seen as a case of linguistic borrowing.

Extract 2: code-switching[1]

91	Doctor B:	I'm sure that you can arrange it erhm? Are you married to a Mosotho man?
92	Patient:	I was married to a Mosotho man then he passed away
93	Doctor B:	Ooh, can you speak Sotho
94	Patient:	Yes I speak it fluently
95	Doctor B:	Really? ((Addresses her in Sotho: O a bua? –You speak Sotho?))[2]
96	Patient:	((laughs and responds in Sesotho: Ke a bua- I speak Sotho))

[1] Note that the researcher was not in the room during consultation, thus, only extrapolates from what is transcribed from the recordings that were done under very strict ethical consideration. This explanation is true for all the excerpts.

[2]Translation of L1 expressions into English follows immediately after, to facilitate understanding for Non-native speakers of the L1

97	Doctor B:	Now this lady wants us to speak in English when we could actually speak the language we both understand
98	Patient:	((Laughs)) Eh
99	Doctor B:	(Continues in Sotho: Bana ba gago ba kae- where are your children?)
100	Patient:	((Responds in Sotho: Ba teng, ko skolong- they are here, going to school))
101	Doctor B:	Ok that's nice. Ooh see now, that's why I don't like this tape otherwise we could speak Sotho. Now we are forced to speak
102	Patient:	English
103	Doctor B:	We're forced to speak English because this lady wants to understand us, the researcher wants to understand us
104	Patient:	Uhmm
105	Doctor B:	Alright the next time S we gonna speak Sotho.
106	Patient:	Yeah
107	Doctor B:	When are you planning to be back?

The use of explanation and repetition

The interactants display their understanding and give their explanations of the medical terminology and concepts through the use of linguistic strategies such as repetition, detailed explanation and demonstrations. The doctors and patients use simple everyday speech and registers to describe symptoms, complaints and even the medication despite the technical nature of some of the concepts that are discussed during the HIV/AIDS consultation (see Wetherell et al. 2002; Traynor 2006). Doctors reveal a lot of sensitivity to patient's level of understanding and go to great lengths to explain each one of the medication in simple language for the patient to understand, even if it means incorporating local imagery and colloquialisms. One of the most common and recurrent communicative strategies used by all the doctors in this study is the use of detailed explanation and demonstration, to describe both the disease and the medication. For example, Doctor C says, "You can see that although it looks like that, (this is the purple ones), it's going to look like this in the future, okay?" (line 85, Consultation 8). He describes the shape of the drugs, simultaneously giving the verbal explanation and demonstrating by

showing the physical appearance and name of the drug. He emphasises through repetition, "It's that one. You will see that it's Lamivudine, Lamivudine" (line 89, Consultation 8).

The organizational structure of HIV/AIDS consultations

Turn organisation and duration

The CA analysis provides an understanding of the HIV/AIDS consultations in ELF, in terms of turn time and structure. It has been found that in turn organization, turn time usually indicates power and control as evident in male-female interactions (Spender 1980: 44). Consequently, the frequency of turn-taking and duration would be an indication of control and power. In medical discourse, this is usually in favour of the doctors who are supposedly more knowledgeable in the illness regardless of their gender (see Beisecker 1990; Orr 1996; Cordella 2004; Moa 2005; Heritage & Maynard 2006). However, in this study, control is shared and is never absolute since it is constantly negotiated between the doctor and patient depending on what is actually happening in the consultation (Sacks et al. 1974, Boxer 1992 & Wooffitt 2005). But generally, possibly because the doctors are more proficient in ELF than most of their patients and more informed of/about the illness, the doctors' turns are more elaborate, explicit and more frequent than those of the patients. The data generally reveals that turns are equally shared in terms of number since none of the interactants refuses to take a turn even if this is just to respond with a sound or mumble. Also, it is observed that the more proficient the interactants are the longer their turns, which renders their consultation more elaborate and says a lot about how much they have appropriated ELF as a communication tool.

