Pharmacy practice in hyperdiverse, urban communities: perspectives of independent community pharmacists in East and South-East London

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I Kathryn Duckett, confirm that the work presented in this thesis is my own. Where information has been derived from other sources I confirm that this has been indicated in the thesis.

Signed .....[redacted].....

Abstract

This study considers pharmacy practice in hyperdiverse, urban communities through the eyes of independent community pharmacists, who are underrepresented figures in anthropological research. Taking the role of the pharmacist as being dynamic and negotiable, this is an investigation into how pharmacists find ways to be relevant in the light of, or even in spite of, a shifting professional remit and the changing landscape of community pharmacy in Great Britain, (where almost 50% of pharmacy contracts are held by just 9 national chains). The study explores 'independence' as it is positioned by the pharmacists; expressed through a rhetorical framework of autonomy, engagement and the bespoke nature of practice, narratively embedded in accounts of urban situations.

The research takes an ethnographic approach and was conducted in East and South-East London boroughs combining participant observation and active interviews with pharmacists. All but one of the pharmacists represented in the study were from ethnic minority backgrounds; this reflects a bias typical of urban independent pharmacy. The urban setting presents particular challenges but also particular opportunities and this study demonstrates how pharmacists cope with the constraints and possibilities afforded by their situation.

In exploring concepts of professional personhood the study highlights the pharmacists' focus on the importance of autonomy and the creation of distinct professional personas. The significance of engagement with customers is examined through stories of 'acceptance' and developing pharmacy 'communities' alongside the practice of maintaining personal relationships. This reveals the use of cultural capital by the pharmacists, taking advantage of shared cultural heritage and language skills to provide a distinct service offer. The value of

providing a 'bespoke' service is investigated through areas of particular significance in differentiating independent pharmacy; 'time' and 'specialism'. The discussion concludes by raising questions about the place of independent pharmacy within the profession and emphasising the contribution independent pharmacists can make to the delivery of care in this setting.

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Chapter 1. Community pharmacy in a changing world

In this study I concentrate on the figure of the independent community pharmacist. The pharmacist has been neglected by anthropology and independent community pharmacy in particular has rarely been put in the spotlight. Taking the role of the pharmacist to be dynamic and negotiable, I investigate how these pharmacists find ways to be relevant in the light of, or even in spite of, a shifting professional remit and the changing landscape of community pharmacy in Great Britain* (where almost 50% of pharmacy contracts are held by just nine national chains (Company Chemists Association 2010). Privileging the perspective of the pharmacists I met above that of the public or policy makers, the study explores 'independence' as it is positioned by the pharmacists themselves; expressed through a rhetorical framework of autonomy, engagement and the bespoke nature of practice.

My research was conducted in the East and South-East London boroughs of Tower Hamlets, Hackney, Newham and Southwark and the pharmacists' rhetoric is narratively embedded in accounts of the inner-city, referencing urban places and people. These boroughs have in common a population that suffers from multiple deprivations and in which nearly half of all residents describe themselves as being from 'ethnic minority' groups (Office of National Statistics 2001). I have used the term 'hyperdiverse' throughout this account to characterise the places that I visited because I have found it best portrays the extreme, but not extraordinary, urban setting where diversity is simply a fact of life. While the term 'hyperdiverse' has been used to describe a 'multi-ethnic' situation, here I have employed it to evoke a much more expansive idea of diversity, including different ages, educational and

* I refer to Great Britain/ United Kingdom where statistics are appropriate. Policy details where indicated however relate particularly to England. Where pharmacists have used particular terms I have reflected their usage as appropriate.

socio-economic factors as well as simply ethnic background. In work that explores the nature of hyperdiverse settings within the American medical system Good* suggests that hyperdiversity is found in situations where 'meaningful differences exist along many dimensions in addition to race/ethnicity/nativity/culture' and can create situations 'in which the link between racial/ethnic identity and 'culture' is broken' (Good 2010).

The challenges presented in working within this urban context provide a symbolic framework for practice and a reference for pharmacists in describing a particular and valuable role. Considering the pharmacist as a product of his environment, this research also therefore contributes to an understanding of how health is managed in the urban setting. Obrist argues that the view of urban health has largely been defined by examining 'conceptual links between health, urban environment and poverty' (2006: 19). While these links serve as a political background to this discussion what this investigation into pharmacists and their practice provides is an understanding of urban health provision from a different perspective. By looking through the eyes of pharmacists and the world they have created within a particular social, environmental and historical context this research concentrates on local solutions rather than problems and demonstrates how 'ordinary' people cope with the constraints and possibilities afforded by the urban space (ibid.).

This introductory chapter is organised into three sections. The first aims to give a brief introduction to pharmacy and to contextualise the changing landscape that these pharmacists find themselves in. I then turn to the contested nature of pharmacy as a profession and how the struggle for recognition has affected the development of pharmacy practice. The second

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* Who acknowledges Seth Hannah in developing this work. Hannah also presented these ideas at the Society for Medical Anthropology Conference 2009, Yale University. Breakout session 1. Friday 25th September: Shattering Culture: American Medicine's Responses to Hyperdiversity Presentation: Clinical Care in Environments of Hyper-diversity: Race, Culture, and Ethnicity in the Post-Pentad World.

part of this chapter draws on anthropological theory to describe how I will refer to this background in the following discussion and how these tensions might be viewed through the construction of pharmacists' personhoods. Finally I examine the pharmacist within the wider anthropological literature.

Chapter Two situates the research in more detail, in terms of both people and places, beginning by explaining why I particularly chose to study *independent* pharmacists. I highlight the importance of opening up a debate around these marginal characters in the pharmacy world and the value of examining how they present themselves in the context of this process of change. I go on to discuss the urban places this research was conducted in. This chapter concludes with an outline of the thesis.

1.1 Pharmacy profile: People, Policy, Profession

1.1.1 Pharmacy workforce

Pharmacists in Great Britain practice in a variety of different fields including; industrial or research based pharmacy, hospital pharmacy, and community pharmacy. Pharmacy based in the community refers to pharmacy conducted through retail outlets providing medicines and other services to the general public. There are 12,974 community pharmacies currently operating in Great Britain (Royal Pharmaceutical Society of Great Britain 2010). Of these around 46% are independently owned or part of small independent chains (Department of Health 2004). An 'independent pharmacy' refers to a pharmacy business that is sole owned or part of a chain that has no more than five outlets. The number of independently owned pharmacies in England and Wales is in decline, between 1998 and 2008, the percentage of

pharmacies comprising five or fewer outlets fell from 57% to 39% (NHS Health and Social Care Information Centre 2008). Small independent chains/ independent multiples are considered to be chains of 6-300 outlets that would be eligible for membership of AIMp, the Association of Independent Multiple pharmacies (2007). The 'multiples' as I have referred to throughout this study are large chains of greater than 300 outlets including companies that make up the Company Chemists Association (CCA). The CCA has nine companies in its membership that may or may not have pharmacy as their principal business. They are: Boots, The Co-operative Pharmacy, Lloyds Pharmacy, Tesco, Sainsbury's, Wm Morrison Supermarkets, Asda Walmart, Rowlands Pharmacy and Superdrug. These nine groups alone own over 6,400 pharmacies representing approximately 50% of community pharmacies in Great Britain (Company Chemists Association 2010).

A pharmacy workforce census carried out in 2008 which included over 30,000 of the 48,794 pharmacists on the professional register found that 21% of respondents were actively working in a hospital pharmacy environment, 18% in 'other' areas of practice including industry but the vast majority, some 71% of pharmacists held a position in community pharmacy (Seston, Hassell, and Schafheutle 2009: 20)*. Of those pharmacists who reported working in community pharmacy, whether as their principal employment or as a locum pharmacist, 79.1% stated that they worked in a medium or large multiple pharmacy as compared to 42% who were working in an independent pharmacy or small chain (Seston, Hassell, and Schafheutle 2009: 34)*. Around 13% of community pharmacists own their own pharmacy while 31% are pharmacy managers (Table 1.1). Pharmacy owners are more likely to be male and are more likely to have been qualified for ten years or more (Hassell 2009).

* A pharmacist may have a position in two separate sectors, or two different jobs in one sector, hence percentages exceed 100%.

Table 1.1 Gender distribution of independent community pharmacy roles

Job	% overall	% males	% females
Owners	13	23	5
Managers	31	29	33
Relief	10	7	13
Locum	9	4	13
Second	37	39	35

(Hassell 2009)

Pharmacy as a profession, and in particular independent pharmacy, has been associated with a high proportion of ethnic minority practitioners and first generation migrants (Hassell, Noyce, and Jesson 1998). Analysis of the British pharmacy register, carried out in August 2007 demonstrated that 19% of those registered, where some reference to an ethnic group is documented, recorded their ethnicity under the title of 'Indian, Pakistani, Bangladeshi or Other Asian' with Indian being the predominant group (13.5%), followed by Pakistani (3.6%) (Seston, Hassell, and Schafheutle 2007). 'Chinese' and 'Black' pharmacists each accounted for approximately 3.5% of the register. This should be viewed in relation to figures in Great Britain and Northern Ireland as a whole which show that the total ethnic minority population in the 2001 census was 9.1% and that the total Asian or Asian British population was 4% (Office of National Statistics 2001). New entrants to pharmacy meanwhile included 43.9% from ethnic minority groups with 29.9% being of 'Asian' origin (Willis, Shann, and Hassell 2006). Although represented in all sectors of the profession, members of ethnic minority groups are over-represented as business owners within the retail sector and under-represented in managerial positions and hospital pharmacy.

The pharmacists in this study represented this 'typical' independent owner/manager profile, most are male and those that are pharmacy owners tended to be the longest qualified.

Pharmacists from a variety of different ethnic backgrounds took part in the study, only one of whom described himself as being 'white British'. As much therefore as this work examines pharmacy practice in a hyperdiverse setting, it also examines the experience of an ethnically diverse group of pharmacists within this context.

1.1.2 A changing world

We are facing an ongoing revolution in pharmacy

Alex Gourlay, Chief Executive of Alliance Boots Health and Beauty Division[•]

Community pharmacies in Great Britain operate as private, retail businesses providing National Health Service (NHS) services on a contractual basis that includes the dispensing of prescriptions and a range of other services. It is technically possible to open a pharmacy without an NHS contract selling only 'over the counter' medicines which are able to be sold without prescription but under the supervision of the pharmacist, General Sales List medicines which may be sold in any retail outlet and a range of other goods and services the business sees fit to provide. In reality, for most community pharmacies NHS contracts run alongside the commercial sale of medicines and other products and make up a very significant proportion of business, as much as 80-90% in some cases (Office of Fair Trading 2003).

The National Insurance Bill of 1911 established the basis for modern community pharmacy formalising the link between general practice prescriptions and pharmacy dispensing (Homan

[•] Quote taken from a lecture given by Alex Gourlay, Chief Executive of Alliance Boots Health and Beauty Division: 'Pharmacy and Health in 21st Century Europe', 13th January 2011 at the School of Pharmacy New Year Lecture 2011, held at the Royal Society, London.

2005: 132). The bill required that dispensing of government subsidised prescriptions be carried out only by contracted pharmacists and reimbursed pharmacy through a contract for this service. For the first time there was recognition of the need to 'formally separate drugs from doctors' (Hunt 2005: 84-86). The way of working established in 1911 allowed pharmacy to adapt fairly easily to the announcement of the National Health Service Bill in 1946 which came into effect on the 5th July 1948. This relationship also established the requirement for the pharmacist to oversee all dispensing with the result that, even today, the pharmacist is required to be in dispensary for most of the working day and counter sales are generally undertaken by pharmacy assistants who work under supervision of the pharmacist (Hunt 2005: 91-92).

The seeds for significant change in the way community pharmacy operated in England were sown when in 2003 the Department of Health published *A Vision for Pharmacy* (Department of Health 2003) setting out the potential for the future of pharmacy. It recommended development in four key areas in addition to dispensing: better access to services, helping patients get the most from their medicines, redesigning services around patients and ensuring high quality services. In the same year the 2003 General Medical Services (GMS) contract (Department of Health 2003) came into force allowing services previously carried out in general practice to be contracted out to other providers (Richardson and Pollock 2010). Marking the beginning of an era of radical change *A New Contract for Pharmacy* was published in 2004 taking on board recommendations from *A Vision for Pharmacy* and implementation began in April 2005. The GMS contract and the New Contract for Pharmacy were 'complementary reforms' in that together they allowed community pharmacies in England to provide a new range of services within their NHS contracts, some of which had historically been undertaken by GPs (Richardson and Pollock 2010). The aim of increasing

the services provided by pharmacy was that it would 'increase access and patient choice, reduce GP workload, and lower costs to the NHS (Department of Health 2008). The basic structure of the new contract was described in three tiers: essential, advanced and enhanced (Fig 1.1):

Figure 1.1 The New Contract: three tiers of service

ESSENTIAL	ADVANCED	ENHANCED
National Contract		Locally Commissioned
8 Required Services 1. Dispensing of medicines 2. Repeat dispensing 3. Promotion of healthy lifestyles 4. Signposting 5. Support for self care 6. Disposal for unwanted medicines 7. Support for disabilities 8. Clinical Governance	**Medicines use review (MUR) (optional)** Accreditation of premises and training required	**From a range including...** Minor ailment schemes Needle exchange Methadone administration Smoking cessation Weight management

(Pharmaceutical Services Negotiating Committee 2006)

Essential services cover eight key areas and are expected to be provided by all contracted pharmacies which have to comply with national standards. The advanced service 'Medicines Use Review' (MUR)* is also a nationwide initiative; pharmacies opting to provide this services require accreditation of a separate consultation space and special training. Essential

* A structured consultation in the pharmacy that is undertaken by a pharmacist to review the customers use of medicines. They are able to discuss how medicines are used and why they have been prescribed but this is not a clinical review. Findings can be fed back to prescribers by the pharmacist. The review must take place in a consultation room.

and advanced services are funded nationally. Enhanced services are commissioned and funded locally by Primary Care Trusts (PCT's) to reflect particular local needs and they are negotiated in competition with other healthcare contractors. The most common enhanced services provided are smoking cessation counselling and methadone administration (NHS Health and Social Care Information Centre 2008).

The uptake of these services by trusts and by pharmacies is hugely variable across England. A number of reasons for this have been highlighted including poor evidence for positive health outcomes, a lack of understanding from commissioners, poor reimbursement rates and the perception that in actual fact general practice dominates decision making processes (Carroll, Hewitson, and Carroll 2010). A survey of 31 trusts found that just over 40% of pharmacies are providing three or more enhanced services, whereas 13% are not providing any (Blenkinsopp et al. 2009). There was significant variation across the four PCTs included in my study. Using per-capita spend as an indication of the level of uptake of services, a recent survey conducted by the professional publication *Chemist and Druggist* (Chemist and Druggist 2010) showed Tower Hamlets has a per-captia spend on enhanced services of £6.68 per person and City and Hackney has a spend of £5.10, these two boroughs are at the top of the table for the country as a whole in terms of the uptake of service provision. Newham is eighth with a spend of £2.52 while Southwark is thirtieth of 152 PCTs in England with a spend of just £1.23.

In addition to the new contract, independent prescribing, brought in with legislation in May 2006, allows qualified pharmacists to prescribe any licensed medicine for any medical condition 'within their competence' with the exception of controlled drugs. It is important to note that there is a significant stress on the separation of prescribing and dispensing roles

except in exceptional circumstances (Department of Health 2006). As such the new prescribing remit has little potential in store impact, and none of the pharmacists I encountered during my research had acquired 'independent prescriber' status.

A more frequently utilised means of expanding the pharmacist's remit has been the introduction of patient group directions (PGDs). PGD's were introduced in August 2000 and use has expanded in conjunction with the new contract. They allow the pharmacist to supply particular prescription only medicines to specific patient groups without the requirement for a physician's prescription. Unlike pharmacist prescribing, PGDs do not require an additional formal qualification although there may well be additional local training requirements.

Complicating this background of change in government policy has been the reorganisation of the professional bodies that regulate and represent pharmacy. Towards the end of my data collection I attended the 2009 the British Pharmaceutical Conference in Manchester. The overriding pre-occupation of the conference was the (now completed) dissolution of the Royal Pharmaceutical Society of Great Britain and the creation of a separate regulatory body, the General Pharmaceutical Council and an entirely independent professional body, the Professional Leadership Body (PLB) for Pharmacy which retains the Royal Charter. This change represents yet another shift in the status of pharmacy as the newly created body has a chance to mould a new vision for the profession. In his presentation introducing the PLB, president of the Royal Pharmaceutical Society of Great Britain, Steve Churton, attempted to outline this new approach. He suggested that a modern professional pharmacist in the eyes of the leadership body is required to have a focus on 'patients, safety, health and wellbeing'.

They should be 'brave' and able to take responsibility in decision making and demonstrate a 'commitment to development*.

Given the nature of change that pharmacy has seen it is perhaps not surprising that, as Noyce (2009) explains, much recent pharmacy practice research has focussed on the impact of this new contract, examining the implementation and uptake of services for example: Pumtong et al. (2008) on the Pharmacy First Minor Ailments Scheme; Harding and Wilcock (2010) on Medicines Use Reviews; George et al. (2010) on community pharmacy contribution to weight management schemes. In this study however, while the process of change provides a backdrop to research, the contract itself or contractual services are not placed at the centre of enquiry. In taking this approach I have avoided concentrating on the delivery of any part of the new contract in particular but instead explore how these pharmacists interpret the changing world of pharmacy in their own way and what it means for them a on a day to day basis. The result has often been a focus on elements of practice that actually fall outside contracted services where independent pharmacists feel they are able to create a unique offer.

1.1.3 Pharmacy as a profession: 'The physician's cooke'

One of the difficulties in realising and rationalising change for pharmacists on an individual level has been the ongoing struggle in defining a professional remit for pharmacy. Pharmacy as a profession has faced and continues to face a number of challenges stemming in large part from a longstanding dispute with the medical profession over a mandated territory, sub-ordination to the physician through control of the prescription, the duality of the pharmacist's role as businessman/healthcare provider and finally the growth of the pharmaceutical industry

*Quote taken from a presentation given by Steve Churton, president of the Royal Pharmaceutical Society of Great Britain: Introduction to the new professional leadership body at British Pharmaceutical Conference. Manchester, 2009.

which has resulted in a decrease in skill required in the preparation of medicines within the pharmacy. Internal divisions between the more 'scientific' or 'medical' branches of industrial and hospital pharmacy versus community pharmacy where the pharmacist is seen as an 'overeducated distributor' have also contributed to the difficulties in maintaining professionalism and status (Mesler 1991). A body of (largely sociological) work has attempted to investigate these concerns.

The dispute with medicine can be traced back through the evolution of pharmacy as a distinct field and the historical jostle for control over particular aspects of the production, prescription and dispensing of medicines. The role of the pharmacist in England has its roots in that of the apothecary. The apothecaries were a specialist sub-group of the Company of Grocers in the middle ages but in the 16th century the Society of Apothecaries was formed which established some control over dispensing medicines while physicians became responsible for the prescription (Morgall, Traulsen and Bissell 2004). Thompson identifies this excerpt from a diary written by a physician in 1588 describing the role of the apothecary which illustrates the deep roots of this conflict:

> *He [the apothecary] must fyrst serve God (...) he must meddle only with his vocation (...) and that he must remember that his office is only to be ye physicians cooke.*
>
> *William Bullein, physician, botanist and rector. 'The government of health' 1558*
> *(Thompson 1929: 266)*

In addition to this tension surrounding the control of medicines the basis for this conflicted role is also framed by pitting the profit driven pharmacist against an altruistic GP bound by the Hippocratic Oath. This opposition highlights the dual role of the pharmacist as being a particular reason for their lack of professional standing and suggests that their involvement in business renders them less able to make ethically sound decisions. Hughes and McCann

carried out a qualitative study which aimed to examine perceived interprofessional barriers between community pharmacists and GPs and presented these two extracts in illustrating the continuing strain on relationships:

> ***GP***
> *There is definitely a conflict between the NHS primary healthcare team effort that we all feel we are involved in and with pharmacists and their role as the shopkeeper and their role in looking for profits for themselves.*
>
> *(Hughes and McCann 2003: 602)*

> ***Pharmacist***
> *They [some GPs] don't have any opinion at all about community pharmacists. They think we have no role, they think we are shopkeepers that are useless and are grasping for greater things (...) The GPs see us as commercial and they have the idea that we make loads of money.*
>
> *(Hughes and McCann 2003: 602)*

In spite of all the recent reforms which have attempted to resolve this uneasy relationship, continued sniping has appeared in press. For example, in 2009 Steve Fields, chairman of the Royal College of General Practitioners was quoted in the national newspaper The Guardian as follows:

> *(...) a pharmacist makes their profit selling over-the-counter drugs whereas your GP has no pecuniary benefit in giving you medicine (...). And the next problem is that many of the things available over the counter don't work - most vitamins and cold remedies, for example, are a complete waste of time - but they are still things that make lots of profit for the pharmacist. So it would be far better for your health if you invested your money in fruit, but if you go to the pharmacist he or she is unlikely to suggest that, and you're likely to come away with a jar of pills that won't do any good.*
>
> *(Moorhead 2009)*

One of the most significant contributing factors to this difficult relationship is the reliance on and deferment of the pharmacist to the GP through the latter's control of the prescription. There is a sense that in spite of their specialist medicines knowledge, pharmacists are powerless without the action of the GP. This ultimately decides the relationship between the

two parties as the GP maintains control of the pharmacist's clinical autonomy (Edmunds and Calnan 2001). As Melville and Johnson, suggest: 'subordinating pharmacy to the position of a sub-division of medicine' (1982: 180-181). Cooper, Bissell et al. (2009) propose that this subordination can lead to ethical passivity and a sense of powerlessness in day to day decision making. These oppositions are repeated within this research as the pharmacists use their contested position in relation to the GP to elaborate on aspects of their professional personhood.

The debate surrounding the remit of pharmacy has contributed significantly to the difficulties faced in establishing pharmacy itself as a true profession. McCormack (1956) described pharmacy as a 'marginal profession' and others since have used terms such as 'incomplete' (Denzin and Mettlin 1968), 'limited' (Harding and Taylor 1997) or 'quasi-profession'(Edmunds and Calnan 2001).

While pharmacy maintains many of the outward characteristics of a profession as described by Carr-Saunders and Wilson (1933: 138) for example; an occupation based upon specialist intellectual study and training to provide skilled service and advice, its own code of ethics, formalised recruitment and formal self-governing institutions, it also has been accused of failure on a number of counts. Denzin and Mettlin (1968) propose that the incomplete professionalism of pharmacy stems in great part from the inability of pharmacy to take control of the social object around which they are organised i.e. medicines. They suggest that pharmacy is attempting to be a profession without a 'mandated territory'. They also accuse the profession of being incapable of maintaining professional occupational cohesion (Denzin and Mettlin 1968).

A pharmacist's 'mandated territory' or centre of expertise is usually considered to be based on their specialist knowledge of the products that they work with: the chemistry, pharmacology and formulation of drugs. Not only is this knowledge restricted through the prescription however, it has also been eroded over time through industrialisation and the removal of any requirement for the pharmacist to engage in the preparation of medicines. Other advances such as the availability of information about medicines and even the sale of medicines online have also served to compromise their field of expertise (McDonald et al. 2010).

A number of writers have attempted to re-describe ways in which pharmacy can retain a degree of control. For example Dingwall and Wilson (1995) suggest that 'The social object of pharmacy's practice is reframed as the symbolic transformation of the inert chemical into the drug' through the role they play in dispensing to the customer. A similar argument is put forward by Harding and Taylor (1997) who suggest that the special role of pharmacists is that they are given public permission to 'inscribe prescribed or purchased drugs with a particular meaning for the user' and that this process may benefit customers by giving medicines additional value.

In refashioning this territory others have looked to extend the remit of pharmacy in a process of 'reprofessionalisation' (Birenbaum 1982). In doing so it has been suggested that the community pharmacist's role should move from a 'technical' position founded in dispensing and compounding to a more 'cognitive' one in which their remit is expanded to include a more clinical element involving patient counselling (Bond 2006). Van Mil and Schulz (2006) go so far as to claim there is 'no future in the act of dispensing'. They suggest that machines

or highly trained technicians could take over this role and that the academic training of the pharmacist gives them the responsibility to provide 'care instead of pills only' (ibid.).

This attempted expansion has resulted in the movement away from a technical, medicines based role to a disease and patient orientated function and taking on new services such as those described in the New Pharmacy Contract (Cooper, Bissell, and Wingfield 2007).

Historically however pharmacy practice research has highlighted the quality and quantity of advice giving in the pharmacy as being particularly limited. For example Hassell et al. (1998) illustrate the narrow limits of advice given in the pharmacy accompanying products. They describe the advice given as being almost wholly focussed on the product with little overall health advice proffered at the point of exchange. As such the move to engage pharmacists in a new and expanded advice giving role has not necessarily been a straightforward step. The new contract has gone some way to reframing this role but research continues to show that the successful uptake remains difficult in general terms e.g. Stevenson et al. (2008) Rogers (2009) and in terms of specific advice giving services e.g. Blenkinsopp (2010).

The idea of providing care has been expanded upon, especially in the US and developed into the idea of 'pharmaceutical care' described in a landmark paper by Hepler and Strand (1990) as being built on a 'fiduciary duty to serve the patient and an ethical obligation to work for the patient's best interests' (Austin, Gregory, and Martin 2006). Commentators such as Worley and Schommer (1999) attempted to develop the idea of pharmaceutical care further by describing key factors that influence quality of care centred on the patient such as a 'participatory' and patient outcomes focussed approach (Austin, Gregory, and Martin 2006).

However this notion of pharmaceutical care is yet to be fully embraced in pharmacy in England and Wales (Rogers 2009).

Pharmacy has also sought to regain some control from the medical profession over prescribing and recommending medicines. This has been possible due to the reclassification of an increasing number of drugs previously only available on prescription as 'over the counter' medicines which can be sold in pharmacy, and as discussed, the introduction of PGDs and a limited number of 'pharmacist prescribers' (Bush, Langley, and Wilson 2009). In some quarters the increased remit of pharmacy has been viewed as an intrusion into the territory of medicine and this expansion has at times been greeted with apathy and defensiveness in particular by general practice (Cooper et al. 2008).

The pharmacist's ambiguous role has not always been cast in a negative light. In work less concerned with the profession and its status but concentrating on the meaning of this tension for pharmacists in practice a number of studies highlight the fact that for the community pharmacist, their uncertain professional status can actually become an advantage. For example, it ensures that the perceived social distance between themselves and the customer is less than that assumed between physician and patient, allowing the pharmacist to move between a position of 'professional expert' to 'wise friend' thus creating a very flexible, responsive role (De Young 1996; Hassell et al. 1998, 1997). Authority in community pharmacy therefore frequently tends to reside more in a personal charismatic approach than a clearly defined official position. This social proximity also allows the pharmacist to act as a 'social integrator', playing a significant role as a point of local knowledge exchange (Rogers et al. 1998). As will be discussed in more detail in Chapter Five, this 'local' value has been somewhat confusingly adopted by the profession and by government policy makers. In

conjunction moves to create a more clinical pharmacist, pharmacists are simultaneously required to be locally orientated, based at the 'heart of the community' (Pharmaceutical Services Negotiating Committee 2011).

1.2 Rhetoric culture

Rather than prioritising the discourse of policy makers and professional bodies, this research aims to explore the role and value of the pharmacist as it is expressed by pharmacists themselves. Taking into account the backdrop of change and uncertainty I wanted to explore personal interpretations of professional personhood within the microcosm of the pharmacy. 'Personhood' in a Maussian sense refers to a social role, 'acted out within a wider cultural context' (Harvey 2008) hence I was concerned with understanding the people I met in the context of their professional role as 'the pharmacist' and how they describe and occupy this particular position.

Throughout the following discussion I make reference to the rhetorical strategies the pharmacists employed to persuade myself, themselves and the assumed readers of any output of this research, of their validity and value. In *'Culture, rhetoric and the vicissitudes of life'* Carrithers suggests that examining rhetoric can be especially useful in situations where people experience change and demonstrates through a number of examples how rhetorical strategies can be used to enable people to describe a place for themselves in the world while negotiating a range of different issues (Carrithers 2009). Emery (2010) successfully takes on this 'rhetoric culture' approach in the analysis of rhetorical strategies used by farmers in North York Moors in describing farming personhoods. There are a number of parallels that

can be drawn between the pharmacists in my study with these farmers who also are attempting to rationalise ongoing policy changes and an emerging 'modern' approach to farming with traditional farming values. In conducting my analysis I found referencing this approach especially helpful in explaining my empirical findings and also in positioning myself within the research context.

Rather than referring to the classical 'art' of rhetoric which is employed by trained speakers, rhetoric in this 'naturalistic' sense is considered a part of everyday life. It does not just refer to carefully planned persuasive speech acts but also includes unplanned, unconsciously developed talk, encompassing an 'intuitive sense of situational suitability and appropriateness'. Natural rhetoric also includes action and so in discussing the rhetorical strategies of pharmacists I also discuss the performance of practice as part of a rhetorical approach (Oesterreich 2009: 53).

This approach meanwhile sees culture as being a 'repertoire' of ideas and outlooks 'mutually intelligible among a set of people' (Carrithers 2009: 5). Recognising that, as Ingold points out, investigating 'culture' in the field does not produce neatly bound customs and consistently held beliefs:

> *...what we do not find are neatly bounded and mutually exclusive bodies of thought and custom, perfectly shared by all who ascribe to them, and in which their lives and works are fully encapsulated*
>
> *(Ingold 1994: 330)*

Carrithers, emphasising culture's 'rhetorical edge', proposes a number of reasons for examining the use of rhetoric in anthropology (Carrithers 2009: 6). Firstly he suggests that because rhetoric can be seen as a 'force which conveys cultural material' it can help to

illuminate the dynamism of social life (Carrithers 2005b). Secondly he points out that this is force not just applied to others but is also something we 'do to ourselves'. As Nienkamp explains, 'talking ourselves into (or out of) things, arguing with ourselves, berating ourselves' (2009). So while rhetoric is concerned with strategically pursuing or defending particular interests in interactions with other people it can also show how people rationalise their own experiences and construct personhoods especially in response to change or ambiguity (Carrithers 2005b). Thirdly rhetoric helps us to understand 'new cultural forms' in social life as people are able to use 'cultural ingredients' to pull together their own interpretations of events (ibid.).

This third point leads us into analysis of the relationship between individuals and social structures and the exploration of power relations in order to understand how people are able to utilise these cultural ingredients (Rapport and Overing 2007: 3). It is not my intention here to explore in detail the debate between 'agency and structure'. However it is useful to provide a perspective to support the following discussion.

The debate manifests simplistically as a notion that social structures are either: abstract ideas, created by individuals that cannot determine the actions of the people involved in creating them or embedded such that all action is governed by a 'set of structural relations':

> *(...) that structures are in fact sui generis and determine the very nature of individual consciousness and character – so that individual 'acts' are merely the manifestation of an institutional reality, and a set of structural relations.*
> *(Rapport and Overing 2007: 4)*

As Rapport and Overing discuss (2007: 4-5), a number of attempts to rationalise both these views have been put forward but usually ultimately one or other of the options is privileged,

often the latter 'more communitarian world view' for example Giddens' structuration theory (Giddens 1984) or Bourdieu in the theory of practice and the habitus (Grenfell 2008: 27-67). For the purposes of providing a frame for this research Lukes' presentation that allows for both the ideas of agency and structure and the interplay of different choices and strategies is especially helpful (Emery 2010). Lukes (2005: 68-69) suggests that social life can be understood through examining the relationship between power and structure and observes how this relationship creates a 'web of possibilities' that allows people to make choices and pursue goals within a set of restrictions that may expand and contract over time. As such Lukes suggests, people can operate within a dominant discourse as a rhetorical frame but the boundaries of this frame are continually negotiated, both from above and from below:

> *social life can only properly be understood as an interplay of power and structure, a web of possibilities for agents, whose nature is both active and structured, to make choices and pursue strategies within given limits, which in consequence expand and contract over time*
>
> *(Lukes 2005: 68-69)*

This 'top down and bottom up' negotiation of individual versus structural power fits well with Carrithers notion of 'doing and being done to' and the rhetorical 'borrowing' of cultural elements (Tilly 1999; Carrithers 2005b). In this sense the hegemonic discourse surrounding the professionalism of pharmacy and the independent pharmacist's role within this world can be seen as a 'dominant rhetorical frame' that defines the territory that pharmacists are able to draw upon in describing their place in the world. Cruz articulates this idea as follows:

> *Because actors situate their struggles within a dominant rhetorical frame, political contests between them engender a collective field of imaginable possibilities which I define as a restricted array of plausible scenarios of how the world can or cannot be changed and how the future should look*
>
> *(Cruz 2000: 277)*

Throughout this discussion therefore I have referred to elements of this dominant framework

which are either used 'against' pharmacists or that they use as part of their own attempts to persuade and build into their personal constructions of the role of the pharmacist.

The accounts pharmacists presented to me were framed by their desire to convince me of their value but also reflect their attempts to rationalise change for themselves and how they represent themselves to others. In examining the way independent pharmacists describe their place in the world we can gain some insight into the effects of the changing landscape of pharmacy at grassroots level. I also examine the strategies pharmacists employ to convince their customers of their worth in their attempts to survive the challenges of the urban environment and how this environment is used symbolically to reinforce the value of independent pharmacy.

1.3 Anthropology and the pharmacist

In anthropological research, while considerable work has been undertaken to examine the identity of the physician, from the process of training and 'making' doctors (Pollock 1996; Good 1994) through to practice and in particular examining the doctor patient relationship (Kleinman 1980; Verghese 1994; DiGiacomo 1987; Helman 2006); research taking place within the pharmacy or placing the pharmacist at the centre of the enquiry has been limited.

A number of anthropologists have examined pharmacy by way of work which highlights the life of pharmaceuticals and follows them as they are 'transformed' under the control of different stakeholders, including the pharmacist (Nichter and Vuckovic 1994; Van der Geest, Whyte, and Hardon 1996; Kamat and Nichter 1998). In this work however it is medicines

rather than practitioners that are centre stage. In 2002 for example, Whyte et al. published *The Social life of Medicines*. This includes a chapter examining the role of the pharmacist as a provider of medicines but the voices of the pharmacists themselves are notably absent from this analysis (Whyte, Van der Geest, and Hardon 2002: 91-103).

Whyte et al. conclude that anthropological investigations find it difficult to place pharmacy 'within the familiar structure of processes and categories that characterise the understanding of medical systems' (2002: 91-92). They suggest that in relation to community based pharmacy in particular, the extreme variation in shops and their proprietors makes them hard to evaluate (ibid.). They do however highlight the potential importance of studying the pharmacist suggesting that pharmacists and their shops are a 'strategic vantage point from which to consider healthcare systems, precisely because they do not quite fit' (ibid.).

What work there is that places emphasis on the pharmacist tends to focus their role in developing countries. For example, in 1988 a collection of sixteen papers on transactions and meanings of medicines in developing countries was published covering thirteen countries in Asia, Africa and Latin America (Van der Geest and Whyte 1988).

Studies conducted in developing countries further highlight the conflict between the role of the pharmacist as shopkeeper and as healthcare professional, often discussing a lack of professional practice or even professional qualifications. A number show how the sale of medicines can be in some cases, almost entirely removed from expertise and highlight the informal or even illegal exchange of medicines (Igun 1987; Olsson et al. 2002; Kamat and Nichter 1998; Cross and MacGregor 2010). More positively, several studies document the pharmacists relative 'closeness' to their customers both physically and socially and begin to

describe the intimate relationships possible within the pharmacy environment. Another conclusion drawn from this body of work is that in many situations pharmacists perform a role that is more similar to that of a doctor (Logan 1983; Ferguson 1981; Haak 1988) especially where access to physicians is either limited or financially prohibitive (Logan 1983).

As Whyte et al. discuss, within the pharmacy 'the opposition between the formal and the informal is not necessarily a simple one'. They go on to point out that anthropologists have highlighted the importance of informal relationships within formal structures and indeed how these formal structures actually rely on the informal in order to function successfully and 'adapt ideals to reality' (2002: 97). In this study I highlight how through social relationships within the pharmacy, even regulated by a highly bureaucratic system, informal relations and adaptations are also extremely significant in becoming a successful pharmacist.

I also aim to explore the pharmacists' perception of their position within the social relations of therapy and how this differs from the ideal presented within the dominant discourse. Power relations within the clinical setting have been discussed in detail in anthropological studies but the pharmacy presents a challenge to the traditional assessment of the healthcare professional/patient relationship. Logan's work in Mexico highlights the issue of the identity of the end-user protagonist of pharmacy services as either customers or patients. Explicitly positioning users as shoppers and consumers of services she remarks that one of the strengths of the pharmacy lies in the fact that people are customers and not patients and as such are able to retain a level of control over their own treatment (Logan 1988: 114-116).

The distinction between the position of the pharmacy end user as a 'patient' versus a 'customer' is especially important in the light of the fact that in current pharmacy education, practice and research these protagonists are more frequently described as patients. The status of customer being reduced to referring to non-medicine or healthcare based transactions. As Austin et. al point out this suggests a very different type of power relationship 'based on differing levels of knowledge and skill and culminating in various behavioural expectations' (Austin, Gregory, and Martin 2006). The focus on patient status has been enhanced by the discourse of 'patient centred care' which has been taken directly from medicine and applied to the pharmacy. A Kings Fund article which attempts to define the nature of patient centred care explains it as follows:

> *Patient-centred care has many definitions but a well-accepted one is offered by the Institute of Medicine: 'providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions'. In today's NHS it has come to mean putting the patient and their experience at the heart of quality improvement.*
>
> *(Kings Fund 2010)*

This idea of patient centredness is translated into the pharmacy and is perpetuated through research, government policy and training. For example, The Centre for Pharmacy Postgraduate Education (CPPE) now provides a Patient-Centred Care open learning programme.

Although throughout this work the pharmacists used both terms interchangeably to describe pharmacy users I have referred to them as customers throughout in order to highlight their relatively empowered status and to reflect the manner in which their status and their impact on pharmacy practice was actually discussed by the pharmacists. Chapter Seven deals with these concerns in detail, and demonstrates the potential importance of customer status in a patient centred NHS.

Chapter 2. Situating the research

This chapter situates the research more particularly in terms of people and place. First I explain why I chose to study independent pharmacists in particular and how this group of pharmacists are especially interesting due to their position at the margins of this 'marginal profession' (McCormack 1956). I then introduce the urban landscape that provides the context for this ethnographic account, and consider how this setting has been explored in previous research.

2.1 Why examine 'independent' pharmacy in particular?

We often discuss 'community pharmacy' as if it is a coherent or homogenous entity, but although many pharmacy practice studies include a split in their sample between pharmacists working in the independent sector as opposed to those working for the multiples, conclusions are rarely drawn that delineate strongly between the two. This is understandable as the profession is making attempts to present a united front and make broadly applicable recommendations. The independent sector is also complicated by the status of independent chains/independent multiples which occupy an 'in between' position, not solely owned pharmacies but clearly lacking the nationwide presence and organising power of the multiples. Within these smaller chains there are also a range of different financial and contractual arrangements that may add an additional layer of complication in defining independent status.

Taking all of this into account however, based on assessment of the different business models, generalisations that do not attempt to draw some distinction between independents and multiples overlook some significant differences. In addressing the pharmacy 'revolution' at a recent conference Alex Gourlay, the chief executive of Alliance Boots, Health and Beauty Division recommended that it is time to take a 'global view', forming partnerships with the pharmaceutical industry, 'driving consolidation' and 'driving efficiencies and best practice'*. In short, he claimed, there is a need for pharmacy to address change that is 'fast, global, and now'. This is from a company which owns over 3000 pharmacies across Europe and beyond to Asia and the Middle East*. The language alone suggests a very different perspective and a very different sphere of influence to that possible in an independent, or even independent chain pharmacy.

Bush, Langley et al. (2009) describe how the growing 'corporatization' of the community pharmacy sector has seen the multiples, rise to a dominant position in delivering pharmaceutical services. Richardson and Pollock (2010) point out that the implications of this increasing dominance have not been fully investigated and they suggest that this shift in the marketplace will affect both service provision and attempts to expand the pharmacists' professional role, in particular as the pharmacy professional body has limited jurisdiction over the terms and conditions of employee pharmacists in large corporate chains. Taylor and Harding sum up the fundamentally different approach to business that independents and multiples take as follows:

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* Quotes and figures taken from a lecture: 'Pharmacy and Health in 21st Century Europe', 13th January 2011 at the School of Pharmacy New Year Lecture 2011, held at the Royal Society, London.

> *Corporate pharmacies maximize profit through economies of scale and rationalization, independents pursue profit maximization primarily by service delivery.*
>
> *(Taylor and Harding 2003: 143)*

Ritzer (2000) uses the term 'McDonaldization' to describe the way in which working practices can become routinised and standardised in order to create efficiencies in service. He demonstrates that this approach has spread from the fast food sector and now defines the customer experience across a range of businesses and services including healthcare. Harding and Taylor (2000) go one step further and suggest that this 'McDonaldization' applies to multiple pharmacies in Britain.

The standardisation of practice is desirable in order to create a consistent brand experience across a large number of nationally distributed outlets. Ritzer describes four dimensions of rationality which are required to successfully produce this kind of service: Efficiency, predictability, calculability and control (Ritzer 2000). Efficiency is made possible by providing a standard range of products and services and often attempting to mechanise as much of the process as possible to maintain consistency. Predictability refers to elements that affect the customer experience, ensuring that store layouts, staff dress, transactional conventions etc... are the same in all stores. Calculability is possible due to the large quantities of stock the multiples are able to buy thus creating medicines as 'bulk' commodities sold on the basis of cost rather than reliant on the skills of staff. Finally control is exerted by adopting protocols that determine how services are delivered, restricting the possibility of employees to provide a differential service and requiring an adherence to company defined standards and procedures (Ritzer 2000; Bush, Langley, and Wilson 2009).

It has been suggested that this shifting approach to the way pharmacy is practiced and the decreased personal involvement and autonomy of the individual pharmacist within large multiples may be resulting in the de-skilling of pharmacists and directly threatening their already weak professional standing.

> *Successful large bureaucratic organizations require rational and routinized procedures for maximizing efficiency, and this is reflected in their delivery of rationalized, standardized pharmaceutical services dictated by company policies. Thus the autonomy of pharmacists employed in such organizations to practice discretion in their occupation is precluded.*
>
> *(Harding and Taylor 1997: 556)*

The multiples have also been accused of failing the profession through their need to place shareholder interests over and above potential customer benefit, adding fuel to Denzin and Mettlin's criticism that the business focus of pharmacy is difficult to reconcile with the 'altruistic attitude' required of a profession (1968). One example which Bush (2009) used to support this accusation was the decision of Tesco (Britain's largest supermarket group) in response to concerns raised by some of their customers to halt the supply of Emergency Hormonal Contraception (EHC) to girls under the age of 16 without a prescription (Gray and O'Brien 2002; Pharmaceutical Journal 2002). In another example, a 2008 a review of the MUR service found that chains had implemented the service more rapidly, but reports also suggest that chain pharmacies pressure employees to conduct as many reviews as possible in order to maximise profits from this service (Murphy 2007; Bradley et al. 2008).

Another concern, which is largely absent from the professionalization debate is an acknowledgement of the influence that brand identities of the multiples have on professional identity. The 'brand' sits as a higher level communicator with the consumer and defines the professionality or otherwise of the pharmacist on his/her behalf. The independent pharmacist/ pharmacist working for a small chain however must create a professional persona as a

business imperative in order to distinguish themselves within a crowded marketplace and to compete with the corporate power of the multiple brands which promise customers a reliable, familiar experience. Without the constraints of a 'name' such as 'Boots' or 'Asda' the pharmacist's identity becomes the pharmacy 'brand'; the character that influences the shop environment and defines a large part of what customers consume during their experience in the pharmacy.

The 'ideal' community pharmacist could perhaps be seen to be independent, able to practice without an additional layer of guidelines and regulations imposed by a parent company. Small independent practitioners however inevitably lack the reach of representation enjoyed by the multiples and this leads to a sense of marginalisation (Bush, Langley, and Wilson 2009). Marginalisation often necessitates challenging the value of conventional ways of thinking hence examining the peripheries may reveal a different way of viewing the world and I was especially interested in the creative solutions these pharmacists provide to the challenges of their situation (Napier 2003: 72). However, being on the periphery means that independence is also synonymous with isolation, self-determination and 'single-handedness'.

Observers such as Tallis note that autonomy in healthcare is generally no longer seen as a 'good' thing and independence for general practice at least, is actively discouraged (Tallis 2004). This trend is in line with an emphasis on 'scientific-bureaucratic medicine' which moves away from individual knowledge and the exercise of clinical judgement towards a guideline driven and 'evidence based' model of care (McDonald, Waring, and Harrison 2006). A number of authors (Harrison 2002; Harrison and Smith 2004; Power 1997) suggest that this trend can be viewed in the light of a wider public sector discourse which aims to

found professional practice on 'confidence' via the use of surveillance and monitoring as opposed to trust in expertise and authority. 'Modern' pharmacy is expected to follow suit.

The powerful critique of single-handed practicing GPs resonates with and influences many of the criticisms levelled at the independent pharmacy sector. There are a number of reasons why single-handed practice has been highlighted as 'a cause of concern' within the NHS (Fry 1983). Firstly it is suggested that single-handed practices are less efficient because they have higher structural costs such as staffing, premises and facilities compared to group practices. Given the limited opportunities for economies of scale, single-handed practices tend to have fewer ancillary staff, less well built premises, and a relatively smaller range of services. As such, they have been associated with poor service provision, and the profession has argued that without adequate capacity, single-handed practice may fail to provide a high standard of care (Wang 2008). Paul Corrigan contends that a small business model cannot support primary care services in a modern NHS;

> *... (the) small business model for general practice is not sufficient for some of the tasks we now expect primary care to take on; and in some areas of the country it does not work at all.... A small organisation with few assets is unlikely to put its entire future at risk by investing in, for instance, a new diagnostic capacity. For small business, precisely because they are small, the risk entailed in making the decisions about investing in the diagnostic equipment can be too high.*
>
> *(Corrigan 2005: 10)*

The same might be said of pharmacy. Many independents still do not have consultation rooms due to space or financial restrictions and so cannot provide services such as MURs which require a specific private area for consultation. They are also rarely able to support more than one pharmacist in store hence they are restricted in the time they can devote services outside the dispensary. This is particularly pertinent in the light of increasing calls for the pharmacists to free themselves up for consultation based services. In the last few

months for example the Pharmacists Defence Association has proposed that community pharmacies should adopt a two pharmacist model and that this might be necessary in order to take on a more 'clinical approach':

> *Community pharmacies should adopt a new, two-pharmacist model in order to have a more clinical and interactive approach to patient care. (...) A second pharmacist could run a clinic from the pharmacy's consultation room, focusing on the pharmaceutical care of patients including the management of long-term conditions and transition between primary and secondary care. The clinic-based pharmacist would hold the contract for this service, and hold a register of patients and their medical records.*
>
> *(Pharmaceutical Journal 2011: 258)*

Secondly, single-handed GPs working by themselves have been criticised for being professionally isolated and having no regular peer contacts, leading to the possibility that GPs working alone could be less aware of their own quality standards. Smith (2004), who led the Shipman Inquiry, commented that the term "single-handed" itself implied a lack of engagement with professional peers, and that might result in a failure to keep up to date with current practice standards. The same might be said of the term 'independent' when referring to pharmacy practice. Cooper et al. (2009) highlight the difficulties pharmacists from all community pharmacy settings face through isolation suggesting that the lack of peer contact on a daily basis impacts on decision making. Solitary working in particular was shown to impede the 'transmission of professional values and norms' and also 'ethical discourse'. For pharmacists working in multiples this sense of isolation in some ways could be seen to be mollified by group ways of working that impose certain standards on practice and an assurance that companies at a management level are very much engaged with professional bodies and are able to transmit values of good practice to their staff.

Exploring how these particular independent pharmacists present themselves to the world highlights this tension between these two very different approaches to community pharmacy.

It is important to understand the effect of fundamental changes in pharmacy provision on independent pharmacy and also to learn from pharmacists who are able to creatively interpret a new direction in a manner that is directly responsive to a localised set of needs rather than being dictated by national (or even international) interests. For independent pharmacists this research provides a 'stake in the ground' to discuss representation and the professional face they present to the world.

2.2 The urban setting

2.2.1 Study situation

> The stats don't lie do they? I mean, it basically shows that as you go across from West London to East London health gets worse really! You know, you can't really argue with the stats.
>
> **Pharmacist 7**

This ethnography was carried out in the inner London Boroughs of Newham, Tower Hamlets, Southwark and Hackney (figure 2.1). All four areas contain a heterogeneous mix of neighbourhoods consisting of pockets of extreme affluence, as their boundaries include London's wealthiest business districts and most vibrant creative centres, as well as some of the most deprived and socially marginal neighbourhoods in London facing high unemployment and identified health inequalities. As previously discussed, these boroughs also have in common a population whereby nearly half of all residents describe themselves as being from 'ethnic minority' groups (Office of National Statistics 2001). These areas have long been places of arrival for migrant groups and diversity is part of the history as well as part of the present summed up in this quote from one of the pharmacists in this study:

> The history is amazing because I have seen changes over the years, when I first moved here it was a mixture of working class whites with West Indian Africans, together with some people from West Africa. Then they moved out and the generation of Indians, mainly from the West part of India came along. They made good and moved out and now we have from Aldgate and all that the Bangladeshi population moving in mingled with Pakistanis so those changes have brought a change in business you know.
>
> **Pharmacist 3**

It is these residential areas that define primary care services across the four Boroughs and this study did not include pharmacies in wards considered to be part of the extremely affluent City of London or Canary Wharf business districts or the highly desirable Dulwich village.

Pharmacy coverage across the four PCTs is extensive including a large proportion of independents/independent chains*; Tower Hamlets has 45 community pharmacies of which 36 are independent/independent chains. Newham has 63 community based pharmacies of which 53 are independent/independent chains, City and Hackney has 64 community based pharmacies of which 41 are independent/independent chains and Southwark has 62 of which 43 are independent/ independent chains. (Chemist and Druggist 2010; NHS Choices 2010).

Chapter Four describes the characteristics of this urban setting in more detail using the pharmacists' perspective to highlight aspects of this situation that are especially significant in practice.

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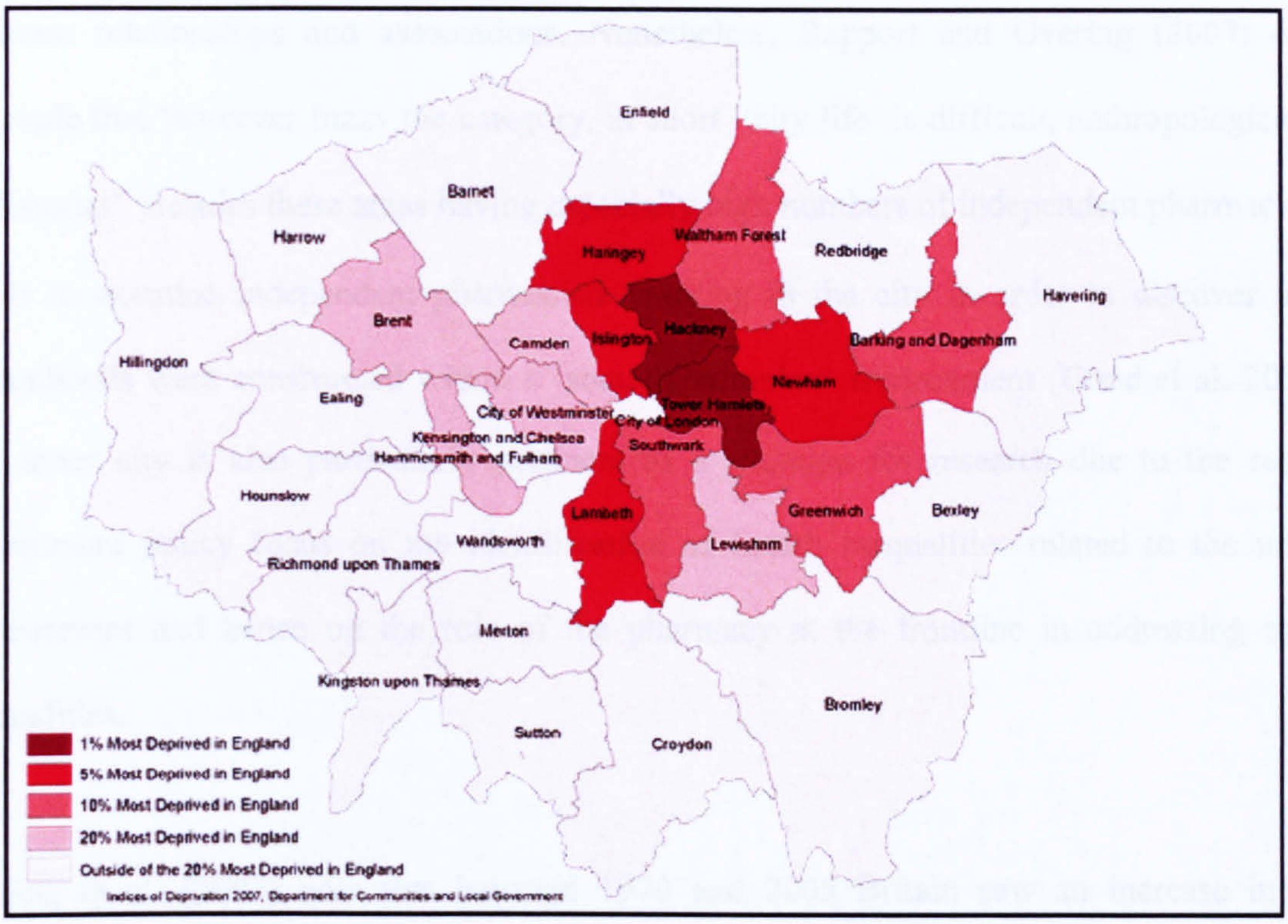
* Inclusive of all wards. An 'independent pharmacy' refers to a pharmacy business that is sole owned or part of a chain that has no more than five outlets. 'independent chains' are considered to be chains of 6-300 outlets.

Figure 2.1 Map of London Boroughs and indices of deprivation 2007



(The City of London Corporation 2007)

There is some debate over the need to examine the city as a special entity with distinctively different relationships and associations. Nonetheless, Rapport and Overing (2007: 409) conclude that 'however fuzzy the category, in short, 'city life' is difficult, anthropologically, to discount'. Besides these areas having especially high numbers of independent pharmacies I chose to examine independent pharmacists working in the city in order to discover how personhoods were constructed within a 'socially complex' environment (Good et al. 2002). The inner city is also particularly pertinent as a situation for research due to the recent government policy focus on the identification of health inequalities related to the urban environment and hence on the role of the pharmacy at the frontline in addressing these inequalities.

Dorling et al. (2007) note that between 1970 and 2005 Britain saw an increase in the geographical segregation of deprivation and prosperity. In particular, the urban concentration of poverty has increased and this is demonstrated in a range of different statistics including employment figures and housing status. For example a Joseph Rowntree Foundation report points out that in some cities in England more than half of households have incomes of less than 60% of the national median and associates these statistics with high levels of economic inactivity becoming concentrated in particular localities and neighbourhoods (Joseph Rowntree Foundation 2008). Social inequalities have long been associated with negative effects on health. *The Marmot Report* demonstrates this link in England highlighting the relationship between the socioeconomic characteristics of neighbourhoods and both life expectancy and disability free expectancy (Marmot Review Team February 2010: 16).

A number of government policies and reports have set out plans to tackle inequalities. These include the 2003 *Tackling health inequalities: a programme for action* which described the

Government's plans to take action on wider determinants of health (Department of Health 2003) and the *Health inequalities: progress and the next steps* report published in 2008 which set out commitments to reduce inequalities by 2010 (Department of Health 2008). However, although the role of pharmacy in helping to address these identified health inequalities has been in general terms the subject of recent attention (Timbs 2008), no specific mention is made of the provision of services aimed at this target within the pharmacy contractual framework. Instead these concerns are dealt with through the development of services to meet local needs and more generally through the pharmacy remit in promoting public health that the Department of Health identified and listed in its public health strategy for pharmacy in *Choosing health through pharmacy* (Department of Health 2005).

Obrist et. al suggest that from the perspective of medical anthropology the key questions for study in the city relate to how people who are embedded in these urban neighbourhoods 'experience, interpret and respond to those aspects of city life that they consider problematic', focussing on how these individuals 'problematize' concerns (2003). They suggest that within the confines of urban settings people need to be creative in the way in which they deal with their surroundings:

> *In constrained urban settings, people have to use their reflective capabilities as they must confront new situations, contingencies and uncertainties that interrupt the daily routine.*
>
> *(Obrist, Van Eeuwijk, and Weiss 2003: 270)*

In exploring the performance of practice in the city therefore, this study does not seek to find solutions for health inequities/inequalities. Rather it intends to highlight the role of these understudied practitioners in the delivery of primary care in the city and explore how pharmacists are providing every day solutions to the vicissitudes of inner city life.

2.2.2 Culturally competent care

The urban experience is rarely investigated in a holistic manner in pharmacy practice research and is even less frequently examined through the eyes of pharmacists themselves. Studies tend to focus on specific concerns such as access or use of the pharmacy by particular minority groups. For example Huckerby et al. (2006) examined the process of taking healthcare to black and minority communities using a pharmacy led initiative. Otherwise the urban setting is touched upon in studies that examine the delivery of particular medicines or services, for example: Fitzgerald (2009) on interventions for alcohol issues, Sheridan (2000) on needle exchange and Wagner et al. (2011) on Minor Ailments. A number of pharmacy studies carried out in America refer generally to the urban context in examining the challenges of providing pharmaceutical care in cross cultural interactions; exploring education in and delivery of 'culturally competent care' (for example Arya 2005; Assemi, Cullander, and Hudmon 2004; Evans 2006; Mullins et al. 2005; O'Connell et al. 2007). It is important to touch on the relationship of this body of work to my research because, although I did not start out with these problems at the centre of this enquiry, cross cultural interactions and/or the provision of healthcare to minority groups became a feature of this study.

While the principles and objectives of culturally competent care have strongly influenced my thinking I have deliberately steered away from the deterministic approach that has come to characterise some 'cultural competency programmes' to frame this discussion, aware of the potential for this discourse to 'slide, often unwittingly, into potentially damaging forms of overgeneralization and stereotyping'(Willen, Bullon, and Good 2010). I have also attempted to reflect the pharmacists' experiences which emphasise the un-extraordinary nature of cross cultural interactions in a hyperdiverse world and their framing of 'competence' as it relates to practice.

The basis of the argument for a distinct and particular focus on cultural competency is the failure of health systems and individual practitioners to address inequities and inequalities related to ethnicity. The aim of culturally competent care (or transcultural care) programmes which proliferated in the 1990's was to represent an effort to 'better prepare both individual physicians and 'the system' to deal well with cultural differences' (Taylor 2003). They also aimed to respond to calls for practical solutions to earlier research which had largely concentrated on simply identifying and documenting inequalities and disparities. The movement sought to answer questions such as 'How could well-meaning people (healthcare providers) provide inequitable care?' and 'How does the culture of medicine including the training of medical students... and the organization and delivery of health care affect patient treatment to produce documented disparities in therapeutic action and the quality of care?' (Good 2010).

In developing programmes in practice however a number of significant concerns have arisen surrounding the practical interpretation of this concept. One difficulty is the danger of creating singular identities based on reified cultural difference ('plural monoculturalism') ignoring the fluidity and plurality of identity (Sen 2007: 156-160). Well intentioned models* have been handicapped by the perceived absence of choice about identity creating cultural boxes both for patients/customers and *de facto* for healthcare professionals themselves (Sen 2007: xii-xiii). While much of the literature surrounding culturally competent care pays attention to the influence of the dominance of biomedical culture (Good et al. 2002), culturally competent care programmes/models have also been criticised in practice for falling into the trap of being considered uni-directionally, preserving a hegemonic white majority

* For example Leininger's 'Sunrise' model aimed at providing a framework for understanding a patient's cultural background (Leininger 1995). Often complex in structure these models are criticised for attempting to provide formulaic 'checklist based' understandings for different cultural groups.

stance and forgetting that the culture of the physician and the culture of the health system within which they are working is a 'far from neutral' background (Fox 2005).

Authors such as Fox (2005) have questioned the need for culturally competent care as a separate agenda from 'client centred care' i.e. 'care focussed on the needs of the individual and involving advocacy, empowerment and participation in decision making due to the attention to cultural requirements' (Srivastava 2007: 20). Advocates of culturally competent care however suggest that the slow progress of change in addressing inequalities and inequities related to ethnicity begs specific questions regarding the prioritisation of these concerns and how policy is translated into action (Tilki 2006 p-32). While rejecting potentially formulaic programmes/models it must be recognised that the movement as a whole has had an important role in calling for a focus on the provision of equitable care (Good et al. 2002).

In this study, it is important to note the complex nature of cross cultural interactions. While the pharmacists were obviously in a socially privileged position all but one were members of so-called 'minority' groups and the transactions occurring everyday in the pharmacy crossed multi-dimensional cultural and social divides. I observed at least as many (if not more) cross cultural interactions in total as I did shared cultural interactions and the pharmacists experienced as many problems in communicating with their White British customers as they did with customers from ethnic minority groups. The pharmacists themselves did not necessarily recognise the practical *skills* they felt employed in dealing with customers of a different cultural background as being particular or distinct from the skills they used in dealing with customers with whom they had a shared heritage. Pharmacists did however discuss in detail relationships that rely on particular cultural understanding. They highlighted

the fact that cross cultural interactions could be particularly challenging and that they required particular attention and effort. They also highlighted training/ support needs that related to facilitating good communication in a cross cultural setting.

Acknowledgment of the short comings of the interpretation of culturally competent care in practice forces us to examine how a more 'broad gauged' approach to managing healthcare in a hyperdiverse environment that is both professionally and practically relevant (Fox 2005). As Betancourt (2004) suggests this approach does not allow culturally competent care to become a 'panacea to singlehandedly eliminate disparities' but rather views cross cultural communication as part of a range of communicative practice skills that are 'necessary' in delivering high quality care. This study will consider the categories that are acknowledged within constructs of cultural competency in its widest sense, concerning professional personhoods and examine the challenge of delivering primary care within pharmacy in a manner which is judged to be physically, socially, culturally and morally appropriate by the pharmacists themselves. In exploring the pharmacists' experiences this research hopes to contribute to work that seeks to build a knowledge base that looks towards creating a 'more informed universalism' (Good 2010).

2.3 Outline of thesis

Chapter Three describes in detail the protocol and design of this study and discusses how I gained access to the 'working world' of the pharmacists. The following findings have then been organised to demonstrate the way in which pharmacists describe their role through the rhetorical use of three overarching and connected themes; autonomy, engagement and 'bespoke service'. These themes provide a framework for the forthcoming discussion.

The first section of findings concentrates on the pharmacists positioning of themselves as professionals within a particular environment and explores the idea of autonomy in shaping professional personhoods. Chapter Four sets the scene by describing the demographics of my respondents, briefly outlining the routes they have taken to becoming independent community pharmacists. I then introduce the practices I visited and the urban context they are situated in. This urban context provides a powerful backdrop to the pharmacists' narratives and I felt that it was important to represent the pharmacists' personal accounts of their world and of the challenges it presents in practice. In Chapter Five I discuss pharmaceutical personhoods, concentrating on what it means to be 'independent' and how this shapes the pharmacists' ideas of professionalism. In doing so I explore the rhetorical value of autonomy in creating a 'more professional persona'. I then go on to examine independent interpretations of the new direction of pharmacy and historical tensions through the role of the pharmacist as a businessman.

The next two chapters focus on engagement within the pharmacy; firstly at the level of the community, and secondly through relationships with individuals. Chapter Six concerns engagement at a community level, characterised by a two way process of fitting in and being accepted by the community as well as being able to reach out to more 'remote' communities/

networks that are based on ethnicity and language. Chapter Seven meanwhile deals with engagement on a one-to-one basis which is highly personalised but governed by a set of rules or a 'way of being' that draws on a perceived need for 'respect' and the default status of the pharmacy user as a customer not a patient. The trope of 'respect' is particularly expressed in dealing with diversity and difference in the pharmacy. I then examine how continuity of pharmacy staff enables respectful relationships to become more intimate.

Good relationships are an important differentiator for any small business but relationships with customers are not only built on an emotional connection, they are also reliant on the quality and nature of services provided. Chapters Eight and Nine examine how pharmacists as independent healthcare practitioners are able to define and differentiate their offer in this most practical sense; building both on the potential for flexibility through autonomous decision making and on their ability to engage with customers enabling a personal service tailored to individual needs. In doing so it features two key areas: Chapter Eight looks at time in the independent setting and how 'taking time' or 'not having time' are used metaphorically in describing the benefits and the problems associated with independent pharmacy practice. I also discuss how the use of time impacts on advice giving. Chapter Nine examines practical specialism i.e. offering flexible solutions tailored to customer needs and particularly highlights the provision of creative solutions, the provision of specialist stock and employing staff with particular language skills.

Finally these themes are pulled together in Chapter Ten and I discuss the possible implications of these findings for continuing anthropological investigation into the world of the pharmacy and also look towards policy and practice.

Chapter 3. Methodology

This chapter describes the research methodology and analytical approach taken in this study.

I also aim to provide an account of methodological issues encountered during the process of research and reflect on the impact of my presence in the field.

3.1 An ethnography of urban independent pharmacy practice

> *One becomes an ethnographer by going out and doing it (and writing it up). Fieldwork of the immersive sort is by and large definitional of the trade.*
>
> *(Van Maanen 2006)*

This study is an ethnography of urban pharmacy practice which seeks to put the independent pharmacist at the centre of the enquiry. Ethnography has long held an association with anthropology and encompasses a theoretical and philosophical perspective as well as a methodological approach. While acknowledging the difficulty in describing a 'definition' of an ethnographic approach Hammersley and Atkinson (2007: 3) depict an ethnographic methodology as typically involving the researcher 'participating (...) in people's lives', usually over a period of time, watching, listening and asking questions. Elaborating on this, they suggest that ethnographic accounts usually have the following features:

- 'People's actions and accounts are studied in everyday contexts'
- 'Data are gathered from a range of sources (...) but participant observation and relatively informal interviews are the main ones'

- Data collection is comparatively unstructured. Research design is malleable and structures are not usually built into the process of data collection to categorise what people are saying or doing through structured questionnaires or observation schedules
- A relatively small scale focus to enable in-depth study
- Data analysis involves the interpretation of 'meanings functions and consequences of human actions' and produces verbal descriptions explanations and theories

(Hammersley and Atkinson 2007: 3)

They also stress the need for reflexivity in ethnographic research, highlighting the importance of acknowledging the position of the researcher within their work (Hammersley and Atkinson 2007: 15).

Taking an ethnographic approach enabled a close examination of the role of the pharmacist and the day to day challenges of pharmacy practice. To produce this account the study included participant observation carried out within seven pharmacies following the daily lives of the pharmacists working there and active, in-depth interviews with 36 other pharmacists working in the study area.

Given the emphasis ethnography places on 'fieldwork' I could have chosen to carry out solely observational research and perhaps stayed in just one pharmacy for the length of my fieldwork. This approach might have been anthropologically valuable in producing an extremely detailed account of pharmacy life but I felt would have been of limited value in investigating the potential of pharmacist personhoods. The range of different voices in this research have been important to enable an exploration of a variety of rhetorical approaches and lend richness to the analysis. I was also conscious that independent pharmacy practice is

often defined by 'quirky individuals' and that any research that concentrated on just one or two locations and central characters could perpetuate this stereotypical view and hence make a less valuable contribution to the debate.

Although the methodological basis for ethnographic research remains field based participant observation, increasingly other methods such as interviewing are also used. Hammerlsey and Atkinson go on to suggest that ethnographers should not 'shy away' from interviewing to collect information on 'described events and discursive strategies'. They also point out that a combined methodology has advantages as interviews enable the ethnographer to see differently in observation work and vice versa, producing a depth of understanding (2007: 103). Hockey also suggests the potentially important role interviewing can play within an anthropological, ethnographic context (2002: 210-222). She contends that the research interview is a 'culturally appropriate form of participation in Britain' suggesting that as a practice it is close to Western categories of experience (ibid.). She highlights the fact that the extraction of fragments of time and a reliance on accounts rather than direct experiences are features of daily life that people are used to negotiating. In the pharmacy in particular this fragmented experience is especially pertinent. As such Hockey argues, interview data need not necessarily be seen as the 'poor handmaiden' to participant observation (ibid.).

While the strengths of ethnographic enquiry lie in its ability to provide a deep and rich understanding, ethnographic studies are often criticised for a lack of generalisability. These claims are countered by suggesting that ethnographies produce descriptive and explanatory elements which can be generalised to a larger population or can be more generally valuable through theoretical inference.

3.2 Sample

To organise this chapter I have broken down the elements of fieldwork into discrete sections however in practice there is significant overlap in terms of the relevance of certain points of discussion raised. It is important to note that the two methodological processes occurred alongside each other simultaneously informing development and progressing analysis.

3.2.1 Entering the field

As part of the funding for this study I undertook an MSc course at the London School of Hygiene and Tropical Medicine (LSHTM) in 'Public Health Services Research'. The dissertation prepared for this programme served in part as a 'pilot' study to test access to this group of pharmacists, develop questions and to build contacts within the study areas. The pilot aimed to investigate the perceptions held by ethnic minority pharmacists working in independently owned community pharmacy of their relationship with ethnic minority customers in East London. The research involved in-depth focussed interviews with nine pharmacists. Key themes identified regarding the pharmacist's role included: the potential importance of empathetic understanding through experience of being the 'other', the importance shared ethnic identity and language in particular interactions; the renegotiation of illness narratives; the flexibility of the role of the pharmacist and managing a pragmatic medical syncretism within the pharmacy (Duckett 2007).

Conducting this research enabled me to refine the recruitment process described below and gave me the chance to get to know the pharmacy and the urban environment better. It also provided me with contacts who were especially valuable in arranging placements for my

observational work. The interview data from the MSc. project has been included in and re-analysed as part of this investigation with the exception of an interview with Mr P who had retired but who introduced me to his replacement Mr E who agreed to take part in the participant observation work. Mr P's interview was excluded so that the pharmacy was not represented twice.

3.2.2 Defining independence

As previously touched upon defining 'independence' is not as straightforward as it might at first sound. I could have limited myself to pharmacists working in pharmacies that were sole owned or part of chains of five or less which is a commonly used definition in pharmacy practice research. This however is already a complicated story, why five pharmacies rather than ten as I have seen in some alternative definitions? Even 'chains' of two stores usually employ pharmacy managers to run at least one of the shops on a daily basis; are these managers 'independent pharmacists'? In one sole owned pharmacy I met a pharmacy manager who ran the establishment on behalf of the owner. How would he have fitted in to this picture? Limiting this definition would also have failed to take into account the fact that pharmacists working for independent chains can feel quite distinctively part of the independent sector and expressed very strongly that their way of working was consistent with being 'independent'. To the other extreme I could have included pharmacists working in chains of up to 300 shops that are described as 'independent multiples' but which have corporate branding, sophisticated in-house training programmes, practice standards etc. that align their way of working more closely with the multiples. For the pharmacists in this study meanwhile the definition of being 'independent' seems to rely on less tangible elements such

as the level of corporate intervention within the dispensary and how the financial and contractual arrangements described above affected practice.

In practice it was also very difficult to pin down the exact financial and contractual details of all the pharmacies I visited in spite of cross checking pharmacists' accounts with data available on the pharmacy register, at Companies House and publicised through the Freedom of Information Act. For example, two of the pharmacies represented here are part of a chain of five that might be considered to be 'independent' by the usual definition. It transpires however that the holding company that owns these pharmacies has a large wholesale and distribution business, hence financially at least these two pharmacies were in a very different position to a traditional 'independent'.

For the purposes of this study I excluded pharmacists working for multiples that are members of the CCA. I also took the decision to exclude pharmacies from a particular 'independent multiple' that has 166 branches nationwide and significant representation in two of the PCTs. I felt that this was sufficiently different in scale to be considered a 'large independent chain' and could be perceived to have largely nationally rather than largely locally driven interests. Beyond this however, as I was concerned primarily with how the pharmacists presented themselves as professionals I took the pharmacists' impression of their status as an 'independent' as the most important signifier that made them (rather than necessarily their pharmacy) eligible for inclusion. Using this criteria, the largest chain represented in this research consisted of 38 branches, the majority of which were based in London and the South East. In total 20 pharmacy managers and 23 pharmacy owners took part in the study.

3.2.3 Depth interviews

Purposive sampling was used to select pharmacists for interview. Using this method respondents are chosen on the basis of previously identified characteristics to select 'information rich cases for in depth study' (Liamputtong and Ezzy 2005: 44). In other words the sample is 'intentionally biased in order to get answers to questions of practical importance' (Bernard 2002: 182-183).

The NHS 'find a pharmacist' website and the Pharmacy Register* were used (NHS Choices 2008; Royal Pharmaceutical Society 2008) to identify all of the independent and independent chain pharmacies in the target boroughs. Pharmacists who were either 'owners' or the principal pharmacy manager in store could be included in the study if they spent the majority of their time within the particular pharmacy that I met them in (a number of pharmacy managers regularly work in two or more pharmacies and owners may split their time between a number of different shops). 'Owners' in this context is used to refer to proprietor pharmacists who own (or at least have a financial stake in) the business as well practice as a pharmacist. These owners are also 'contractors' as the NHS contract for that particular pharmacy is held in their name. Pharmacy managers were all employee pharmacists. Locum pharmacists were excluded from the study as I wanted to concentrate on pharmacists who had decided to take up permanent positions in the independent sector.

While not being intended to be statistically representative I did aim to reflect the gender, age and ethnicity of the wider study population within the group of pharmacists that I interviewed. Ethnicity in particular provides the framework for much of the following discussion and was key to shaping professional identities in practice. Although I did not set

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* Referenced here to the Royal Pharmaceutical Society of Great Britain, now available at the General Pharmaceutical Council: http://www.pharmacyregulation.org/theregister/index.aspx

out to sample specific ethnicities, given the profile of independent pharmacy and in particular independent pharmacy in an urban community setting I did anticipate that I would encounter pharmacists from a range of different ethnic backgrounds. It would have been possible to single out particular ethnic group for closer study however, informed by the work I conducted in my pilot study I felt that to do so would have been to reify the concept of ethnicity in a way that did not reflect daily life in a hyperdiverse setting.

Pharmacies were also purposively selected to ensure the four East and South-East London PCTs chosen for study were represented in a balanced manner although the analysis does not compare and contrast PCTs but rather takes this area of study as a single social field. Within this field I wanted to ensure that my study included a range of different urban settings and so I purposefully selected pharmacies in three emblematic urban locations: 'remote', underserved housing estates, 'local' shopping parades (in other word small collections of shops that serve a nearby residential population) and the overcrowded, highly competitive high street.

I visited the majority of pharmacists in person in order to recruit them into the study; this had the benefit of being able to get a feel for the shop and an understanding of the local area before returning to the pharmacy at a later date to conduct the interview at the convenience of the pharmacist. I had initially attempted to introduce myself to a number of pharmacists by telephone in order to arrange an initial meeting. I found however that I was often prevented from speaking to the pharmacist by staff answering the phone and that pharmacists were much less receptive to the idea of taking part in the study in a 'cold calling' situation. In total five of the sample were first contacted by phone. I did not make any attempts to contact pharmacists through either professional organisations or local PCTs in order to avoid the

sense that research was part of a 'surveillance' exercise or could constitute in some way an 'official' comment on their behaviour.

I began with the intention of interviewing a minimum of 20 pharmacists. As in quantitative work the sample size in qualitative work is considered sufficient when it is able to support the analysis required (Liamputtong and Ezzy 2005: 49). This number was based on what was expected to achieve 'theoretical saturation' based on previous study designs however data was continually reviewed throughout the study and I felt that there was a requirement for more interviews to be conducted in order to gain a deeper understanding of the findings.

In total I visited/contacted 109 pharmacies out of a possible 143 across the four PCTs (excluding wards in the City of London, Canary Wharf and Dulwich Village). Of these 31* consented to me arranging some time for an interview. Some were excluded after being contacted as the owner had already been interviewed in another pharmacy (i.e. they were part of a 'small chain' of pharmacies). A number of pharmacies were visited while the owner/manager was away and had a locum pharmacist in place in the store. Of those that declined to take part the overwhelming reason was not having enough time to spare to be interviewed. It should be noted at this point that the pharmacists who agreed to participate may have been systematically different to those who did not although it is not possible to substantiate what those differences might be.

Negotiating time was the most challenging aspect of recruitment, I had initially hoped to conduct interviews outside the pharmacy in order to avoid interruptions and to ensure that the pharmacists could speak freely without other staff overhearing. This however proved difficult

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* I also included in this analysis interviews conducted in the pilot study, hence in total there were 43 pharmacists represented, 36 through interview and 7 through observation.

as pharmacists were very reluctant to agree to being interviewed outside their working day. Due to long opening hours, the physical ties to the pharmacy and the lack of cover for single-handed pharmacists they were usually extremely reluctant to give up their time outside work or to leave the premises. Finding time during the day was also a struggle and I frequently had to go back to the pharmacy a second or even a third time as the interview would often be postponed. I soon became aware of some general rules: don't try to speak to a pharmacist first thing on a Monday morning; there will be a queue of people waiting to see him with ailments and concerns that have arisen over the weekend. Find out when the nearest GP is closed, as it is likely (but not always!) to be less busy and most importantly, try not to arrange two interviews on one day!

Initially a small financial contribution was offered to pharmacists in order to compensate them for their time and in line with expectations of health care professionals taking part in research. I found in practice however that the mention of a monetary 'reward' caused an awkward discussion and embarrassment for the pharmacists. This was partly because the amount offered did not actually compensate for the time the pharmacists spent with me but also because some felt that they 'couldn't take money from a student'. 'You need it more than I do' was a common response or 'I'm really happy to help someone with their studies'. While a few pharmacists commented that it was 'nice to have their time recognised' a number refused the payment completely or asked me to donate the money to charity. As a result I dropped the offer so that 15 of the interview candidates were paid and the rest were not. There was no difference apparent in the time afforded for interview or the quality or nature of responses between the two groups.

3.2.4 Participant Observation

I aimed to conduct observation work in six to eight pharmacies covering a range of different pharmacist and pharmacy situations and in total seven pharmacies participated in this part of the research.

Three of these pharmacists had previously taken part in the pilot study and were the first points of contact I made in arranging access to pharmacies for observation work acting as key informants. Mr E in pharmacy five was introduced to me by Mr P who had taken part in the MSc pilot and had since retired. One of the other pharmacists I conducted observation work with was also already known to me through previous work I had done conducting research into over the counter pharmacy products. A further two pharmacists were selected after meeting them through the process to recruit for the interview. These two pharmacists were selected purposively to ensure a range of different pharmacy types were represented in the observation work.

3.3 Data collection

3.3.1 Depth Interviews

Patton (1990: 278) explains 'the purpose of interviewing is to find out what is in and on someone else's mind...we cannot observe feelings, thoughts and intentions'. The aim of the interviews I conducted was to inform my observations and to collect cognitive data from pharmacists themselves, gathering their perspective on practice within this setting in their own words. All the interviews were audio recorded and were conducted alongside observation work between October 2008 and August 2009.

Although a general topic guide was used as a focus the interviews were 'active' in-depth interviews. More formally organised interviewing techniques such as semi-structured interviewing suggest an emphasis on consistent questioning and minimal involvement of the interviewer in the process. An active interview however emphasises a more conversational structure and fluid negotiation of meaning (Holstein and Gubrium 1995: 38-39 and 56). Rather than providing a fixed structure the topic guide in this case provides key concepts as a malleable framework for the interviews which are conducted using open-ended questioning (ibid: 76). This stimulates discussion around a number of themes while still allowing for the emergence of new topics of interest through the natural progression of conversation. The interviewer is not expected to be passive and is able to probe answers, suggest ideas or build on themes presented by the interviewee.

Of the 31 interviews in this phase of research (not including those from the pilot study*) 17 were carried out within a private space within the pharmacy and twelve were conducted in the dispensary. Only 3 were held outside the pharmacy; one over lunch, one in a nearby park after the pharmacist had finished work and one in an office that was separate from the pharmacy itself. The interviews ranged from the shortest which had to be stopped after just thirty minutes to the longest which took over four hours to conduct and included a total two and a half hours of recorded dialogue.

Interviews held in the dispensary were often disrupted by staff asking questions or by the pharmacist having to serve customers. These interruptions did cause the flow of discussion to be broken and as such were more challenging to conduct. Dispensary interviews were also

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* Of the nine conducted for the MSc two were held in private pharmacy space and seven in the dispensary. Based on this experience I was not surprised at the number of interviews carried out in the dispensary in the main body of this study and was confident in the quality of interaction that was possible in this space.

challenging because they were not in a private space and could be overheard by other staff members who were frequently brought into the discussion and asked for comment and opinion. Pharmacists are very used to a lack of privacy and continually being on show and so were unfazed by this situation however there was a sense that in these cases content was self censored and/or presented for staff to hear as much as being presented to me. In spite of these difficulties however these interviews were no less valuable in understanding how the pharmacists account for their position and how they highlight features of practice that they wish to be seen. I was also able to observe how these pharmacists interacted with their environment during the interview.

Any interview situation is a performance of some sort by all the parties involved and Collins points out that at any time in an interview the subject 'might be addressing audiences other than the one immediately present' and that during an interview several versions of the 'self' might be presented (Collins 1998). It is also important to note that the performance of various roles does not stop when the audio recorder is turned off. All encounters involve some kind of performance and while it is tempting to assume that the 'naturally occurring talk' that arose between myself and the pharmacists during observation work was 'less 'staged' than the interviews in fact, as Holstein and Gubrium note 'this is only true in the sense that such interactions may be staged by persons other than the interviewer' (1995: 17).

Mindful of the fact that interviews are not repeatable experiences but are contingent on time, place and the relationship between interviewer and interviewee, rather than attempting to secure 'reliability' or 'validity' an active, responsive interview concentrates on how 'meaning is constructed' the context of this construction and 'the meaningful linkages that are assembled for the occasion' (Holstein and Gubrium 1995: 9).

3.3.2 Participant observation

Participant observation aims to collect data on behaviour and interactions and in this case I was especially interested in the performative and discursive strategies of the pharmacists. This part of my research was especially significant because although this thesis places significant emphasis on persuasive talk it is also very much about context, situation and performance. The importance of observation, especially where respondents may not be consciously aware of modifying their behaviour but where behaviour is very much part of the persuasive strategy cannot be ignored (Silverman 1998).

I have retained the expression '*participant* observation' because although I did not have a specific role within the pharmacy environment I did establish distinct relationships with the actors within the pharmacy and participate in everyday pharmacy life and interactions. I spent a lot of time chatting to staff as they worked and was often asked to move boxes or make tea. Being engaged in the pharmacy life allowed discussion of processes and interactions and allowed me to gather informal interview data throughout the observation period. In contrast, a non-participant observation method requires a strategy whereby the researcher observes without interaction and maintains distance from his/her subjects implying an unengaged process.

Research took place between October 2008 and August 2009 over a period of one month within each pharmacy. Within this period observation sessions were agreed with the pharmacist to cover to the range of opening hours of the pharmacy in order to get a sense of the clientele and interactions at different times. Sessions were usually around four to five hours a day after which I would return home and write up the days findings. I chose to take this approach as the pharmacy represents an intense environment for research. Hammersley

and Atkinson suggest that long bursts of observation can lead to the researcher loosing the ability to 'see' (2007: 37). They recommend breaking up the working day as a more productive approach (ibid.). Limiting the time spent in each pharmacy to just one month had obvious implications regarding the depth of relationship that I was able to form with respondents. While I was able to build a level of confidence I could not claim that any of the relationships I formed were close or deeply felt by either party. For the purposes of this study however, as I was interested especially in a public representation I compromised depth of understanding for the ability to experience a number of different presentations of the independent pharmacist.

The focus of this research was quite specifically limited to the pharmacy shop itself. While a concentration on such a specific location does not allow for a broader, contextual account it does allow for examination in detail of a particular social world. It should also be noted that the pharmacist's view of the world from day to day practice barely extends beyond the counter let alone beyond the shop door. Due to legal restrictions which require the pharmacist to be present at all times for the dispensing and sale of medicines the pharmacist himself very rarely leaves the shop all day and if he does so it is for an extremely short time period, perhaps to buy lunch. This limited world and quite literal physical ties to the shop itself places a restriction on especially single handed pharmacists ability to involve themselves in wider community based concerns or to expand their practice out of the shop environment. As such I felt that it was appropriate to retain a similarly restricted focus to reflect the lifeworld of the pharmacy.

I discussed in detail with each of the pharmacists how they wanted to handle my presence in the pharmacy. I found myself stationed in a range of positions depending on the layout of the shop, from being seated within the dispensary to sitting on the 'customer' side of the counter.

In all cases I was able to move around the pharmacy if I wanted to get a different view. I made sure I was able to speak with the pharmacist in the dispensary as well as the counter staff as they worked and I was able to get a clear picture of all the transactions involving the pharmacist that occurred in the pharmacy. It was important that customers were also able to see me as I did not wish this to be considered 'covert' research. I also made sure that I was not sitting in designated private space in case customers specifically requested a private consultation with the pharmacist. Only two of the pharmacies had consulting rooms, for the others private space was either designated at one end of the counter or to one side in the dispensary area. I agreed with all of the pharmacists that if they felt my presence to be disruptive or unsettling for customers then I would be happy to leave (in fact this was not felt to be necessary at any point during the research).

I recorded observations in the field using logs of daily activities, a personal diary and methodological and descriptive field notes. Field notes included observation and analysis, descriptions of what was seen and experienced and also perceptions and interpretations of events as they occurred. Selective attention is inevitably a problem for any observation work and it can be challenging to know what to look at or indeed how to write it down. I addressed this by having a simple checklist within which I made a note of every encounter/ piece of dialogue that took place in the pharmacy recording details about time, space, actors and communication process. Time was set aside to ensure that notes were written up on the day in most cases and within a week in all cases. There are obvious drawbacks in relying on note taking as a record, especially in ensuring that all the detail of interaction is captured. In writing up notes I often added more information from memory or additional comments or reflections. Writing up the notes therefore became part of the analytic process.

Many of the interactions observed both between staff themselves and between staff and customers, took place in languages other than English. Given the array of different languages encountered during my work (even the smallest pharmacy I visited had fluent speakers in three languages other than English), it was unfeasible to arrange specific language support so I had to rely on *ad hoc* translation from the pharmacists and pharmacy assistants. There are limitations to this approach in that not every encounter could be fully translated and I was reliant on the relevant member of staff providing me with their perspective on the encounter. Nonetheless it was possible to gain an understanding from body language and tone to lend colour to the described accounts. Importantly however, this struggle with language and meaning reflects the reality of the pharmacy environment. Pharmacists themselves are rarely able to understand all the transactions that occur within their pharmacy.

The members of staff that I met during my observational work included counter assistants and dispensing assistants as well as staff without formal qualifications such as staff working on other, non-medicine related counters. These staff were of particular importance although they were not the subject of investigation in this study. They were able to act as additional informants and through informal interviewing gave me another perspective and a chance to explore and develop analytical themes. I was also especially grateful for the warm welcome everyone I met provided. These staff members were instrumental in my integration into the pharmacy space, positioning my role within the pharmacy as 'one of them' behind the counter.