In some cases though, the length of the consultation is influenced by the gravity of the patient's case. For example, the shortest consultation with a single patient lasts only 01. 32 minutes because the interactants are not engaged in any disease-related interaction. In contrast, the longest consultation lasts 28.09 minutes. But, in terms of control, the doctor unavoidably remains the dominant partner as s/he determines the course of the consultation by initiating more turns, asking most of the questions and often unilaterally deciding on topic changes. The patient comes through almost as a docile participant who takes very little, if any

initiative of his/her own, to communicate his/her views and desires. But ELF interactants use a strategy like code-switching to a particular L1 to select and identify the next speaker as seen below.

Extract 3: Modification of preselection rules

5	Doctor A	Are you happy with your CD4 of 271
6	Patient	((speaks in Xhosa: 30? unclear))
7	Nursing Sister	((responds in Xhosa: Uthi isuka ku-30 ngoku)) – ((She says it has risen from 30))
8	Doctor A:	What is she saying?
9	Nursing Sister:)	((Speaks in Afrikaans; unclear)
10	Doctor A	Ok ((responds in Afrikaans: Dankie, hy's baie ….unclear))

Negotiating meaning and understanding

Bearing in mind the fact that interactants come from different linguistic backgrounds and possess varying proficiencies in English, there is an assumption that ELF communications are riddled with misunderstanding. However, ELF interactants display their level of appropriation of the language through their ingenious power of negotiating to resolve misunderstanding using the "let it pass principle". Meierkord (2006a) and Firth (1996) attribute much of the achieved level of understanding in ELF and lingua franca communication to this principle. Evidence from the data confirms findings that have shown that misunderstanding is not as common an occurrence in lingua franca interactions as one would expect (Firth 1990; House 2003; Mauranen 2006), though remarkably few occur (Bae 2002; Pitzl 2005). This is because both interactants generally accept some of the phonological, phonetic, lexical and syntactic variations which may cause misunderstanding as part of the communicative process since they are aware of their varying and limited proficiencies in the language they are using. They strive to achieve a degree of understanding and mutual intelligibility, and deliberately ignore some of the linguistic items that they misunderstand or simply abandon a problematic sequence and continue to a new topic. In ELF-interaction it has been observed that interactants sometimes recognise misunderstanding, and either do ignore it completely, try to resolve it or they just "let it pass". For example, in

Extract 4, after Doctor A has explained the different stages of HIV disease to the patient, she notices his belt. She observes, "Ugh this is a nice belt…" (line 38). Although it is not clear what the patient says in lines 39 and 41, Doctor A goes on to ask, "Oh is it a traditional belt?" (lines 40 & 42). Repeating the question indicates the doctor's seriousness about what the belt stands for. But the patient's emphatic, "No" (line 43), could be answering any of the two questions the doctor asked, thus, "No, it's not traditional" or "No, it's not for looks" – so, an ambiguous answer. But from the tone and urgency in his voice he could also be suggesting that the doctor discards any ideas she might have about the belt and so they drop the topic. However, this interpretation of the interaction at this point may not be correct but the doctor 'lets it pass' This illustrates the co-operative nature of ELF interactions (e.g. Firth 1996; Seidlhofer 2001; Meierkord 2002).

Extract 4: Joint negotiation of meaning to resolve misunderstanding

37	Doctor A:	Eh! We have HIV disease we have stage 1 no symptoms, stage 2 little bit of symptoms, stage 3 is when somebody has that white thing on the errh realm of the tongue if you look in the mirror you will see it. Just just you know I will just like to explain to you that if we if we start ARV it is not for nothing ok? S can you get up (Background noise)
38	Doctor A:	Ugh this is a nice belt, did you buy it?
39	Patient:	((unclear))
40	Doctor A:	Oh is it a traditional belt?
41	Patient:	((unclear))
42	Doctor A:	Is it traditional? It's not for the looks?
43	Patient:	No
44	Doctor A:	Oh (laughs) what is it for? Is it the jackals
45	Patient:	Errh it's a what can I say, it is a it's a sea dog
46	Doctor A:	Eh?
47	Patient:	It is a sea dog
48	Doctor A:	Is it a seal?
49	Patient:	It's a dog that we get from the sea
50	Doctor A:	A dog from the sea. Is it a seal?