3.4 Ethical considerations

Ethics approval was gained from the LSHTM human subjects committee (appendix 1). Written consent was required from all participating interview subjects and staff from observation sites. Participants were supplied with information sheets and consent forms produced to standards set by the Association of Social Anthropologists (ASA). Appropriate steps as outlined by the ASA and LSHTM were taken to ensure suitable anonymity and confidentiality. Mindful of anonymity; while it is relevant to highlight the boroughs that I conducted research in order to enable understanding of the urban context I have stopped short of any link between respondents and place. I have also assigned numerical identifiers to respondents throughout this study or, where appropriate used pseudonyms 'Mr A' Mr B etc... or changed other details in order to disguise identity. Any proper names used to indicate customers or staff in the pharmacy are also pseudonyms.

Aware of the criticisms of 'anticipatory' informed consent (consent given before an interview/ interaction) (Miller and Bell 2002: 53-70; Parker 2007) the pharmacists were asked to sign forms to say they were prepared to take part in the process and that (in the case of interviews) they were happy to accept audio recording equipment being used (appendix 2). The sections requesting permission to use the information and requesting the possibility of use of anonymous quotes were filled in most cases by the respondent after completion of the interaction. Some insisted on filling the whole form immediately to save time and in these cases I checked back with the respondents at the end of the interview to ensure they were happy with their decision.

Signs and information leaflets were available in the pharmacy during the observation process to ensure customers using the pharmacy were notified of the research process and had access to detailed information if wanted (appendix 3). There were strong ethical considerations raised concerning the status of customers during the research and the balance between informing them of the work taking place while not overburdening them and causing concern, especially given the focus of this study meant that they were peripheral to rather than central to the research. I was very conscious that I did not want any ethics process to be simply an 'ethical panacea' that was more for my benefit than for customers or pharmacists (Corrigan 2003; Parker 2007). Whilst it was clearly important for customers to understand my role in the shop and to recognise that research was taking place, it was also important to respect their needs within the pharmacy environment. Breaking into every transaction with consent forms and paperwork may have been both an irritant to customers and, importantly, may have put them off visiting the pharmacy future. I was also conscious that the pharmacy preserves anonymity for customers who, if they do not hold a prescription may chose not to reveal any personal details at all in the space and who may be unknown to the pharmacist himself. Any consent process may have disrupted this situation and left people feeling more, rather than less exposed. An agreement was reached with the LSHTM ethics committee that bearing in mind the open nature of the pharmacy environment signage and leaflets would be sufficient to notify customers of my work without being too intrusive. I also made sure that there was no attempt to disguise my presence within the pharmacy and made it quite clear that I was listening and taking notes. What emerged in practice was an informal process in which customers who were regulars or who had been engaged in significant conversation were often introduced to me by the pharmacists themselves to ensure that they hadn't missed the available information and I would then have a chance to explain my research. Importantly, this type of interaction also ensured that, rather than just handing out leaflets that in many

cases customers were unable to read, the nature of my research was conveyed sensitively and appropriately.

3.5 My presence within the research

In the past, anthropology has placed a significant emphasis on the need for researchers in the field to hold an 'outsiders' perspective. This outsider status was felt to be critical to research as the process of adjustment to any new situation enables the researcher to 'see' culture in a way that insiders are necessarily unable to do. This position has however been criticised as being taken too literally and too simplistically and there has recently been an increase in the amount of fieldwork that has been carried out 'at home' (Raj 2003: 11-12). I was in the odd position of being neither (or both) 'insider' and 'outsider' in the field. My fieldwork was produced 'at home' in that I live and work in London, however until my research began the boroughs I visited in East London were very much an alien world that I could not pretend was familiar or known. Additionally the pharmacy space was not a space that I was used to working in, although time spent working in laboratories and in the pharmaceutical industry enabled me to speak 'the language' of the pharmacy with relative ease.

3.5.1 Being in the pharmacy

Inevitably my performance within the pharmacy environment had an impact on what was seen and on interactions that took place, highlighting again the point that research is a mutually derived process and dependent on both parties. A particularly important point that shaped discussion was my status as either a 'student' or as a 'researcher'. While I was not

aware of consciously adopting either of these roles later analysis showed that in my interactions with the pharmacists I assumed these positions as talk progressed, creating a foil for their stories. A number of the pharmacists very much assumed the role of teacher and this resulted in conversations where I felt as though I was being presented with the 'received wisdom' and a version of events 'as they should be'. Nonetheless, I found that this position also elicited instructive tales of 'how it really is', 'giving me the low down' on life in the pharmacy, almost as if I might be in training to be a pharmacist myself. These pharmacists tended to cite their enthusiasm for supporting academic work and young people studying as their motivation for taking part in the research. For others I was a researcher in a position to report back to the wider world. For these pharmacists taking part in the study often had quite an explicit political agenda, reflecting their particular desire to promote the value of independent pharmacy. A concern therefore in reflecting the pharmacists' perspective is that I am acutely aware that while I have a responsibility to tell their story I also have a responsibility to present a balanced view of their practice and its value.

Being a 'middle class' white British female within the pharmacy environment also inevitably had an impact on my vantage point from within the pharmacy and people's perceptions of my presence within this environment. The extent to which ethnicity and gender 'mattered', as with many interactions in this hyperdiverse world fluctuated and was contingent on situation and context. Nonetheless, 'who I am' did influence the way particular issues were presented, especially as discussion turned away from pharmaceutical practice and towards subjects that explicitly referenced ethnicity, culture or language. In these situations I was very consciously aware of my 'white Britishness' mattering much more and it became a point of contrast in some discussions: 'you would not be able to open a shop here', 'you would find it difficult to practice because you have no language'. Much of the discussion that follows centres around

cross cultural relationships and my personal experience cannot help but shape my representation of that debate. I am aware of, and have tried to take account of, the requirement to represent but not reify ethnicity and difference and also wary of the trap of being blind to similarity as it is often less obvious and less exciting. In addition I was aware that my 'outsider' status lead to a somewhat 'utopian' presentation of the urban context through the pharmacists' desire to present a positive view of the communities they worked within and felt that they represented. These descriptions contrasted powerfully with a more measured view that emerged during observation work.

Although I am not trained as a pharmacist, I have a scientific as well as an anthropological background and have worked within a pharmaceutical environment for a number of years. This meant I was able to speak the 'language of pharmacy' relative ease which was a significant advantage. Being familiar with medical terms and practice jargon I was able to pass, if not as 'one of them' then as 'part of their world'. While potentially a concern in giving up my status as a more complete outsider in terms of the valuable ethnographic lens this can provide, foregrounding my 'pharmaceutical identity' shaped an 'in the know' peer to peer relationship for observation and interview processes and helped me fit more quickly into the dispensing world rather than the world of the customers. This collusive relationship helped me to get further towards hearing pharmacist tales told in their language rather than tales filtered for general public consumption.

The process of being 'researched' also potentially has an impact on behaviour, consciously or sub-consciously on pharmacists and their staff. During observation work it was very hard to measure what impact my presence had on the pharmacists and their work. At times I was aware of pharmacists being extra vigilant and perhaps spending more time than they might

usually have done in explaining medicines to customers or being more conscientious about pharmacy processes.

It is also important to note that this thesis is a partial account in a number of senses. As pointed out, the research methodology renders this necessarily a partial story and further investigation might take into account different sides to this story. It is also partial in the sense that there is always selectivity in what respondents choose to reveal. Finally this thesis also necessarily reflects my interests and there is selectivity in terms of what I had the time/space to include. The following discussion therefore reflects a combination of both mine and the pharmacists' agendas.

3.5.2 Impact on pharmacy transactions

Although customers were not the object of study in this research, as I was viewing their interactions with the pharmacists and clearly an additional presence in the pharmacy space, I was concerned that I might have had some bearing on the way they approached their use of the pharmacy and the pharmacists' time. As discussed I attempted to minimise the potential research impact on transactions. Nonetheless my physical presence and features such as gender and ethnicity may have been a concern.

Perhaps surprisingly however (and certainly in contrast to concerns I had before conducting this research) customers did not appear to be at all concerned by my presence when using the pharmacy and I felt that I had very little impact on the nature of most interactions within the pharmacy space. This may sound unconsidered however when I spoke to the pharmacists about how they felt that the research had impacted on their day I was reassured that I was

'nothing special' and that their interactions had seemed to be as usual, although without discussing in more detail with customers I cannot verify this position.

The majority of counter assistants and dispensing assistants were female so I did not stand out as being unusual behind the pharmacy counter from a gender perspective. If anything being female was an advantage as women are the heaviest users of pharmacy and are most likely to engage with staff for advice and guidance. The hyperdiverse nature of the communities I was working within and the multiethnic nature of pharmacies also ensured that I did not immediately stand out as being 'ethnically' especially unusual or different. Two of the pharmacies in which I carried out observation research employed white British staff. In one pharmacy the white dispensing staff and pharmacist were Russian so in this case most customers assumed that I was also Russian. Reflecting the increasing number of Eastern European migrants in this part of London, customers and staff in general would regularly assume that I was Polish. One assistant even remarked that he could tell 'from my accent' that I was Polish (In actual fact my slightly 'out of town' accent is related to being born and raised in Liverpool, not Poland!). For the majority of people however it was obvious when I spoke that I was 'not from round here', 'educated', 'a nice girl'. Once established, my out-of-town status had a clear impact on informal conversations I had with customers. People were very keen to present a positive view of the local community. I also fitted in with their stereotyped image of a 'researcher'.

> You are going to be a doctor? You look like one, I can tell you are well educated and you are studious.
>
> **Observation Pharmacy 6: Customer**

Ultimately this lack of disruption in pharmacy life was also due to the busy, varied nature of even the smallest independent community pharmacy. The pharmacy environment is fluid and involves a range of actors who are different in every pharmacy and vary throughout the day. At any one time there may be a number of assistants at the counter, dispensing assistants and the pharmacist working in the dispensary, staff employed to man the shop floor, sales representatives, delivery staff, staff from the GP surgery or from other pharmacies in the shop and last but not least a number of other customers waiting, standing at the counter, sitting on chairs provided, talking to each other and to the staff. Transactions are often brief and people are constantly moving in and out of the pharmacy space. At any moment an interaction between the customer and staff can be interrupted by other customers or the phone or a new delivery. As such the addition of another party in the store seemed to cause little upset to routine or consternation amongst customers. Neither did the idea of research being carried out within the pharmacy appear to be unusual. Pharmacists are regularly involved in surveys and satisfaction questionnaires on behalf of the PCT and customers appeared unfazed by notices highlighting a new piece of research. At the time of my research one pharmacy was conducting a customer satisfaction survey involving handing out forms to regular customers and another had a notice about calling in customers on Warfarin in for review as part of a piece of research. At no time did anyone raise any negative comments and nobody requested a private consultation as a result of my presence in the pharmacy. In fact I observed that there were very few requests for privacy in the pharmacy in general. Throughout the observation period customer led concern for privacy was noted mainly in conjunction with the ('public') request for emergency hormonal contraception.

Some regular customers noticed my presence as being 'different'. They were either introduced to me by the pharmacist or stopped to chat themselves having read notices about

my research or simply because they were curious about 'the new girl'. Again, I had perhaps been expecting a more reserved response from customers however I was actually quite overwhelmed by the positive reception that I received. Among those who asked about my work there was a huge amount of support and encouragement. The research in many cases became a topic of conversation that was 'owned' by the pharmacy and its regular customers, encouraging discourse and storytelling.

Inevitably a study of practice in a particular place involves representation of the people within that place i.e. the people who utilised the pharmacies I visited. Regular customers were often keen to tell me how 'great' their pharmacist was and to impress on me the importance of keeping the shop running, aligning themselves with the pharmacists' political agenda. These informal discussions also helped to integrate me further into the pharmacy and often stimulated reflective conversations with the pharmacists once the customers had left the shop. In this sense therefore these informal spontaneous interactions helped to elaborate ideas and develop themes for discussion.

3.6 Data Analysis

There are various practical methods that have been proposed to enable the process of analysing ethnographic data (Bernard 2006: 463-522). Most importantly I wanted to be able to combine the results from my observation and interview work and so for clarity I felt it was important to use a process that was appropriate to both types of data. With this in mind I have avoided the use of narrative or discourse analysis for example as I was not interested solely in stories or language features but also rhetorical strategies in performance and notes on practice from my field diary. I elected therefore to use a 'reflexive, constructivist approach' informed by grounded theory methods such as outlined by Charmaz (2006: 148-149). This approach, while informed by some of the practical techniques for data analysis that are core to grounded theory analysis steers away from the positivist assumptions of the grounded theory method originally described by Glaser and Strauss (1967).

In practical terms this approach involves an iterative process of careful reading and re-reading of notes and transcripts, annotating thoughts and coding the data into themes. The process begins as soon as the first transcripts and field notes are written up. One advantage in beginning analysis while still collecting data is the ability to take ideas back into the field and explore and refine concepts.

Coding was initially produced within individual interview transcripts/ notes examining the content line by line to develop a provisional coding scheme (open coding). This scheme developed from early data could then be applied as a focus and developed when looking at subsequent input. The next step was then to re-interrogate the data and explore ideas both within and across accounts, looking to find relationships between categories and develop

initial ideas into more complex themes. I continued to read and re-read the data until no additional themes felt apparent. I did not however use a detailed scheme of 'axial coding'* to interrogate the data, taking the view of (Charmaz 2006: 61) that a strict analytic scheme could restrict the analysis.

> *...relying on axial coding may limit what and how researchers learn about their studied worlds and, thus restricts the codes they construct*
>
> *(Charmaz 2006: 62)*

Green adds that paying attention to 'deviant cases' within the research, i.e. being concerned with differences as well as similarities, is particularly important to interrogating and questioning findings (Green 1998). Throughout my analysis I was careful to look for responses/ situations that appeared to fall outside the 'norm' and use comparison to further refine my ideas.

Interview data and observation data were analysed separately at first however at the thematic stage results from both inputs were pulled together. It was important to find a balance between the two datasets, I did not want to privilege the observation data and my own interpretation of the realities of practice above accounts gained in the interview setting. Rather I wanted to compare and contrast themes that arose across the two sources and then to integrate the findings, in order to provide a coherent story.

Coding was initially developed using QSR NVIVO 8 software to handle the data however the throughout the study and especially during the later stages of analysis the development of more complex themes was worked on in an 'old fashioned' printed format. The advantages of using this kind of software to manage large datasets is discussed by Bazeley (2007: 3-4) and I

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* Axial coding is a process of relating codes to each and seeks to identify causal relationships between categories.

found the equipment very useful for organising and keeping track of data. Beyond this utility however I applied caution, as advised by Kelle (1997) and (Seidel 1991) amongst others, to ensure that a reliance on software did not create distance from the data and that I did not allow the tools the software provides to produce the analysis.

In attempting to take a critical approach to the analysis and presentation of findings I have tried to move beyond a purely meaning centred focus, i.e. concentrating on individual explanatory models, towards examining issues within a broader social framework. This approach challenges a 'devotion to particularity' within anthropology and a reluctance to examine ethnographic findings within the bigger picture, contending that 'such introspection allows anthropologists to remain bystanders' within a broader discourse' (Ferguson 2006: viii).

Chapter 4. People, places and possibilities

This chapter intends to set the scene by providing a descriptive account of the people I met and the shops I visited. As part of this account I have included a brief description of career paths taken to becoming an independent pharmacist. This background informs the later discussion of pharmacists' personhoods as they are currently constructed as these stories of 'becoming' inform the 'cultural ingredients' pharmacists draw on in order to explain their place in the world.

I also provide an account of the challenges of daily practice in this urban setting in the words of the pharmacists themselves. This serves to introduce the situation for research in more detail. The challenges described were also used rhetorically by the pharmacists throughout this study to frame their experiences and provide the context in which the process of change in practice is enacted.

4.1 Who took part in this study?

4.1.1 People

The gender, ethnicity and age profile of the pharmacists who took part in this study was consistent with what might have been be expected from analysis of the pharmacy register as discussed in the introduction*. Reflecting the significant gender bias typical within

* A detailed breakdown of respondent characteristics on an individual basis has not been provided in order to ensure identities remain protected.

independent pharmacy of the 43 pharmacists that took part in this research there were just four who were female.

Table 4.1 shows the number of years the pharmacists represented in this study had been qualified for. The most recently qualified pharmacist had been practicing for just 18 months while the most experienced proudly showed me certificates that proved he had been qualified for 50 years. As might be expected, those who had been qualified the longest were more likely to be pharmacy owners whereas, those who had qualified most recently were usually younger and working as pharmacy managers.

Table 4.1 Years since qualification

Years since qualification	Observation	Interview (incl. pilot)
0-5		7
6-10	1	5
11-15	2	5
16-20		4
21-25	1	6
26+	3	9

I met pharmacists from a wide range of ethnic backgrounds and Table 4.2 demonstrates the variety of self defined 'ethnicities' which they represent. A number of the pharmacists presented ethnicity qualified by place for example 'Indian but from Kenya' or reflected a complex heritage in describing themselves as 'British Asian' or British Indian'. This reveals the multifaceted nature of ethnicity and while I do not wish to present the concept unproblematically in the following discussion I have reflected the pharmacists' descriptions

in the particular contexts in which they were used. What was perhaps surprising was that only one pharmacist in the study described himself as 'British, white, native I support you would call it'. It should also be noted that none of the other pharmacists who were contacted but who did not take part in this research would have described themselves as being 'white British'.

Table 4.2. Self-reported ethnicity/country of origin

Ethnicity	Interview	Observation
Indian	12	1
British Indian*	3	
Indian from Kenya **	2	
Indian from Tanzania**	1	
Indian from Uganda**	1	
Ghanaian	5	1
Nigerian	5	1
Bangladeshi/Bengali	3	2
Chinese	1	
Jamaican	1	
Pakistani		1
Russian		1
White British	1	
Zimbabwean	1	

*Articulated as: 'I'd say I was British first then Indian really', 'British with Indian heritage', 'I would say that I am definitely British, British Asian, British Indian'.

**'Ethnically' Indian but who lived in either Kenya, Uganda or Tanzania before coming to Britain for university or following displacement due to the political situation.

16 of the pharmacists represented in the study were first generation migrants to Britain including three of those with whom I conducted observation work. Of these 16 pharmacists, three completed their pharmacy training overseas and then took a one year 'conversion' course after arriving in the country. This course is a post-graduate diploma in pharmaceutical sciences for non-European Union (EU) qualified pharmacists which entitles them to 'pre-registration' status. Currently there are four courses available at: Aston, Sunderland, Brighton and the Robert Gordon University in Aberdeen. Following this course, as with anyone qualifying with a degree in pharmacy from a British university, they are able undertake a one year period of pre- registration practice after which they can apply to enter the Pharmacy Register as fully qualified pharmacists. To put these figures into perspective, in 2007, internationally trained pharmacists represented 8.8% of the 43,262 registered pharmacists (Schafheutle and Hassell 2009). While analysis of the pharmacy register in 2001 showed that 16% of all pharmacy students were from 'overseas' and in 2001 the majority of these, some 53%, were from outside the EU (Hassell 2007).

The route to independent practice begins with the decision to pursue a career in pharmacy. While a few of the pharmacists I met described being a pharmacist as being 'something I always wanted to do', for most it was a decision taken when selecting university courses. The reasons the pharmacists gave for choosing pharmacy as a career echoed themes that have been described in previous accounts (Willis, Shann, and Hassell 2006). The most commonly cited reason as explained below by pharmacist 1 put pharmacy as a 'second choice' after failing to get the grades required for medicine.

...why did you choose to do Pharmacy in the first place?*

I hate it when people ask me that one. Right, do you want the model answer or do you want the real answer?

Give me the real answer [laughs].

Okay. The real answer is this. My dad always wanted me to be a Doctor. I liked the idea of it, but I wasn't as passionate as my dad about it. I went to my A Levels (...) and I did very poorly in the first year, and yeah, I did very badly. So by the middle of the year, even though I had ideas that maybe I'll do something medical related because my dad talked to me so much about being a Doctor I thought, okay (...) will I be able to do it because of the high standards and the entry rate standards required? (...) So I was looking around and it was deadline day to give in your UCAS form, is it UCAS forms? (...) I was looking round thinking Dentistry, Pharmacy? I don't know why I picked that one, I really don't, but yeah, that was the reason. That's the story.

Pharmacist 1

The next most commonly discussed drivers included the strong influence of family already being in the business (and hence even at this early stage a sense that the structures were in place to support an ongoing career) or a desire to own their own business. Other frequently cited reasons that were often also used in support of these principal drivers included 'being good at science' or wanting to work with people.

> Yeah, well, I grew in the Pharmacy background, so possibly that influenced me ending up being a Pharmacist. I love people, and being able to at least provide something towards making other people happy, making them sad at times [laughs] (...) you know, every aspect of, you know, it's great and yeah, that's the more reason.
>
> **Pharmacist 17**

The pharmacists in this study fell into two groups regarding career choices after university.

Those who had always intended to be independent pharmacists with their own business like pharmacist 2, as opposed to those who had come into independent pharmacy later on. In the latter examples this was perhaps because they had always assumed that they would work for one of the multiples but then changed their minds or like pharmacist 3 chose independence after considering (or working in) other branches of pharmacy practice:

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* Throughout, unless otherwise indicated my responses, as the interviewer, are indicated in bold type

(...) because my uncle has about 10 or 11 pharmacies, where I worked so that way was open to me. I worked for him for my pre-reg and that. I saw how he did things and I saw how he was and he was a great influence on me so for me it was almost a no brainer. That was, what I was going to do, the moment I even enrolled in pharmacy course I had that...it was like that is what I am going to do and that is it. I never had, there was no other, there was nothing else in my mind.

Pharmacist 2

Deep inside I was a hospital pharmacist but when I came out the money was so lousy, I needed the structure to support myself and my family so, and at the time there was the Idi Armin fiasco and all Asians were asked to leave so being an elder, I had a responsibility to go for a little bit of better wages which happened to be in community pharmacy at the time, so that's really the basics of it.

Pharmacist 3

Even those pharmacists who had always had an 'independent calling' did not usually go immediately from pre-registration training to being an owner or manager within an independent pharmacy setting. For most, there followed a period of locum work in community pharmacy which provided them with experience across a range of different pharmacy environments and across a range of different locations. Often this period of locum work included experience of working for one or more of the large chains or multiples such as Boots or Superdrug. In total 22 of the pharmacists had significant experience either on permanent contract of as locums working for multiples prior to entering the independent sector.

As previously highlighted, although well represented in all sectors of the profession, members of ethnic minority groups are over represented as business owners within the retail sector and underrepresented in managerial positions and hospital pharmacy. Seston et al. (2006) in a study of pharmacy students' career intentions suggest that there is some link between ethnicity and entrepreneurial intentions including the influence of family business opportunities and expertise. Platts et al. (1997) meanwhile discuss in detail the reasons ethnic minority pharmacists give for choosing independent community pharmacy. They suggest that

these pharmacists are more likely to choose work as an independent, both due to the motivation of business and property ownership and disillusionment with their prospects in the corporate environment that relate to structural discrimination.

With respect to the latter point, the pharmacists I met did mention dissatisfaction at their prospects within the multiples but this was not tied explicitly to disenfranchisement or discrimination with the exception of one older pharmacist who felt that it would be 'not like that these days'. As a group they certainly seemed to have had a wealth of experience in working for these large organisations. Their move towards independence was positioned as a positive rejection of the status of employee and there was no reported sense that the corporate environment was one in which it was not possible to achieve success. Of course this does not mean that structural discrimination was absent. It's influence may not have been disclosed to me due to my position as a (white British) researcher and/or their desire to present a positive perspective of the choices they made. It may also not have been fully acknowledged by the pharmacists themselves. In Chapter Five I discuss in more detail the link between ethnicity and place and it was in this sense the pharmacists spoke more fully about perceptions of 'who I am', how they were able to 'fit in' and how this affected the choices they made.

To the former point regarding the potential motivation of business prospects the pharmacists did make particular and explicit links to either their ethnic background or migrant status in these terms. While again discussed in a very positive light, these particular choices can also be viewed as part of a bigger picture relating to the status of ethnic minority groups and there are elements of these narratives that reflect a restricted set of opportunities.

For first generation migrants or the children of migrant families the choice to become an independent pharmacist was linked particularly strongly to the ability to be able to quickly establish a profitable business base in a new country.

> My father at the time was alive and he said look, you have been educated so if you get in a profession where you could build up some sort of monies that could help the rest of the family. I think that was the sober emotional point that made me start up on my own basically.
>
> **Pharmacist 11**

Narratives of becoming an independent pharmacist have become part of 'migration success stories' with significance extending beyond professional life and becoming about opportunity and belonging. Many of the people I met could be seen as living up to the trope of the 'successful migrant' as thriving professionals with good incomes and good education (Raj 2003: 34). 'Classic' stories such as 'The Waymade Story' described to me by pharmacist 29 related tales of struggle and achievement and these stories demonstrate the potential of pharmacists to move beyond small business to much larger scale enterprises:

> And some have been very, very successful. Waymade is one of them; he's a Patel in Basildon. Again, they were chucked out from East Africa, Uganda when Idi Amin chucked out all the Asians (...) but they went through uni. It was tough and when they made it, they worked hard (...) they literally just worked their backsides off and then obviously they made it (...) Waymade is a classic, you know, two brothers, with nothing and today they own one of the biggest wholesalers in generics. You know, they took chances as well.
>
> **Pharmacist 29**

Although there are many parallels that can be drawn between pharmacists and studies of other 'ethnic entrepreneurs' such as Brettel (2003), Pécoud (2004), it is important not to assume that pharmacists are similar to these groups in all respects due to the extensive, (and expensive) university level training that they are required to achieve before being able to practice.

Mandel uses the term 'professionally ethnic' to describe Turkish migrants to Germany and their attempt to become part of an 'ethnic elite' (Mandel 2008: 90). For these workers the desire for professionalism is identified as being a way of rising above their migrant status and an attempt at finding acceptance as part of a cosmopolitan 'professional class'. While in part referring to these ideals, the self conscious, personally acknowledged desire for professionalism expressed by the pharmacists was not always externally referential. The desire for recognition was often related back to status within ethnic communities or referred to status 'back home' rather than in British society in general. In my conversations, as if to rationalise their choice of career to me, this was reinforced through explanations that while a pharmacist might be of a 'lowly' social position in Britain, 'back home' pharmacy is held in much higher regard:

> Well, it's a very, it's a renowned profession in my country, to be honest. Medicine and Pharmacy, they are two renowned because we've only got one Medical School of Pharmacy in the whole of the country. That's what – that's one thing people in this country wouldn't know, I mean, the cut-throat competition we have back home. So out of that one School of Pharmacy, out of a country of 12 million you only needed 28 people to qualify for Pharmacy.
>
> **Pharmacist 31**

As part of an educated and successful middle class a number of the pharmacists, in particular those with an Asian background cited the fact that their parents put pressure on them to have a profession and financial security as the most significant driving factor in choosing independent pharmacy.

> I ended up being a pharmacist because like in most Asian families, everyone wants a doctor and this and that, doctors I really knew I wouldn't get the grades so I just went for pharmacy really. That was it.
>
> **Good choice?**
>
> No, no, I should have done architecture.
>
> **Pharmacist 10**

The notion of professionalism espoused here links owning one's own business very closely to the idea of being 'more' professional. Simply working for someone else does not provide the same cachet or opportunity for success. Being 'self standing' in the community is of particular value:

> It happens with a lot of Asian subcontinent people, the big push is to be self-standing in the community, Doctor, Pharmacist, Accountant, etc,
>
> **Pharmacist 28**

Some of the pharmacists explained that an additional reason for the increased numbers of Asians in particular entering into independent pharmacy is related to the financial barriers that exist in setting up in practice. They felt it was actually easier for them to become independents because they were more likely than their white British counterparts to find funding for their own shop through family connections. Pharmacist 29 explained to me:

> I think it's probably to do with what family support they have of actually buying a Pharmacy (...). To be an – that's one of the reasons I, for example, if I wanted to borrow x thousand pounds from an uncle or my dad (...) my dad would say, "Yeah," 'cause he knew that, you know, there would be – we have that structure, that family structure, whereas I think sometimes in other cultures, "Sorry, how can I lend you, you know, you've got to go and do it yourself," so that'll be a bit of a, you know, the financial background as well.
>
> Yeah and absolutely the support as well of family, so even now, I've got my family's support. If I really wanted my dad to suddenly help me or anyone, you know, even I'm constantly talking to my uncle. You know, although he was here, we more often exchange ideas, so we've got that family network of helping people.
>
> **Pharmacist 29**

This rhetoric of the financially empowered and ambitious 'Asian' pharmacist was repeated to me by the only white British pharmacist I was able to interview as part of this study.

> I go to meetings, pharmaceutical meetings and I'm virtually the only white face at these meetings (...). It's been completely taken over by the Asians, completely and

utterly.

Why do you think that is?

They're ['Asians'] well educated, they're ambitious and I think their parents perhaps possibly would have had – operated the shops, corner shops or something like that... the parents had the money to set them up and the families all, sort of, helped work in the shops.

Pharmacist 26

On the basis of this financial incentive to enter into the profession and the need for independent pharmacy to be seen as being able to provide significant financial rewards. Pharmacist 29 went on to speculate that in the future there might actually be a decrease in Asian pharmacists choosing independence. In his view the new contract made the choice less clear cut as profits were in practice more difficult to come by and restricted by the attitude of the PCT towards commissioning services.

(...) just to answer the other question why, you know, the next, sort of, Asians may not go into a Pharmacy is because the good old days where there were huge profits on the dispensing side are gone (...) They've gone, so now it's going to be services, but not everyone's forward thinking like [this PCT]. You've got to have at least ten services to make a living.

Yeah, yeah.

At least, I mean, one or two services isn't going to – 'cause there's no throughput, you've got no patient base. You know, you might get one or two smoking cessations, but what's that going to do?

Pharmacist 29

Following on from locum work and/or a permanent job in one of the multiples the first position for most as independent pharmacists was as a pharmacy manager. For many this move was then a step on the ladder towards owning their own business. Of the pharmacists represented here, 23 of those owned the pharmacy in which they worked and 20 were principal pharmacy managers in independent pharmacies or pharmacies which were part of small, independent chains. The observation work I carried out was with two pharmacy

managers and five pharmacy owner-proprietors. Of those five that owned their own pharmacy one had very recently taken over the shop and it was his first pharmacy practice. The other four had been in business for many years and were well established as independent practitioners. One of the pharmacy managers was working for a small independent pharmacy chain while the second, who had been in the pharmacy for just six months worked for another pharmacist who owned a further three pharmacies.

4.1.2 Shops

The pharmacies represented in this research included eight based within housing estate shopping facilities, 16 on busy high streets and 18 in small parades of local shops. The practices I visited varied in size, service provision and location. The smallest being a number of singlehanded practices supported by just one full time member of staff while the largest employed up to ten staff in various roles in relatively spacious premises. The largest pharmacy for example had two pharmacists, one pre-registration trainee and six ancillary staff on site the day I visited to conduct my interview.

There are a range of potential roles for staff in the pharmacy. Since 1996 anyone who is involved in selling medicines over the counter or in handling prescriptions has been required to undertake formal training. Most of the staff I met were counter or dispensing assistants. Counter assistants have the most basic skill set, they are able to be involved in the sale of over the counter medicines and offer advice on common conditions under the supervision of the pharmacist. Dispensing assistants are more highly qualified and are able to help the pharmacists with a range of different tasks in the pharmacy including prescription receipt and collection, putting together prescribed items, ordering stock etc. I only met two pharmacy

technicians throughout the course of this study who are the most highly qualified of pharmacy staff. Technicians are able to prepare medicines and other healthcare products and supply them to customers. They also able to take an active role in providing customers with guidance in taking medicines (General Pharmaceutical Council 2011).

In some of the larger pharmacies there were also staff without any pharmacy training who worked at counters that did not sell medicines or who were solely concerned with a non-customer facing role on the shops floor, unpacking boxes, stacking shelves etc... Some of these larger pharmacies also had delivery services employing staff particularly in this role.

Larger stores with additional 'non medical counters' would often be selling goods such as perfume, electrical items or photographic equipment. Some of the smaller shops however had very little stock that was non-pharmaceutical because this had become no longer viable in the face of stiff pricing competition from the multiples and supermarkets. Around half of the pharmacies I visited had created consultation rooms and so technically had the ability to offer services such as MURs although in many cases these rooms were actually being used to provide services such as taking passport photographs or even as storage space. Table 4.4 describes in more detail the seven pharmacies in which I conducted my observation work.

Table 4.3 Observation pharmacy characteristics

	Location	Staffing	Shop description
1	Council owned property in a small parade of shops Mainly residential trade	1 pharmacist owner 1 counter assistant	Small shop floor, limited non-pharmaceutical stock but specialist products aimed at Afro-Caribbean market No consultation room
2	Estate based, council owned property in a small parade of shops Mainly residential trade	1 pharmacist manager 1 regular locum 1 pre-reg* pharmacist 2 dispensing assistants 2 counter assistants 3 regular part time staff 1 delivery boy	Large shop, part of an independent chain, Consultation room
3	Busy High St location (very close competition from Boots and Superdrug as well as another independent) Significant passing and office based trade	1 pharmacist owner 1 dispensing assistant 2 counter assistants 2 electrical/beauty counter assistants 2 regular part time staff working on the shop floor	Large shop, significant trade on beauty and electrical counters No consultation room
4	Estate based, council owned property in a small parade of shops which are in the process of being closed and moved as the estate is re-built	1 pharmacist owner 1 regular locum 2 dispensing assistants 1 counter assistant	Small shop, premises not refurbished in some time and stock being run down in anticipation of being moved No consultation room
5	Close to train station, part of local shopping parade Significant trade from local businesses	1 pharmacist owner 2 dispensing/ counter assistants	Small shop, just taken over by new pharmacist Consultation room
6	Within busy market, close to underground station Significant passing trade as well as residential from nearby estate	1 pharmacist manager 1 dispensing assistant 4 part time counter assistants	Medium sized Beauty products stocked and large range of non-pharmaceutical items
7	Local shopping parade Mainly residential trade	1 pharmacist owner 1 regular locum 1 part time dispensing assistant 2 part time counter assistants	Small shop with very limited non-pharmaceutical stock No consultation room

* Pre- reg = pre registration, pharmacist in training

4.2 The urban context

The following discussion outlines the situational context for the research in terms of the areas in which the fieldwork was carried out. In highlighting the pharmacists' descriptions of their situation and the challenges of negotiating inner city life this presentation intends to frame the day to day reality of pharmacy practice not just against a backdrop of change 'from above' but also within the context of a constantly changing urban setting.

Perhaps naively, I had greatly underestimated just how much 'urban-ness' would matter to the pharmacists that I met. While I expected to find a close connection to their surroundings I had not anticipated that the nature of the urban environment would be quite so critical to pharmacists' personhoods and that pharmacists would be so concerned with producing 'urban pharmacy' as a distinct and defining offer that they, as independent pharmacists, would be best placed to provide. In fact throughout this study the toughness and complexity of the urban setting provides the backdrop to, and is symbolically associated with, the pharmacists' struggle for relevance and aligned to personal perceptions of their resilience and adaptability as practitioners.

The pharmacists frame this socially complex environment through a number of particular urban challenges. These challenges are referred back to and provide the context for much of the following discussion and include: competition (and the need for differentiation), diversity (and the requirement to be able to relate to their customer base), poverty and social marginalisation (and the requirement to provide flexible arrangements in practice) and finally crime and anti social behaviour (and the need for 'being savvy' and a positive outlook).

4.2.1 Competition, choice and survival

> This area is so competitive, there is one just over the road, a few down the High St even Boots. There are so many pharmacies.
>
> **Pharmacist 24**

Customers in the city often have a number of options when considering which pharmacy to use. This array of potential alternatives was a particular defining feature of the urban environment forcing pharmacists to compete for attention. In pharmacists' discourse the idea of 'competition' is largely discussed as a negative and competitors are usually identified as being the multiples not other independents which are usually positioned more positively as offering 'choice'. The multiples represent a threat to business and independents position their challenge as being a collective struggle for survival. This struggle was also contextualised by the difficult economic climate for small business throughout the period of my study.

18 of the pharmacies I visited were based on local shopping parades, the smaller premises often with lower rents than the high street attract independent business. Representing some of the most vulnerable businesses in the study, along with many other small independent shops, they are finding times are tough. The shopping parades in which they are located are increasingly unable to compete with the threat of the supermarkets and larger stores which although absent from these small collections of shops are lurking not far away in busier shopping streets. In the face of dwindling footfall these pharmacies are no longer as 'convenient' as they once were. Historically these shops had derived some income from acting as general stores for household goods and toiletries in addition to medicines but this business has been hit by the dramatically lower prices supermarkets are now able to offer customers. Unlike stores in more affluent surroundings, they are unable to supplement their core prescription work with a turnover from the shop floor through the sale of high value

cosmetic or over the counter branded medicines to compensate for the loss of business. As customers head out to larger high street stores to do their general shopping they are increasingly likely to pick up prescriptions and medicines in these locations as well. While I did encounter a number of strong success stories, the worsening economic situation throughout my study was adding further pressure to those businesses already finding times hard.

One example of this type of business was Observation pharmacy 6. which was located in permanent premises alongside what used to be a thriving daily market. During the year of my study trade in the market had dwindled and almost half of the shops in the parade surrounding the stalls had closed down. Although the pharmacy maintained a steady prescription business, passing trade for over the counter or shop floor goods was severely hit and a topic of conversation among staff and customers alike:

Pharmacist: Alright James

Customer: Empty today isn't it?

Pharmacist: Afraid so

Observation pharmacy 6

The seemingly inexorable decline of small shops and, most potently the loss of local services like the local post office is as emotive in urban areas as it is in remote rural settings. In fact the post office analogy was picked up on a couple of times during my research both by customers and by pharmacists to illustrate the problem:

> ...it is like the local post office in some ways especially down here we get so many people who are local who would definitely miss it; they like to have a local personal service.
>
> **Pharmacist 21**

Customer: Actually chemists are a bit like post offices, they are dying out'

Pharmacist: Yes, it is a shame; the big boys are buying out the small places like us you know.

Customer: Yes, like the post office, you suddenly notice that they aren't there when you need one for stamps or something, it must awfully difficult for the old or the handicapped you know, people who aren't able to travel far.

Observation pharmacy 1

In much the same way as the post office is important not just for the services it provides the pharmacy is able to act as a linchpin for other local businesses. Not part of this study but the council of another London borough, Wandsworth make this point on a webpage which calls for the support of small businesses:

> *A local post office does more than provide a friendly and accessible service for its customers. Very often it helps to attract other shops to a local parade (...).*
>
> *(...)Post offices, like pharmacists, are key to the vitality of locations which are often far removed from the nearest high street. There is concern that when a popular shop goes others follow. The result is less choice for residents and, for those with the least mobility, an increased sense of isolation.*
>
> *(Wandsworth Council 2010)*

Observation pharmacy 1 provided an example of a successful small pharmacy which managed to attract people to the parade of shops. This pharmacy faced the major disadvantage of not being close to any one particular GP surgery. As Mr A put it, 'everyone who brings a prescription in here has had to make a special effort to come here' as they would have gone by at least one other pharmacy before getting to his shop. Quite often Mr A would send people next door to a coffee shop to wait while he prepared their prescription or people would 'do a run' of the shops in the parade, collecting some items from the corner shop, popping into the laundrette and then coming to the pharmacy. If the pharmacist was out of stock for certain household goods he would send people to the grocers and vice versa. And so a business community was built up around the pharmacy.

Life on the high street itself is not necessarily easier. As previously touched upon, it is technically possible for an independent pharmacist to open a 'pharmacy' anywhere selling general sale and over the counter medicines. Importantly however, under regulations introduced in 1986-7 and reviewed in 2005 (and 2009 although this review came into effect during my study), NHS contracts are spatially regulated. Under the 2005 rules PCTs only grant contracts where they are satisfied that services are 'necessary or desirable' for a local area and this effectively restricts entry into the marketplace. Pharmacies that were opened before 1987 faced no such restrictions and were not forced to close or relocate after the 'control of entry' system was put in place. As a result, particularly in urban areas on historically busy high streets, there are still clusters of pharmacies which may be no more than a few shops away from each other, artefacts of a bygone era. (Galbraith 2007; Pharmaceutical Services Negotiating Committee 2011)

The old high streets of East and South-East London therefore represent an extremely overtly challenging environment for business. On one high street that I visited for example, two of the pharmacies represented in this study were located on opposite sides of the road with a further establishment owned by the brother of one of the pharmacists only five shops down. The high street also contained Boots and Superdrug multiples. In another instance, one of the pharmacies was actually located directly next door to a Boots store, while on another high street no less than five independent pharmacies were located in a stretch of shops that was no more than 500m long with a large Boots store at the end of it.

This level of competition leads to a thread throughout much of the pharmacists' narratives that relates to strategies of differentiation. A differentiated offer is key to survival and the pharmacists constantly compare themselves to the multiples as to prove their value to

customers. The pharmacists also frequently used this strategy to explain their value to me resulting in a very negative presentation of the multiples. As a caveat to much of the following discussion, many of the pharmacists were positive about the service provided by multiple pharmacies, however making direct comparisons to the multiples is the easiest way of articulating a deeply felt 'difference' in the face of the success of the multiples offer.

> That is not to say that people like Boots and Super Drug don't offer a good service, I think they do, in their own way, they do a good job and they are good at what they do. You have to respect that and you can't slag them off. I think they do offer a good service, it is a different service to what we provide but I do have every respect for them.
>
> **Pharmacist 14**

Eight of the pharmacies I visited were located on council owned housing estates and occupied rented properties within the small parades of shops that specifically serve the estates. These parades usually included newsagents, laundrettes, a convenience store and a couple of fast food establishments. In some cases there was also an associated health centre/GP surgery. These East and South-East London estates have 'a history of stigmatisation' (Cattell 2001) and suffer acutely from well documented social problems such as anti-social behaviour, crime and violence. Cattell (2001) describes developments in East London like some of those I visited as 'ugly and alienating', 'potentially hostile environments containing fractured, isolated communities'. Pharmacist 14 pointed out that the multiples don't have shops in these locations:

> (...) there are a lot of estate based pharmacies like ours, you don't see a Boots or a 'Super Drug Something' here so there is space for an independent
>
> **Pharmacist 14**

Nonetheless, some pharmacists have carved out very successful businesses, finding possibilities in these locations that others might avoid. While inevitably these low income estates do not attract the larger stores there is often a sizeable prescription base available from a population with low personal mobility which is sufficient to provide a significant and relatively protected business opportunity for a small pharmacy.

In observation pharmacy 2. Mr B was a manager in a small independent chain based on a large housing estate. This particular pharmacy demonstrated the potential of these estate based pharmacies and business was flourishing. While they did not offer a wide array of services they had a very large dispensary and one of the largest number of trained pharmacy staff of all the pharmacies that I visited. Growing a business however can be challenging as there is little opportunity for expansion and being based in rented council property these pharmacies are subject to the whim of council controlled decisions regarding the future of the estates that they serve. Observation pharmacy 4. illustrated this vulnerability very well as the pharmacy served a large estate that was being demolished and its inhabitants relocated.

When I first met Mrs D as part of the MSc pilot project her pharmacy was a thriving small business, next door to a newsagents and a laundrette. Most of her prescription trade was driven by a health centre just around the corner which also served the estate population. The shop was bright and cheerful in contrast to the grey day outside and Mrs D had a queue of customers waiting to be served.

When I returned a year later Mrs D was in a very different position. All the other shops in the parade were closed down and boarded up, the health centre was also due to close, it was being relocated in a few weeks time. Demolition work had begun on the estate and only one

of the tower blocks was still inhabited. It had recently snowed and was an exceptionally cold day. Inside the pharmacy the heating was no longer working properly and Mrs D and her staff were keeping warm using electric heaters. Most of the stock in the shop had been run down and the pharmacy was being kept in business largely by a core of regular customers who refused to go anywhere else.

The estate itself had been sold on to a private property company. As Mrs D explained the new development meant that she had to move, the other shops in the estate parade had all been relocated along with the residents to a new development. The property company was supposed to find suitable premises for all the businesses however and the only property they had offered to the pharmacy required paying three times the current amount of rent and would have rendered the business unfeasible. Due to pharmacy opening restrictions Mrs D was unable to move her shop to premises she herself had found on the other side of the busy main road that ran along one edge of the estate; an application to the local PCT for a minor relocation order had failed because crossing the main road was considered to be 'moving neighbourhoods'. The mood in the pharmacy was far from optimistic while I was with them, however there was considerable support from customers. On a daily basis she was visited by people offering their encouragement and had managed to put together a petition with over 500 signatures supporting her move across the road. As we will see in Chapter Six. the signatures on the petition were not only local but included customers located well outside the supposed catchment area for the pharmacy.

4.2.2 Hyperdiversity and deprivation

How would you describe the community that you serve with this pharmacy?

It is multicultural it is, you know, low income, although we have got some posh areas just up a bit from here, some expensive areas, but I don't serve them, probably only two percent of the population pay. Very few people pay. It is mainly residential too.

Pharmacist 23

For the all pharmacies in this study a large percentage of their customer base was made up of a population that might be considered to be on the margins of society by a number of different number of parameters as compared to a national average. These marginalised groups particularly include:

- Economically marginal: unemployed, elderly, single parent families
- Economically and socially marginal: Ethnic minority groups, refugees, chronic sick including the mentally ill
- Legally, economically and socially marginal: drug users, illegal immigrants and petty criminals

(Winchester and White 1988)

This customer base defines the scope and requirements for practice and raises two of the key concerns that pervade pharmacists' experience of the urban environment; diversity and deprivation. Pharmacists position these challenges to practice as both an opportunity (to provide a specialised service) and as a threat (to providing the best possible care).

Of the two, the biggest challenge facing pharmacists in this study was in the overwhelming majority of cases, cited as being practice in a hyperdiverse setting. In fact this could be said to be one of the defining features of pharmacies I visited provoking daily discussion and

attention in the life of the pharmacy. As in this account from pharmacist 27 this challenge is also positioned as being unique to the inner city and requires a particular approach to interactions with customers:

> The biggest challenge here? I would say the sheer diversity so having to constantly change your, well, not change but adapt rather to each and every customer you may get through the door so ranging from say a 12-13 year old who may for example want the morning after pill right up to say a 70-80 year Muslim gentleman with minimal English and minimal scope for taking in what you are telling him, or perhaps not even wanting to take it in, not being very flexible - and everything in between.
>
> You have got to manage all sorts of views of particular needs and things that you just never, you wouldn't actually have considered until they mention it. (...) I have worked outside London where you may get the people that you see on any given day will pretty much be from the same circle, from the same ethnic background, now that is not to say that you treat them as if they are all the same but you know they are from much the same ethnic and social strata where here it is much more challenging.
>
> **Pharmacist 27**

Language barriers and 'differences in beliefs' were most often cited as the particular difficulties diversity brings in practice. Instances of misunderstanding and miscommunication were very common. In observation pharmacy 2 for example I watched a particularly fraught transaction as a Somali customer was trying to explain to the pharmacy that she didn't want to take her prescription in a dosette box as her GP had indicated because she was going away on holiday. The pharmacy staff meanwhile once they understood this information struggled to explain that they would need permission from the GP to give her the medicines in the original boxes instead and that she would have to come back later in the week. Summing up the problem after they had finally managed to convey all the information they needed the dispensing assistant turned to me and said:

> She is fine apart from the fact that she has no patience, we can't communicate with her and she can't communicate with us!
>
> **Observation pharmacy 2: Dispensing assistant**

In addition to a diverse population these areas suffer from high rates of unemployment and a consequently a high percentage of people living on state benefits. The financial hardship of the local population has a very direct impact on the nature of pharmacy business that it is possible to operate in these areas.

> I mean it is a health action zone and you know, it is ear marked...well, the health is particularly poor and the people have not got much money. If that is the situation as compared to more affluent areas where they are prepared to pay the odd bit for their vitamins, paracetamol or health foods the situation is here that people prefer or feel that they should be able to get it on the National Health because they just don't have the funds available to pay themselves. Which is understandable obviously if you have got several mouths to feed but it does put the structure of the NHS in the local area under strain and obviously puts pressure on ourselves a little bit because the number of scripts generated are greater that it would be otherwise.
>
> **Pharmacist 5**

On a day to day basis from the pharmacists' perspective the challenge associated with this low income population is the knock on effect that poverty has on attitudes towards health. This urban population is positioned as one in which many people either refuse to or are unable to identify themselves as 'responsible biological citizens' which impacts upon their ability to respond to healthcare in the way that they are expected to.

> A lot of people around this area are not very good, because when I used to work in West London where you have a different type of people, where people are more affluent they will look after themselves more regularly themselves rather than with someone pushing them (...).The majority of people[here], they just don't care about their health.(...) because of this attitude, if I am gonna die, I am gonna die, that kind of attitude so they don't look after themselves very well. So we are like stuck in the middle.
>
> **Pharmacist 10**

Rose and Novas (2005: 451) describe biological citizens as being both constructed 'from above' by medical authorities and other policy makers and also constructed by the individual who lives responsibly, educating themselves about sensible lifestyle choices. They claim that

this level of responsibility is expected by public health policy and those that don't comply become 'problems' in the system:

> *'The enactment of such responsible behaviours has become routine and expected, built in to public health measures, producing new types of problematic persons.'*
> *(Rose and Novas 2005: 451)*

Pharmacists position themselves as the frontline in a struggle to engage with these 'problematic people' enabling them to take some control in decisions about their health and to facilitate them in working with the healthcare system. They felt that the particular locations they found themselves in and the particular services they provided meant that they saw more of these customers than the multiples. Pharmacist 11 whose shop was based on a housing estate explained:

> So urban independent pharmacies are in the forefront of this, simply we are at the forefront but we don't have the resources, the big boys are ready with the resources (...) Do you see what I mean, but I probably see more of those patients than Boots does on the High St, comparably but their voice is louder than mine. Which I feel is really wrong. If you can put that point across in your study, well I would be glad that at least something is going the right way and someone is understanding that we need support as well.
>
> **Pharmacist 11**

4.2.3 Possibilities and positive presentations

For pharmacists this urban environment is also defined by opportunity, especially the opportunity to provide more tailored personal services. The PCTs I worked within also have more enhanced services in place than many outside the capital and for some pharmacists this presented the chance to exploit the potential of services commissioned specifically to serve these socially deprived populations.

I think over here you can concentrate on all the different services but in other areas like the North East of England and other areas of London no, they are a bit slow, it is mostly prescription based, they don't have the services even though it is the way forward and the future for pharmacy.

Pharmacist 15

I had never sort of been in [this PCT] before I came to work here and when I did my pre-reg[istration year] I did it in Hertfordshire actually and there they didn't really do anything, they had never heard you know of the minor ailment scheme being run anywhere and you know things like EHC on a PGD, none of that. (...) I guess what I have found with [this PCT] is that for want of a better word it is more sort of deprived area so I think in that sense you know the government does fund these kind of areas a lot more extensively because the health of the area probably isn't as good.

Pharmacist 13

While the pharmacies visited in this study were located in some of the most socio-economically deprived areas in the country, none of them could be described as having the 'fortress' mentality described below in a study by Rogers and Hassell (1998). Nonetheless the external problems of the urban environment do spill into the pharmacy and for pharmacists this represents an additional challenge to practice that requires resilience and a certain 'streetwise' local knowledge.

The Fortress
There is a high razored fence around the whole of the building which is within the health centre compound. There are metal shutters on all the glass windows and door and iron bars at the high windows. The area looks as though it is under siege. The shops are all boarded up or have grilles on the windows and doors. Large Alsatian dogs are barking through the pub fence.
(Rogers et al. 1998: 368)

For the most part this manifests as a daily battle with shop lifting. Something I witnessed through regular 'stand-offs' between known offenders and pharmacy staff and inadvertently helped to prevent by being an additional pair of eyes. The pharmacy also regularly has to deal

with unruly customers in particular customers who have been drinking. The job of dealing with them usually falls to pharmacy staff with the pharmacist being called in as 'back-up'.

Apart from these daily concerns there were also more deep rooted fears that relate to more serious violence and intimidation. These issues did pose a threat in the pharmacy and cannot be overlooked although they did not seem to be overwhelming the service that was being provided. The 'social disorganisation' of the city as described by Hassell et el. (1997) for the most part, did not extend into the pharmacy environment.

> (...) we see quite a lot of criminal element so you have got to be careful who you say things and what you say too, you don't want to upset them, it is just one of those things.
>
> **Pharmacist 21**

> I mean you can call the police so they do nothing so what happens when you leave the pharmacy, I mean the customer says you know, I will come back with my mates and they will destroy your pharmacy. So it's very bad (...) and you don't know what is going to happen round the corner.
>
> **Pharmacist 8**

The pharmacists however were very keen that these difficulties should not define practice and there was a suggestion that local knowledge of the urban setting put them in a privileged position in terms of managing these concerns. Publically they were very keen to present a positive view of the urban setting and a view that concentrated on possibilities rather than problems:

> We have nice people in the community, you hardly ever find people coming in and shouting in the shop or whatever. I mean when I tell people I am living in [this PCT] they are always like whoa, but for example, last month I was having some time off and I got in a locum, a lady locum. She rang me and she was like 'will I be able to find a safe place to park?' 'Do you think my car will be safe?' I said 'come, what car do you drive? When you come here the cars they drive here are better than your car, nobody will be worrying about your car!'
>
> **Pharmacist 24**

> Working here? (...) the people here are absolutely fantastic, you are living in a deprived area but people are amazing, you see all sorts and you, once you get to know them, they are very loyal and they don't create any problems, I have nothing but positive things to say about working in [this PCT].
>
> **Pharmacist 14**

4.3 Summary

The pharmacists represented in this study are in many ways 'typical' of urban independents throughout Britain, both in terms of their demographic profile, the profile of the shops that they work in and to a greater or lesser extent the customers they serve. The particularly high number of pharmacists from ethnic minority backgrounds may not be a surprise but this diversity amongst the practitioners that I spoke to is as important in framing the following discussion as the diversity of the customers they serve. These stories of making choices reveal expectations of the role of the pharmacist and provide a personal historical context against which current personhoods can be elaborated.

As a small business in the city, independence also comes with both vulnerability and a requirement for resilience, pharmacists juggle both of these aspects of living life on the margins (Obrist 2006). Chambers defines vulnerability as not only exposure to risks, but also lack of means to overcome these risks, (Chambers 1989). Resilience meanwhile describes the ability to bend not break, Obrist suggests that resilience in the city requires 'living successfully with urban health risks'(2006: 324-328). For these pharmacists we might think of it as practicing successfully with urban health challenges. She also asserts that resilience requires the ability to manage the unpredictability of urban life:

> *Resilience under conditions of rapid urban change means learning to live with unpredictability and uncertainties that interrupt daily routine. It also means having to deal with diversity.*
>
> *(Obrist 2006: 325)*

A number of consistent themes arise that shape the pharmacists' experience of practice. Firstly pharmacists need to carve out an offer that is distinct and differentiating in the face of, seen or unseen, strong competitive threat from larger stores. Secondly the daily realities described reflect the demands of the urban pharmacy's customer base. Finally, urban knowledge is required in order to survive in the hyperdiverse world.

Chapter 5. The independent experience

In this chapter I begin to examine the different ways in which pharmacists are able to articulate their professional status as part of their construction of personhoods as 'independent pharmacists' and in doing so investigate how they take into account the background of change within pharmacy.

Carrithers suggests that personhoods are negotiated and contingent (1992). Rather than being fixed over time he contends that they are self conscious projects that take into account the options available to a particular person at any given moment and are dependent on the situation that they find themselves in (ibid.). Personhoods are therefore constructed through the interplay of 'agency-cum-patiency' i.e. the way in which individuals both act on, and are acted upon, at a particular point in time (Carrithers 2005b). As such the formations of individual personhoods 'are only ever momentary rhetorical attempts in the play of agents and patients' (Emery 2010: 22).

In investigating this situation of 'agency-cum-patiency' I explore how pharmacists have, or have not, attempted to incorporate the efforts of the professional bodies and other policy makers to refashion their role into their professional personhoods. I also consider how they rationalise the collective professional tensions surrounding the status of pharmacy through individual experiences.

Firstly I first discuss how being 'independent' had a relevance for these pharmacists far beyond simply indicating the trading status of the pharmacy in which they work. In fact, the

idea of independence was the driving force behind much of their talk, it framed the creation of professional personhoods that were primarily defined by evaluation against those that are not independent i.e. pharmacists working for multiples. Independence becomes a value that can be adopted as being personally relevant and representative, something to be proud of and something to defend.

The second part of this chapter brings to light a series of similarities and differences which demonstrate how independent identities span a spectrum of possibilities. I explore how being independent brings with it a sense of professional isolation which means that these pharmacists can feel removed from the centre of power and unable to influence the direction the profession is taking. In spite of this isolation however, independent pharmacists have the ability, at least on a very personal level, to translate for themselves the new direction of pharmacy, and this for some can be very empowering. Discussion then turns to how pharmacists are able to move towards or strongly react against the emergence of the modern 'clinical pharmacist' and how they reinterpret historical concerns over the role of business in their professional capacity.

5.1 Being in...and out of control

And why did you move from the multiples to your own practice?

You want to be independent.

Just for that independence?

Independence, that's it isn't it?

Pharmacist 30

The very word 'independent' is synonymous with individual determinism, existing without ties or support. In response to my questions around the attraction to, the value or benefits of independence the answer was always on the same lines: 'being my own boss', 'control', 'it means I am in charge of my own destiny'. This interpretation of independence in terms of autonomy and self sufficiency is articulated through two key ideas. Firstly, the possibility for control over day to day decision making. Secondly the suggestion that greater freedom to exercise professional judgement makes independent pharmacists more 'professional' practitioners.

While the rhetoric of autonomy in the pharmacy does refer to sense of intellectual control it was also often presented in much less ambitious, applied terms. In this pragmatic sense the discussion surrounding autonomy relates to a colloquial understanding of professionalism, in terms of 'doing a good job' (Last 1986: 6-7). Like the single handed GPs in Green's study (1993) one of the biggest benefits of autonomy discussed by the pharmacists I met was simply being able to exert control over time, daily activities and the working environment. In other words, the freedom to make practical, personal decisions.

These 'small freedoms' are often expressed in relative terms and the antithesis of being an 'independent' is working for a large multiple such as Boots or Superdrug where day-to-day control is exerted over all the pharmacists activity. Many of the pharmacists had personal experience of working for multiples and presented a wealth of stories to highlight the potential for frustration and the sense of powerlessness that can occur when working in a corporate environment. Stories often contrasted the restriction and irritation they felt at being under the weight of corporate rules and regulations, with the ability to be the decision maker and instigate change (as either manager or owner) in an independent shop.

> (...) it was the frustration that set in. When you saw a good idea, it wasn't [a good idea] 'cause you had to go to Head Office for sign-off and they always said, "No." Whereas here, if I want to change the prices of ten lines just like that, I can do it now and then I can go back, and I can see the fruits of that really quickly, and it gives you a drive.
>
> **Pharmacist 29**

Autonomy allows the pharmacist to set personal standards for quality and success rather than being judged against corporate aspirations. The involvement of a corporate 'way of doing things' was positioned as an additional layer of bureaucracy that blunts the potential of the pharmacist to take a dynamic role in the direction of the pharmacy. In multiples this is replaced by a responsibility to respect process as the pharmacist is a 'representative' of the brand. Pharmacist 27 who was a pharmacy manager in a small chain had had recent experience of working for multiples. He articulated the sense of restriction he felt in terms of 'less room for manoeuvre'.

> (...) in the multiples you have got essentially directives thrown out from head office which can't be helped but there is less room for manoeuvre around those. (...) and there is a lot more paperwork and more to-ing and fro-ing between, much more corporate basically. You can basically just work in a more structured fashion but where sometimes a bit more flexibility is needed obviously it is more difficult.
>
> **Pharmacist 27**

By contrast independent practitioners position themselves as being 'heroically autonomous'. Heroic particularly because autonomy over personal decision making comes with the challenges of running a small business. These challenges included having fewer resources, both financial and in terms of premises and staff, the latter meaning that they were less able to delegate administrative duties, or to rotate staff to allow time off for training/ holidays etc. Self sufficiency and independence therefore come hand in hand with a sense of greater administrative responsibility. In particular, pharmacists frequently report the administrative elements of the new contract and other legislative processes as being a significant pressure as exemplified by the quotes below. This sense of an increasing burden is very similar to that

described in a study of single handed GP practices carried out by Lunt et al. (1997) after the 1990 contract was introduced. Here again it was managerial and administrative tasks much more so than involvement with customers that caused the most significant job stress but also related to a diminishing return on personal investment 'working harder for less'.

> The biggest challenge in working in pharmacy lately has been the amount of paperwork we are subjected to. You are working harder for less basically. There is lots of changes in the NHS and they want pharmacists to do more, rather than just dispensing prescriptions
>
> **Pharmacist 8**

> (...) pharmacy is getting more pressure now in terms of the way the contract and the new system is organised so that everything is being pumped on to you to take it and that is where the pressure is coming from. You are doing so much now and the reward is not directly proportional, that is where the frustrating thing is, that is why you are not happier now, you are doing so much but the reward is not directly proportional, that is where the stress comes from, that is it, you think you are doing so much but the returns are the same.
>
> You get more tired and you get more frustrated so you get all 'why bother' (...) So you are forced to do it but what can you do, you have to run the service, otherwise you are not a profession[al].
>
> **Pharmacist 24**

The paradox is that, given the percentage of business independent pharmacies derive from providing NHS services, they are absolutely dependent on the NHS contract negotiated by professional bodies on their behalf to define their role and remit. In practice autonomy concerning performance and management is of a very limited nature; pharmacists are restricted not only by the confines of the pharmacy contract, but also by professional standards and by the business potential and financial stability of the pharmacy. During my study I was present in one pharmacy while representatives from the Royal Pharmaceutical Society* conducted a review of standards and in another which was subject to a review of procedures by the PCT, reminders of the significant level of regulation applied to the

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* The Royal Pharmaceutical Society of Great Britain, now dissolved and it's regulatory functions carried out by the General Pharmaceutical Society. The Royal Pharmaceutical Society is now a dedicated professional leadership boy.

business. It is therefore the symbolic power of autonomy and independent thinking that is most significant in defining the pharmacists' sense of self; an 'imagined control' that in reality can be practiced only within the confines of a very strict system of codes and legislation. This symbolic power gains strength from being positioned relative to a perceived lack of self determination in working for multiples where it is felt that additional rules and regulations further stifle the opportunity for personal freedom.

The sense of autonomy so keenly felt by the independents and the driving force in their professional identities perhaps should not come as a surprise when discussing pharmacy owners. Nonetheless, even employee pharmacists in the independent sector such as pharmacist 18 feel they have professional autonomy in a way that they do not if they are working for one of the multiples.

And do you find that in spite of being part of a, kind of, a small chain then?

Yeah you can, you know, you can do, you know, you can make decisions... yeah, you can make decisions on your own (...) So yeah, it's – you've got flexibility.

A bit more freedom?

Yeah, it's much freer; you can do things on your own.

Pharmacist 18

This degree of autonomy was demonstrated to me by the ability of pharmacist managers to agree to meeting me and in particular in them allowing me to conduct research within the pharmacy. This would not have been possible in Boots for example, where the research would have needed to have been sanctioned by 'head office'.

The fact that independent values could be talked about and performed even by pharmacy managers shows the rhetorical power of the idea of autonomy and it's persistence throughout

this field even though autonomy for managers is still tempered by a controlling hand. It should be noted however that in my observational work it did appear that the input of the owner was seen more in the organisation of the shop floor than of the dispensary. This may be an important factor in distinguishing pharmacists who work for chains but still feel 'independent' from those who feel less comfortable describing themselves as independent pharmacists. For some of the younger managers who enthusiastically described the benefits of independence it was possible that they placed more emphasis on autonomy in our discussions than they really felt, perhaps building pictures of the pharmacy personhood they eventually hoped to occupy as an owner-practitioner. I must stress however that throughout this research there was no particular difference in the way personhoods were articulated or practice performed between owners and managers.

To further accentuate the idea of freedom within independent pharmacy the pharmacists also contrast their autonomy with that of colleagues working in the NHS (hospital) environment who can be 'bossed about' as described in the quote below from pharmacist 21.

> I suppose compared to the NHS or whatever, I mean, in the NHS obviously you've got loads of Pharmacy, if you're the type that wants to – well, can be bossed around, or whatever then the NHS is good for you, but if you want to be independent and use your own initiative and yes, then the community, yeah
>
> **Pharmacist 21**

Contrast is also made with their old adversaries the GPs who are described as being burdened with too many controls over their time and task allocation and a lack of freedom in decision making:

> GP's can only go by the book, that's the advantage of pharmacies, we can incorporate things....
>
> **Pilot Pharmacist 1**

> There is a lot of red tape in pharmacy (...) but I think we are able to be more flexible than the doctor maybe in style, in how we deal with people.
>
> **Pharmacist 7**

Throughout this study the figure of the general practitioner is contested. Individual relationships with GPs were described and observed to be good. Most pharmacists reported a successful working relationship with local GPs, like those described below, and felt that they had the ability to call them and discuss problems relating to prescribing or particular customer concerns and indeed I witnessed a number of these types of interactions during the course of my observation work.

> (...) you get along with the GPs and, you know, you can phone their sometimes direct line, we've got a direct line, so, you know, that makes the job much easier.
>
> **Pharmacist 18**

> **(...)** we have a very good relationship with the local GPs and GPs phone us sometimes, confirm doses, and we phone GPs when we feel something is – hasn't been done right on prescriptions. And I think when you're working in tandem with the GPs and if you're both supporting each other you do feel part of the community. Yeah, you do.
>
> **Pharmacist 31**

In spite of these very functional personal relationships however, descriptions of relations to the medical profession in general were almost always negative. To this latter point I found that, supporting findings from Cooper, Bissell et al. (2009), pharmacists still describe their subordination to the GP. Pharmacist 5 for example pointed out that some of his customers call him a 'doctor' as a compliment but then immediately dismisses this as being an insult because his knowledge is not really that well respected. Pharmacist 10 meanwhile uses the idea of the pharmacist as a shopkeeper to explain a less worthwhile position and suggests that freely available* advice in the pharmacy is second rate advice.

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*Advice in the GP is also 'free' in monetary terms however the 'cost' pharmacist10 refers to in this quote is overcoming the barriers to access i.e. making an appointment, waiting to be seen or waiting for referral.

I think, well, obviously pharmacists aren't as highly rated or valued as GPs or doctors erm and that is only natural, that has always been the case, medicine and doctors have always been highly rated in society whatever society you look at and are like, you know as a compliment they will call me a doctor, we both know that I am not a doctor but they will call me Dr X, so really I accept that even if the compliment is really a, actually a bit of an insult'

Pharmacist 5

Yes, a doctor, strictly, if you say you are a doctor everyone knows you are a professional straight away, with being a pharmacist it is not the same, it is more a shopkeeper, there is a big chasm between the two because on the one hand you go to the doctor, you do anything wrong, you are out of the door. You go to a pharmacist and you can walk in as you please. Because you get free advice it is always second best advice, it is not considered first rate.

Pharmacist 10

The idea of independence does however give the pharmacist some power back in relation to these ideas of subordination and passivity in the sense that it enables them to present a more decisive and active version of professional personhood as compared to practitioners in multiples. Somehow the pharmacist practicing in a multiple is twice subordinated, once to the physician and once to the corporate name. Pharmacist 27 went on to explain this requirement to defer to 'the brand' or in fact a 'brand representative' in the form of a store manager (who is not a qualified pharmacist) as follows:

Because you know you have got your pharmacy laws obviously and ethics but then you have your company rules and regulations which is like an extra layer of regulations which obviously means it is more difficult to, not circumnavigate but just to work around sometimes, you, because a greater discipline is needed and in some of those environments.

You have a store manager who is not going to be a pharmacist so you have not fighting, but different perspectives, you have to work with each other so they are going to be trying to enforce corporate and company regulation which does not always necessarily overlap with pharmacy law or perhaps pharmacy best practice, so, it is interesting. In an independent obviously you are not going to have another manager watching you who is checking or enforcing things which are fine for general retail but are not the first priority for pharmacy.

Pharmacist 27

For him there was an underlying tension between the corporate and pharmaceutical ethics which could threaten decision making in the pharmacy and best practice. Importantly, beyond

simple daily control, the involvement of a commercial perspective also limits clinical autonomy and the ability of the pharmacist to make professional judgements. The idea of a corporate way of doing things puts distance between the pharmacist and his customer. This distance potentially threatens the proximity required for a moral response to situations.

There is a considerable body of research which supports the importance of autonomy in clinical decision making for practicing healthcare professionals as determinant of job satisfaction (Lichtenstein 1984). Green (1993, 1996) in her studies of singlehanded GPs also suggests that having a monopoly over clinical decision making was an especially important benefit of singlehanded practice.

Autonomy over clinical practice is, as previously discussed, limited. Nonetheless, the pharmacists make much of their potential to judiciously 'bend the rules' or have 'flexibility'. How this supposed 'autonomy' and 'judicious rule bending' is (and is not) performed will be discussed further in Chapters Seven, Eight and Nine. However what is important here is how this idea is taken on as being central to independent practice and used persuasively to create a distinctly independent offer. This ability to be flexible was given particular priority in the urban environment, linking independent pharmacists to the complexity of their surroundings and setting up the premise of their offer as being able to be responsive to and reflective of customers need.

> Also, as a small independent you can orientate services around specific patients, whereas in a multiple or a large chain you don't have the independence to do that. They have their protocols and their standard operating procedures and you have to follow that. If the patient falls outside of that you can't really do a lot to help them, you can't be flexible.
>
> **Observation pharmacist 1**

Those that don't respond well to this relative freedom, for whom the lack of structure is a threat, struggle. For these pharmacists there is collusion with rhetoric that positions the independent as somehow less professional, disorganised and 'behind the times'. One of the pharmacists I spoke to for example had recently joined an independent store as a pharmacy manager but was considering a move back to a multiple in order to regain a sense of organisation and control.

> To be honest, I prefer the more bigger chains because it is more structured and organised. And everything, there is procedures for everything. I like that. But here it is just a bit, very, like I made a lot of things up.
>
> **Pharmacist 9**

5.2 New model pharmacists?

5.2.1. Isolation and being 'on the edge' of the profession

Independence and autonomy can also be associated with a sense of isolation. Isolation was positioned as both a positive and a negative in this research, in some senses related to freedom while conversely also leading to a sense of being professionally mute and powerless to influence central decision making.

'I think we're the last of the Mohicans' Pharmacist 16 said to me during his interview. For him and for a number of other pharmacists in this study, independence was intrinsically linked to a kind of 'sacred marginality' (Rapport and Overing 2007: 267) and they deliberately position themselves as liminal characters, sitting outside the 'system'. They feel somewhat 'separate' from the rest of the profession and use their ambiguous professional status to fuel this sense of difference. While these pharmacists recognise that this lack of

involvement or engagement with the centre has lead to them being labelled 'loose cannons', 'dissenting' or 'unregulated' at the same time this status offers privileges that they were reluctant to concede. The feeling of being 'a loner', actually enjoying being able to choose to be isolated from other professionals was still, for some, a significant part of being an independent pharmacist:

> (...) that was a real attraction really, I mean before you were as isolated as much as you wanted to be because you could be in contact with your other colleagues if you had to be but (...) I suppose I am a bit of a loner so I like my own place and I like to do my own thing but you can't do that now can you? You are part of a bigger team which is difficult for me to cope with sometimes; you have got to make adjustments.
>
> **Observation pharmacist 7**

Cooper, Bissell et al. (2009) describe pharmacists as 'islands' and those that I met had very little professional contact with other pharmacists on a day to day basis. Perhaps the odd phone call or running down the road to borrow medicines from a neighbouring pharmacy to fulfil a prescription but there was no chance for daily discussion of professional duties except in instances where there was a cross over with a locum pharmacist or if a pre-registration student was undergoing training within the pharmacy. Cribb and Barber (2000) suggest that isolation may lead to difficulty in understanding the guiding principles or values of the pharmacy profession and heighten the sense of difference from other professionals. 'Difficulty in understanding' might sound like a quite a pejorative description, however it did appear that professional distance made it more difficult for pharmacists to interpret the course of the dominant rhetorical framework as they lacked a professional partner to discuss the daily reality of new initiatives with*. An important difference for independent pharmacists as opposed to those who work for the multiples however is that, without a corporate body to take over the responsibility of interpretation for them, they are required to rationalise for

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* In a number of instances in observation pharmacies I became that informed partner and a sounding board for interpretation and speculation.

themselves a functional negotiation of the new direction of pharmacy. Their independence forces them to at least attempt to understand what these changes might mean for them and their practice and come to some kind of personal resolution, even if that does result in rejection of the dominant ideology.

Professional isolation is often articulated through a sense of being on the margins of the NHS and a profoundly felt 'lack of voice'. When discussing the professional community the fractured nature of independent pharmacy representation was consistently mentioned as a significant drawback in terms of 'being heard'.

> I think in our PCT for example, people higher up the food chain OK, like our chief exec etc. I don't think have any idea what is happening down here. They do not have a clue. Their rules come from even higher above, from government level and they just tell them a set of guidelines and say, we want this. And then they try and push. I mean they look at all the stats and everything and throw stats around left right and centre but I don't actually think they understand what to do with those stats
>
> **Pharmacist 2**

The challenges of being on the edge were met with two very different strategies. Everyone seemed in one way or another engaged in a struggle for survival or for the right to have a voice. For some, this struggle manifests as a declencionist plot in which they are surviving against the odds in a harsh world. Those pharmacists who were more fatalistic about their future saw a course of inevitable decline rather than increasing opportunity. They felt that as independents they would be slowly and inevitably squeezed out of business, unable to compete and increasingly irrelevant.

> But I think the way government policies are towards pharmacy means that they are going to be in decline. I think the amount of multiple owned pharmacies is now 65% so gradually all the independents are selling up.
>
> **Pharmacist 8**

And what do you think the future for independents is?

I think its bleak (...) the Government have got to realise and wake up to the fact that like, you know, we are a vital resource

Pharmacist 29

For one pharmacist the direction of change felt so out of control that he had decided to leave the profession and had plans to set up a hotel instead. He blamed the representative bodies for negotiating a 'poor deal' in the new contract that compromised independent pharmacists ability to remain financially viable as to his mind it was only possible to take on the new spectrum of responsibilities in a two handed practice. His concern, quite overtly expressed, was that decision making power was influenced too strongly by the multiples and that therefore contractual arrangements were shaped to fit their business model:

We just went head over heels into this and stuffed ourselves. We're just – so as our governing bodies are not really a unity and they don't have the voice so it reflects onto the Pharmacists, and also the other problem is when you have a governing body, you have members from multiples as well as independents and that's where you fall apart because multiples are a different race altogether.

Yeah, it's just a, kind of, a whole separate...

Yeah.

...different, sort of, practice.

Yeah, and so if you have committee members of ten and at least five or six are from multiples of different types, you're really buggered for those anyway.

Pharmacist 22

For others, survival was a positive challenge and the changing landscape of pharmacy offered them a chance to take on a different role and seek out new opportunities. This latter group, were most likely to view their participation in this research as a chance to promote independent pharmacy and to publicise the need for variety and choice on the high street.

5.2.2 Clinical professionals...or a search for lost values?

So with all of this in mind how far have these autonomous and 'isolated' professionals come in engaging with the new 'clinical pharmacist' of today's NHS? How do these polarising views about the new direction of pharmacy shape professional personhoods in a practical sense?

Given the range of different levels of engagement with the dominant discourse it was perhaps not surprising to discover a wide range of interpretations of a 'modern' pharmacist. These spanned those who connected fully with the idea and presented themselves 'almost like doctors' (Logan 1983) to those who rejected the new clinical remit in favour of maintaining a clear, almost oppositional distinction between the offer of the GP and the 'friendly pharmacy' focussed on efficient dispensing. The extremes of both of these positions are marginal. One occupies a leading edge, attempting to shape a new role before the 'big boys' from the multiples are able to react. The other poses an outright rejection of the dominant discourse and retells the professional story as a search for lost values creating a point of stability in a world of change.

One of the most straightforward ways of understanding where in this spectrum the pharmacist owner/manager sits is simply to spend five minutes observing the shop. Due to the fact that independent pharmacists are responsible themselves for building, mobilising and maintaining a vision for the business, as soon as you walk into an independent pharmacy it is possible to get some idea of the nature of practice and the personality of the lead pharmacist because their identity is inexorably stamped on the appearance, atmosphere and organisation of their world.

At one end of this clinical spectrum were pharmacists who have embraced the new direction of pharmacy with open arms, sensing that for them at least, it can provide opportunity and the chance for greater job satisfaction in practice. Those pharmacists who favoured this more clinical persona tend to consciously emphasise medicines and medical products and services in store and were concerned with presenting the pharmacy as a 'healthcare centre'. They often contrast their pharmacies with 'old fashioned', 'run down' or 'less professional' independents. For example, pharmacist 28 highlights 'embarrassing' examples of other independent pharmacies that fail to meet up to this clinical ideal:

> If I go into a Pharmacy, it's got to be like the European type*. You know, when I go into a European Pharmacy, it's brilliant. (...) wherever I could see, it's messages coming out or it's their medications, this medication, medications you actually know that you're in a medical environment (...) There are some Pharmacies that I just really wouldn't want to work in ever, not 'cause they're dirty, just 'cause of the amount of rubbish they keep and there's quite a lot of them that are just plainly cluttered and not thought out (...) I mean, when I first walked in here, I could show you photos ten years ago, it was like I'd got some cobbler's junkshop. It was just a complete mess.
>
> **Pharmacist 28**

Shops will usually display health related posters and have stands full of leaflets produced either by the local PCT or by pharmaceutical companies. These pharmacists often express their desire to create modern 'clean' looking pharmacies with white/green/chrome fittings and with defined spaces for waiting and talking to customers (even if they did not have the space to create a consultation room).

> The environment can have (...) a great influence on the way you work and the way people see you as well. As you've probably you've seen the Pharmacy's a bit archaic and it needs a lot of development, so we are having that done soon, so I'm

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* Pharmacy across Europe occupies a different role to that in Britain. Three broad models exist, in Scandinavia pharmacies are highly medicalised and tend to be larger. In France, Belgium and Southern Europe although often practicing in smaller pharmacies the pharmacist also takes on a more clinical role and pharmacies tend to sell less general goods than would be expected in Britain. Finally in Central and Eastern Europe including Germany pharmacies are also more clinically focussed than the UK but tend to provide a broader range of services (Van Mil, Schulz, and Tromp 2004).

> hoping that will provide us with an incentive to raise the standards and push the boundaries and also for patients to think this is a place where we can... give it a bit more of a clinical medical look, rather than a shop look, which I think is the way forward and I think that's the way Pharmacy is moving. That's why you see a lot of Pharmacies now having renovations and that type of thing, yeah.
>
> **Pharmacist 1**

Amongst these pharmacists there was a feeling that this style of pharmacy was the future, most in line with professional developments and also most capable of creating difference from the multiples. It is interesting to note that due to the intense competition over household goods and beauty products etc. some of the smallest shops are stocking less and less 'other stuff' and are focussed much more on medicines. This almost re-centres the pharmacy offer on the subject of the pharmacists' core expertise. If anything, one could argue that larger multiples such as Boots where the pharmacy is reduced to a 'dispensing corner' and which offer a significant range of non-healthcare related products have a more confused offering than some of these smaller stores.

A significant driving force in terms of these pharmacists' personal perceived worth is being 'clinical' which translates into professional worth and respect. This 'medicalness' is understood to be of value to the population they serve and conveys a sense of status and authority. They turn more to professional bodies, other professionals and symbols of their 'medicalness' for validation. New services are clung to as having the potential to increase 'professionalism' and showcase the potential of pharmacy.

> I think it's very good that they're pushing so many enhanced services into practice, which is very good, and I like it, you know. And then people beginning to know, understand, what Pharmacy's all about, because before they think we're just a shop and it's not, but now they have seen what other services Pharmacy can provide and the knowledge and the depth of knowledge within the Pharmacy (...). We feel a bit of pride.
>
> **Pharmacist 25**

However the ability to fully embrace this new role is governed by outside influences. In this sense the pharmacist is ether reliant on the GP or the PCT to determine what services they are able to provide and, far from being empowering, the new pharmacy role can simply add to the position of powerlessness and subordination

And what of the services are you offering here?

> Err we do smoking cessation, and we do flu jabs and we do EHC*, those are the extended services we do at the moment, because this PCT unfortunately is not that pro-active. It is just, it takes some time because the doctors don't want to let go of services. It is like the flu jabs we have this time, the doctors were not willing to let go so we had to wait until they had finished, and if they had any remnants then we were 'allowed' to proceed, otherwise we were not even 'allowed' to tell our customers that we do flu jabs which I thought was a waste of training which was stupid but that is what they agreed with the local GPs, but hopefully next year it will be organised better.
>
> **Pharmacist 21**

In practice as will be discussed further in the following chapters, this professional approach had yet to significantly impact upon the way pharmacists formed relationships with customers or how they provided core pharmacy services. In this sense, even for these most forward thinking pharmacists, the dominant rhetoric does not succeed / had not yet completely succeeded in causing a change in behaviour. As a result in the following discussion of engagement and the development of practice these pharmacists do not stand out from their less progressive colleagues.

For other pharmacists the more clinical role is very unappealing. Rapport et. al (2009) highlight 'the over-abundance of non-health-related items at counter and shop front of some independent pharmacies 'from perfume to hairspray, from ornaments to glass figurines' and explicitly link this confusion of goods to the 'ambivalent nature of the pharmacists role, torn between dispensing and retail sales'. From the pharmacists I investigated however, far from

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* Supply of emergency hormonal contraception through a PGD

being torn between retail and dispensing this supposed 'confusion' stemmed from a sense of rejection of a clinical approach and related to a quite deliberate attempt to control the pharmacy environment. Priority in these shops is given to being 'comfortable' and 'familiar'.

> Yes, I mean I think number one the environment is different, it is not that clinical. There is no fear of an injection or anything like that.
>
> **Pharmacist 11**

> They think 'Oh [name] Chemists', they can come down and visit us instead of Boots, Boots is Boots, the flashy Boots pharmacy, instead this is [name] pharmacy, refurbished now mind you, it was in a bit of a bad condition before now, so it is a slightly smarter version.
>
> **Pharmacist 15**

> It feels a lot more intimate dealing with a general independent rather than going in to somewhere like Boots or SuperDrug. Which tend to have like an overly clinical or official like feel about it. I think that we have to be there to listen and sometimes just the ability of a client to come and talk to you, they will go away feeling better. If they go away feeling better, stronger, happier, then that has got to have some sort of beneficial impact on their health.
>
> **Pharmacist 7**

For these pharmacists there tended to be a definite move away from the 'medicalisation' of pharmacy on the grounds that it was potentially alienating, and even inappropriate in a community pharmacy environment. Their approach was much more restrained concerning their clinical remit, preferring to focus instead on what Rapport et.al. (2009) call their 'role as an expert technician' which 'involves dispensing the correct and appropriate amount of medication swiftly and efficiently 'the pinnacle of professional activity''.

> **Right, because you do have to have somebody in the dispensary but these additional services require you to be away from it.**
>
> Yes, you have to be away from the basic dispensing process and you can't do that because it is the core, you can't ignore it.
>
> If you don't have that then you won't have people walking in, you won't have the footfall if we don't provide that service, and you can't tell people to come back, that would be wrong, they are not willing to come back and also there is a

complicating factor that there is a pharmacy every hundred yards here.

Pharmacist 11

Mr C in observation pharmacist 3 ran a busy and successful high street pharmacy and he had one of the largest floor spaces available of any of the pharmacies I visited. Unlike many of the other pharmacies he had the radio on throughout the day. A large perfume counter was situated next to the pharmacy counter and this drew significant business all day. Women would come to hand in a prescription or buy some 'bits and pieces' and then linger at the counter where the pharmacist's wife would engage them in conversation. Mr C was determined however that he could not find space for a consultation room. To his mind the downsides to creating this kind of facility were that he believed in order to make proper use of the room and maximise its potential he would be required to hire an additional pharmacist to cover dispensing duties and that the revenue potential of this space was better served in the existing arrangement. He also argued that not only was the financial incentive for delivering services too small to merit the use of the retail space for this function but that the PCT his pharmacy was located in had not engaged in commissioning services to an extent that made them of true customer value. From his perspective the consultation room would simply become an MUR room and he was very sceptical that the MUR service provided more value than his current practice. He was very keen to point out the success that he had had in creating a 'professional' but not 'clinical' space had provided, enabling people to 'open up' in a way that he felt they could not do in other healthcare spaces.

This reaction against the new contract almost created an even more fiercely independent pharmaceutical personhood. In pursuing a strategy of opposition this allows pharmacist to describe 'what we are not' and they are able to use this contrast to re-position their focus on

traditional pharmacy values as being 'real' pharmacy. There is an implied criticism that those who take on the clinical role too enthusiastically are 'trying to be something they are not'.

> If they make it too elaborate we will end up just being a less good version of A&E
>
> **Pharmacist 19**

These two positions represent the extremes of a 'clinical spectrum'. While there was a sense that pharmacists pick and choose elements of change that fitted their personal perceptions of what is appropriate, the pharmacists could be broadly grouped into those who were more and those who were less clinically orientated. Pharmacists were able to 'talk themselves into' particular services on the grounds that they were more or less suited to their position. For example, some of the 'clinical rejecters' were happy to be involved in minor ailment schemes or methadone replacement therapy because these elements of the new contract were felt to be 'medicines based' however they rejected parts of the contract that they felt were more obviously to do with diagnosing and advising.

5.3 Independent businessmen

What made you want to become a pharmacist?

I always wanted to be.

Did you? That is interesting.

Yes, I was about 12 or 13 and I decided that it what I wanted to do, I also wanted to own my own business and it was the perfect profession to be able to do both. So, yes.

Pharmacist 14

One of the difficulties in reconciling independent pharmacy with ideas of professionalism has been the concern over the status of the pharmacist as a shopkeeper. As independent pharmacists are so obviously tied to the management of shops inevitably they have become synonymous with direct financial gain. The credibility of the pharmacist may not reside in or be valued according to business credentials however the blunt facts are that, unless independent pharmacists are at least competent businessmen, they will fail. There is no bail out system to support economically unviable but somehow clinically beneficial businesses.

> You have to compete with your neighbours, your colleagues to maintain your level of income, your salary, your livelihood. So therefore you have to position yourself in a very (...) well, you are in a competitive area as it is so if you get complacent then your business will suffer and errrm you have got wages, salaries, everything you have to fork out for and so to keep that money coming in you have to provide a very, very good service, you have to have good premises, you have to provide good service, everything and that includes all of these free things that we do (...).We are private, we are effectively private, we are still funded by the NHS but it is simply a case of this, if you provide a good service we will pay you.
>
> **Pharmacist 2**

Many of the pharmacists actually described 'being commercial' or having a 'business brain' as being more of an asset when working for the multiples and dealing with sales targets and the requirement to push certain lines, perhaps own brand medicines, in favour of others.

> (...) because it is a commercial operation and attitudes are different, it is very commercial. I mean I remember, and I don't think it is right and I might as well just say it I remember when I was working with Boots and they would push us in to selling what they would call 'Link Selling' which was like selling you cough mixture then you sell cough cold pastilles then you sell paracetamol.
>
> **Pharmacist 11**

As with a number of other studies (for example Edmunds and Calnan 2001; Hughes and McCann 2003) I found that the business aspect of independent could be polarising. For some the commercial side of retail pharmacy is attractive and motivating. For these pharmacists, the idea of not working for someone else and having direct accountability as a businessman

as well as a professional was central to the sense of autonomy previously discussed.