51	Patient:	Is a dog what can I say I don't know the name of the dog you know from the sea they have small dogs
52	Doctor A:	Jackals
53	Patient:	From the sea, we get from the sea
54	Doctor A:	Only at the beach
55	Patient:	At the beach
56	Doctor A:	But it's not a water animal
57	Patient:	It's a water animal
58	Doctor A:	It's a water animal ehm?
59	Patient:	Yeah
60	Doctor A:	Any pain?
61	Patient:	Nothing
62	Doctor A:	Ok alright ((ruffle of paper)), alright if you were to start on ARVs when would you like to start?
63	Patient:	Uhmm, uhmm!

Types of repair

CA distinguishes four kinds of repair, namely (i) self-initiated self-repair, (ii) self-initiated other-repair, (iii) other-initiated self-repair, and (iv) other-initiated other-repair (Liddicoat 2007: 173). In this study, two kinds of repairs are distinguished and they also show a use of the 'let it pass principle'. These are: doctor-initiated repairs and repairs that are initiated by the patient.

a) Doctor-initiated repair

In Extract 5, the doctor changes topic from the blood pressure medication to an assessment of the patient's condition. The doctor suggests further blood tests and tells the patient of her (the doctor's) suspicion of a condition which she describes using an abbreviation that is evidently unknown to the patient, "...Just uhm the other thing that I could do, I suspect that that is PPE ok?" (line 83). She immediately realises that the patient might not know what PPE is and that this may unduly alarm him. This is what Mauranen (2006: 137) has described as "proactive repair" because the speaker pre-empts a misunderstanding and immediately initiates the effort to subvert it. So she proactively initiates self-repair in the same turn to explain what the abbreviation is, "...That's something

that is associated with HIV alright?" (Extract 5, line 83), and further tries to allay the patient's fears by reassuring him, "Uhmm. I really don't think it is anything more worrying than that…." (line 85) and promises the intervention of a dermatologist (line 85). The repair effort is apparently successful as evident in the patient's satisfaction and total agreement with the doctor's plan, "Yes exactly" (line 86). Although the patient agrees, the doctor's explanation does not really say what PPE is.

Extract 5: Doctor-initiated self-repair

83	Doctor A:	Errhm then we can do the uhm bloods next month hey?'Cos you are almost a year on treatment hey? Just uhm the other thing that I could do, I suspect that that is PPE ok? That's something that is associated with HIV alright?
84	Patient:	Yes
85	Doctor A:	Uhmm I really don't think it is anything more worrying than that. But to be on the safe side we can make an appointment with a skin specialist and they just take a small, small, they take one lesion. They take it out, they send it away to the lab, they have a look under the microscope and tell you exactly what it is. Would you like that?
86	Patient:	Yes exactly

b) Patient-initiated repair

In Extract 6, Doctor A apparently had asked the patient previously to tell his spouse about his HIV-positive status. But her question (line 7) indicates she realises the patient's reluctance to do so as revealed in, "A:ah about the status" (line 8). Doctor A changes the topic in line 9 abandoning the desire to know what the patient told his wife and introduced a more serious matter of getting the patient on ARVs (line 10). The patient's response in line 12 is punctuated with interjections such as 'wow' and 'eish' indicating his fear of being on ARVs for life. Doctor A affirms his fear with the question, "Are you worried about …" (line 13)

and "The lots of tablets because it's gonna to be five tablets a day eh?" (line 15). The patient agrees and explains that he is worried that the treatment is for the "whole life y'see?" (line 16). But Doctor A cuts in to say ARVs are a "lifeline" that has been given to the patient but misunderstood the patient's "whole life..". The patient realises this, so he initiates a self-repair which clears the misunderstanding. His explanation, "That is why I'm not feeling so good but it's nothing it's part of life I can carry" (line 18), indicates that he understands that ARVs are a lifeline but did not cherish the idea of being on them for the rest of his life. The doctor catches on and acknowledges his worry by restating and verbalising this fear, "Ok so you have this fear about going on this treatment fi::ve tablets a day for the re::st of your life eh?'(line 19). But when the patient says, "I can't do it" (line 20) the doctor understands. So her reply, "But on the other hand you want to" (line 21) makes it clear that they are both talking about his worry. This, the patient confirms with a "Yes" (line 22) which indicates a successful resolution that leads to a topic change.