> I look at myself as a businessman as well, not just a pharmacist, this is one of the unique professions where you are able to combine the two and play around with it, I can return to being just a pharmacist on its own if I like but the whole idea is that I have contact with the public.
>
> **Pharmacist 9**

Nonetheless, the requirement to be involved in business was also reported as a 'necessary evil' and as a source of stress, positioned outside the core pharmacy job. Some pharmacists who directly opposed an ability to engage with the business side of practice with being a medical professional, and suggested that there is some tension between the two. These pharmacists tend to describe themselves almost as 'stewards' rather than managers of a business for profit, they position a responsibility for longevity and to maintain the business but distance themselves from financial gain.

> The only thing I have found is basically if you get your head too much, well, it depends how much you are into business, my stance is basically I run my shop and I do my business but I am not out there to expand and do this, because there is enough stress as it is. The more you dive into it, unless you are into that sort of thing, of getting into the business or on boards and stuff. I'm not. So I avoid the hassle because it just creates more stress.
>
> **Pharmacist 10**

> It is difficult, I mean we are the only business I know where you would actually advise people not to use stuff, you know, don't buy that but that is the way we are trained and that is what we do. It is difficult yeah, I mean you have some people who are really on the business side and you have some people who are more wanting to be healthcare professionals and it is hard to marry the two together at times really.
>
> **Which side would you say you were on?**
>
> I would say health really; I was never really attracted to the business side.
>
> **Observation pharmacist 7**

However I would like to tease apart 'business' and 'medicine' as in most cases these two

elements of modern professional pharmacy were not viewed in opposition in practice. Quite the contrary in fact, because some of the most 'medically minded' pharmacists I met were also actually some of the savviest and most entrepreneurial business owners and they did not seem to find that these issues fought with each other. Again, taking a colloquial interpretation of professionalism, being a good businessman was part of 'doing a good job' and as such seen as being more, rather than less professional. Pharmacists who were not businesslike could be viewed as 'shoddy', 'inefficient' demonstrating a small minded approach to their work.

As discussed, the business element of practice was, for a number of pharmacists in this study, a significant motivating factor in entering into independent pharmacy as a career path and for these pharmacists there was no embarrassment about the business side of practice. In fact, it was often those pharmacists who rejected a 'medical identity' who also seemed to most strongly reject a 'business identity'. In the case of pharmacist 10 quoted above, while refusing the idea of being a 'businessman' he also strongly rejected the idea of a new, more clinically minded approach. Some of the pharmacists most involved with a clinical programme were also very focussed on the potential business benefits that these activities can bring and also the potential problems in terms of remuneration and pharmacy time. For example, two of the pharmacists who spoke most enthusiastically about the potential to exploit the clinical aspect of practice were also especially concerned with how this new idea for pharmacy would function from a business perspective and spoke quite defensively about their need to preserve a viable business model:

> So I'm, yeah, I'm at the stage where, yeah, I'm optimistic, but (...), I'm happy to provide the services. I think it's a good thing, but I don't want Pharmacy to be taken advantage of, which it has been in the past (...).sometimes people, when Pharmacists say that, people accuse them of being greedy and they're saying, "Oh,

they're just business minded," but at the end of the day we have to. (...) I'm more than happy to provide it as long as, you know, we don't lose out as a result of it.

Pharmacist 1

Yes, again, I think there is a balance to be struck. You can provide a service but at the same time if that service isn't remunerated properly then I won't provide it. There is only so much altruism there.

Pharmacist 14

5.4 Summary

The idea of independence becomes all encompassing in describing professional identities and demarcates a distinct kind of pharmaceutical personhood. This wide ranging potential gives independence rhetorical force. Pharmacists attempt to rationalise their position as 'independent' through the use of the concepts of autonomy and self sufficiency, offered in interview to persuade both themselves, myself and a wider audience reached through this study, of their validity as practitioners. They pull on different cultural 'ingredients' including both historical values of independence and new values of pharmacy to create their own rhetorical interpretations, reacting to their situation of both being and not being in control (Carrithers 2005).

The notion of independence expressed through autonomy evolves alongside the discourse of change. It allows pharmacists to take back some power for themselves as the idea of being autonomous can work both for and against the dominant ideology. This rhetoric of self determination can be used to position pharmacists both within but also apart from the wider health service, occupying simultaneously a place on the periphery through isolationist talk, while also allowing exploration of a leading edge of the profession. In this way, independence sets up the constraints and possibilities of practice. Sometimes it is a box to be

put into, at other times it is expansive, and empowering.

While much of pharmacy literature focuses on discordant identities in my study I found much less confusion than might have been expected on an individual basis. Instead I discovered pharmacists who, in practice, successfully and confidently (at least within the confines of their own world) occupied different niches across a spectrum of potential medical identities. That is not to say that conflict was absent or that they were unable to engage with the wider discourse around the role of pharmacy. However in terms of day to day practice, they are required and they have for the most part succeeded on a personal level, to reconcile being businessmen and professional healthcare practitioners. Arguably, there is more pressure on independents to come to a personal resolution of the problem because they cannot rely on a centrally defined articulation of their role, and they must form for themselves a framework and scope for their work.

Chapter 6. Community Engagement

What makes a good Pharmacist?

A Pharmacist must be knowledgeable, that's the best thing that you have to know enough to be called a Pharmacist. You must have your knowledge at your fingertips to be able to convince your customers. And then after that when you have had your knowledge then obviously we go to the attitude, you must be accessible, you must be approachable. People want someone who they can approach to be able to open up their hearts and tell you what their problems are and then you can be able to help them.

Pharmacist 31

Pharmacists often refer to their ability to engage with customers as being a critical part of becoming a 'good' pharmacist. They directly link their ability to connect with people in a meaningful way to having the professional autonomy to determine how they interact with customers. As a result they also explicitly suggest that independent pharmacists are able to establish 'better' relationships than their 'less empowered' collegues working for the multiples. Alongside this, as with any small business, interactions with customers in the independent pharmacy are highly visible and the development of close personal relationships is described as a business imperative as well as a professional choice. The combination of these factors means that the close customer relationship has become symbolic of independent pharmacy and is a much utilsed theme in pharmacy discourse.

The suggestion that independent pharmacists are particularly good at engaging with and sustaining relationships with customers is certainly not a new idea. Nevertheless, in the light of a renewed focus on the 'patient' and a dominant rhetoric that redescribes the pharmacy as a 'healthy living centre' at 'the heart of the community'(Pharmaceutical Services Negotiating Committee 2011), it is especially relevent to re-investigate relationships and explore how

pharmacists use this idea of engagement in developing their role. I have considered relationships in the pharmacy at two levels. In this chapter I deal with relationships between the pharmacist and the 'community' while in Chapter Seven I explore relationshsips at the level of the individual.

This chapter is split into three sections. In the first I examine how pharmacists respond to the public as well as policy makers in shaping professional personhoods through the rhetoric of 'acceptance' and 'fitting in'. I explore the relevance of 'community' within everyday practice from the pharmacists' perspective; how it relates to the people that use the independent pharmacy and the relationships that pharmacists form at a local level in the hyperdiverse inner city.

The second part of this chapter is concerned with ties to communities or rather, social networks, that extend beyond the local and the special relationship pharmacists are able to sustain with a much more widely distributed population. Through these relationships I examine how pharmacists use other facets of their identity to shape distinct roles, drawing on language, ethnicity and shared cultural heritage.

Finally I address the idea of the pharmacy as a 'non-place', a space which is used by disparate, unconnected people creating transient relationships and loose connections. This paradox highlights the fact that public facing pharmacy personhoods cannot afford to be completely defined by community.

6.1 The community in community pharmacy

Becoming the 'local community pharmacist' was considered to be particularly important in establishing a successful independent pharmacy. The pharmacists directly related 'localness' to independence due to the reliance of independents (even within independent chains) on their immediate surroundings for business survival. This attachment to place sets them apart from the multiples, however the relationship between pharmacists and community is not necessarily straightforward.

> If you look at it, that was how the independents were built, they were supposed to be in the centre of the community, that is the way, so they try to shorten the bridge, that bridge, that gap (...) in a big company it is different. It is not the same. That is how it is.
>
> **Pharmacist 24**

'Community' is a notoriously difficult term to pin down as a conceptual tool nonetheless it is a term which is used consistently as both an academic and a popular concept evoking 'a thick assortment of meanings presumptions and images' (Amit and Rapport 2002: 13). The idea of community as it is referenced within community pharmacy is especially difficult to define in particular because the expressions 'local', 'neighbourhood' and 'community' are often used interchangeably as labels. The meanings of these terms however are theoretically quite distinct: Locality is a 'generic quality of place' as described by the people that use that place. Local for different people at different times might be within a few streets, within a town, within driving distance (Knox and Pinch 2006: 193). The scale of 'local' and who might be included in any 'local community' in this study depends very much on the position of the pharmacy; for those on estates local tends to refer the immediate housing area, for smaller shopping parades local usually means within walking distance of the pharmacy, and for the high street shops pharmacists' descriptions of a local community might refer to anyone who

regularly uses that high street, even though they may drive or take public transport to get there. Neighbourhoods describe 'a territory of people with broadly similar demographic, economic and social characteristics but not necessarily significant as a basis for social interaction' (ibid.). The concept of community meanwhile, although much debated, in short refers to a group created around a shared history, shared experience or shared culture or shared attachment to places, real or imagined (ibid.). Delanty suggests (2003: 181-189) that community is based on 'communication and communicative ties' being 'more about belonging than boundaries'. The idea of urban communities existing at all has been debated with some questioning whether, in the city; traditional communities can exist, suggesting new types of relationships based on networks of association based on personal connections:

> *(...) this on the one hand means accepting that urban strangers are not necessarily tied to each other or inclined to recognise each other dispersed as they are in the city familiar only with particular spaces, locked into elective networks of belonging and intimacy (...)*
>
> *(Amin 2010: 4)*

This discussion considers the 'local community' to be a loose association of 'people from round here' tied together through a sense of belonging to a particular locality but not necessarily including everyone within that locality. At whatever scale, to become a 'local community pharmacy' the pharmacy and its resident pharmacist need to be a part of the daily reality of the people within that locality and able to 'fit in' with 'people from round here'.

In the wider pharmacy literature there is an uncomplicated presentation of community relationships which rarely explores how 'communities', or groups of people who may or may not be 'local', choose to use pharmacies i.e. investigating the difference between being the 'local community pharmacy' and the people that make up the so called 'pharmacy community' (which might actually include representatives of different communities or

individuals without community). Nor does it explore how pharmacists themselves actively select localities to work within or how pharmacist professional personhoods are affected by the communities they work with.

The pharmacy community is often assumed simply to be a local residential population, usually living within walking distance of the pharmacy and registered at a local GP surgery. These local 'communities' are based on the symbolic construction of territory, in other words, defined more by place than by people. The boundaries used to notionally define limits of practice create a sense of ownership of the people that live within these borders and at times it is almost as if the self selecting nature of the pharmacy community is completely overlooked. For example the Pharmaceutical Services Negotiating Committee (PSNC) which is the representative body for community pharmacy on NHS matters has recently produced a series of branded messages which champion the 'community'. These place the pharmacy at the 'heart' of the community re-positioning it as a 'public health service delivery centre' created specifically to serve local needs (Figure 6.1). Nonetheless, there is little discussion of how this might be achieved except by simply exisiting as a service offer or how different types of pharmacy with different interests (for example: independent versus multiple, local versus national interests) might or might not be capable of achieving this status.

Although 'local communities' are instrumental in the pharmacists' experience the those that I met in this study have a much more complex and nuanced view of how these communities might be constructed. This influences where they choose to practice, the nature of pharmacy relationships and the ultimate success of the pharmacist is often personally measured by perceived status within that community. Raising the question, do pharmacists choose communities or do communities choose the pharmacists they wish to represent them? The answer seems to be that both processes are important.

Figure 6.1 'The heart of the community'

PHARMACY
the Heart of our Community

The *Heart of our Community* logo has been produced to visually represent a number of PSNC's key messages:

- That pharmacies are highly trusted providers at the heart of the communities where people live and work;
- That pharmacies are highly accessible (99% of people in England can get to a pharmacy within 20 minutes) and offer free and confidential health advice without the need for an appointment;
- That as pharmacists and their teams provide a wider range of clinical and wellbeing services (including weight management, stop smoking, substance misuse programmes, sexual health testing and NHS Health Checks) pharmacies are moving ever closer to becoming 'healthy living centres', catering for the broad public health needs of the whole community.

(Pharmaceutical Services Negotiating Committee 2011)

6.2 Becoming part of a local community

6.2.1 'Fitting in' and acceptance: finding a place to practice

> I think I do identify with this community quite a lot, yeah. I think it's important as well when you have a Pharmacist (...) they should be able to identify with that community.
>
> **Pharmacist 31**

Much of the pharmacists' discourse around community centred on the topic of 'acceptance' and the idea of 'fitting in' shaped their approach to the hyperdiverse, urban environment. Hyperdiverse is not intended to be a euphemism for 'all inclusive' and belonging to 'round here' is complicated by factors such as ethnicity, socio-economic status and experience of the inner city. The pharmacists individually made judgements about their personal ability to relate to 'people from round here', and the potential for finding a place within a local community. This understanding of their capacity to function as a 'good' local community pharmacist and engage with customers had a significant impact on their choice of practice.

The requirement to 'fit in' is often informed by their experiences as locums. Almost all of the pharmacists who took part in the study had been a locum at some point in their careers. In this position the feeling of transience and the difficulty in building close connections with customers is keenly felt. Pharmacist 16 summed this up and stresses the importance of knowing people and being known:

> (...) when I used to work as a Locum I used to go to different places every day. One day you go to a very rich area, one day you go to a very poor area, and you can never get through [to people]. Now I know my patients (...) now I know people, I know by names. I can joke with them. I can ask them what they do, where they're going. They ask me too.
>
> **Pharmacist 16**

This uncomfortable feeling of distance as a locum informs an ideal of 'the pharmacist' as a character that should be socially close to the local community in which they are working. This was common across the spectrum of different pharmacists I met, 'clinical' or not. They often described feeling that in order to be successful it is important that customers sense immediately that their pharmacist is able to understand them and share their worldview, creating a direct unspoken bond.

For those who wish to open their own shop, restrictions on the opening of new pharmacies and the high degree of competition for existing contracts means that the major motivating factor in finding a place to practice, for some, is pragmatically simply opportunity. However, a significant number of others include in their reasoning the fact that they particularly chose to practice in East or South-East London, specifically due to the demographics of the potential customer base. There was a particular emphasis on choosing a place to practice in which they felt socially comfortable and where they were able to make immediate connections with customers through a sense of shared experience. For example, pharmacists 5 and 1 discussed how ethnicity, linguistic and cultural knowledge strongly influenced their decision to practice in a hyperdiverse community.

> Because, well, a) it is a heavily ethnic area, b) there is a mosque around the corner and I am Muslim erm c) it was on the market. It is not really a question of where shall I open my pharmacy it is about which pharmacies are available for sale. Obviously there is a contract limitation. So this seemed to be the appropriate one, it was not too far from where I lived, so it was fine.
>
> **Pharmacist 5**

> I mean, I know the area. I know the types of patients and I know the languages, so – and the – as a result the culture as well, I can understand the culture of different communities there, so, yeah, it's – that's a great benefit as well.
>
> **Pharmacist 1**

This need to choose a 'socially appropriate' place to practice was discussed in detail and presented as the reason for the high numbers of ethnic minority pharmacists practicing in this particular part of London. Platts et al. (1997) also highlight the density and frequency of ethnic minority owned pharmacies in urban environments, hypothesising that linkages with the local community based on a shared ethnic cultural background are vital in maintaining these businesses in the face of competition from multiples and supermarkets. This view was supported strongly by the pharmacists in this study although at this local level, more important than a specific shared background, was simply a shared belonging as part of this diverse urban community. While these choices are consistently presented in a positive light as 'this is where I choose to be' by default they also uncover a sense that in areas that are mainly white, British and middle class these pharmacists felt they would be less successful.

> (...) we are ethnic community pharmacists, mind you in this area we are the majority! The white people are the minority you know, really that is how it is you know.
>
> **Pharmacist 6**

> Err well in this area I am really good! I blend in sort of thing, but it does, if you go up North [Northern England] they don't really trust me and I mean trust plays a big part in health, medicines especially, they won't take their medicines if they don't trust you (...). Yeah, over here yeah, people feel a bit 'at home' as well, if they see someone from India or anything like that, Pakistan, they can be more open with them.
>
> **Pharmacist 15**

The pharmacists' rationale for this requirement is based on the impression that seeing one's self reflected in the healthcare professional behind the counter creates a feeling of implicit trust. Anything that is a barrier to building trust was considered to be a significant problem. A number of pharmacists cited areas where they felt that they themselves would be less trusted, 'up North', in the country or in white middle class suburbs.

Emic descriptions of being close to customers make distinctions between 'them' and 'us' customers being 'like me', 'like us'. Identification with customers in this way is informed by their own experience, a sense of 'knowing how it is' to be part of this particular urban environment (Duckett 2007). Burke describes how rhetoric is used in this process of 'identification' (1969). As Rumsey remarks 'For Burke, rhetoric is all about the process by which persons, entities and positions become identified with one another' (Rumsey 2009: 128). Burke demonstrates the process of identification by describing a politician who, when addressing some farmers begins by stating 'I was a farm boy myself' (Burke 1969: xiv). Very similar strategies were used by the pharmacists here: 'I came myself so I know', 'I'm from a working class background myself' or 'I know how it is round here because I lived here myself'. Burke calls these types of statement 'stylistic identifications' which are used to find shared interests, experiences or beliefs between the speaker and others (Burke 1969: 46).

He also points out that this process of identification is as much to do with self persuasion as it is to do with persuading others. For the pharmacists in this study the practice of describing their 'fit' with particular communities certainly served a dual purpose, in part outward facing but also in terms of resolving their own place in the world and justifying their professional value through the process of engagement.

Pharmacists don't just use this strategy to align themselves with local communities, they also use identification as a way of differentiating themselves from others – in this case white British pharmacists (who would not/ could not identify with the hyperdiverse community):

> People will come to me because I am not white, I am brown, so that barrier is broken' which if I had an English colleague come along they would be saying 'Oh, Mr [X] is not here, I will come back tomorrow'
>
> **Pharmacist 3**

> I mean it is just helpful because when the clients come into the store, sometimes if they see someone that they look like or they can relate to then it all helps the customers feel more comfortable I mean for example myself, I come from Ghana, West Africa so if you have a West African customer come in to the store then they can see obviously, clearly that I am from that part of the world so they feel more comfortable speaking to me than they would possibly an Asian pharmacist or a white pharmacist and vice versa.
>
> **Pharmacist 7**

The idea of, as Kapuscinski describes, 'crossing the border of your own racial zone' permutated pharmacists discussion of 'fitting in'. These pharmacists describe the importance of being able to draw on this experience in this hyperdiverse community.

> *You can spend your whole life without thinking, without wondering about the fact that you are black, yellow or white until you cross the border of your own racial zone.*
>
> *(Kapuscinski 2008: 54)*

It was felt that there would be significant barriers particularly to white British pharmacists practicing in these hyperdiverse urban areas in terms of their ability to forge a connection with local people. Not only do these pharmacists (it is assumed) have a lack of experience of being 'the other' to inform their interactions with customers from ethnic minority groups, but also being white British in this context is automatically equated with being educated, professional and middle class. In other words, socially distant on more than just one axis.

> You [A white British pharmacist] would be a bit stupid to open here. You wouldn't open here. Why would you do that, yeah? So you would choose the leafy suburbs of Hertfordshire. Ok.
>
> **Pharmacist 5**

There was therefore a general assumption that any heightened social distance would be too great to conquer. While boundaries can be crossed there was a sense that the gap in understanding might just be too big. An unquantifiable distance that would somehow render

the care given less valuable or less complete. These extracts from pharmacists 2 and 28 show how they tried to explain to me how a white British pharmacist would be a 'duck out of water':

> (...) the thing is [if] you can't understand your customer how are you going to relate to them, how are you going to help them? You can't help them, you know. I couldn't have someone from Surrey come in and suddenly walk in here. I mean they might do a great job but they are not necessarily going to understand the customers. I mean, you know, maybe that is a prejudice maybe they can I don't know, I have never been in that position because I have never had those people come to me, but I just feel that like (...) they are going to be a duck out of water.
>
> **Pharmacist 2**

> I think what I'm trying to get at is if they can relate to you more, not that Anglo Saxon Locum won't work, I think you've got to be approachable, but I think if you're Anglo Saxon you'd have to try from a different angle to make sure that they didn't view you – outsider is the wrong word, but that you're empathetic more than anything else because culturally you will be viewed as different and so therefore you have to go out of your way to break down that barrier (...).
>
> Once you get talking to them, I don't think it probably matters too much. But (...) [customers] will not relate to that Pharmacist as well, no matter how professional or how much capacity they've got, they're just not going to relate to them in the same way.
>
> **Pharmacist 28**

The need to be able to identify with the local community was substantiated through the presentation of (or the performance of) the difficulties *even* they face in a hyperdiverse setting. The pharmacists used examples of such problems to benchmark to the issues that outsiders would have and to emphasise for me the amount of time and effort needed to engage with customers in this setting. For example in this account of confusion over names:

> ...if they want to tell me something I say to them to bring somebody who can speak the language, but they just turn up and their names are so similar. You know you have Rajinder Patel, and Rajendar Patel and if you hand out the prescription you can't believe, sometimes there are two customers with the same initial standing [there] (...). And then you know you get 'is that for you – yes' 'is that not for you – yes' so then you can't tell! You have got to be able to get through properly, what is your address, where do you live, what is your name and all that, whereas probably the British society you don't need that
>
> **Pharmacist 6**

Pharmacists often referred back to these sorts of incidents during my observation work, calling them to my attention – 'you see how difficult it can be' or 'imagine how much harder that would have been if I didn't understand' in order to highlight the challenge of diversity and the need for identification.

This difficulty in building a successful community relationship with 'social distance' was also demonstrated by the only white British pharmacist who took part in my study. Pharmacist 26 had had seen the population in the local area change considerably over time. He felt able to communicate with 'the old family', a core of white British customers who had been in the area since he took over the pharmacy more than 50 years ago, however he found it increasingly difficult to build effective relationships with the new urban community. In particular he struggled to relate to the large Bangladeshi population in the area and described how a break down in understanding lead to a lack of trust:

Do you think that's changed over the time that, you know, the Pharmacist as a figure in the community?

I don't think that's changed a lot. No, there's still a respect from the people that we know, the old family, we get quite a bit of respect.

Yes, yeah, and do you think that's continuing, sort of, through the generations or...?

Well it's certainly not continuing with the new populations [recent migrants, especially those from Bangladesh] that I was talking about (...). So it doesn't matter what you tell them, they don't trust you. Now the old customers, the people I've known for years, like that one you saw.

Yeah, the lady the other day.

(...) I mean, if I advised her something, she would take my word for it.

hmmm.

But they don't. They think you're trying to cheat them

Pharmacist 26

The ability to practice identification with this urban community was dependent on more than just straightforwardly ethnicity. It was also determined by an idea of closeness to the social lives of people in the area based on a understanding of that particular place. Many of the pharmacists I spoke to had lived or worked in East or South-East London prior to taking over shops in the area. They felt they had an intimate knowledge of place which those from outside, no matter what their ethnicity, would be unable replicate. In this way, the urban space itself allows pharmacists to create a shared experience, a shared narrative with their customers.

I suggest this is an 'idea' of closeness rather than anything more concrete as this 'urban knowledge' was not necessarily specific or even necessarily 'current'. From their talk and their behaviour one might be forgiven for thinking that the majority of the pharmacists represented in this study lived, as well as worked, in the area that their pharmacy was based. For many however these ties that they have to the area may in fact be historical. A number of the pharmacists had actually moved with their families out of the area and were commuting from far more affluent parts of London and beyond.

Do you live in the area?

No, I live about 25 miles away from here. But I still feel part of it, once you mention [this PCT] my eyes light up. I am part of all the talk most of the customers would think that I live in the area.

Pharmacist 24

I live in [North West London]; people ask me, "What the hell are you going to [this PCT] for?" I say, "Well 'cause I like it. It's not a question – the money is not the thing, I like it."

Pharmacist 16

The requirement for being close to the locality therefore is very much a symbolic one. Being able to demonstrate some kind of understanding or at least for customers to be able to believe in the potential truth of social closeness seems to be enough to successfully practice identification.

Those pharmacists who were too distant from this cultural milieu, for example by being brought up in affluent areas outside London, were considered to be as removed from the local population as any 'white British' pharmacist would be*. In this way, being from an ethnic minority group was only 'useful' if you could utilise ethnicity alongside other references to practice identification. If not, as a superficial signifier, this potential advantage was lost. Pharmacist 28 who had explained in great detail the benefits of identification through a shared 'ethnic perspective' then went on to say:

> (...) whilst it would be a slight advantage I think to be of a certain ethnic minority, unless you could use that; so if you had someone that was Indian, but effectively been educated out in the Shires and gone to a boarding school and couldn't relate to the population, it still wouldn't be an advantage.
>
> **Pharmacist 28**

Pharmacist 16 equated this sense of distance to an 'aloofness' which restricted the pharmacist's ability to practice empathy with his customers and to be flexible enough to meet the demands of the socially complex urban world.

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* White British pharmacists were stylistically always assumed not to have roots in 'round here' and being 'too posh' to understand the lives of local people. By contrast I met a number of white British pharmacy assistants who *did* come from 'round here' and who appeared to have little difficulty in 'fitting in'. In fact these assistants (as with most of the ancillary staff I met) actually acted as repositories of local information for pharmacists no longer living in the area. For example, in my interview with pharmacist 14 he described how his assistant 'Jean' lived just behind the shop and knew 'everybody'. He described how 'people will come in and she knows what is going on with them'. Meanwhile 'Pauline' who I spent a lot of time chatting to in Observation pharmacy 7 was a former landlady and very well known to customers and clearly a very popular 'fixture' within the pharmacy.

Yeah, because, you know, when you become a Pharmacist like many of the youngsters now become qualified at 26, 27, and they are brought up like English people. They've gone in university, English, everything's like English, and their manners, everything is perfect, okay (...) but they cannot get on with the people, because they have never been out in the communities. They're just from school to college, and college to university, and university back to business, so they only know going [to] work in the morning, get the money and going home; they don't know other things (...). If you stay aloof in this then you stay aloof forever, you can never make friends.

Pharmacist 16

This was demonstrated markedly by one particular interviewee who described himself as being 'British first then Indian really' and who had been brought up outside London. He described himself as 'very English' and he could not speak any other languages. He felt rejected in his pharmacy in favour of a well loved dispensing assistant and made the point that it is not just about the pharmacist choosing the community, the community also chooses the pharmacist. A year after our interview he had in fact left the area and moved out of London:

(...) and also because of the way I was brought up and stuff, I went to like private schools and stuff and so my language is not that good. (...) So err I can hardly speak any other languages and here is very, very none English. I find it really difficult. Like it is lucky I have got the other staff like, to translate. Otherwise I would be in trouble.

I mean, even here, like I would say that 80% of the calls we receive, they are not for me, they are for the guy, did you see the guy out there with the glasses? (...) Because he lives around here and he speaks the language. Even though he is not the pharmacist, everyone thinks of him as the pharmacist. Even the doctors ring for him and speak to him on his mobile and stuff like that.

Yeah, I mean, that is why I want [to leave]. Well, before this I was a lot of times in [X town], and stuff which is easy, yeah. They are less. I don't know. I liked it more there than here to be honest.

Pharmacist 9

6.2.2 Differentiating against other 'Others'

The 'Other' in this context of community was not only the white British pharmacist. The pharmacists also regularly compared themselves to GPs (who are positioned as socially distant) or pharmacists practicing in multiples or rural/sub-urban communities (who would not identify with the urban context). Identification and differentiation are therefore dynamic processes and dependent on situation and context.

In juxtaposing the position of the pharmacist with that of the GP, their ability to relate to customers is often contrasted with the GPs 'aloofness'. 'Fitting in' is assumed to be less important for the GP who can remain a distant figure of authority both in terms of physical accessibility and in terms of social closeness. The pharmacist on the other hand encourages more frank communication and the sharing of 'secrets' by being embedded in the community:

> I think that is right, yes, we are more into the community than GPs, and people are more frank with us, I don't know why. A bit more open and GPs well, they are just the GP if you know what I mean. It is different. Whereas a pharmacist is I think part of the community, I don't know. I think some people think that.
>
> **Pharmacist 15**

> The customers see us as being very much if you like, part of their social group, and they will give you great secrets! They will tell you things they don't tell their doctor! They will tell you sometimes they have skipped a tablet but they would lie to the doctor. It is a big advantage.
>
> **Observation Pharmacist 1**

6.2.3 Being a part of the community

6.2.3.1 Getting established

> I know people who are excellent Pharmacists, far better than me, but it would take them a couple of years to [coughs] develop themselves into, not necessarily do it themselves Pharmacy wise, but develop themselves in terms of knowing the community. And that's just, you know, that's not any fault of theirs, it's just that when you go to a community you have to understand how the community's divided, how it's united, the type of people that it's made up of, what their individual needs are, and that process can take a couple of years, and I think I've only – I've been here two and a half years and I think I've only just, you know, got to that stage now.
>
> **Pharmacist 1**

Being able to 'fit in' and be accepted by people in the local area is one thing, but a much deeper relationship must then be forged at a community level, in becoming 'a part' of the community. Legitimacy and authenticity are gained from being perceived to be a figure of note for 'people round here'.

Of the seven pharmacies I visited for my observation work, three were owned or managed by younger pharmacists who were in the process of establishing themselves in their position and four were owned by older pharmacists who had been practicing in the area for many years. It was striking to observe the different points along the journey and the different relationships each pharmacist had managed to construct.

In Observation pharmacy 5, Mr E had taken over his business seven months previously from a well established pharmacist Mr P who had owned the pharmacy for the last 35 years. In spite of having been in the pharmacy for over half a year, almost every day a customer would come in and ask for the Mr P. The two counter/dispensing assistants who had been with the pharmacy for around six years each were trying to introduce Mr E to everyone and to break the news of the change to the customers:

Customer: So where is the other gentleman?

Assistant: The pharmacist? Mr P? He has retired; he was finding it difficult to come to work. His knees and everything; he lives in [North London].

Customer: Oh, I'm sorry to hear it; whenever you see him you must give him my best regards. I didn't know Mr P retired. I will miss him, he was such a nice guy.

(he points at the new pharmacist Mr E and addresses him)

well, you are the new guy I suppose, hello.

Assistant: **(addressed to me after the customer has left)**

We are introducing Mr E to all the people which is important, it is important that he knows them you know. A pharmacist is a very important role and people need to know him. We try to bring him to the counter to explain things to people.

Observation pharmacy 5

As 'The New Guy' Mr E was under scrutiny; for many customers Mr P was still 'The Pharmacist' and Mr E was potentially transient, not quite accepted. Mr E was very aware of the need to maintain the links Mr P had built up over time in order to keep the business viable. He recognised that the assistants gave him a vital 'upper hand' because they had a great relationship with all the regulars and discussed how maintaining continuity through 'the girls' was absolutely critical in him retaining regular business which could so easily be lost to a much larger independent pharmacy just around the corner.

In observation pharmacies 2 and 6 meanwhile the two pharmacy managers were a little further ahead in establishing themselves. Mr B in pharmacy 2 for example was a quiet but commanding presence. The festival of Eiid occurred when I was in his pharmacy and throughout the day of celebrations customers dropped in with tins of chocolates and sweets and to thank the pharmacist in particular. Mr B was clearly very touched by the number of well wishers and surprised by the attention he received. One customer commented that they

had come to wish 'their' pharmacist well which was a significant achievement in terms of acknowledgement in this position.

The pharmacy is contained in a very small, defined world, a fragment of the space which holds the local community. However the sign for pharmacists that they have 'made it' as part of a local community is recognition outside the confines of the pharmacy space. This type of recognition was often played back to me within interviews to show how attached the 'local community' are to their pharmacist. In these tales of 'acceptance' the pharmacists exclude the idea that any other local pharmacist might exist, even if they are positioned just down the road from another business:

> You are still the pharmacist, even if it is your day off. Oh yes, wherever you go you are the pharmacist; you don't stop being the pharmacist. Even if they see you in a shopping mall they will come over and ask you
>
> **Pharmacist 23**

> I go out to the Post Office or to buy lunch, and I'm stopped on the street, sometimes three times before I get to where I want to go, and they talk to me. In the Post Office, I'm in the queue and they talk to me, "What are you doing in here?" In the bank, so it's good, that is the satisfaction I get.
>
> **Pharmacist 19**

In addition to the pharmacist being 'owned' by the community the pharmacy itself can function as a 'community' space, in other words a space in which people have a stake and are represented. Pharmacists foster links to the community by encouraging talk and information exchange in their shops and the shop becomes a space for gossip, storytelling and meeting. In doing so the pharmacy becomes a social space, and the staff become part of the process of facilitating the flow of information through the community.

While I was carrying out my observation work there were many incidents which reflected this social function but none more so than following an accident that happened one morning close to observation pharmacy 7. A number of customers were lingering in the pharmacy and chatting with the pharmacy assistant, the pharmacist himself was working in the dispensary. Sirens were heard which did not provoke much interest but around fifteen minutes later we could hear a helicopter close overhead. This galvanised the pharmacy into action and the counter assistant rushed to the window to see what was going on. A young woman then came into the pharmacy to deliver the news that a little girl had been knocked down by a car. Apparently the girl had been in the shop with her mother only that morning and was well known to the staff. The pharmacist stopped working and came down to talk to the woman and the assembled customers. As we heard the helicopter taking off, followed again by the sound of sirens more people come to the pharmacy with additional snippets of news. The family were well known in the area and were having a birthday celebration so there were lots of children playing in the street. It appears the girl ran into the road and the driver of the car could not stop in time. The next day we were still receiving updates on her condition from various customers. The assistants became experts on the case and people came to the pharmacy to find out what had happened and what the latest news was. To everyone's relief she was in hospital for a few nights but made a full recovery and was back home by the end of the week.

6.2.3.2 'Wisemen'

Over time some pharmacists, in particular pharmacy owners who will often be in the same practice for many years, go much further in creating a locally determined, public persona. The pharmacists I met in observation pharmacies 1, 3, 4 and 7 had been established for many years and were very well known characters. In these pharmacies in particular customers

would regularly tell me how 'great' the pharmacist was and how much they would miss him/ her if they had ever left.

This idea of the fully engaged community pharmacist was often presented as the 'ultimate' achievement for the independent. Becoming 'The full package' or 'The master' as described by pharmacists 15 and 16 was defined by being more than 'just' a pharmacist. For these individuals there was recognition of a broader community role, either through direct involvement in life outside the pharmacy or by the kind of advice it was possible to gain within the pharmacy space, becoming a place to discuss social problems and to gain support over a wider range of issues than just health. For example within these pharmacies I witnessed (and was sometimes engaged in) conversations on topics from where should children go to school, to dealing with teenage crime and where to go on holiday.

> He [the pharmacy owner] is a Dad figure, that's it. (...) he is involved in the church you know, and things like that, always into fund raising, community services, going to charity events, many other things, not just pharmacy. He is that full package.
>
> **Pharmacist 15**

> (...) the boss who owns this shop he is a master. He – 14th year now (...) he loves people and people know him by [Andy], they all call him [Andrew]. They shout on the door, "[Andy]," and, you know, even if they're passing by they say hello.
>
> **Pharmacist 16**

These pharmacists take on a role that is more akin to that of a 'wiseman' within the community, a transformational process that presents them with greater community authority (Duckett 2007). This authority however is based on a charismatic influence rather than being connected to specialist pharmacist expertise. The pinnacle of independent pharmacy therefore is not reliant on holding more technical knowledge (perhaps compared to the 'ultimate' physician) but rather built on the capacity to built deeper and more extensive relationships.

6.3 Being the 'Bengali Pharmacist'

The pharmacists I met often described themselves, or were referred to by others, using their ethnicity to define their professional persona. For example in the quotes below from 'the Ghanaian pharmacist' or 'the Bengali pharmacist' or in observation pharmacy 4 customers would sometimes wait for hours to be served by Mrs D 'the Russian pharmacist'. She was very well known by other pharmacists in the area who were obviously used to being asked about her and who would regularly direct customers to her pharmacy. These signifiers were not superficial, rather they related to a specific role played by the pharmacists in serving particular communities or perhaps what might be better described as networks* of people.

> I mean it wasn't planned but that is just how it is. Accidental rather than judgement but a lot of Bengalis will come in here specifically because I am the Bengali pharmacist, I can speak Bengali and I can give them extra information.
>
> **Observation pharmacist 6**

> I come from Ghana and word goes round and people just come. Somebody say, "Oh there's a Ghanaian Pharmacist there," and they might not be able to express themselves well in English, then they speak my language...so it's very helpful and it brings in customers.
>
> **Pharmacist 19**

> Some people come here and say 'where is the Russian pharmacist?'! She is my friend, I know her very well. I say 'go to this woman!'
>
> **Pharmacist 5**

Pharmacists discuss how people are driven to use their particular pharmacy through a need/desire to consult a healthcare professional who speaks their language or perhaps has, to a greater or lesser extent a shared cultural background. In spite of the seemingly small reach of these shops, a significant proportion of business from these social networks would be from

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* A network being: 'A relevant series of linkages existing between individuals which may form the basis for the mobilization of people for specific purposes under specific conditions' (Rapport and Overing 2007: 327). I have deliberately adopted this term here rather than 'community' as I felt it better described the patterns of association in these disparate co-ethnic groups spread over a wide area.

people all over London (and in some cases beyond) falling outside the policy driven 'neighbourhood' boundaries and without ties to local place.

> (...) today I've had somebody and they come all the way from Edmonton. I have clients that will come from as far as Essex and you're looking at maybe Chelmsford, because they're comfortable and they know you would at least understand and speak to them, you know.
>
> **Pharmacist 17**

> Oh yes, they do, they do, they will come from outside [this] PCT to speak to me (...) some of them post the prescription and say, ok you get it ready and next Friday I will come and they take a trek all the way in to get it. I suppose it gives them more confidence to think oh, well, 'he is my type so he can't make a mistake' or probably 'I must give him my business', but, yes, we find that when you have got your same people they tend to come to you.
>
> **Pharmacist 6**

In the most basic sense, these communities are based on language. Pharmacists distinguish between two types of customer; those who can and those who can't 'speak'. For pharmacist 10 for example, having 'no language' means that finding a pharmacist who is able to speak their language is a 'requirement' while those who can speak, can be more 'English' in their pharmacy selection. In other words they have more choices. This description supports research by Jesson et al. (1995) who found that half of non-English speaking respondents they surveyed specifically used a pharmacy where someone could speak their language.

> It depends, there are two types of customers, you have got the customers who are basically, they are quite, well, English. They treat the pharmacy as just a standard shop, they will just come and go, but where you have got people who have got limited English, they actually use it as a requirement, whereby what happens is they will try and go to the doctor who can understand their language and then they will also specifically go to a pharmacy which they are comfortable with, when they have established that then they do not like to make movements.
>
> If they are more well established in the English language then they don't mind to go to other establishments because they find it easier, but once they know they are comfortable in a place and they know that we can get on with them they will actually stick with it
>
> **Pharmacist 10**

Beyond providing language skills alone, the pharmacists take on the role of a social 'broker' (able to 'transmit values of society to new comers'), or a 'patron' (able to 'dispense favours'), negotiating the boundary between ethnically described networks and British society /the city /the healthcare system (Brettell 2003: 127-128). Like 'Dr Larry' in Viladrich's study of Argentinean migrants' health networks in New York, the pharmacists here position themselves as being in a 'unique position' able to span two worlds (Viladrich 2007).

> *As somebody who intersected two worlds, Dr Larry shared his patients' cultural allegiance while being, at the same time, a formal player in the biomedical American system. Therefore he was in a unique position to perform as a link between the health care system and immigrants' informal social webs.*
> *(Viladrich 2007: 313)*

For new migrants in particular this role as a social broker/patron can be especially important. In observation pharmacy 4 as Mrs D explained, she not only provided language support but also answered 'simple' questions about a very wide range of subjects.

> Russian people most of them they cannot speak English and they need some help with stupid questions they don't know how to ask themselves. Simple things like the hair peroxide – yes it exists in this country of course it exists, go to your chemist and just ask, lots of things like this one, a lot of advice for colds and things because they are run down when they get here, new environment, new things so stress related as well so this I help with as well.
>
> **Observation pharmacist 4**

Pharmacists will often draw on their language skills and 'cultural understanding' in order to translate and communicate with other healthcare professionals on behalf of their customers, picking up on miscommunication that has happened in primary or secondary care. Pharmacist 20, 'The Chinese pharmacist' explained:

> ...and there's another problem, quite often we have to interpret for the Doctors. The Doctors will phone us or, you know (...) Doctors, probably through lack of communication or understanding, sometimes they prescribe the wrong medication, and sometimes they don't understand the symptoms that the patient try to convey, and this a problem too with the language. It's quite a common problem we have

> with the Doctors, sometimes they don't understand the patient's sort of language or they cannot understand the patient.
>
> **Pharmacist 20**

In observation pharmacies 2, 3 and 5 I noted a number of these sort of incidents whereby the pharmacist was required to intervene behalf of customers. These interventions involved making a number of phone calls to GPs and in one incidence getting in touch with the hospital concerning the care of an elderly lady who had little family support.

The pharmacy can also become a place where an understanding of cultural issues can negotiated alongside issues of wellbeing. In Observation pharmacy 6 for example I discussed this role with Mr F following a particular transaction in which a customer had asked advice on treatment following circumcision.

> Yes, obviously we have to deal with that and we have our own independence to deal with that. For example, I know that round here a lot of people are circumcised but they are not being done by a qualified doctor or their GP, I mean they won't tell us that. I know that. They are coming in and buying instillagel or they are asking for antibiotics or whatever. Obviously I sell them the instillagel because seeing as they have done it so it is best to treat it and obviously for antibiotics I tell them to go to the doctor but I can also have a word with them and have a chat about things and about what they are doing and let them know what to look out for if there are any complications or whatever. They do come here for help when that sort of thing happens.
>
> **Observation pharmacist 6**

The GPs in Viladrich's study also played a particular role in 'sorting things out' for their customers, helping them to negotiate 'the system' or enabling them to construct more effective illness narratives (Viladrich 2007). This undoubtedly was also true of the pharmacists in this study however I have discussed this practical offering in more detail in Chapter Nine as this kind of fixing and negotiating service was not restricted to the customers they served through these particular co-ethnic networks. Well known customers in general

were able to command special attention within the pharmacy and marginal customers in a variety of situations required this kind of help.

Even if people can speak English proficiently they will still travel to find healthcare practitioners who share the same first language. In observation pharmacies 1 and 3 in particular, customers who had travelled to see the pharmacist would often linger longer than usual in the shop and conversation would move fluently in and out of English.

> We have other – we do have people coming in who are Nigerians as well, Africa Nigerian...background, so that does happen. They think okay, you know, explain things to them better, they – even people, like, that speak English and they can communicate quite well
>
> **Pharmacist 17**

For these customers pharmacists can provide a vital connection to a 'way of doing things' that feels familiar. For example, in Russian community pharmacy, half of all prescriptions are still compounded on the premises. Formal training in Russian pharmacy involves use of 'herbal' products and Russian customers use a significant proportion of herbal medicines (Indritz 2002). In response to this, Mrs D had a wide range of different remedies available in her pharmacy and as I witnessed, her services were extremely popular.

> We still have a lot of tinctures, herbal tablets (...) first of all when I study my pharmacy course, we are taught about these things. This is a special course the Russians use, it is valued. It is because of my knowledge people come here, in British pharmacy it is different.
>
> **Observation pharmacist 4**

These identities as the Bangladeshi or Ghanaian or Chinese etc. pharmacist were not promoted beyond the pharmacy and so customers rely on informal networks in order to seek expertise. As with Viladrich's GPs, some of the pharmacists reference life outside the

pharmacy for example, at the temple or at the mosque which enable transmission of information informally (2007).

Kleinman (1980: 51) notes that the 'customary view' dictates that healthcare is organised by professionals. He suggests however that 'lay people' are in fact able to make decisions in how to 'activate' healthcare by deciding 'when or whom to consult, whether or not to comply'. These kinds of choices are exercised by pharmacy users. Customers are free to choose when and under what circumstances cultural familiarity is important and when what the choreographer Alvin Ailey eloquently describes as 'blood memories' matter. Ailey suggests that blood memory describes a kind of collective understanding which is not necessarily articulated overtly but which pulls people together across social boundaries, neutralising other differences which may otherwise apparent e.g. social distance and which, under other circumstances might render communication difficult (Kourlas 2009; Alvin Ailey American Dance Theatre 2009). Pharmacists describe a search for the familiar, for references that reassure and that are rooted in 'home' comforts as being especially important for people who feel ill or vulnerable in some way.

The interactions described however are not reducible to a simple equation of 'culture = community = ethnic identity = nature = culture' (Baumann 1996: 17). An excellent example to illustrate how these boundaries of association are extremely fluid and reliant on the customer rather than chosen by the pharmacist was the situation in observation pharmacy 3. To shatter the idea that cultural similarity is *necessary* in ethnically defined networks neither Mr C nor any of his staff were Vietnamese and yet he became known as the 'Vietnamese pharmacist'. 15 years ago he started to work with a local surgery just round the corner who began to employ a Vietnamese GP one afternoon a week to serve the needs of a small but

significant local population. On Thursday afternoons the pharmacy was routinely full of Vietnamese, and now through word of mouth also Chinese customers. The nurse from the surgery would pop round during the afternoon with messages and information about particular customers and as Mr C explained his longstanding association was now such that the children and grandchildren of his original customers will still use his pharmacy.

> (...) and in the beginning you used to get these 7 & 8 year olds coming and translating for their mother and grandmothers, and they are now gone [from the area] (...) but still they remember where they used to initially come and there is a sense of loyalty. They know that when they couldn't speak they would come here and they were looked after, so when they are able to speak they still come here.
>
> **Observation pharmacist 3**

6.4 Isolated people and non-places

A Place according to Augé is 'a space where identities, relationships and a story can be made out, a non-place is a space where this is not possible'. The independent community pharmacy in fact has an element of both characteristics (Augé 2008: 63). For some customers the pharmacy is just another shop where one can experience contact *without* community (Pile and Thrift 2000: 7). At certain times in any of the pharmacies I visited it was quite possible to walk in to find silence, perhaps one or two people waiting, reading a newspaper perhaps or just staring into space and anonymous shoppers browsing the goods. Throughout the day in most pharmacies there is a continuous stream of customers who simply do not have an identity in the space beyond 'the man in the red shirt' or the 'lady with the shopping trolley'. Transactions can be anonymous and fleeting and customers are often clearly unknown to the pharmacy staff. These customers do not know each other or the pharmacist and there is no sense of ownership of the pharmacy space. They utilise the facilities efficiently and do not

interact more than necessary. If no prescription transaction is undertaken it is possible to be totally anonymous. This is unlike the situation in the clinic where everyone must be labelled and accounted for. For many people the pharmacy simply marks a collection point at the end of their medical journey not a place that they need to become a part of.

The pharmacist cannot allow him/herself to be completely defined therefore by the idea that somehow everyone in the pharmacy is connected within that space by anything other than their use of the services. Community can suggest exclusivity and a need for belonging but the pharmacy is also very much a place for outsiders and the isolated, a place for strangers and people 'passing through'. This sense of openness is required not least because as a place the pharmacy is also utilised disproportionately by marginalised groups such as the elderly, the chronic sick or street addicts reliant on methadone/needle replacement services. As a result even in local 'communities' the assemblage of people within the pharmacy space brings to the centre people who might be very much on the periphery of community life.

> Sometimes this very lonely guy comes in and he wants to speak to Mr K (the pharmacy owner), no one else. He has got this connection with Mr K, he has been seeing him for like 25 years and he knows him really well. You know they come round and they say whatever it is they have to say.
>
> **Pharmacist 15**

The pharmacy is required to serve people who have no connections either to each other, to the pharmacy or to the local area. These customers include those who are just visiting or working nearby or perhaps people who might be living in the area temporarily but who don't intend to stay. Like those travelling to use the pharmacy from 'co-ethnic social networks' they may be registered with GPs outside the area. Officially therefore, in terms of healthcare provision at a government policy level, these are people who may be considered to be part of other local communities. These 'others' play a significant role in the life of the pharmacy and

so cannot be dismissed although they may be often silent within the pharmacy space, and removed from community concerns.

Some high street pharmacies actually 'specialise' in a more itinerant trade of commuters or shoppers meeting the needs of an urban population who are used to being or perhaps actually desire to be anonymous, at least in this particular aspect of their lives.

> I mean most of our business is the shop floor really and people, people come off the street and just browsing in and out, it is a high footfall area.
>
> **Pharmacist 13**

> Around here well, there's a lot of local, but because of the walk-in clinic, so I've – I mean, there's a bit more new patients that come from all over the place, because of the walk-in
>
> **Pharmacist 18**

Big brand names like Boots, Superdrug or the large supermarkets come into their own when serving this kind of passing trade as the consistent promise of the brand name can provide a longer term relationship that does not rely on the personality of the pharmacist. The larger names give a sense of security and familiarity, especially for customers who did not regularly visit one particular pharmacy. Shoppers today are well used to placing their trust in large, national or even international brand names and so the 'familiar but distant' relationship on offer is something they feel comfortable with.

> Yeah, there is not really a relationship that much in Boots but some people will go to Boots because of that though you know. Some people will go to Boots because of the name, like it is Boots
>
> **Pharmacist 9**

These customers would be unlikely to recognise themselves as being part of a community with a shared sense of belonging and they do not get the benefits of the pharmacy as a

communal place. Pharmacists therefore have to become adept at managing transitional interactions with the same care and attention. There is a real need to embrace 'whoever might next walk through the door' without making any judgement about their 'belonging' because these 'others' define the pharmacy space as much as the recognised 'communities'. Hence as much as community pharmacy is a collective exercise it is also about brief interactions the production of individual relationships.

6.5 Summary

Rather than thinking of a singular 'pharmacy community' this research highlights the need to consider the different communities and individuals that use the pharmacy and the place the pharmacist occupies within these different relationships. The pharmacy does not create 'a community' but it is a place that can be used by different communities or networks which may overlap at different times as they use the pharmacy space and it can also be a place without community values for some transient users, a transactional non-place.

The idea and possibility of local community however remains a deeply felt aspect of pharmacy practice. 'Fitting in' is a significant part of building pharmacists personhoods and they use a rhetoric of acceptance in order to describe their relationship with, local communities. In doing so they acknowledge the importance of 'customer power' and this acknowledgement shows how pharmacist personhoods are not just contingent on a rhetorical framework 'from above' but also 'from below'.

Successfully being 'part' of any community requires knowledge, participation and a privileging of that particular community's needs. A high street multiple with national aims and objectives cannot privilege local needs while still upholding 'brand values' and so involvement in community life is something that the independent pharmacist can use to their advantage. Being able to practice identification with hyperdiverse urban communities appeared to be especially significant for these particular pharmacists in negotiating the complexity of the urban milieu. Expression of empathetic understanding through being part of a common group of 'others' in wider society, creates a sense of belonging and collective continuity that sets these pharmacists apart from peers, in particular white British pharmacists, who it was felt would be unable to create this close connection.

Pharmacists are also able to occupy alternative personhoods that allow them to be active in more widely dispersed co-ethnic social networks with a subtly different role in practice. Acting as brokers or patrons within these networks is an added dimension to the potential of practice for ethnic minority pharmacists. This role provides an opportunity that for some was unexpected but that perhaps helps these small businesses to survive in urban contexts where establishing a successful business seemingly should be very tough by extending the reach of the pharmacy beyond locally constructed boundaries.

Inherent in pharmacists discourse is a movement between a commitment to localness and quite specific ties to a particular situation as opposed associations with communities and individuals represented in pharmacy that aren't restricted by proximity (Massey 2005). This need to see beyond the community is also a defining feature of the malleable pharmacy space and of pharmacists' personhoods.

Chapter 7. 'The art of the individual'

To manage the requirements of all the individuals that use the pharmacy pharmacists articulate a need for what might be described as 'personalised pharmacy', rooted in the creation of relationships with individual customers.

Regular customers, who can be relied on to provide a steady trade, are the lifeblood of any small business and pharmacies are no exception. The long lasting personal relationship remains the 'holy grail' of independent pharmacy and this relationship is consistently presented as an 'ideal'. This does not mean that pharmacists need to form deep or lasting relationships with every customer; it does mean however that they must be adept at breaking down barriers and able to create a space where familiarity is possible for anyone. The 'art' of the individual as it was explained by one pharmacist forms the foundation for practice:

> Oh yes, you have to be different with everyone. You have individual customers. That is an art, that is, an art you know. Everyone can serve a customer but to serve according to that customer is an art, people are different. It is important, the way you speak to them, even body language, social forms, all of these things are really important, otherwise they are not happy. No, they are not happy at all.
>
> **Pharmacist 15**

In the light of the recent focus on the need for patient-centredness within the pharmacy pharmacists' assertions of success in this aspect of care take on a renewed significance. In investigating this theme discussion turns to how and why these particular independent pharmacists felt that they were able to deliver successful relationships. Especially pertinent in contrast to the dominant discourse is the importance pharmacists give to positioning

pharmacy users as customers as opposed to patients and highlighting the potential of customer choice. The notion of being able to develop good customer relationships becomes an integral part of professional personhoods and they present the independent pharmacist as 'the engaged pharmacist' as opposed to the 'distant pharmacist' of the multiples. Producing better relationships and providing personalised care become central tenets of the argument that pharmacists use to support the value of independent pharmacy, and key to resisting the competitive threat from the multiples.

The process of beginning to engage with customers on a one-to-one basis is articulated and performed by pharmacists through the trope of 'respect'. Respect brings together a number of core pharmacy values such as customer empowerment, social closeness, acceptance and restraint. In the inner city respect also encompasses urban values that require a concern for equal opportunity and a requirement to pay attention to and acknowledge the individual. In organising these ideas around a malleable rhetorical theme pharmacists are able to describe the nature of their relationships with customers through a 'way of being' or perhaps a 'philosophy of service' which can be then be passed on to staff.

This 'way of being' in the pharmacy also helps pharmacists to bridge the gaps between dealing with unfamiliar, anonymous customers through to building new relationships and to developing and sustaining close personal ties with a core of regular customers. The idea is expressed most clearly when pharmacists discuss the practicalities of dealing with difference, especially cross culturally. In this sense the their invocation of respect again mirrors an urban discourse in which the notion of 'respect' is quite consciously used as a tool in brokering interactions.

Respectful interactions have the potential to develop into close relationships. Critical to the success of long standing relationships is continuity of care. Trustful therapeutic relationships are described as the principal advantage of the independent pharmacy where intimate knowledge of customer needs enables the best possible pharmacy service.

7.1 Positioning the relationship: equality and respect

7.1.1 'Contempt for all'

Kleinman and Eisenberg remind us that patienthood is not a biological condition but a social state (1981: 12). In pharmacists' talk both the terms 'patient' and customer' are used to describe the people who use the pharmacy. Despite this apparently ambiguous use of terminology however, when asked to describe the process of *engaging* with their end users, it was the status of pharmacy clientele as customers that proved most significant in creating the platform for successful relationships. Customer (i.e. someone whose needs are required to be *served*) was the 'default position' for interactions as opposed to patient (i.e. someone whose needs are required to be *identified*). This default is mindful of the fact that other healthcare professionals 'patients' remain can remain 'customers' in the pharmacy in spite of receiving potentially complex therapeutic regimes from the pharmacist. This distinction is critical in providing the best possible personalised care through the conscious acknowledgement of customer power. It sits in opposition to the dominant rhetorical framework that consistently emphasises the need to provide patient centred care. As we will see in Chapter Eight, the user as a patient is a status that is activated within a limited number of particular advice seeking interactions.

Pharmacy customers are in a position of relative power through their ability to exercise control over which pharmacy they choose to use. This is heightened in the urban setting where other options are freely available with little additional effort for many customers. Pharmacists recognise and actively build on this empowered customer status. They frame the basis for one-to-one engagement in the pharmacy by locating the customer in a position of choice and the pharmacist as being dependent on that choice to maintain business:

> I mean, to me probably it's due to the competition, you know, and you want your customer to stick to you. It's unlike the Doctors, that's why.
>
> **Yeah, that's true, they don't have that.**
>
> (...) because it's not easy to change your Doctor, just, you know, but here they come and you don't treat them well then they have choices to make, you know.
>
> **Yeah, that's true.**
>
> They can go somewhere else (...). So this has made the Pharmacist, you know, I don't know, the way we are trained is really show everybody the same respect and you have time for them only, but I must admit when I used to work for a company I didn't care so much.
>
> **Pharmacist 19**

The exercise of customer choice was simply but powerfully demonstrated on a number of occasions by customers who had been kept waiting for prescriptions to be dispensed asking for the scripts back and taking them elsewhere.

This notion of choice is often expanded upon as a particular benefit of pharmacy through explanations of 'equal rights' within the pharmacy space whereby the power to choose is not, as it so often is in other situations, dependent on social status. As pharmacist 5 joked he had 'contempt for all, one rule for all!' The idea of 'equal value' is helped by the fact that pharmacists are reimbursed for prescriptions through their NHS contract. Even the most

economically challenged customers can represent considerable fiscal value in the pharmacy in a manner that they are unlikely to command under any other circumstances. As such socially marginal customers often represent some of the most commercially valuable long term relationships in the pharmacy.

> So whenever somebody comes into the pharmacy, no matter what their situation, they could be a recovering heroin addict or they could be the Lord of Worcestershire, I treat them in exactly the same way, as human beings, as someone I have got to provide a service to and I think that is the starting point.
>
> **Pharmacist 7**

The idea of equality is used to suggest a notion of equal possibility within the pharmacy. This sense of possibility is a platform on which to construct relationships rather than a concept which can explain how these relationships are created and maintained. It informs routine interactions, meeting initially on a superficial level 'on the surface of their selves' (Rapport and Overing 2007: 236). As one pharmacist put it, this 'equal value' is not based on a deeply philosophical premise but rather is rooted in a pragmatic need to treat everyone who walks in the door as a potential business opportunity; a 'service mentality' that speaks to the retail heritage of community pharmacy:

> If somebody came in now and wanted to speak to me then I would have to stop this interview and I would have to go and speak to them. Because it is business orientated, apart from obviously being a fantastically altruistic person it is business and you have to do it.
>
> **Pharmacist 5**

Difference and social inequality are notionally nullified by giving everyone the same status as a customer and as a customer anyone in the pharmacy is able to demand courtesy, service and an almost deferential nod to their concerns.

7.1.2 Practicing respect

Elaborating on the idea of 'equal status' in the pharmacy the pharmacists in this study utilise the trope of 'respect' to describe their approach to interactions in the pharmacy space. If 'equal status' describes the position of the pharmacy user on entering the pharmacy, 'respect' is used to describe a 'way of being' that characterises the nature of interactions in the pharmacy as a direct result of this equal status. Respectful acknowledgement, respectful acceptance of beliefs and reciprocated respect are all themes that emerge as part of this concept in the pharmacy. In short, respect is used as an all encompassing term to describe the type of personal and considerate service that customers can expect to receive.

The idea of respect is subtly different from an expression of care, or of responsibility for maintaining patient dignity as one might expect to uncover in the value sets of healthcare professionals. Nor is it based on deference of the customer/patient to a higher authority. As one pharmacist told me, for many of his customers it is easy for them to interpret an interventionist, paternalistic approach as being confrontational; as he put it 'sometimes people round here are not much good at just discussing things'. His opinion was that it is critical for customers not to feel backed into a corner; they need to 'emerge with pride intact'. Respect in the pharmacy therefore centres on paying a certain amount of attention to the demands of the customer and acceptance of (rather than a questioning of) their needs. In this sense 'respect' locates the pharmacy interaction in a space between privileging the medical authority of the healthcare profession and privileging the therapeutic agency of the customer. It allows the pharmacy to become a place where customers can negotiate and manage the therapeutic interaction in spite of power inequities between themselves and the pharmacist and a biomedical framing of the transaction as the pharmacy crosses the boundary between the professional and the lay worlds.

In their study of 'ideals' and dilemma's' in pharmacy practice Benson, Cribb et al. (2009) also identify respect as being important in the pharmacy however they align this 'value' with respect for medicines and a paternalistic attitude towards customer needs. While the pharmacists do display careful regard for medicines, in this study I found that the term was used rhetorically by them in a very different manner in positioning the customer-pharmacist relationship. Benson, Cribb et al. (2009) suggest that the paternalistic attitude led practitioners to struggle to recognise the value of 'patient choice' and found that only some pharmacists in their study exercised respect for customer choices in order to qualify a paternalistic approach. This may reflect the fact that over half of their sample included hospital pharmacists and pharmacists working in positions of administrative authority. Of the 18 community pharmacists in the study they had representation from a number of different types of pharmacy but the results do not draw any distinctions between them. In my particular study group of independent community pharmacists I found that, overwhelmingly, customer choice takes precedence and a 'respectful' approach was a common strategy discussed even by those pharmacists who had expressed the desire to create a more 'clinical' pharmacy persona. While inevitably this respectful approach might at times be put under pressure in practice, and may even break down, it at least served to provide a framework for managing customer relationships.

In elaborating on the idea of respect, pharmacists return to the practice of identification with the social status of customers. This identification (as discussed in Chapter Five at a community level) leads pharmacists to claim that they are close to the lifeworld of customers. This claim is based on the idea that a feeling of empathy and shared experience allows them to relate to their customers more completely, facilitating 'understanding' for their personal circumstances and rendering them 'more equal' than other healthcare professionals. Social

closeness somehow renders respect more real, more possible. The degree of truth in this idea of 'closeness' of course varies considerably. While the pharmacists might be comparatively closer to their customers in status than other professionals (in particular GPs), having been to university, holding a 'professional' position and having a good income means that they are still socially removed from the population they serve. As Burke suggests however it is precisely this difference that raises the need for identification:

> *Identification is affirmed with earnestness precisely because there is a division. Identification is compensatory to division. If men were not apart from each other there would be no need for the rhetorician to proclaim their unity.*
>
> *(Burke 1969: 22)*

Although it is impossible to undo the, real or perceived, consequences of education or wealth, this practice of identification is key to the possibilities pharmacists have in developing customer relationships.

> I think that the main thing is to be down to earth, I mean in my situation I think that, well, I am from a working class family, I am born and bred in London, I like to think of myself as very humble and I don't look down on anyone or look up to anyone in that kind of way (...). I mean obviously I went to university but I think that it tends to be quite common that in a lot of professions there is that air of arrogancy so they tend to find it hard to deal with people, they are not on their level and errm I think it is very, very important that you are able to relate to your customers where possible and give them due respect as your clients. Definitely.
>
> **Pharmacist 7**

One version of this 'respectful' philosophy was described by an older pharmacist who had run a successful pharmacy at the end of a crowded high street since for nearly 25 years. He felt strongly that as the lead pharmacist in any independent setting it was necessary to have a clear and consistent idea of how customers should be treated in the pharmacy. Without the framework of a big brand name to fall back on Mr S described how he had adopted a policy

which enabled him to create a successful platform for business. His understanding of 'respect' is based on a requirement to think of customers as family members, to treat them as brothers or sisters. In his conceptual appreciation 'respectful' interaction allows for a very close and personal relationship.

> My mother wished me well when she opened the doors of the pharmacy with a little advice and the advice she gave me was if I get anyone young coming in, think of them as my son or daughter, and when they are my age think of them as a brother or sister and anyone elderly coming in think of them as my mother or father and serve accordingly and give them the same respect that I would give my own and that has been my success story basically.
>
> I have done that, I have respected people in due form that way and over the years that constant reminder is always there. If you walk in and you are about my age I will take you as my sister and I will respect you likewise and make sure you are looked after as I would like my sister to be looked after in any other pharmacy. That has been the motto with all of us. And when I pick staff up I basically do always tell them the same, that that is very important.
>
> **Pharmacist 11**

7.1.3 Dealing with difference and exercising restraint

> People can feel threatened by change and difference, but everyone has the right as a human to respect
>
> **Pharmacist 16**

The idea of respect is particularly invoked when talking about and managing difference in the pharmacy. It is especially important in describing cross cultural differences which, as previously discussed, represent one of the most important challenges of the urban pharmacy environment. In order to create a bond between customers parallels are actively drawn with personal experience of crossing cultural divides to inform a shared experience of what it is like to be 'on the other side'.

I know because I came myself in this country. So I understand when you come, when you can't speak. I understand so I make a bridge with my knowledge of what is happening in this country...it can be scary you have to explain every step, you go to the GP, then you go to the hospital, it is not like at home, it is not the same.

Observation pharmacist 4

I think that's one of the main problems with people. People, they live a life, but they haven't got another life to compare it with, so they think that's it, that's the way it should be. But then if you have seen the other side of the coin and you see people coming in and I'm sure you do sympathise more and you understand problems people go through and you listen to them a bit more, yeah.

Pharmacist 31

The pharmacists and pharmacy staff that I met and observed in practice were largely very successful in producing a pragmatic and accessible way of being with customers. Their experience of the urban environment appeared to enable social competence and a fearlessness in approaching 'difference' that seemed to be a world away from 'culturally competent care' models which reify potential differences and place significant responsibility on the shoulders of customers/patients to be able to explain themselves and their understanding of the were a coherent, mutually understandable fashion. In certain pharmacies I visited, such as observation pharmacies 1, 4 and 7 for example, the vast majority of transactions would be cross cultural. Social differences were raised quite pragmatically and explicitly in the pharmacy in a way that I found quite surprising in some ways. This is perhaps difficult to appreciate from field notes alone but the example vignettes given here go some way towards illustrating the frankness of pharmacy life:

Example 1.

The pharmacist calls out 'Peter' and two men say yes, after the confusion is sorted out one of the men explains to the pharmacist that it says 'Pierre' on his prescription because he is from Mauritius but he answers to Peter:

Customer: We have lived with the French for hundreds of years, my

first name is French and my last name is Indian, we speak French too because we live with them, there are Indian, Chinese and Zulu Mauritians but the white ones are French. All the cultures are living together, it is happening now in England. In your country [Bangladesh] you don't live with other people.

Pharmacist: Not true! We lived with the British for 200 years! [Laughs]

Customer: Not really the same though is it' [laughs]

Pharmacist: Perhaps not. You are like the Somali people, they speak French and they also speak lots of other languages.

Observation pharmacy 5

Example 2.

Discussion in the pharmacy between some white British customers and the Pakistani pharmacist about the right thing to say to someone if a Christian has passed away:

Pharmacist: What is best do you think 'God have mercy on his soul?' 'God rest his soul'? There must be something you are supposed to say?

Customer: I think you can say both, probably the second one I'd prefer.

Observation Pharmacy 2

Example 3.

Pharmacist: Where are you from sir?

Customer: I'm Polish, from Poland. Do you find it difficult dealing with people like me?

Pharmacist: Not at, not at all. When we cut the flesh we are all the same colour

Observation pharmacy 7

On reflection however, rather than being confrontational or challenging I found that the pharmacists responded to customers openness and that interactions were comfortably negotiated. As such, what made them good at giving 'respect' was their confidence and assurance in handling different situations and their ability to listen and ask questions. In

asking questions pharmacists were not afraid to display a lack of knowledge which goes against the grain of a traditional medical model where confidence and knowledge are the property of the physician and critical to maintaining authority. Crucially in the performance of respect open questioning ensures that exchanges do not feel patronising, maintaining the balance of power between customer and pharmacist. As Napier suggests in discussing the ability of rural GPs to deal with difference; 'those who are 'good' at dealing with difference do not know what they do not know...but can recognise a 'known unknown'*. As the norm rather than the exception in daily practice the pharmacists' assuredness in dealing with these interactions creates a positive, affirmative atmosphere. In my conversations with pharmacists I initially found myself trying to read much more into the idea of respect and confidence; falling into the trap of trying to create a set of rules governing respectful behaviour. In fact *not* creating rules seemed to be the most important lesson that could be learned and pharmacists continually brought me back to a much more straightforward interpretation based on simple approachability and listening. As pharmacist 7 explained, just a smile can be enough:

> **Yeah, yeah, it is because health is such a difficult thing, you look for that extra level of security or something?**
>
> Yeah, I think it is that confidence. But I think it depends on the approach of the pharmacist and the staff as well. I mean it could be like the most basic thing, like a smile, I mean a smile breaks down like a million barriers and that sort of shows someone that may have sort of a delicate subject that they want to talk about that maybe, they may be approachable so maybe it might be just something like that. And a smile you know it performs across all races. So it just depends about that approachability, sort of tone of voice, body language, facial expressions that sort of make people feel comfortable, feel at home as much as possible.
>
> **Pharmacist 7**

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* Quote taken from a lecture given by David A. Napier, 5th March 2010: 'Can cultural competency be taught? Or, is a little knowledge a dangerous thing? In UCL Medical Anthropology Lecture Series held at University College London

Sennett (2003: 207) notes that 'Respect is an expressive performance. That is, treating others with respect doesn't just happen, even with the best will in the world; to convey respect means finding the words and gestures which make it felt and convincing'. The smile or simple physical acknowledgement enables the pharmacist to make respect felt even if they do not know the customer's name. This special physical recognition can be deployed strategically. Pharmacists are very rarely out of earshot of what is going on in the pharmacy but they are seldom actually at the counter and so cannot possibly meet every customer. They may shout a greeting or other acknowledgement from the dispensary but otherwise they are often a silent presence in the pharmacy transaction. When they do make the effort to come and speak to a customer therefore it represents a special acknowledgement.

Respect is also used rhetorically by the pharmacists to place boundaries on their role in these cross cultural interactions, for example in explaining the limits of their involvement with customers' personally held health beliefs. Dealing with hyperdiversity also means dealing with a huge spectrum of different ideas about health and wellbeing which may well lie outside Western biomedical ideals. In a manner that might be considered to be at odds with the production of a 'clinical pharmacist' they place restrictions on their capacity to persuade customers into a biomedical understanding; stressing acceptance and regard rather than a need to 'change someone's way of thinking'. It is suggested that the pharmacy is a place where different beliefs are accommodated as compared to the GP surgery where beliefs would be contested. 'We are not meant for those kind of things' said pharmacist 31.

(...) you have to be very careful as well when you respond to the different things because, well, while you're here to try to help the person, but I don't think it will be a good idea to try to change someone's way of thinking. Well, you could somewhere else, but not in a Pharmacy setting. We're not meant for those kind of things...it's about working with them and not trying to change them. Yeah, we do respect everybody's feelings or everybody's beliefs and we can only work within those guidelines.

Pharmacist 31

Under these circumstances pharmacists display particular respect for self diagnosis and treatment. Pharmacist 14 describes a 'respectfully passive' position that removes his responsibility in dealing with non-biomedical medicines and for customer beliefs that fall outside the system.

> Yeah, you have to respect what other people do for their own health care, you know there is quite a big Vietnamese/Chinese community around here and they often use you know, Chinese medicines for various ailments. I have no problems with them, my only problem with it is that I don't understand it so I can only advise them on what I understand so that is what I do. They sometimes ask me to say, is this stuff any good and I have to say sorry I don't know. I can only advise on what I know and that is what I do.
>
> **Pharmacist 14**

At times, this respectful restraint feels like a somewhat detached approach, especially when contrasted with the brokering role described earlier in 'culturally similar' exchanges. A more involved representation of this respectful position however is one in which the pharmacist is responding to different ways of thinking and work with customers in developing a therapeutic understanding.

Mr C in observation pharmacy 3 (who it should be noted was a particularly strong rejecter of the 'clinical pharmacist' model) described to me how he tried to take on a more 'respectfully active' role following a discussion with a customer whose father was suffering from Bells

Palsy. The customer had asked for his advice regarding combining recommendations from an ayurvedic practitioner along with biomedical treatment. After the consultation Mr C explained how he tried to understand what people felt was wrong with them and how they felt any alternative remedies might help them, as he put it 'trying to find the truth in the tale'. His approach, although not informed by any formal structure, quite naturally fitted with the type of questioning suggested by Kleinman in eliciting a patient's explanatory model for their disease (1980). He then would explain to the customer why he might recommend a particular biomedical therapy or why he felt their GP had recommended a particular treatment and discuss how this might fit within the way his customer viewed the world. Explanations were offered rather than imposed and customers were free to reject those explanations. In this sense he went part of the way to persuading customers into a biomedical perspective but did so in a very restrained, fashion that placed biomedical solutions within or alongside the explanatory model of the customer rather than requiring customers to accept a biomedical way of viewing therapy.

7.1.4 Mutual respect and lack of respect

Respectful interaction as Bauman explains is a mutual process dependent on giving and receiving by both parties in order to establish 'a relationship of mutual honour ' (1996: 104). Successful relationships therefore require acknowledgement of the pharmacist's knowledge in spite of the ability of customers to wield the power to choose.

In general pharmacists were positive about the level of respect they felt able to command from customers. This idea of respect on an individual level for the pharmacist sits in stark contrast to the pharmacists' concern over a lack of respect for the profession in general. It is

another example of how pharmacists play with the ambiguities of their professional status and are able to pick and choose elements of narratives depending on situation.

> Yeah, I mean people do respect their pharmacist. Which sometimes I find that hard to believe. I mean I speak to my missus and she is like, yeah, we do respect our pharmacists. I think maybe because I am in it now I think well maybe it is not a big deal but I think the general perception of the public is that they do respect their pharmacist. I find it hard to get into my head because I am just a normal bod but they do.
>
> **Pharmacist 7**

> Yes they do. Most of them, they have equal respect for the pharmacist as much as they do for the doctors, they know that we can help them to the same level that doctors do and they come to us for advice definitely.
>
> **Pharmacist 12**

As a mutual process, a respectful relationship does not just have boundaries in terms of the pharmacists' behaviour but also in terms of what type of interaction it is and is not acceptable for customers to involve them in and the limits of demands that they make within the pharmacy. Pharmacists 1 and 25 for example described some of the most common incidences in the pharmacy that they felt lead to a break down in respect. A perceived lack of respect leads to a lack of trust on both sides and when respect in the pharmacy is lost customers are labelled as 'problematic' and 'challenging' (Good et al. 2002).

> (...) sometimes if what you say to them isn't to their liking then, they, yeah. It's not always, yeah, it's not always a good relationship, but, I mean, I try my best. If they understand there's a limit to what I can do then that's fine. Sometimes (...), people come and they try to exceed the limit then, I mean, I can only do what I can do
>
> **Pharmacist 1**

> (...) I mean, they demand in such a way they're arrogant, in an arrogant way, you know.
>
> **Yeah, yeah, rather than respectful?**
>
> So, that's what happened and other things. I'm expected to open all day for them. Yeah [laughter from the assistants and myself]. All day, every day.

Yeah.

Yeah, from nine to 12 o'clock [laughter]. And when you tell them you're shut and, "No, no, I want to take my medication quickly," you know.

Pharmacist 25

While on the whole, as discussed pharmacists were adept at managing cross cultural interactions they also recognised, and I witnessed during my observation work, that in spite of this ability interactions where communication across cultural boundaries floundered were the most common cause of a 'loss of respect' in the pharmacy. This failure to communicate was common to pharmacists from all ethnic backgrounds and seemingly irrespective of experience.

In interviews when referencing these difficulties in practicing within a hyperdiverse setting pharmacists from all backgrounds resorted to stereotyping of particular ethnic groups, putting customers into 'cultural boxes'. These stereotypes were often presented to me un-problematically as 'typical profiles' and were used to frame behaviour that pharmacists find hard to manage. For example, pharmacist 8, himself of 'Asian' descent explained:

For example you are dealing with the Asian community, regardless of what you tell them, they don't listen to anything that I say to them. Especially the diabetics, they don't want their treatment anyway.

Why is that?

Because they don't accept that they are ill. I have an Indian customer and her granddaughter was born type 1 diabetic and I mean she needs insulin and she was blaming the daughter in law.

Mmm, mmm

Yes, I mean that is how they perceive illnesses, it is because of the daughter in law (...) and that is how they are. And quite a few, especially of the Pakistani population, they inter marry their own cousins and things and so

> consequently they have quite a few deformities and things. (...) There are lots of things. You get the West Indian population or the Nigerian population and they have very high blood pressure because they eat a salty fish diet and things like that, blood pressure leading to diabetes, heart problems.
>
> **Pharmacist 8**

The reasons why communication failed seemed to be particular to each case and as much contingent on customer as well as pharmacist behaviour, apart from what appeared to be a correlation with a busy shop which put pressure on the time available to talk. I witnessed a number of such incidents which show that pharmacists are not perfect communicators and that being 'ethnic' and 'other' is not always sufficient to create understanding. Failure to communicate resulted in exasperation on the part of both parties. For example in Observation Pharmacy 6 (although this pharmacy should not be singled out as being especially different to any other I visited) a Turkish woman with very little English language ability came to the pharmacy to fill a prescription. Unfortunately the product she had been prescribed was not in stock. There followed a very difficult discussion trying to explain this to her, both the pharmacist and the assistant (neither of whom spoke Turkish) tried to convince her to take a note back to her GP requesting that the prescription was changed. The pharmacist and the customer became increasingly frustrated and the 'respectful questioning' strategy of the pharmacist became paternalistic and patronising. In the end the customer stormed out of the shop, probably with very little understanding of what had happened or what she should do next and before the pharmacist could call her GP and try to explain the situation to him.

7.2 Building relationships from respectful interactions

7.2.1 Familiar faces

Continuity of staff is located as being the thing that enables pharmacists to move from respectful interactions to close, personal relationships. It is contrasted with a lack of familiarity which is potentially 'intimidating', especially for customers who find communication difficult. The multiples often have regular locums, staff rotation policies and pharmacists will choose to move from store to store in order to progress careers. As a result they are positioned as being unable to sustain close relationships because they don't have the consistency of staff to become truly involved with customers.

> The thing about Boots and SuperDrug (...) they do fall back on the fact that they are using regular locums, you don't get a familiar face, you can't always get the language spoken that you require and going to some of these places like Boots and stuff. Again, if you are not familiar then they intimidate people so they avoid them.
>
> **Pharmacist 10**

Continuity therefore becomes something that independents can excel at. It is a clear differentiating factor that independent pharmacists use in comparison to the 'transient' nature of pharmacists in the multiples. This continuity, coupled with their ability to leave the dispensary and talk to customers allows pharmacists to 'become human' and engage with customers over a period of time. It should be noted that this reported and observed ability sits in contrast to findings of Cooper et al. (2009) who found that pharmacists were isolated from customers. The pharmacists felt that this was as a direct result of having autonomy over their time and being able to control the type of relationships they wished to build, again in direct contrast to their experiences in the multiples:

> If you're hiding behind that counter that's no good. I've done it in Asda and Tesco, and you hide behind the counter and you don't know people. They just come and take it like a machine; you are a robot. Here you are human.
>
> **Pharmacist 16**

As a way of proving or confirming this notion of longstanding relationships, names take on a totemic status within the independent pharmacy. Knowing customers' names, and putting names to faces, is the foundation for relationship building. This seemingly small detail becomes the starting point for developing a closer connection and establishing a conversation. It also allows the pharmacist to control the pharmacy space and lets customers know they have been seen.

> He is a really good pharmacist. He always knows every single name
>
> **Observation pharmacy 1: Customer**

It is not just about knowing customers names however, it is also important that the pharmacist himself is known by name creating a direct personal connection. Pharmacist 24 re-iterates the point that the pharmacist becomes the pharmacy 'brand' for independents. The major selling point and the personality of the pharmacy. For the multiples however the brand name itself is the primary focus for 'close' and lasting relationships and the defining factor in terms of pharmacy culture.

> In an independent they will say 'Benjamin gave it to me' not 'I got this from Boots'. They will mention you by name, they will not mention somebody from Boots, they won't use the pharmacist's name. It is a different thing altogether.'
>
> **Pharmacist 24**

The 4 pharmacists I met in observation pharmacies 1, 3, 4 and 7 that had been established for some time were all known to various customers on first name terms whereas as discussed the other three were beginning to establish relationships, in particular Mr B who was clearly

beginning to become quite well known and well liked by his customers. This closeness was part of the performance of practice in the pharmacy creating the sense of an intimate, informal environment. For example, on one particular day in Observation pharmacy 1 a series of encounters were introduced as follows:

Pharmacist: Good Morning. Lovely Jean, how are you? And how is my friend Fred? (asking after husband).

Customer: Wazzup Uncle A (addressing the pharmacist)
Pharmacist: Hello Boss, how are you today?

Pharmacist: Hello, how are you Mrs Jones?
Customer: Oh Mr A, it is good to see you

Observation pharmacy 1

This familiarity is meaningful on an individual as well as a collective basis. As one pharmacist put it, just seeing the same person whenever you come into the shop means that people feel more confident in asking questions when they need to.

Some people won't come in on a day I am not here. I usually take Friday's off and Saturdays and some patients will not come in unless they see me because they feel I know their history, I know them. Some people will come in and only see the locum because they normally come in on a Friday because they are used to him and they feel that he knows them a bit more, he knows their medicines and bit more and he knows their condition.

Observation pharmacist 1

I have got people who come in here and you know, I did the pregnancy test on their mum before they were born you know, so, I have seen it all going on you know! It is relationships really you know, people get to know you, they get comfortable with you, they trust you, that is it, you are here for a time you know, I have been here for over 20 years so that is quite well a constant, they see you as a constant figure there.

Observation pharmacist 7

7.2.2 Becoming friends and family: 'It's Mr C or nothing...'

Close relationships are possible in the pharmacy space and I observed many examples of close, very personal interactions between pharmacists and customers. In observation pharmacy 2 for example one morning an elderly lady came into the shop. Mr B saw her immediately and I was surprised to see him leave the dispensary and greet her on the shop floor. She had with her a bag of medicines. Mr B said hello very quietly and gently touched her arm. She said that she'd come to the pharmacy to give him back the medicines her husband had not used and especially to thank him for all his help. Mr B nodded and said 'we are always here for you, you know that' and then walked with her to the door. I learnt afterwards that her husband had died only a few days ago and that she had spent a long time in the pharmacy talking to Mr B about what was happening during his illness. This touching but brief encounter demonstrated the potentially intimate nature of pharmacy relationships and how involved pharmacists can become in people's lives.

This intimacy built up over time leads to a feeling of trust between customer and pharmacist which strengthens the relationship and opens possibilities for the pharmacist in terms of providing a service that no other establishment will be able to match.

> Because, well I don't know if it is trust or not trust but people might think, 'you are not my doctor so why should I give you that information', but I say build up the rapport, the communication is probably all there, build on your friendship with the customers and their confidence in you so when you say things they will listen. It takes time to build that relationship but once you do the confidence is there and it is easier for you to do anything you want because they know you, you have the knowledge and they know you are there as a health professional, as part of the team so they trust you, they come back for anything they want.
>
> **Pharmacist 24**

Trustful, relationships are especially important for potentially very isolated customers. For example, a number of the pharmacists I visited had built up particular relationships with customers on needle exchange or methadone replacement programmes. The pharmacists felt these relationships were especially valuable simply for providing these particular customers with a sense of being seen and being valued in a world which all too often affords very little appreciation or acceptance. During my interview with Pharmacist 28 'William' a methadone user registered at the pharmacy phoned to say that he was 'back from holiday' (i.e. he had just finished a prison sentence). On resuming our interview the pharmacist explained that William was an 'unstable character' with significant health problems. The pharmacist explained to me that he felt he has a responsibility to maintain continuity for him. He felt that he could chat and joke with him and that William was able to tell him things he was unable to tell anyone else. For William, the pharmacist felt that he represented an 'island of normality in an otherwise chaotic life'.

Other 'difficult' customers discussed were teenage boys, especially on some of the estate based pharmacies. Familiarity and therefore a sense of understanding of their circumstances certainly seemed to help what might be otherwise difficult relationships.

> (...) just before you came in we had a number of kids in, well they are really young men now but we have known them since they were children but if they go to any other shop they would have been worried about them because they have a reputation but again because we have known them for such a long time we just say you know 'make sure you don't touch anything', 'we are watching you', we joke with them and they joke back, one of them had a knife I said 'just be careful what you put in your pocket, you don't want to cut anything off' so he said 'no, no, no I am not trying to rob you' and I said 'no of course not, you are ok, it's alright'
>
> **Pharmacist 21**

In Observation pharmacy 7 Mr G, had built up a significant level of trust with this hard to reach group. Throughout my time in his pharmacy I saw more teenage boys in the pharmacy space that I saw in total in all six of the other pharmacies I visited. 'Big G' as he was known had built up a great rapport with these young people who seemed to turn to him for advice and support even in non health related issues. For example I noted that he had written a reference for one boy and had helped another understand forms he needed to fill in order to find a work placement.

The dual commercial and personal benefit for the pharmacists in creating these longstanding relationships is loyalty. Pharmacists were keen to demonstrate loyalty to me and regular customers were 'shown off' and encouraged to talk to me about my work. There was a feeling that this kind of close relationship with a specific practitioner was becoming rare in today's NHS but that such continuity was valued by customers. Without exception, all of the pharmacists represented in this study felt that the ability to form longstanding relationships was a reason why people would keep coming back to their pharmacies rather than go elsewhere. Ultimately, the sense of intimacy can change the nature of relationships, and a business sense develops into something deeper and with greater significance for both parties. Seven of the pharmacists use the words 'friend' or 'family' to describe their relationship with regular customers:

Assistant: If I go on holidays they will say, "Where is Mary? Where is Mary?" If she [the assistant] goes on holidays, "Where is Di? Where is Di?" Because they do ask, they do miss you. Yeah.

Pharmacist: They have a close relationship, it's like a family, you know.

Pharmacist 25

Here we don't call them our patients, we call them our friends anyway, but the big groups patients just walk in and they don't go there again so you don't establish that friendship, as compared to the independent which you establish it,

Pharmacist 24

'It's Mr C or nothing. He has been my friend for 20 years'

Observation pharmacy 3: Customer

7.3 Summary

The relationship between pharmacy users and pharmacists is reliant on the relatively empowered status of the customer (rather than the patient) in the pharmacy and this relationship construct is in danger of being overlooked with a renewed focus on 'patient centred care'. In the pharmacy the asymmetry of biomedical knowledge does not necessarily translate directly into an asymmetry of power as has been documented in encounters within the clinic (Pilnick 1998). Through the exercise of choice and the recognition of customer knowledge a 'more equal' interaction is constituted by both parties.

This in turn leads to a 'way of being' in the pharmacy expressed using the trope of respect which is especially valuable in negotiating difference. Giving respect to customers requires being responsive, courteous and recognising customer beliefs. In turn pharmacists can expect customers to afford them status and to adhere to certain standards of behaviour within the pharmacy. Respectful relationships can become intimate relationships over time based on familiarity.

Sustaining relationships is also something that the pharmacists take great pride in and during the interview process what is not revealed perhaps by examining the text alone is the passion and conviction with which they talk about this subject. Even the most cynical of the pharmacists I spoke to, including one who had just taken the decision to leave the profession, who was in the process of turning his pharmacy into a hotel still emphasised the importance of personal connections in practice. In fact his reason for leaving the profession was tied directly to the fact that he no longer felt able to put the effort required into building the quality relationships that he felt were necessary for successful independent practice (although he intended to continue doing locum pharmacy work). The pharmacists work consciously at the construction of relationships and in the absence of any real connection to the medicines that they dispense relationships are in many ways the real 'craft' of independent pharmacy.

Of course it is impossible to have a close relationship with every single customer however the independent pharmacy as a space for trustful, close relationships seemed to be a 'story' bought into both by pharmacists and by customers alike and in that sense served both parties in shaping the narrative of the independent pharmacy. Although the depth of relationship was in some cases superficial it was the *idea* that a relationship had the potential to develop if and when it was *needed* that was important. 'Relationships' are used in narratives to provide both the emotional leverage and the moral closure that is sought in storytelling. In other words they provide both the substance for rhetoric and the resolution of rhetorical tales that seek to justify independent pharmacists place in the world (Fernandez 2009: 157).