Extract 6: Patient-initiated repair

7	Doctor A:	So you did speak to her about HIV but you didn't tell her about your status?
8	Patient:	A:ah about the status
9	Doctor A:	Ok alright ok oh how do you feel about ARVs because I see P has been giving you counselling about ARVs:::? A:n:d she spoke to you about having to start ARVs?
10	Patient:	Y:e:s, yes
11	Doctor A:	What is your feeling about it?
12	Patient:	I:: just because I:: wow I:: eish you never stop errh to to to to of drinking the ARVs. I refuse of it b'cos I can't eat errh carry on I can't eat errh so much errh a lot of errh of of tablets 'cos sometimes errh I can't say agh errh I can't eat it I can't drink it but I will try that is why I feel so bad
13	Doctor A:	Are you worried about …
14	Patient:	Ye::ah and…

15	Doctor A:	The lots of tablets because it's gonna to be five tablets a day eh?
16	Patient:	then I was going to take it a long may be the whole life y'see
17	Doctor A:	Y:e:s, yes it's a lifeline
18	Patient:	That is why I'm not feeling so good but it's nothing it's part of life I can carry
19	Doctor A:	Ok so you have this fear about going on this treatment fi::ve tablets a day for the re::st of your life eh?
20	Patient:	I can do it
21	Doctor A:	But on the other hand you want to
22	Patient:	Yes
23	Doctor A:	Ok S just quickly come over here, would you like to sit on the be::d and let me quickly have a look at you? Can I can I quickly just have a look at you?
24	Patient:	Yes

Conclusion

This research focused on the different ways in which interactants have appropriated English through their use of ELF in a medical discourse in a multilingual context. Specifically, the study looked at how the transmission of information between doctors and patients manipulated the language during HIV/AIDS consultations to suit their purposes. The aim of this study was to show how doctors and patients use ELF as a tool to negotiate and discuss important health issues and establish personal relationships in the clinic. The study has brought to light key linguistic and communicative features typical of ELF used by doctors and patients to facilitate communication during consultation and ensure mutual understanding on issues related to a life threatening disease such as HIV/AIDS. These include the use of metaphors and analogy as well as simple, less sophisticated grammatical vocabulary items, the use of collaborative negotiation of meaning, detailed explanation, indigenisation and code-switching. The interactants are more concerned about making their point than they are about respecting conventional grammatical rules,

which is why they transfer syntactic structures from one language to the other or blatantly distort rules to ignore the conventional grammatical mistakes of their interlocutors. Furthermore, the mixing and transfer of linguistic features from their L1 is a display of the embeddedness of the participants in the setting and their appropriation of the language, which marks the discourses as particularly South African. In particular, the doctors use local metaphors and analogy relevant to the South African milieu to make some of the HIV/AIDS technical terminologies and related concepts more accessible to patients. The study has contributed to HIV/AIDS communication research by providing insight into doctor-patient interactions in a multilingual clinic from a data-driven analysis of life situations and has revealed that people can actually appropriate colonial languages even in post-colonial times.

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Appendix A: Transcription Conventions Ten Have (1999: 213-214, 2004: 183-184)

[[	Start of simultaneous utterances
]]	End of simultaneous utterances
[	Beginning of overlap
]	End of overlap
(0.0)	Intervals within and between utterances measured in tenths of seconds
:	Extension of the sound or syllable it follows
::	More colons indicate much longer sound or syllable
	Word underlining indicates emphasis

Capitalisation indicates an utterance or part thereof that is louder than the surrounding talk

((…)) Utterance that is the researcher's comment
(…) No hearing is achieved for the string of talk
↓ indicating a fall in the tone of voice
… Indicate ellipsis, parts omitted in a quotation
? Indicating a question/request
! Indicating surprise
°°° °°°Utterance spoken slightly lower than surrounding speech

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