Chapter 8. Time: perception and 'reality'

> You hear everything about their lives and because our pace of work and nature of work is different [to the multiples], we can help in different ways
>
> **Pharmacist 28**

As we have seen, being 'good' at building relationships was a key feature of pharmacy personhoods. Being able to develop these successful relationships relies practically on the amount and quality of time that pharmacists feel able to devote to their customers. As a consequence of this time as a resource becomes a preoccupation in the pharmacy. Throughout my research both in interviews and in day to day talk, either in terms of abundance or constraint, time was a consistent theme. It was also the vehicle through which pharmacists discuss a wide range of different pharmacy values.

While pharmacy time is un-regulated and unrestricted, in the eyes of pharmacists it is one of the most important 'commodities' that separates pharmacy from general practice and independents from multiples. The idea of having more time, or perhaps more importantly more quality time, is of huge perceptual value although it is not something that is measured in monetary terms within the pharmacy space. It is not just the quantity of time that is at stake in building relationships, ease of access i.e. immediately available time, is an especially important feature of the pharmacy environment.

Paradoxically however the use of time is contested. A lack of time was also a particular feature of pharmacists' talk and 'being accessible' is related to interrupted time which distracts from a professional and efficient practice. Time is also perceived to be under threat from new contract services which call for regulated time; drawing the pharmacist away from

the dispensary/counter. Meanwhile, time is also the most noticeable stressor for customers. During my observation work waiting for prescriptions to be dispensed was the most significant trigger for tension within the pharmacy and the most frequent openly discussed concern amongst customers in the pharmacy space.

8.1 Tempo

> *In a world where time cannot be measured, there are no clocks, no calendars, no definite appointments. Events are triggered by other events not by time.*
>
> *(Lightman 1994: 126)*

Key to shaping the tempo of the pharmacy is physical accessibility. Without any appointment system and no 'reception' to field enquiries the pharmacy is an unusually open healthcare environment in this country. Pharmacists contrast their 'freely available' access with the idea of restricted access to the GP. Many noted that their customers seem to be finding it increasingly difficult to get appointments to see their GP and so this idea of convenience is highlighted even further:

> You don't need appointments, it is very easy. I mean even if I go and see my doctor I have to talk to the receptionist who is always very officious so that is a barrier and the receptionist is looking at you in a 'why are you wasting the doctors time' and when you are in there you feel pressure. But like when you are talking to me now, we can sit here already for half an hour and nothing has happened, it is ok. It is much more relaxed.
>
> **Pharmacist 8**

> Yeah, we are more available, you know, a person can just walk straight in off the street and ask, 'can I talk to a pharmacist?' You know, you can't do that at a GP surgery. You have to wait a couple of days or longer, so yeah we are definitely much more available. Obviously we are not as qualified as a doctor would be and we are limited to what sort of things we can advise on but often that is enough for the patients.
>
> **Pharmacist 14**

Nothing demonstrates this accessibility better than my research methodology. I was able to walk in to any pharmacy, at any given time and request to speak to the pharmacist. On the telephone I could be put off by assistants and told that the pharmacist was too busy to speak to me but in store, as a potential customer my concerns had to be given priority. In every case my initial request was able to be fulfilled if not immediately then certainly within ten minutes or so.

This kind of immediate physical accessibility was felt to be of particular value for the urban populations these pharmacies serve. Pharmacists discussed how their customers often struggled to plan their time in the way that much of the rest of the healthcare system demands. They cited the 'tyranny' of booking appointments significantly in advance, organising repeat prescriptions etc. As such the immediacy of availability of the pharmacist is especially valuable as a 'safety net', helping people to manage healthcare needs and respond to concerns as they arise.

> People being the sort of background they come from they don't really plan themselves (...) they are not that organised, they just do things as things happen.
>
> **Observation Pharmacist 6**

Different perspectives of time were also linked to the hyperdiverse nature of the urban population. The pharmacists explained that they had to manage culturally diverse expectations of how time should be used and take into account subtle cultural differences regarding waiting, prioritising and scheduling and more obvious differences such as holidays and holy days. Being 'convenient' allows the pharmacy to fit with different expectations of time and gives customers flexibility in how they make use of pharmacy services.

In many ways this physical accessibility actually equates to emotional accessibility. Not only can a customer walk into the shop at any time in most independent pharmacies they can also actually see the pharmacist at work. Availability without fuss and without barriers means people feel more able to talk and 'ask little questions'. This is often compared with the relative exclusivity of the GP in general practice which potentially provides not just a physical but also an emotional barrier to customers:

> A lot of people come to us because the GP is not going to listen, they are not going to get an appointment in time or that it is just a waste of their time anyway.
>
> **Pharmacist 2**

> And also you see, we are in the community, we are not in an enclosed place like a doctor, we see everything that is happening here, we see everything, from baby food, whatever they want, they come in here to buy it and they speak to us.
>
> **Pharmacist 5**

The pharmacist in the multiple meanwhile is positioned as being 'hidden away' in the dispensary. This physical distance and the requirement to call them out onto the shop floor to get an answer to a question renders them emotionally less accessible much like the GP.

> Pharmacist: But in the big store they just put your prescription…
>
> **Interviewer: In and out.**
>
> Pharmacist: In and out, in and out, you know.
>
> Assistant: Or sometimes [customers are] frightened to ask a question that they think – probably they're so busy at the back.
>
> **Pharmacist 25**

For the pharmacists the reality of this openness can have disadvantages. As hinted at in the quote from pharmacist 14 at the opening of this section, accessibility was potentially seen to devalue the pharmacist's advice, the ability to answer trivial questions almost by default meaning they are seen as less capable of answering complex problems.

The pharmacy 'routine' is also defined by unpredictability. Pharmacists become adept at managing their time by teaching customers what is expected of them – a tactical use of greeting from a quick 'Hello' to a more expansive 'hello, how are you?' either closes down or opens up the space to talk. Nevertheless, the pharmacy day is constantly interrupted and customers place demands on the pharmacists' time. Although assistants do act to officiate the use of the pharmacist's time if customers can see the pharmacist they expect them to respond immediately. Handing control of time to the customer rather than placing it in the hands of an administrator such as the receptionist in the GP surgery gives control of the pharmacy interaction (and therefore some power) within that interaction to the customer.

> **Your pharmacy is really open here, is that a conscious decision?**
>
> Yeah, we have always been open to be honest, although sometimes it does have drawbacks because people will just come in and start talking to you because they can see you, even though you might be doing something. They don't realise that you may be checking something or using the computer so there are drawbacks but it makes it feel more open, more user friendly and less clinical.
>
> **Observation Pharmacy 6**

> (...) as soon as they walk in they can see me. Sometimes it is not a great thing because I can't hide away and sometimes you think oh no, I don't want to speak to them and you just want to crawl into a corner but for them it is like, ah, there is the pharmacist and they make like a beeline and they just go straight down and they can just come and have a chat. As soon as they come in I am like, don't make eye contact because as soon as you make eye contact it is like, that's it. But you know, the way it is quite good because you know, they feel like they can just come in and have a chat.
>
> **Pharmacist 13**

Observation pharmacist 3 amongst others discussed with me in detail the problems he faces in managing a lack of continuous time to be able to concentrate on something. He was very keen that this reality of pharmacy was reported back as in his mind the level of stress caused by a lack of continuous time was under-reported.

> Our job is to dispense the drugs and dispense accurately, this is the thing, because when you do so many things you can't do (...), efficiently, hmm hmm, you know, like say, for example, you get the Pharmacist working at the back there, and if the Pharmacist gets interrupted, so his concentration is sometimes compromised, hmmm, so it's so easy to make a mistake if there's someone talking to you while you are doing a prescription, and typing a label, and someone interrupts you, and then – the phone rings, and so much interruption, so it's so easy to make a mistake
>
> **Pharmacist 20**

As a direct result of this accessibility, once the shop opens for business the tempo in the pharmacy is reliant very much on the flow of customers and the world outside the pharmacy door. During the pharmacy day there are periods of quiet and then a flurry of activity. Different people use the space at different times, the workers, the mum's the old people, the people on their lunch breaks, people straight from the GP surgery. The course of the day follows periods of intense activity and then relative quiet, linked to events in the 'outside world' such as opening and closing of nearby schools and workplaces.

Time in the pharmacy therefore runs, by in large, on what Levine (2006: 81) describes as 'event time' rather than 'clock time', in other words the pharmacy is a place where events are triggered by other events rather than by the clock. In fact, the clock is almost absent except to define the limits of opening and closing. Time is fluid between these points. Instead of a symbolically metered out ten minutes in the GP surgery, pharmacy 'routine' tends to be focussed on much larger chunks of the day. Appointments are usually made for 'the morning' or 'the afternoon'.

My methodology demonstrated (and was determined by) the nature of 'event time' as I found that attempting to impose 'clock time' and making appointments in the pharmacy was frustrating, if not impossible. On one particular, quite typical day, I arrived for an interview arranged for 10:00. After a delivery had been made, several customers had been dealt with and a call from the GP time had ticked away and it was nearly 11:00. The pharmacist

suggested that perhaps I should go and get a coffee and come back in half an hour to give him a chance to get some prescriptions ready for collection at lunch time. I duly returned to find five or six customers waiting to be served. 'Come back at 12:00' said the pharmacist. After another coffee I went back to the pharmacy, one of the assistants was just about to go on her break and the pharmacist looked particularly stressed. 'Shall I come back at 14:00' I offered? The interview was finally finished, after a few more interruptions at about 16:30. Another attempt I witnessed to control activity by 'clock time' in the pharmacy was also very unsuccessful. Mr G in Observation pharmacy 7 tried to control the time when the minor ailments service* he provided could be used by customers in order to reduce paperwork. He designated two hours a day over lunch for people to use the service; however it was poorly communicated and did not fit in with local requirements. As a result he was constantly either turning people away to other pharmacies or breaking the rules in order to help people out.

Hall described the rules of social time as a 'silent language' (1959). The culture and conventions in every independent pharmacy are particular and each pharmacy has its own 'unique temporal footprint'(Levine 2006: xvii). A customer going from one to another finds himself in an alien environment and needs to become acquainted with how things are done. This was especially important with the informal rules of the pharmacy with regard to waiting. In spite of being 'convenient and accessible' the unregulated nature of time means that the pharmacist can have both more time and less time at unpredictable points in the day. Inevitably in busy pharmacies customers sometimes have to wait for attention. Waiting can be a communicative and social process or (quite commonly) fraught and frustrating as it directly contradicts a key benefit that customers expect from the pharmacy. I observed many incidents where tensions rose enough for customers to make direct complaints to the

* An NHS contracted service for people who don't pay for prescription charges. If the pharmacist agrees that it is necessary, they can provide registered customers with an over the counter or general sale medicine free of charge

pharmacist or where they would talk loudly amongst themselves about how poor the service was. As tempers become frayed other tensions come to the surface that speak to wider issues both within the pharmacy and in the wider community. For example in one incident there was a suggestion that the Bangladeshi pharmacy assistants were preferentially serving Bangladeshi customers and 'showing favouritism', keeping other customers waiting.

For customers, waiting can become a defining feature of the pharmacy experience and notwithstanding the supposed 'time advantage' of the independent waiting was the most common flashpoint in the pharmacy. This kind of antagonism causes considerable stress for the pharmacists who are aware when customers are becoming frustrated.

> It was difficult as first to be honest, even now it is. Customers are not happy sometimes, the pressure is often if we are under staffed, you know sometimes we don't have enough people. It is really difficult sometimes because you have to talk, talking is essential, part of the job so...you get used to it after a while, the main thing is you know, you are there to help them out really isn't it, that is the main thing.
>
> **Pharmacist 15**

8.2 Duration: Having time and giving advice

Pharmacist: But we've always got time for the patients.

Assistant:: Yeah, we make time, don't we?

Pharmacist 25

As well as being unregulated, time in the pharmacy is in theory unbounded. This ability to, theoretically, spend as much time with customers as they want or need is also a major part of pharmacists' presentation of their value. This unbounded nature of time is compared again, inevitably, with restricted interactions in the GP surgery but also with multiples where it is

felt that pharmacists are not able to take enough control over their own time and so therefore are unable to choose to when spend more time with customers.

> I think the reason we guys tend to do well as independent pharmacists is because it is one to one service basically (...). My staff will spend ten to fifteen minutes with a customer if they want to talk to them. You just don't get that in Boots. You can't do it.
>
> **Pharmacist 8**

> (...) sometimes the Doctors are busy, you know, say, for example, our local surgery and they say, 'Okay, you've got five minutes' and some of the Doctors they put a clock there on a table, and five minutes, 'That's five minutes, you know, finish this' and they say, 'Okay. Thank you, bye, bye. Next.' and so they [customers] feel, sort of, they have not been properly seen.
>
> **Pharmacist 20**

This expansive use of time however actually occurs much less often than might be supposed from pharmacists' talk. In reality, time is very precious in the pharmacy and is 'dispensed' with care. Even the 'regulars' rarely spent more than ten minutes actually in the shop and so the family histories and stories discussed in previous chapters as being so important were elaborated upon relatively slowly. Building up a rapport is a slow process and a picture of the people using the shops was usually compiled in a piecemeal fashion. This explains why in practice continuity of staff becomes so vital in providing a personal service. Even for the best known customers, the pharmacist sees fragments of a whole story, snap shots of lives. They are involved for a brief moment and then abandoned; there are no notes, no follow-ups. Confined to the shop the pharmacist must rely on the to customer return to pick up the thread again. As such there will always be gaps in the pharmacist's knowledge and they are not involved in a straightforward narrative sequence. As the counter assistant in Observation pharmacy 5 described:

> Yes, slowly, slowly you find out. For example, the last time you came in you remember Gina? [a customer who had been in the pharmacy the day before] (...).
>
> So me and the other girl got chatting to her and we found out that her mum had a

> stroke and she is living with her and her father is also having problems, basically step by step we found that her whole family were ill. For example her daughter, she has that thing where she has fits and that. Her husband also had a car accident and hurt his back. Suddenly we found out all this information which you would never have done otherwise. So from that we were able to give her help and advice.
>
> **Observation pharmacy 5 – counter assistant**

As has been reported in previous studies (Tully, Hassell, and Noyce 1997), I found that many, if not most, transactions in the pharmacy were carried out in an expedient, functional manner with no input at all from the pharmacist (Austin, Gregory, and Martin 2006). These interactions occurred without discussion and simply involved the hand-over of goods either in exchange for money or for a prescription document or limited advice giving that was handled by the pharmacy assistants. Although not taking an active role in the transaction this signals passive 'acceptance' and implicit sanctioning of customers' requests by the pharmacist.

Considering transactions concerning medicines or the giving of health related advice perhaps 25% of the interactions I observed involved a request for basic information or validation of decision making. At the most basic level of interaction, initiated by either party the pharmacist was involved in either endorsement of products chosen by the customer ('yes, that will do the trick'), straightforward reinforcement of advice surrounding prescription products (you've had these before? Twice a day') or uncomplicated recommendation of goods sold directly by the pharmacy. These exchanges were usually brief and to the point, advice was not elaborated on or questioned.

Of critical importance in envisaging the role of the pharmacist as a clinical touch-point and again matching the findings of the previous work mentioned above, only a small number of interactions involved a more in-depth discussion with the pharmacist. On these occasions the customer would initiate a specifically medicalised encounter by asking to speak to the

pharmacist or more rarely it was the pharmacist himself who exerted a 'medical authority' onto the exchange by proactively intervening in a transaction resulting in recommendation or 'added value' active advice giving. This latter more active role was most often in response to certain key questions which that immediately ensured the pharmacist's involvement – such as 'can I have the strongest painkiller you have got?'* Advice giving surrounding prescription medicines was usually given in response to customer questioning around how to take medicines, side effects or concerns over interactions.

As it is the customer that drives the level of response and interaction they feel comfortable with, through verbal or physical cues the challenge for the pharmacist is actually in turning unregulated time into an advice giving situation. In comparison to the consultation as envisaged in the medical environment, which can be seen as a series of actions designed to be performed within a dramatic framework in a formal setting; the pharmacist has to function without the structure of the clinic to guide encounters.

As Austin et al. (2006) point out, the success of the pharmacist therefore is reliant on being able to recognise what interaction is called for at what time. This responsive approach has both positive and negative effects in the pharmacy, on the one hand perhaps providing a greater customer orientation and a service that affords the customer a sense of control and empowerment. On the other hand the shifting requirements of involvement manifest in a patchwork of different, inconsistent decisions and interventions that depend on what the customer gives permission for within the space of the interaction. These interactions sometimes move quickly from 'consultation' to 'conversation' and back again.

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* This kind of question triggers a response from the pharmacist due to concern over misuse of over the counter painkillers, especially those containing codeine.

Supporting studies discussed in the introduction, both in multiples and in independent pharmacy, such as Hassell et al. (1998), I found that pharmacists rarely expanded on product advice to give general health advice in association with purchases or prescriptions largely because they lacked 'permission' from the customer to enter into a discussion at this point. Rather than elaborating on these traditional pharmacy situations to extend the possibilities of their role I found that the pharmacists were very conservative in their approach and did not challenge the status quo in spite of claims to greater clinical autonomy or control of customer/patient interactions.

In fact, even exchanges which do involve a request for more information often fail to become positive situations where the pharmacist is able to dispense more fulsome 'advice'. The restricted clinical role of the pharmacist in any transaction means that they regularly disappoint customers. Frequently, when people actually do engage them in a request for help they are greeted by the answer 'see the doctor' which feels unsatisfactory for both parties. Calls for pharmacists to take on a more involved approach can therefore make the pharmacist vulnerable to failure in the eyes of customers. The inability to take control of even the smallest decision undermines the pharmacist's authority and so it is not surprising that caution is exercised in dispensing advice. This perhaps explains why pharmacists who are keen to position themselves as being clinically orientated fail to perform according to their own rhetoric. For example, the encounter described in Chapter Four concerning the Somali customer wanting her medicines in the original packets rather than made up into dossette boxes was used to illustrate the failure to communicate cross culturally. I could however have cited this case as an example of the failure of the pharmacist's ability to answer customer needs. The crux of the misunderstanding in this case was actually the customers' disbelief that the pharmacist was unable to simply amend her prescription and change the way her

medication was presented.

The most 'successful' interactions I observed in terms of the elaboration of medicines or health advice often involved customers who had left their GPs confused or unsure about what they had been prescribed or how they should be taking it. These advice giving situations differed because the customer outlined a specific role for the pharmacist and positioned their knowledge as being especially worthwhile. In a sense, this deferment activates 'patient' rather than 'customer' status. In an explicitly signalled, more authoritative position the pharmacists seemed more comfortable and confident in their advice giving. Importantly in these cases the customer is notionally no longer 'somebody else's patient' having explicitly put themselves into the care of the pharmacist. The balance of power in these interactions shifts and the pharmacist's biomedical expertise comes to the fore. Both parties constitute a more 'clinical' encounter. For example in observation pharmacy 4 an older woman came to speak to Mrs D about recommendations the GP apparently made 'for her bones'. She explained to Mrs D that the GP had told her to buy 'vitamins' to make her 'strong' but that she didn't understand what he had said. Mrs D had a detailed discussion with her about the supplements available, 'I knew you would explain' remarked the customer. In another case in observation pharmacy 6 a customer came to the pharmacist to check with him about the side effects of a particular medicine. 'I've asked the doctor' she said 'but I wanted to check with you'. In this case the pharmacist spent some time with the customer reassuring her that side effects were unlikely but explaining what to look out for.

More expansive use of time was more often found outside the formal medicines advice giving role. Pharmacists use their 'independence' to create different situations for interaction, opening up possibilities in the pharmacy by building on their understanding of customers

needs and creating a space in the 'pause' before or after the formal transaction in which to engage customers in discussions that touch on a broader concepts of wellbeing. It is in these 'informal' interactions that duration of time available in the pharmacy becomes relevant and valuable.

> I do find here like they will come in for the most trivial things sometimes: I mean obviously I don't mind, I mean I am here to help but when I used to work for Lloyds I did find that people didn't come in just for the smallest of things. Sometimes they just come in just for a chat really, just to get stuff off their chest about them really, I mean often to do with the sort of conditions that they have but it may not be asking directly for advice, just for a little chat really. So I don't know if that is just because of the kind of pharmacy that we are and it is more, like going back to this being more personal, because I mean I doubt that they will be doing that a lots going into Boots or whatever so again I find that quite nice, to have that sort of interaction.
>
> **Pharmacist 13**

> Yeah, they do yeah, they come and explain to us their problems and day to day things they like to tell us about and we listen to them and we talk back to them as well and they are quite happy, they like doing that and some of them just come for that as well yeah.
>
> **It seems like it is almost as important as the pharmacy side of things too?**
>
> Yeah, yeah, it is true. They appreciate that we talk to them and we realise that it is part of their health; they are looking after their health when they come and talk to us. We don't mind spending a little bit of time with them.
>
> **Pharmacist 12**

Sennett (2008: 48) describes part of the art of nursing as being able to explore 'liminal zone between problem solving and problem finding'; 'Listening to old men's chatter, the nurse can glean clues about their ailments that escape a diagnostic checklist'. In many ways the talk that occurs in these transactions is in the same category and functions both to provide a service to customers and as part of building relationships in the pharmacy. This expansive advice giving is in sharp contrast to the very limited advice I witnessed 'dispensed' alongside formal services. Perhaps because in this pause it is clear that the customer wants something more and the pharmacist has been given that implicit cue to step in. Perhaps also, once the 'official' object of their expertise is removed they become freer in their ability to talk as an

'independent expert'. The range of different topics the pharmacists were involved in discussing with customers in these kinds of informal extended exchanges was extremely broad as the following vignettes indicate:

Observation pharmacy 3: 'We'll get you through it', therapeutic support

A young woman comes into the pharmacy and greets the counter assistant who comments that she has had her hair cut. The women says yes, she had come in to tell the pharmacist that she has been diagnosed with breast cancer she cut her hair ready for the chemotherapy as it will fall out. She was set to begin chemotherapy the next day and says she expects she will be coming to the pharmacy more because of it. She chats to the pharmacist and talks about being scared and upset but now she is getting on with it. The pharmacist asks after her young son and how he is coping. She explains that she has told him but that he doesn't really understand yet. The pharmacist says that they will be there for her and not to worry, she can come any time or if she wants anything dropping round then just to call the pharmacy. 'We'll get you through it' he says, 'don't you worry about that, that is what we are here for'.

Observation pharmacy 1: 'We are keeping an eye out', a social service

A lady drops in to the pharmacy to pick up some products that the pharmacist has ordered in especially for her. The pharmacist introduces me to her and explains why I am in the pharmacy. She tells me says Mr A is the best in the area, she won't go anywhere else. The pharmacist has apparently been involved in a media campaign she has set up to raise awareness of knife crime and she is clearly very grateful for his support. She explains that her cousin was stabbed to death two weeks ago and this is what has spurred her on in creating the campaign. After she has left the shop the pharmacist and his assistant observe that this is the most 'together' that they have seen her since the incident. She has been in the pharmacy in great distress several times and they were obviously very concerned. 'We are keeping an eye out for her' said the pharmacist; I think she might need it'.

Observation pharmacy 4: 'Healing hands', almost like a nurse

An older lady comes in to the pharmacy for some hot gel for her knees. Mrs D comes out of the dispensary to say hello, she asks her to sit down and talks to her about her sore knees. Mrs D feels her knees and then massages them. The customer also requests some reading glasses so Mrs D takes her through the process of choosing, the counter assistant helps too, bringing her things to read and showing her how to use the glasses.

These vignettes also demonstrate the malleable role of the pharmacist within the therapeutic relationship and their ability to take on different characters in response to customer need.

This 'shape shifting' allows them to adjust to the dynamics of each interaction (Helman 2006).

It is important to note that this kind of informal advice giving did not include public health messaging which is part of the pharmacists remit under the new contract*. Although I had not intended to assess contractual services public health messaging was consistently brought up during conversations about how people use the pharmacy, the role of the pharmacist and the way in which they use their time.

As a service, public health messaging had a mixed reception on the shop floor, for many of the pharmacists in the study it involved a very passive presentation of material they received from the PCT. Very few felt able to completely engage in the idea of a consultation that required proactively raising health issues with their customers. In stark contrast to the idea of having more time to spend with customers and the desire to become involved in conversation this service was almost always related to having less time and paradoxically no desire to get 'caught up' in speaking to people.

> (...) you can't expect me to be running round to the front all the time to tell them these things. I don't want to either.
>
> **Pharmacist 8**

> I have a stand there, we get almost every week something from a different organisation, I read it, put it on there. Patients in reality hardly use it; kids come along, pick one up write a few things on it and it is on the floor. The only client who will be interested might be someone actually diagnosed with that ailment and they might come or a school kid who has been asked to do a project or whatever. Apart from that there is not uptake by the patient for their wellbeing.
>
> **Pharmacist 3**

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*'One of the Essential Services in the pharmacy contract is pharmacy-based public health campaigns. Pharmacists and their staff are expected to take part in six public health campaigns a year. Campaign topics are selected by PCTs who are also required to provide the appropriate literature and other materials.' (Leicester City PCT Directorate of Public Health & Health Improvement 2007/8).

A few of the pharmacists I interviewed did claim that they tried to involve customers in this kind of direct messaging initiative and they repeated back to me all the reasons why, according to the professional bodies pharmacists could and should get involved. Even these pharmacists however were circumspect regarding their ability to successfully engage with customers and it must be pointed out that during my observation work I did not see any active promotion of health messages. Even the few smoking cessation consultations I witnessed rarely involved 'life coaching' beyond the provision of the associated booklets.

> I mean I guess you can do sort of link sales, if they come in wanting to give up smoking and they are a bit overweight you can sort of say, have you been tested for diabetes or whatever, it is just kind of trying to get that awareness out. It can be difficult sometimes getting people interested really and a lot of people who come in are in a bit of a hurry really, they just come in, get what they want and leave really so I think it can be a bit, well, it is all about communication that is what it is, it is all about communicating with the patient better, trying to get them to understand. You know, it is quite important.
>
> **Pharmacist 13**

Much of the discomfort in involving themselves in this kind of messaging centred on the fact that it contradicts the nature of the pharmacy relationship where customers invite the pharmacists into a discussion. They lack permission from customers to provide *ad hoc* lifestyle advice. It is easier if the pharmacists are able to offer a specific service rather than just 'providing a poster' but even here, telling customers 'things they don't want to hear' was considered a thankless task that puts pharmacy relationships under strain.

> I mean you can do it but it is just that it falls on deaf ears. That is the problem.
>
> **Pharmacist 10**

> Yes, something like, because we do EHC* here and the Chlamydia†, let's say we were not doing it and just providing a poster, it is useless you have no back up, it is

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* Emergency contraception provided through patient group directive
† Chlamydia testing as an enhanced service

not the same as you doing the service, the weight management as well or the smoking, you are promoting people to give up smoking but you are not doing it yourself. If you just have a poster you are telling them something but you have nothing to back it up with. The person will not go and do something about it, even if you signpost them, they will just walk out of the shop, but if you are running the service it makes it a lot easier for you to do more and promote it well.

Pharmacist 24

When it comes to delivering public health messages therefore, the rhetoric in the pharmacy takes a sharp turn away from the idea of expansive time. Quite the contrary, in this sense pharmacists usually cite a lack of time coupled with a lack of willingness on behalf of customers to listen to this kind of advice, in spite of their assertions regarding their persuasive abilities and their desire to draw customers into informal advice giving situations.

How are you finding public health messages in pharmacy?

No, no, not really, we have a list of internet websites but you know, some leaflets, but you haven't got time to take people to one side and talk to them.

Pharmacist 4

8.3 Time under threat

As often as pharmacists assured me of their accessibility and that they had more time to spend with customers as compared to GPs or pharmacists working for the multiples they would also complain that they did not have enough time or that the time that they had was constrained and under pressure:

We get quite a few pharmacists who are depressed you know, this is all they see, and any new initiatives they see as more paperwork.

I have seen that.

> Yes, because they are already running themselves ragged thinking 'I haven't got enough time' and you get into that mentality so anything new that comes in you just think 'I haven't got time to do it', but what you have got to do is to learn to delegate some of the things you do now, the more simple things.
>
> **Pharmacist 21**

Pharmacists use the ambiguities of pharmacy time as a metaphor for the ambiguities of their professional status and to describe the impact of change. McDonald et al. point out that the promotion of freely available advisory and healthcare services provided by the pharmacy is contradictory to a professionalising strategy which requires the public to 'view the pharmacists time as more valuable than their own' (McDonald et al. 2010). The availability of unregulated time both in terms of accessibility and duration is felt to be under threat with the introduction of new pharmacy services such as MURs which happen in the consultation room and take the pharmacist 'out' of normal pharmacy time. Pharmacists felt that inevitably, these type of services will call for the introduction of an appointment system and hence the beginning of formal control of the pharmacist's time. This concern was not only restricted to those who rejected the 'new model' of pharmacy.

Taking the pharmacist 'out' threatens accessibility and duration of time, fundamentally alters the tempo of the pharmacy and potentially changes the power balance with the customer. Many of the single handed pharmacists I spoke to also felt that the provision of an increasing number of consultation based services would require pharmacies to run with two pharmacists, forcing smaller pharmacies out of business or ensuring that the service they provide would be considered to be inferior.

To further illustrate the concerns pharmacists raised, during my research the idea of the 'Responsible Pharmacist' was just beginning to be introduced and was causing significant anxiety among some of those I spoke to. It demonstrated the level to which their time was

beginning to be taken control of. At this point in the introduction of the scheme (which requires pharmacists to display a sign indicating who is the 'responsible pharmacist' and logging the time in the pharmacy) Pharmacists felt that the scheme challenged their ability to have autonomy over the way they use time in the pharmacy space and ironically compromised the public's confidence in the pharmacist as being 'responsible'.

I do like to give patients the advice and so on and the clinical issues, but I just don't like the civil servants and hierarchies pushing paperwork down on us. I'm not sure if you've heard the latest issue is the – for decades, we've had to display a certificate as you work. All of a sudden, we have this new policy Responsible Pharmacist, so it just reflects that we've never been responsible, but now we have to put up a piece of paper, insert a certificate saying who's in charge, basically repeating what the certificate says, but the other thing we have to do is login the time we start work and logout when we finish work.(...) If we leave the Pharmacy at any one point for an hour or more, (...) login, the reason why we left.

Now this is the crunch of it all (...) apart from doing all the paperwork, but this is the most ridiculous thing about it, if we leave the Pharmacy for up to three hours (...) the counter staff can sell things that are not licensed under P or POM*. They can supply anything else. If I go over four hours and I'm not here, I have to do two things: one the Pharmacy has to basically shutdown, literally they can't sell anything...and if I take that same scenario to Mr Patel down the road in the newsagent shop, he's knocking out Nurofen† 24/7 and there's not a Pharmacist around and yet we can't sell GSL‡.

Pharmacist 22

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* P refers to prescription only medicines, POM are medicines which can be sold under the supervision of a pharmacist but are not on general sale to the public

† Nurofen is brand of ibuprofen

‡ GSL refers to medicines that are on general sale to the public, i.e. they may be sold without the supervision of the pharmacist

8.4 Summary

Time in the pharmacy presents us with a number of contradictions: Firstly, the tempo of the pharmacy in terms of the availability of the pharmacist opposes convenience and emotional accessibility against the problem of interrupted time. Secondly, duration of time in the pharmacy presents the paradox of having and not having time.

Fernandez describes metaphor as a strategy: 'a strategic prediction (...) which makes a movement and leads to a performance' (1986: 8). The pharmacists exploit these contradictions in their use of time as a powerful metaphor for the contradictions of pharmacy life. In their interviews and day to day talk pharmacists play on these ambiguities and use time as part of a rhetorical strategy. Elements of practice that they feel comfortable with are usually linked with positive time, reifying the concepts of having more time and greater accessibility. On the other hand, elements of practice that they are uncomfortable with are linked with a lack of time and time pressures.

The quality and nature of advice giving (and hence the ability of lack of ability of pharmacists to take on truly clinical personhoods) is also critically linked to their ability to control time through their relationship with pharmacy users as customers or patients. In the formal, medicines related transaction the dominant rhetoric of an increasingly clinical pharmacist is yet to take root in the performance of the consultation. Instead the performance of the 'good pharmacist' is played out through being responsive to the needs of the customer and responsibly subordinate to the prescribing power of the physician. In more informal advice giving or when power has been taken away from the GP more expansive use of time is successfully employed to provide 'space' for advice giving'.

Time is fundamental in shaping personhoods as it is the defining resource of the 'accessible pharmacist'. As a resource however it is potentially under threat from the changes to the way pharmacists work and these pharmacists as yet had not resolved how they could retain the benefits of a customer centric approach and a retail model of service with the demands of a more clinical and potentially more consultation based approach to practice.

Chapter 9. Practical specialists

> Yeah, yeah, you have to spice it up to maintain your customer or those people who are loyal to you. Boots does not have to do the extra mile because their name is there already; they have built it up already so no matter what, it is the same. Business will come. It is like a corner shop, you have a corner shop and whatever you do if you just put Tesco there, if you put a Tesco Extra there you will have to close it because people will not come in to you because their brand is there already, that's it. So [if you are] independent you have to go the extra mile (...) that is what we have to do.
>
> **Pharmacist 24**

The pharmacist is, much like the jack-of-all-trades GP, positioned as a primary care generalist. One of the themes to come out of this research however was the idea of the independent pharmacist as an expert provider of niche interest goods or services. Pharmacists framed themselves through talk and through practice as specialists, delivering a higher quality, tailored offer.

Making a rhetorical play, the idea of providing a bespoke service was often directly compared to the 'one size fits all service' provided by the multiples. This included contrasting their ability to source goods that customers could not find elsewhere, hiring particular members of staff to improve communication in the pharmacy and less tangibly, finding solutions to a range of practical problems. To this latter point they suggest that pharmacists working for multiples find it more difficult to 'sort things out' for customers on an individual basis due to the need to create a consistent customer experience.

> The thing about the multiples is that they try to make everything uniform but you sometimes don't want things to be uniform.
>
> **Pharmacist 7**

The need for bespoke service is symbolically linked to the urban surroundings and the

particular challenges faced in inner-city practices where customer issues frequently fall outside the perceived 'norm'. Specialism is also a way of transmitting value to customers who are addressed through statements such as 'I'll do this for you this once' or 'because it's you I'll see what we can do'.

9.1 For things you can't get anywhere else

In former times pharmacists would derive significant income from the production of 'medicines' made to their own formulas (known as nostrums). Just one pharmacist in my study continued with that tradition producing treatments for coughs and stomach upsets that had been sold in the pharmacy for over 100 years.

I notice that you make your own medicines, which I've also not seen.

No, you wouldn't.

Proper Pharmacy [laughs].

Yeah, you wouldn't, we're the only ones that still do that.

Yeah?

We do. (...) people come all over England, to get that from us (...) 'cause we're the only people that make it, and it gets sent abroad to family*. That's our cough mixture and that's a children's one, and that's a stomach mixture. That's a different type of cough mixture, but we used to make a lot, lot more.

Pharmacist 26

Rather than provide specialist goods in house the pharmacists I met often made much of their ability to source less commonly available products for customers. The multiples and big chains are inevitably able to provide customers with lower prices on household goods,

* Former pharmacy customers who no longer live in the immediate area or customers' relatives and friends

General Sales List and over-the counter-medicines due to the sheer bulk of their wholesale purchasing power. What pharmacists in larger stores are unable to do however is to source hard to find or less commonly used items for customers. Many of the pharmacies I visited followed the lead of surrounding small businesses and concentrated especially on the provision of stock to serve particular ethnic groups.

> (...) *for example a lot of Bengali people use Boric powder for things, they use that* a lot. A lot of African- Caribbean people want special creams and emollients for their dry skin and stuff and they like rosewater and all that kind of stuff. So we do keep special things in stock.
>
> **Observation pharmacy 1**

While most pharmacists in this study stocked small ranges some, like pharmacist 2, were very sophisticated in their targeting. He derived significant income from an extensive range of items taking note of products advertised on TV or radio stations aimed at particular ethnic minority target audiences.

> It is totally demand led and also it is niche now too. I don't look to compete with the supermarkets on your Colgates* or your hairbrushes and stuff. We have products here that you are not going to find in those places and the advertising for them (...) I mean because if you look at this demographic, it is very Asian orientated so they have their own television channels so what they are advertising we tend to stock here because there is a demand for it so I sell it. There is no point me selling anything else, it doesn't make sense.
>
> **Pharmacist 2**

In addition to stocking different products pharmacists will also get involved in either dealing with medicines customers have brought back from abroad or, very often, requests to send medicines back home. The latter often leads to unusual requests, bulk buying of tablets, or customers buying medicines on behalf of relatives abroad. For example, in observation pharmacy 2 a customer came in to ask about buying a diabetes monitor for a relative in India and wanted to know if this would cause problems in registering the device with the

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* Colgate toothpaste

manufacturer*, while in pharmacy 1 Mr A did not charge a customer for a box of paracetamol as a goodwill gesture because she was buying a wide range of over the counter medicines to send home to Ghana. In pharmacy 3. Mr C showed me a dowry list from Nigeria that one of his customers had sent through to him. The list included a wide range of items from yams to vitamins and perfume, some of which he was arranging to be sent in bulk from the pharmacy.

A particular interest across almost all the pharmacies in the study was meeting the demand for alcohol free and gelatine free products. Many of the pharmacists will investigate the ingredients of medicines, including prescription medicines, for customers. They will advise on or order in suitable alternatives if possible or equip customers to go back to their GP with their concerns. For example in observation pharmacy 2 a customer called to request a gelatine free alternative to Calcichew-D3Forte†. The pharmacist went to some lengths to research potential alternatives for the customer and called the GP in order to amend the prescription. This practice of sourcing goods strengthens pharmacy relationships and enables pharmacists to demonstrate their expertise in a way that customers appear to find especially valuable.

> Well, the main concern is gelatine -free products so we keep an eye on the things that do contain gelatine and advise patients. Now as most things do contain some sort of gelatine we tend to find out what source it is and if there is an alternative to it and things like that. Alcohol is another question now, as far as myself I am aware that alcohol in a medical product is fine to consume rather than consuming it for other reasons so if you explain to the patient then it is up to their own belief whether they want to take it or not or we advise them of an alternative.
>
> **So you are quite an important negotiating point?**
>
> Yeah, exactly, we offer the product and we offer advice and the facts and then it is up to the customers' own belief if they want to take it or not but we give them a lot of options, we tend to stock quite a lot of different variety of the same thing so we can cover these things.
>
> **Pilot Pharmacist 6**

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* These devices are registered with the manufacturing company in order to take advantage of additional customer services

† A calcium carbonate and colecalciferol chewable tablet which is used in the treatment and prevention of vitamin D/calcium deficiency or as a therapeutic supplement e.g. in treatment of osteoporosis

9.2 The performance of autonomy

It was through the delivery of creative, practical solutions that the pharmacists best demonstrated their autonomy over their surroundings and exercised most control in their relationships with customers. They are able to provide them with a uniquely valuable offer through the ability to take decisions that might be slightly outside normal practice or by having the level of authority and responsibility required to be able to bend or break the rules. 'Being flexible' and 'being different' were qualities associated with 'good' independent pharmacists.

> You have got to want to help solve problems. All sorts of random stuff really, sometimes you have to be really flexible and do stuff that is totally off key with what you would normally do, but that is what makes a good pharmacist. You have got to be a bit different, you can't be just doing things straight from the book, you have to go that extra mile for people. That is why they come back.
>
> **Observation pharmacist 7**

There is real value in the idea that in the pharmacy, things can be 'sorted out' in this manner. 'Sorting out' involved a real range of possibilities from tiding customers over with medicines, personal home visits or equipping them with the means to deal with 'the system'. This 'hands on' and involved approach was felt to be especially valuable for customers who may be less confident in large multiple stores which expect a certain level of compliance regarding process and capability terms of language. These creative solutions to problems rarely involved any direct financial gain for the pharmacists but were important in sustaining relationships and creating loyalty amongst customers.

Benson et al. (2009) also discuss the idea of rule breaking and the exercise of professional autonomy as a way of serving the best interests of customers. They however position this

'rule breaking' as being part of a paternalistic professional approach and agree with Fulford et al. (2002) that:

> *(...) the exercise of paternalism, although grounded on beneficence tends to give primacy to the practitioner's professional and personal values rather than those of the patient*
>
> *(Benson, Cribb, and Barber 2009: 228)*

In this study however I observed the exercise of professional judgement to be very tightly aligned to overtly expressed customer needs. When pharmacists did impose personal interpretations onto scenario's the overriding driver to 'sort things out' was a requirement to be able to perform a decisive, action orientated role in response to clear 'cries for help' from customers. I would however agree with Benson et al. (2009) in suggesting that there was little evidence that pharmacists were able to spend time in considering the ethical situation they find themselves in and I felt that self conscious reflections on the effect they may have in customer interaction was largely stimulated by my presence and questioning.

9.2.1 Taking control of a medicines mandate

Although advice giving surrounding medicines was found to be constrained, where pharmacists really seemed to engage in the supposed object of their professional expertise was actually in finding practical solutions to enable customers to comply with medicines regimes or to ensure medicines were available when needed. The ability to act with flexibility and autonomy in this field played to the idea of an autonomous practitioner able to act based on professional judgement. These solutions also demonstrate the practical resourcefulness required to be an independent pharmacist and also provided some of the most powerful 'comparison tales' with the multiples where control over stock and practice protocols particularly limit pharmacists' flexibility in this regard.

One of the most common examples of 'sorting things out' was tiding customers over with medicines when they had not been organised enough in getting repeat prescriptions or follow up appointments or perhaps had run out of medication due to particular 'mini-crisis' situations. One example of this was a customer who came into pharmacy 7 in great distress having dropped the last tablet of her packet under the fridge. Customers like this might be provided with one or two tablets to see them through to their next appointment*. Often the pharmacist would also take steps to ensure that repeat prescriptions were ordered or that appointments were made for follow up if necessary. Taking on this level of pro-activity and practical responsibility for medicines is in stark contrast to the passivity observed in advice giving.

A number of pharmacies had informal arrangements for particular customers surrounding their compliance with medicines regimes. Close and supportive relationships had been built up and the pharmacists played a very active part. For example, in pharmacy 2 'Mike' came on a regular basis for methadone replacement therapy. He was well known within the pharmacy and was always greeted enthusiastically on arrival. Alongside his substance misuse Mike also suffered from mental health problems. His trips to the pharmacy were a significant part of his day and the staff tried to integrate him into the running of the shop. Once a week he was employed to clean the windows, and he was also on hand to help customers with the photocopier. He would usually spend up to 20 minutes within the pharmacy at a time chatting to staff and customers before wandering off. The pharmacy staff felt they had a role in 'keeping him steady' and that this was a significant part of ensuring that he was able to 'stick with' his methadone replacement therapy. Meanwhile, in observation pharmacy 3, 'Fred' came in every day to take his tablet. The pharmacy staff would give him a glass of water and

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* From what I understood of the process in most cases these transactions would be recorded and tablets docked from the next prescription.

Fred would bring in newspapers for the pharmacy and would linger at the electrical goods counter chatting to the sales assistant. Fred had been coming to the pharmacy for 15 years, although he had tried other places he always ended up back in pharmacy 3 as Mr C explained, other people found him 'difficult' manage.

For some customers the pharmacist might be the only person who is able to really monitor how medicines are being used and flag particular problems. In pharmacy 5 for example Mr E made a particular point of speaking to a carer about dosette boxes that had been returned to the pharmacy with a number of days of tablets unused. This resulted in attempts to organise additional support for the elderly customer who was failing to take her medicines without supervision. In another case a story recounted to me both by pharmacist 28 and independently by his regular locum (who I talked to whilst waiting for the interview) was used to illustrate how the provision of personalised care is reliant on the ability of the pharmacist to exercise autonomy. Earlier in the day a women had come to the shop to buy paracetamol. She was well known to the pharmacist who was aware that she had attempted to commit suicide several months ago following the death of her husband. She had appeared agitated and the pharmacist had managed to persuade her to sit down and chat to him. It became apparent through this discussion that she had been buying paracetamol in bulk. The pharmacist accompanied her home and helped her to clear out this hoard of medicine. He then accompanied her on a visit to the GP. The whole process had taken a few hours and in the pharmacist's words 'it was a team effort to sort her out'. Both pharmacist and locum (who was working two days a week in a multiple pharmacy) agreed that this process simply would not have been possible in the multiple setting. In their opinion in all likelihood the customer would not have been known to the staff but they stressed that an even greater barrier would have been the inability of the pharmacist to take the decision to step in and take time out of

the dispensary to help.

Given the presumption that the pharmacist is a profit driven businessman it was perhaps surprising to find another aspect of 'sorting things out' included quite regular small scale leeway in providing payment for over-the-counter or General Sales List medicines. For example, in observation pharmacy 3 a customer who requested some Nurofen* was given a packet of generic ibuprofen the pharmacy and an IOU, while in pharmacy 6 an elderly customer requested a smaller packet of paracetamol as he didn't quite have enough money with him. In this case the pharmacist waived the extra 49p saying 'just pay me back another time'. This flexibility would not be possible in a multiple but was felt to be of enormous value for customers struggling financially. This financial support relies on the high level of trust built up in the pharmacy. I also on one or two occasions saw customers dropping round with money they owed, holding up their end of the bargain.

Most of the pharmacies I visited were also running some kind of delivery service. Often these services were very informal and involved the pharmacist or a assistants personally delivering prescriptions to neighbours or people nearby. In other pharmacies a more formal service had been set up making home deliveries to a large number of housebound customers. These services were for the most part free and offered no financial return other than hoping to secure loyalty from customers. Bush, Wilson et al. note that supermarket pharmacies in particular are less likely than independents to provide a home delivery service and suggest that this provides an example of how decreasing numbers of independent pharmacies might reinforce inequities for those with restricted mobility (2009).

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* A brand of ibuprofen

9.2.2 Negotiating the system and 'arming' customers with stories

'Sorting things out' also takes on the form of either educating customers or negotiating on their behalf, helping them to navigate 'the system'. This concept was mentioned briefly in relation to social networks based ethnicity and language but I found that pharmacists acted in this particular role as a broker/ mediator across all the various user groups in the pharmacy. Pharmacists locate a particular need for this service not only in terms of difficulties caused by cross cultural and communication problems but also due to the socio-economic circumstances of the population they serve.

> A lot of people don't know how to access the healthcare or the services that are available. You know, they are still sort of stuck in their (...) well, not stuck but just don't know about stuff. Obviously being East End, they are set in their ways. Not uneducated but they are working class.
>
> **Observation pharmacy 6**

As part of this role pharmacists are involved in managing customers' expectations of the healthcare system, helping them to understand both what they should, and should not expect. A number of pharmacists discussed the fact that for the customer base they served there were particular problems both in terms of enabling customers to understand their rights and the kind of service they could expect from 'the system'; but also on the flip side dealing with a population who feel entitled to free healthcare and free medicines.

> Because you have got uneducated and illiterate, well not illiterate but err the demograph is far lower. (...) we are not in Chelsea, the expectations are low, they shouldn't be but that is how it is. It is beaten into them in the sense that I am in this position of power and influence and you are not and you never will be and therefore don't question what I say to you. So that the patient isn't informed enough. Ok. They are not informed as to their rights, as to what they can expect, what they should expect. The level of service they deserve and so on. A lot of people are obviously on income support and etc. I mean it is a two way thing, sometimes patients have a lack of respect for the NHS, yeah it is a two way thing, it is a cultural thing and they feel that it is free anyway so why shouldn't I get this medicine. I have a God given right to it and not really understanding how much the medicine costs.
>
> **Pharmacist 2**

The pharmacy is crucial in helping customers develop an effective illness narratives and equipping them with the skills to deal with other healthcare providers. These narratives are 'biomedically acceptable' stories which can help people understand what is happening to them, and enable them to explain their situation in a fluent 'NHS compatible' style, smoothing the course of treatment as they move through the system.

For example, in observation pharmacy 1 an elderly gentleman came to see the pharmacist with the results of a scan his wife has just had. They thought the pharmacist might be able to make sense of the information as the accompanying letter was not very clear. It transpired that they were looking at the results of a bone density test for osteoporosis. The pharmacist himself did not know a great deal about the findings but was at least able to explain why the test had been done and what it might show based on the letter. He told them that he thought it would be perfectly acceptable for them to make an appointment to see their GP if they wanted to know more and pointed out what to query within the results. The letter the customer presented was apparently a copy of the communication between the hospital and the GP which is as standard practice, also been sent to the patient. The pharmacist commented that this kind of communication often caused people a great deal of concern and he regularly had customers coming in asking for help.

Pharmacists were also able to intervene directly on behalf of customers, speaking to other healthcare professionals. In observation pharmacy 5 an older gentleman came into the shop to return some medicines. He handed the bag to the assistant but Mr E stopped him to ask how he was and check the contents of the bag. All the medicines being returned were to treat diabetes and there followed a long discussion in Bengali. Afterwards Mr E explained to me that the man had been hospitalised due to a problem with his leg related to circulation

problems caused by his diabetes. From what he could understand the hospital had changed his medication however Mr E suspected this information had not yet reached the GP. The man had returned the medicines to the pharmacy because he thought did not need to use them now that he was out of hospital and wanted to go back to his 'usual treatment'. The pharmacist said he had tried to explain the situation to the gentleman and asked him to go to his GP as soon as possible. Meanwhile he called the surgery to alert them to the problem and to check the situation regarding the possible change of medication.

9.3 Communication specialists

As previously discussed throughout this thesis, pharmacists are acutely aware of the communication issues diversity presents and of the distress that language barriers in particular can cause customers who are unable to communicate effectively, not just with them but also with any other healthcare professional they may encounter.

We have already highlighted a specialism based on the language of the pharmacist himself and the challenges of dealing with difference in terms of a philosophy of service but much more practically, pharmacists also position the pharmacy staff as 'communication specialists' with particular services available based on language requirements.

> Because a lot of them are quite helpless, because people struggle when they're not able to – well they're trying to express themselves, but when the language barrier is there life could be very uncomfortable, which I can understand the way they feel. So at least we try to fill that gap and help as much as we can, helping them as much as we can. Well, as much as the law permits us to really, and that's it and they do appreciate that, you know. If – and if that's all you can do in a day I think you've done well.
>
> **Pharmacist 17**

9.3.2 Practical tools

As was highlighted in Chapter 7, pharmacists from ethnic minority groups and their staff, while good communicators still sometimes struggle in cross cultural interactions. Pharmacists felt that they were given very little support in delivering practical solutions for dealing with language barriers. There was a degree to which they felt that as ethnic minority practitioners, they were supposed to be 'good at that kind of thing' and therefore did not require much assistance.

> **Do you get any kind of language support from the PCT?**
>
> No, no. that is just. It is all grown up isn't it? You are supposed to do it. It is an education thing. You are supposed to do it. I mean obviously if you are Asian you are supposed to know at least one other language. Otherwise you are a bit of a schmuck, otherwise you know, are you going to reject your own culture and not learn your own language?
>
> **Pharmacist 5**

Some of the pharmacists did mention that courses were available set up by the local PCTs which aimed to help build skills in dealing with communication difficulties caused by language but none of the pharmacists in my study had actually been on any of these courses. There was a general feeling that the content was not practical enough and that the courses on offer were too time consuming.

> You can actually go on course set up by the council. The only issue is that, I have seen is they are not very practical. I mean they give you advice but the only way you are going to learn stuff really is in practice. I mean it is like if you have a medical kit and they put you in a scenario, if someone cuts their finger, what do you do but then when it actually happens in real life most people aren't willing to do it, they run. So firsthand experience is what you need.
>
> **Pharmacist 10**

They were quick to point out that the PCTs invest a great deal money in producing written material in many languages which is in theory 'supportive' but often not especially useful.

Throughout the whole of my study I didn't see foreign language translated leaflets of any kind being used to actively inform any consultation. I only witnessed one young man pick up a leaflet and take it away from the pharmacy and a couple of customers were handed details of smoking cessation programmes. For the most part leaflets cluttered up the counter in piles, were relegated to stands at the back of the pharmacy or were simply stored out of sight in the dispensary.

> Smoking cessation for example, most of my customers are whites. Asians they will come in for the first two weeks but then they will disappear (...).Some whites are really into it, they will ask you for leaflets and ask you for stuff. But Asians they won't really be bothered about it.
>
> **Why is that? A cultural thing?**
>
> No, not really a cultural thing, I think the reason is that they don't know how to read. This pharmacy is for a little bit older people. We don't really have many youngsters coming in, because they can speak English they will go to the big pharmacies, whereas Asian people over 30 who have been brought up back home they want to come to us and they want advice from us. These are the people who are not really that bothered, maybe this is the reason they aren't bothered, it is because they can't read or write, they can't understand it.
>
> **Observation pharmacy 5: Assistant**

Part of the problem with leaflets even if the customers in question were able to read them, is that they rarely gave the right kind of help. Foreign language leaflets provided for various conditions were far too general to be useful or to help in everyday interactions. As the pharmacists explained and I witnessed on numerous occasions most of the time they struggled with much more specific problems such as explaining how and when to take medicines:

> We try and get through you know, with sign language [signs 1 and then 2 and then going to sleep] ONE, ONE, GO TO BED, and then 2 GO TO BED, so you see with sign language and some of them you know this works quite well. It is more; you take a lot more time to explain what they need to do than the old more British society
>
> **Pharmacist 6**

A number of the pharmacists had taken to translating medicine labels by hand where possible. Two pharmacists had begun using a set of simple picture stickers which had both a pictorial and a written description in Bengali of simple instructions. Both pharmacists felt that these stickers had been a huge success and were looking at commissioning more in other popular languages.

> We have a high population of Bengalis in this area and times where the mothers come in and they've just, sort of, come into the country and with babies and sometimes we get these Paracetemol as an immunisation dose, so you want to try and explain to them and they just will smile at you and, "Yes, yes," and just go off.
>
> No, we had that issue. In fact, we've – and let me show you something [door opens]. We've just had these brought in. They're in Bengali [door closes] and it shows you, little stickers saying that bedtime, and teatime and so on.
>
> **Pharmacist 22**

Others described having to overcome common misunderstandings over labelling for example one pharmacist described the steps he took to ensure that customers were not confused by being given multiple boxes of the same medicines.

> The other thing we do over there is that because these days everything comes in packs of 28's and the [Royal Pharmaceutical] Society says you have to label every pack, now unfortunately over here, if you give them three packs which all say take one twice a day, they will take one twice a day from all the packs, so you have to make sure that you strap all the packs together and put one label on the top and say that this is one medicine.
>
> **Pharmacist 21**

9.3.3 Interpretation

In the hyperdiverse setting, pharmacists often do not understand every transaction that occurs in their pharmacy and frequently rely on other members of staff or family members/ friends of the customer to translate for them. As Mr G commented to me after a customer came in specifically requesting to speak to his counter assistant:

> It is a pity your Gujarati isn't up to scratch, then we would know what Zara was saying to all these people.
>
> **Observation pharmacy 7**

It is very difficult to arrange for formal translation resources for brief transactions. However even brief transactions can be critical to ensuring the safe and optimal use of medicines. Pharmacists often rely on family members, friends and even other customers to translate for them. The interpreted consultation however raises concerns, especially when the interpreter is not a member of staff.

> When I did Locums in [a different PCT], that was just very dangerous, I just didn't [know what was being said], you know, 'cause everything had to be done via an Interpreter and I didn't know what was happening, so you just do not feel easy. You don't know (...) actually what message has been passed on.
>
> **Pharmacist 29**

Independent pharmacists felt that they were at least able to use their better knowledge of family circumstances to ensure that the appropriate person was translating. However it was a matter of particular concern when children were involved in translating for their parents and grandparents.

> The doctors round here are mainly white so it is very difficult for them to sort of get their points across. The older Bangladeshi community, because they don't speak a lot of English they have to take their children or some kind of an interpreter which somehow is (...) well number one it is not confidential and a little bit is lost in the translation, you know, when an eleven year old is trying to tell mummy what to do, it can be embarrassing plus they don't really know what to say.
>
> **Pharmacist 3**

One particular example of the difficulty in relying on children for translation was a Turkish family who used observation pharmacy 1. The mother and her son 'Harri' 'who was aged ten came to the pharmacy. Harri translated almost everything apart from basic greetings for his

mother, who was buying a number of different household products. The pharmacist explained to me that he had been translating since he was about four. The pharmacist was particularly concerned that the family needed some extra help. They had been in the pharmacy the previous day. His mother had broken down as she was trying to ask the pharmacist for help in understanding what had happened to her sister who had died suddenly from a brain tumour very recently. The pharmacist was extremely concerned both as Harri was so young that either his English or even his Turkish were sophisticated enough to really explain to his mother what was happening, and that he was being upset by having to hear this kind of information about his Aunt. The pharmacist had tried to talk to him on his own about things first but he wasn't sure that anyone else in the healthcare system had been able to take the time to make sure that he was able to cope.

In order to overcome these difficulties the pharmacists actively employ staff who are multilingual, covering as many of the locally commonly spoken languages as possible. All of the pharmacies I conducted observation work in had staff with a range of different language capabilities. As observation pharmacist 7 put it 'we try to avoid a monoculture' so that there was 'something for everyone' within the pharmacy.

> I always try to mix the staff so that there is somebody for everybody like, so they can sort of relate to everybody who is coming in like. It is very important not to just have one monoculture like. It is a mixed community yeah, so people have to see themselves reflected in what's in the shop like.
>
> **Observation pharmacist 7**

The range of different languages spoken even within the smallest of pharmacies was impressive as can be seen in this extract from pharmacist 2. He went on to point out that in the area in which he worked English was not necessarily the first language used in conversation even with other healthcare professionals. Pharmacist 13 remarked that in fact at

times it was actually more difficult to communicate with customers whose first language was English:

> (...) it is a major, major challenge. The people I employ have to understand a lot of the different languages. I mean I don't speak all of them, but we have Bengali here, Gujarati, Punjabi, Urdu, Hindi you know, Tamil, you know (...) I mean the GPs in this area will phone me and just start speaking Hindi, that must just say it all really. I suppose the first language they speak is Hindi.
>
> **Pharmacist 2**

> I mean we do have sort of multi-lingual staff. It is quite ironic actually; you find it harder to communicate with the English actually so it is about trying to find that balance!
>
> **Pharmacist 13**

As one pharmacist pointed out, there is no substitute for a native speaker in order to really capture the full meaning and the nuance of interpretation, taking on board not just linguistic conventions but also understanding the context in which medicines are used and how they are expected to be taken:

> Sometimes they will come specifically, the Africans and I will explain through him [the counter assistant], I mean sometimes when I speak to them they will take but each culture has their own way of emphasising different things and how you say it so I will explain to him what to make clear.
>
> It is the same thing in [a different] PCT in Bengali, you would explain it but it has to be explained in their way. It is like there are certain medications where it doesn't matter where you take it, before food or after food but in their culture it is very important to know if you take it with food or after food, so you should never say that it doesn't matter, you have to give some kind of timing because they would expect that.
>
> **Pharmacist 21**

Staff as much as the pharmacists themselves are able to provide a connection with other social networks and people will specifically use the shop just for them in a similar way to the relationship described earlier with the pharmacist:

> We used to have someone who worked here and she was from Poland so we used

to get a lot of Polish, Russian, Ukrainian people come here just to speak to her but she has gone now so they don't come any more.

Pharmacist 9

(...) one of our staff used to be Latin American, and he used to work here and all of a sudden, we'd get slowly these Latin Americans coming in wanting to speak to him because they couldn't speak English, but I didn't know there were so many around 'cause they never used to come here, but once he left and they said, "Oh, Patricia?" I'd say, "He's not here," and then they started to filter away and now we don't see them anymore.

Pharmacist 22

In spite of their concerns over customer communication some of the pharmacists felt strongly that the danger in relying on special support or special services for migrants is that this can simply infantilise newcomers to the country and fails to equip them with the tools that they need in order to adjust to life in a new world. The pharmacists were in a number of cases keen to point out that while they were sympathetic in many ways to the difficulties customers faced they did not want to 'spoon feed' them. There was a sense that simple translation was not good enough and that it did not ultimately help customers. Several pharmacists quite explicitly rejected some of the more formal aids to bridging language gaps, suggesting that they did not actively encourage people to progress their language skills; preferring instead to provide educational support for customers rather than language support for pharmacists.

The thing is, in the end they have got to learn. Really. They have got to adapt anyway. We can't spoon feed people. I think the NHS is failing that, in part because they pander to all of this, they have their menus printed in all of these languages and I think it is wrong. If you don't understand then get your own interpreters. Because if you go to Spain and places like that they are not going to say, OK, we will get a translator in. They expect people to speak Spanish. So why are we bending over backwards.

Pharmacist 8

So whilst the system can try and adapt to the needs of the patient, I sometimes find that there's insufficient give by the patient to adapt to where they are, especially when I – well, as the very brown fascist that I am, I have great difficulty with someone that's been in the country for 30 years and will speak virtually no English, and my issue is not the fact that they don't speak English, it's the fact that that is normally then reflected in the fact that in terms of personal cultural practice,

they will expect the entire medical system to work around them…

Pharmacist 28

These pharmacists felt that it was their job to educate and inform in order that customers are provided with the skills to able to take control of their situation within a new and very different system of healthcare delivery. Simply bypassing the need for responsibility and understanding by providing certain support services they felt was actually encouraging and perpetuating inequalities for these groups. They argued in particular that the provision of services that focus on translation or interpretation without any educational component can contribute to the 'racism of low expectation' (Hirsi Ali 2010: 214).

9.4 Summary

While the multiples strive for consistency in decision making, and reproducibility of customer experience, the great advantage of the independent pharmacy is being able to listen, recognise and respond to an individual's needs. Practical solutions to a wide range of problems can be provided in the pharmacy using creative 'rule bending' and resourcefulness which are not possible in the multiple setting due to corporate restrictions.

The cultural significance of these 'small acts of independence' is the practical demonstration of the pharmacists ability to act with autonomy and to maximise the potential of customer engagement. If anything, it is this level of demonstrable autonomy which represents to be the 'real' definition of independence. Importantly, this kind of flexible and responsive service was reported with equal frequency by managers working for independent chains as it was by

owners. This finding was also confirmed in observation work with Mr B and Mr F who were able to demonstrate the exercise of this autonomy in practice.

The 'work' that these performances do in social situations is to transmit these core pharmacy values to customers (and during my research I was also an audience being addressed by these acts). 'Specialist' services are often unrelated to direct monetary gain but instead are aimed persuasively at developing customer relationships and creating trust and loyalty. Acts of independence also bring us full circle in terms of the pharmacists relationship to their environment and the social complexity of hyperdiverse communities. This situation requires a level of adaptability that is especially suited to this mode of practice. Pharmacists align their specialist services with the environment and describe 'urban pharmacy' as a particular and distinct type of pharmacy.

Chapter 10. Conclusion

This closing chapter aims to bring together the themes previously considered and to discuss the implications these findings might have.

Independent pharmacists were chosen as the subjects of this research due to their perceived distance from the 'centre' and hence relative distance from decision making in what has been described as an 'ongoing revolution'* within pharmacy. I aimed to examine how professional personhoods were negotiated against this backdrop of change and how these pharmacists were able to challenge the dominant rhetorical framework by acting on the margins of the profession to form their own interpretations of the role of the pharmacist. The study contributes a discussion that centres on the pharmacist's perspective to a body of anthropological literature that has traditionally overlooked their role, being more concerned with the figure of the physician and examination of medicines themselves.

I have also argued that it is important to investigate the way independent pharmacists are able to respond to change in order to understand the impact of this 'revolution' on a day to day world that is often overlooked. In doing so I discussed how these pharmacists interact with, and become specialists in, their environment, highlighting independent practice that finds solutions to the challenges of the hyperdiverse urban setting.

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* Quote taken from a lecture given by Alex Gourlay the chief executive of Alliance Boots, Health and Beauty Division: 'Pharmacy and Health in 21st Century Europe', 13th January 2011 at the School of Pharmacy New Year Lecture 2011, held at the Royal Society, London. See also Chapter 2 p-13

10.1 Conclusions

10.1.1 Overarching themes

Fernandez suggests that the use of rhetoric to describe and defend roles in life is a 'fundamental' part of human nature:

> *This maintenance of satisfying role performance by argumentative means seems to be a fundamental mission in human life. (...). It is the mission of our argumentative power (...) to preserve our place for our gratifying performances and hence the world in which these things are lodged and to persuade others to recognise that place, that performance and that world.*
>
> *(Fernandez 1986: viii)*

I have demonstrated how the self-identified 'independent' pharmacists represented in this study frame their professional personhoods through the rhetorical use of three overarching and connected themes of autonomy, engagement and bespoke service. Autonomy forms the basis of professional personhoods and enables the pharmacist to exercise control over the development of customer relationships. This ability facilitates engagement with communities and individuals and ultimately makes possible a pharmacy offering that is based upon a bespoke 'personal' service. Together these rhetorical themes are used to identify with a collective interpretation of an 'ideal' independent practitioner. I have also shown how these themes are capable of being reinterpreted and used according to different situations.

These three themes are also used rhetorically to influence behaviour; either to suit or refute the dominant discourse. This was discussed especially in relation to how these independent pharmacists have reacted to the prevailing ideology, encouraging pharmacists to be more clinically orientated, pharmacists at the 'heart' of the community and a requirement for patient centredness. The relationship between these themes and the hegemonic framework makes pharmacists vulnerable to different interpretations of their rhetorical strategy. The core

themes identified can be both used by them but also used against them in enforcing a dominant ideology of pharmacy practice.

I found too that the urban environment itself becomes a protected space for independence. It provides a context for the expression of relationships with customers and their particular needs. The complexity of this setting is used symbolically to support the need for independent thinking, contrasted with an idea of an environment that is 'straightforwardly' middle class or suburban. Pharmacists position the need for autonomy, and hence independent pharmacy, in response to the particular set of challenges presented by this marginal environment. They suggest that they are able to preferentially service the needs of the hyperdiverse inner city through their ability to:

- Contend with ambiguity through the use of professional judgement
- Treat users as customers not patients and practice a 'respectful' way of being
- Be available and have control over their use of time
- Identify with urban lives

In presenting these challenges as being something that the multiples are unable or unwilling to address the urban context serves to give pharmacists exclusivity over a field of practice. It becomes a particular situation within which independent pharmacy can be utilised to its full advantage. As such, the pharmacists in this study were interested in producing pharmacy in the inner city as a particular kind of pharmaceutical practice. They were also keen to point out that this expertise should be acknowledged in wider policy decisions. In this way, the environment itself has its own rhetorical force in describing a special place for independent pharmacy. This alignment of pharmacist personhoods with the complexity and

marginalisation of deprived inner city areas is also used to subvert the need to defer to the centre in order to define a way of being.

10.1.2 Autonomy as a unifying idea

In Chapter Five I discussed how, for the pharmacists in this study, independent status was critical in defining themselves as professionals, whether as owners or managers. They were keen to defend the relevance of independence in a modern conceptualisation of pharmacy practice and as discussed, the desire to take part in this research was fuelled in a number of cases by the idea that my work would allow them to advocate the benefits of independent pharmacy to a wider audience. The fact that managers working for independent chains were able to identify themselves as being independent practitioners demonstrates the persistence and strength of this idea within the sector. This work however concentrated on a group of pharmacists who self selected themselves as being independent. Future research might go further in attempting to understand how and when pharmacists stop being able to think of themselves as independent (the limits of independence) and if pharmacists working for some 'independent' chains are different from others in their ability to connect to this idea and hence what conditions produce independent personhoods.

The most powerful persuasive tool in describing the value of independence is the ability to act with autonomy and the idea of being an autonomous practitioner united pharmacists with very different approaches to practice. This perception of self-determination brings with it a sense of freedom and a sense of opportunity. In spite of the restrictions imposed by professional standards and contractual obligations the sense that, in relative terms, independent pharmacists can also be independent actors was the key differentiating tool in

describing independent personhoods. This goes against an ideology within biomedical systems that increasingly positions autonomy as a threat to best practice and instead stresses evidence based and protocol driven medicine. For these pharmacists autonomy, even in a limited sense, gives them a moral agency that renders them 'more professional'. This moral agency was stressed in particular in comparison to pharmacists practicing in multiples who are subject to an extra layer of corporate rules and restrictions. Critically, in comparison to these colleagues the pharmacists felt that they were more able to exercise personal professional judgement. Pharmacists working for the multiples are considered to be 'twice subordinated' (to the GP and to the brand name) whereas heroic independents cling to a notion of autonomy in order to maintain their value versus the competition.

A range of different strategies were described in an attempt to indicate agency and the idea of the autonomous practitioner was performed through the ability to control engagement with customers and the ability to act using personal professional judgement (again consistent across both owners and manages in this study). This autonomous ideal is promulgated through the telling and retelling of stories of being able to make better choices and take better decisions. These comparison tales pitch the independent against the 'all controlling' multiple or the 'red tape bound' NHS.

Autonomy was a value with contemporary relevance and was discussed with equal potency by those pharmacists who had recently qualified as well as by those who had been practicing for many years. Independence therefore, also becomes an organising thought, providing a collective identity for this group of pharmacists.

10.1.3 A new professional tension

Returning to Carrithers' idea of agency-cum-patiency and the ability to use different cultural ingredients while being subject to change; pharmacists are not always the passive 'victims' of a dominant way of thinking (2005b). To some degree, these pharmacists pursue their own rhetorical strategies and form their own versions of professional personhoods within the confines of what is possible.

While the idea of autonomy is a unifying feature across the pharmacists in this study, being autonomous enables different interpretations of a dominant discourse that is in the process of redefining the remit for pharmacy. The rise of the multiples is leading to an increasing pull on interpretations of professionalism that assume a particular sort of business model and a particular scope of practice. Independent pharmacy challenges these assumptions and forces an exploration of the potential for different types of pharmacy personhood.

The traditional Janus faced community pharmacist is torn between a personality as a healthcare professional and one as a businessman. The two positions are in conflict and unresolved in professional personhoods. What I found in practice however was that these two aspects of the pharmacist's character were not always in tension. On an individual basis while a minority of the pharmacists I met still articulate their position through this narrative, most have found an effective way of being that rationalises both faces. Running a profitable shop and being proficient in business were simply requirements for being a 'good pharmacist' and some of those with the greatest interest in presenting themselves as 'healthcare professionals' also stated quite clearly a strong interest in business.

What seemed to be emerging in practice was a remaking of the fundamental tension in pharmaceutical identities, focussing on those who did and those who did not accept the hegemonic discourse that requires a shift towards a more clinically involved persona.

The essentialised presentation of the independent pharmacist is in opposition to change, but 'independence' can be used as a strategy either to resist or to embrace change. Pharmacists can choose to be at 'the cutting edge' or on the periphery of a new kind of pharmacy. This leads to a contemporary professional tension that sees some independent pharmacists embracing the new direction of pharmacy, drawing on elements of the dominant rhetorical framework in describing professional personhoods. On the other hand, rejecters of the dominant discourse utilise this opposition to create a professional sense of self that references 'traditional' or 'core' pharmacy values. Emic descriptions of this emerging tension position pharmacists as being more or less 'clinical'.

At the time of my research this distinction was best demonstrated in practice by the physical means through which pharmacists are able to project a professional persona in the shop and through their relative uptake of new pharmacy services. More clinical pharmacists are likely to describe themselves as being part of an integrated NHS and self consciously express expertise through alignment with medical authority and the new pharmacy mandate. They were often keen to take part in PCT level decision making and likely to assume a positive future outlook for independent pharmacy.

The 'rules of engagement' in the pharmacy i.e. the position of the pharmacy user as a 'customer' and the subordination of the pharmacist to the physician however restrict the application of a 'more clinical approach'. As yet the dominant rhetoric which calls for more

clinical involvement has not lead to a change in behaviour in advice giving in practice largely due to the pharmacists' inability to overcome these factors. More clinical pharmacists were still adjusting to this new role and did not as yet, base relationships on a more paternalistic, interventionist footing with customers. Although they talk about the possibilities of a more clinical personhood this desire to 'do more' was still ultimately related back to the ability to provide more services and offer more solutions to customers. It is impossible to say how much this situation might change as the development of personhoods is a contingent and continually negotiated process. Further investigation would be needed to follow-up this research and examine whether these 'clinical pharmacists' have been able to embrace their role more fully or whether these signifiers remain superficial.

Less clinical pharmacists meanwhile are more likely to describe themselves as being in an isolated business. Expertise for these pharmacists is expressed through control over a traditional dispensing focussed pharmacy mandate and they were more likely to assume a pessimistic future outlook. Those at this end of the spectrum could be dismissed as being 'nostalgic'. In the critique of independent pharmacy there is a sense that nostalgic idealisation of the past is used to protect independent pharmacy from embracing its future and that independence can prevent practitioners from embracing change and being truly 'modern' members of their profession. Nonetheless these 'less clinical' pharmacists do provide a powerful counterbalancing critique that suggests their role as an autonomous mediator is increasingly under threat as they are pulled into the NHS family. If this development entails giving up their outsider status these pharmacists suggest they could lose their true independence and hence perhaps their true value.

10.1.4 At the heart of which 'community'?

Chapter Six explored the idea of community within community pharmacy. As well as creating 'clinical' pharmacists, new pharmacy policy places great emphasis on the pharmacist as a figure within 'The Community'. The idea of locality dominates thinking about 'community pharmacy' and much writing about pharmacy assumes that 'place and society can be mapped directly onto each other' (Massey 2005: 64-66). Inherent in this assumption is the idea that the main factor driving pharmacy choice is proximity, compartmentalising the pharmacy offer to match the sort of population boundaries that define the limits of local GP practices. What we find in fact is that customers using independent pharmacy make more fluid decisions based on loyalty, familiarity and trust. 'Multiple geographies of association explain the everyday rhythms of encounter in the city' (Amin 2010) and the pharmacy is a site of multiple connections and associations. The modern independent community pharmacist therefore has to find a place within a modern conceptualisation of community that allows for both networks reaching beyond the local and customers without community within the pharmacy space.

What we also see from this study is that community status is not automatic and cannot be artificially imposed. The need for pharmacists to engage with different communities/networks shows that they are not only subject to a dominant rhetorical frame but also subject to acceptance from the general public. The pharmacists' presentations of professional personhoods take this into account and being perceived to be socially close to the customers they serve is positioned as being of critical importance in creating successful acceptance.

As Burke concludes, 'belonging is rhetorical' (Burke 1969: 28). To establish a reputation and to create trust pharmacists actively practice 'public identification' with the concerns and views of these different communities in order to engage with them and build relationships (Britten 2008: 156). Pharmacists' narratives often include a discussion of their integration into communities and a feeling that they are 'like them'; closer to the lifeworld concerns of customers, constructing a 'public' identity for local consumption (ibid.). Burke refers to such acts of persuasion as 'stylistic identifications' in which the speaker 'draws on identification of interests to establish rapport between himself and his audience' (Burke 1969: 46). Being able to practice identification with the hyperdiverse urban community was utilised to explain the high percentage of pharmacists from ethnic minority backgrounds who are able to exploit their connection with particular communities and create successful businesses in seemingly very challenging settings.

The ability of pharmacists to identify with and engage with certain communities relies on the possession of what Bourdieu describes as symbolic capital. While the term capital is usually associated with economics Bourdieu extends this idea, using capital in a much broader sense to refer to: 'a wider system of exchanges whereby assets of different kinds are transformed and exchanged within complex networks or circuits within and across different fields' (Moore 2008: 102). These symbolic capital 'assets' include for example; cultural capital, linguistic capital or scientific capital. Capital assets like these can exist in different forms. For example; objectified capital is materially represented through various different *things*, artefacts such as books or galleries or laboratories. Embodied capital is envisaged as elements of the person including everything from language to bodily stance. In-between these two forms of capital lies habitus. Habitus does not have a material existence but refers to 'attitudes and dispositions', the rules of living. Habitus can be transmitted informally

however it can also become institutionalised capital in form of formal education (ibid: 102-104).

Bringing these ideas together, 'embodied cultural capital' for example might include elements of ethnic identity. Ethnic identity can also be thought of as including aspects of habitus, including knowledge of disposition and attitude, an understanding of the 'rules of the game'. Linguistic capital, defined as 'the mastery of and relation to language', can is also seen as a form of embodied capital in that it represents a means of communication and self-presentation acquired from one's surrounding culture (Bourdieu and Passeron 1990: 114). To illustrate how these forms of capital might be used Bourdieu proposes for example that the more linguistic capital a speaker holds 'the more they are able to exploit the system of differences to their advantage and thereby secure a profit of distinction' (Bourdieu and Thompson 1991: 18).

An individual's command of a shared symbolic capital in discourse, images, goods or actions can also be transformed into economic capital (Portes 2000). The pharmacists in this study were adept at utilising cultural capital to their advantage in this way. As forms of symbolic capital language and ethnicity therefore become 'both [a] stake and a weapon' in the struggle for legitimate authority' (Emribayer and Williams 2005).

It was clear too that the pharmacist's cultural and linguistic capital could be 'used' in two distinct ways. Firstly as part of the 'minority majority' in the area able to identify shared experiences with their customer base. This created a 'connectedness' (contrasted with an assumed white British 'separateness') which allowed for greater intimacy and a more personal interaction. The pharmacists construct a self-conscious 'cosmopolitan' persona

which sets them apart from white British pharmacists and from pharmacists who do not have any understanding of this particular urban setting. This cosmopolitan identity, rather than envisaging them as being 'suspended between' cultures (Baumann 1996: 1-2) sees them as able to rely simultaneously on different types of cultural knowledge; able to move successfully 'from one cultural milieu to another without feeling disorientated' (Pécoud 2004). The cosmopolitan capability described here is not solely focussed on their own versus British culture but rather is about managing the hyperdiverse cultural environment they find themselves in.

Hannerz described cosmopolitanism as an 'openness and desire for social difference' (Hannerz 1996: 103). Mandel criticises this view however as being 'elitist' (Mandel 2008: 48-50). She points towards a more egalitarian cosmopolitan identity which is available without reference to social class or aesthetic taste following Clifford's interpretation that emphasises the cosmopolitan identities of 'translocal' people able to inhabit multiple cultural localities (Mandel 2008: 48-50; Clifford 1997, 1998). This down to earth cosmopolitanism which has a number of parallels with the pharmacists descriptions and performances was also found by Pécoud in his study of German -Turkish entrepreneurs (2004). Pécoud discusses how in areas where cross cultural experiences are a daily reality cosmopolitanism is a requirement of business practice

> *German-Turkish entrepreneurs' cosmopolitanism has both a mental and a practical dimension. Business is a concrete activity that requires actual skills and in this respect, cosmopolitan competencies are essential to business success. This implies that cosmopolitanism is not always a matter of entrepreneurs' will or pleasure.*
>
> *(Pécoud 2004: 16)*

This very practical interpretation of a cosmopolitan way of being does not preclude 'world-openness' or the enjoyment of inter-cultural relationships but also acknowledges a more pragmatic approach (Pécoud 2004).

Secondly, pharmacists use their cultural capital as members of a particular ethnic group with a shared understanding of language, religion and culture to build quite specific relationships with particular co-ethnic communities. As professionals within culturally defined communities pharmacists can also act as ethnic gatekeepers. For these communities the pharmacist can become a mediator of the boundary that exists between migrants and the host society (Brettell 2003: 127). The role of the pharmacist as a 'bridge' between the lay and professional sectors has been discussed for example by Logan (1988) in Mexican pharmacy and by Ferguson (1981) in El Salvador. What is important in this particular case is the extra dimension to this bridging role, spanning not just knowledge boundaries but also representing cultural negotiation (Duckett 2007).

In a recent presentation exploring the practice of cross cultural care in the American hyperdiverse milieu Good rejects the idea of 'cultural matching' as a desirable practice and presents a number of examples where either attempts to create cultural matches have failed or have not been welcome by either patient or practitioner (Good 2010). What I discovered in this setting was that in an organic, choice based situation the decision to seek 'sameness' in terms of the healthcare provider was more complex than just finding someone of the same cultural background. For many, it seemed that rather than a cultural 'match' the search was for a relationship with a healthcare provider who might possess an understanding of and sympathy towards place and situation. Nonetheless, in certain situations the desire to seek out a relationship with a healthcare provider of similar cultural/linguistic background is very

powerful. In this case 'cultural matching' is successful because it is not set up artificially, but because it is responding to a self identified need and the pharmacist is a self identified solution. In this situation 'matching' puts customers in control of identifying cultural aspects they find important, and indeed what other characteristics might influence their decision such as gender or age. Customers expectations are managed through their own investigations and pharmacists might represent 'the best fit' rather than necessarily 'a perfect match'.

10.1.5 Building relationships and managing 'throwntogetherness'

> *The singlehanded general practitioner may know his or her population in considerable depth and may be able to provide the kind of continuing and personal care that is still important to patients and which may be difficult to provide in larger practices.*
>
> *(Green 1996: 609)*

Green discusses how singlehanded practitioners reify relationships and even discuss them as a therapeutic end in themselves (Green 1993, 1996). In Chapter Seven I showed how relationships are used symbolically to endorse the idea of the 'good independent pharmacist' and to present the value of the pharmacy externally. It would be easy to write dismissively about the pharmacists' claims for the significance of relationships as a 'given' in the independent pharmacy environment. However, relationships are particularly and consciously developed within the pharmacy and at the level of the individual engagement remains an important part of pharmacy practice and a key aspect of pharmacist personhoods. Independent pharmacists at either end of the 'clinical spectrum' all cite their ability to engage with customers and create successful personal relationships as being a particular feature and defined advantage of independent pharmacy As we have discussed, the pharmacist is often portrayed as a somewhat 'troubled craftsman' (Sennett 2008), searching for a sphere of

expertise. For the pharmacists in this study, the development of relationships seems to have come to embody that expertise.

Being successful in creating personal relationships is a measure of success as a pharmacist that is both personally expressed and outwardly judged. Engagement with customers on an individual level is also a platform for demonstrating autonomy in the ability of the pharmacist to shape and create trustful relationships over time. Perhaps the most important ingredient in building pharmacy relationships is continuity of staff. This continuity is critical to moving respectful relationships on to more intimate relationships built on a sense of trust. Close relationships unlock the key benefit of the pharmacy in producing tailored care and hence it is not surprising that the ideal of the 'good pharmacist' is closely related to the ability to develop this sense of closeness. Multiples have tried to replicate this closeness through the development of loyalty schemes such as the extremely successful Boots Advantage Card scheme* which aims to give customers a sense that they are being preferentially treated through the collection of purchase history. This scheme allows Boots to put together packages of offers tailored to particular customers shopping habits to give a more 'personal' feel to the shopping experience.

A power balance that is shifted towards the customer and a sense of informality gives interactions in the pharmacy a different quality to those in other healthcare settings. Their reliance on customer choice prevents a privileged education that socialises pharmacists into a 'biologically dominant, 'medical' gaze' from creating too much distance between professional and consumer (Good 2010). The advent of patient centred care as a way of the

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* The Boots scheme enrols customers in a card based programme where for every purchase they make in store they earn points. Each point is worth 4% of every pound spent in store. Points are collected and then can be redeemed against future purchases. Customers are encouraged to treat themselves to luxury items rather than spend the points on everyday purchases. The scheme also allows Boots to gain valuable information on shopping habits and develop personalised marketing.

centre exerting control over how relationships are produced, while admirable in privileging end users needs, perhaps ignores some of the benefits inherent in simply *not* being a patient in the pharmacy space. Within the discourse of these pharmacists we see resistance to this ideological imposition of the pharmacy user as a patient as a default status. They retain a personal level of control by continuing to locate pharmacy users as customers and adopting a service based rather than a consultation based approach to practice. Customers are transformed into 'patients' in a small percentage of transactions as was discussed in Chapter Eight by signifying deferment to expertise and an expressed desire for the pharmacist to take control of a clinical situation .

The discussion of engagement at an individual level is repositioned through the trope of 'respect' which provides pharmacists with a way of being or a philosophy of service. Respect as a 'philosophy of service' in the pharmacy is discussed in the context of customer-pharmacist (rather than patient-pharmacist) relationships and it is a mutual process. Respect does not deny the professional status and authority of the pharmacist, indeed it requires that the customer acknowledge the pharmacists' position. At the same time however it places an obligation on the pharmacist to be driven by listening and responding to the concerns and demands of the customer, irrespective of their social position.

This idea of respect was particularly discussed when describing dealing with hyperdiversity or 'throwntogetherness'. 'Throwntogetherness' is a term coined by Doreen Massey (2005: 149-162) to describe the nature of diversity and difference in contemporary urban life. Throwntogetherness is a practical reality of urban living and the response to this daily diversity is normalised and unexceptional. The pharmacists use their cosmopolitan identities to identify themselves with urban values and an urban morality that allows them to negotiate

this complex and marginal (in societal terms) urban field. As Amin suggests, helping them to rationalise the 'bewildering' experience of urban living:

> *(...) habits of urban living including the social response to diversity are largely precognitive, based on daily reflexes of urban negotiation that require little thought and deliberation. That is how the potentially bewildering experience of urban multiplicity and variety is tamed and domesticated.*
>
> *(Amin 2010: 5)*

Cross cultural interactions are addressed in very simple terms. Pharmacists don't display a sentimental concern but rather dispense an efficient, pragmatic style of care based on intuition and experience. The need to create 'rules' has been negated by concentrating on the 'art of the individual'. Pharmacists build on skills learnt through their experiences of being in the city that are sensitive to but not fearful of difference. This in turn influences consultations and the pharmacists' method of questioning and interpreting. There was both an avoidance of compassion but creation of a shared comprehension and connectedness, which does not rely on a complete understanding. This style of healthcare provision is not particularly different to that which the pharmacists apply in any other circumstances however cross cultural exchange can heighten communication challenges, especially if there is a language barrier.

This way of providing what might be considered 'culturally competent care' is not part of a sophisticated, ideological approach but rather is a natural, intuitive, adaptive response. The pharmacists recognised the value of building on the pharmacy as a place where people could expect good communication. Becoming communication specialists or centres where customers can expect to be able to make themselves understood was a key benefit of the specialisation of independent pharmacy. Pharmacists used staff to extend their ability to connect with co-ethnic networks offering a wide range of languages services even within the

smallest pharmacies. As such, a significant part of the role of the urban independent pharmacist and pharmacy was felt to be defined by explaining, guiding, and translating.

In spite of this success however, cross cultural interactions were both observed and perceived by the pharmacists as being an especially testing aspect of practice. Repeated concerns of misunderstanding, misconceptions and mistranslations peppered everyday talk. In pharmacists' discourse they fluctuate between emphasising a sense of normalised diversity and their competence in dealing with this environment while simultaneously highlighting it as a particular challenge and emphasising their difficulties in managing particular customers. Good* (2010) identified five particular challenges facing healthcare professionals/patients in the hyperdiverse setting all of which were experienced by pharmacists in this study:

- Multiplicity (of ethnic/cultural groups)
- Ambiguity (racial ethnic identity not easily labelled or understood)
- Simultaneity (individuals occupy multiple racial/ethnic categories)
- Misidentification (patients mistakenly labelled as member of particular ethnic or racial group)
- Misapplication (patient is correctly identified but does not share culture of group)

Personal experiences may render pharmacists more malleable and more able to contend with many different cultures. However, it is important to remember that while personal experience of 'being the other' helps these pharmacists to recognise the unknown it does not automatically equip them to deal with every situation that might arise. Little assistance seems

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* Who acknowledges Seth Hannah in developing this work. Hannah also presented these ideas at the Society for Medical Anthropology Conference 2009, Yale University. Breakout session 1. Friday 25th September: Shattering Culture: American Medicine's Responses to Hyperdiversity Presentation: Clinical Care in Environments of Hyper-diversity: Race, Culture, and Ethnicity in the Post-Pentad World.

to be given to ensuring the success of day to day transactions within the pharmacy and pharmacists are arguably being failed by current training and leaflet based support programmes which do not address some of the most basic needs of the pharmacy transaction. It was also argued that enabling successful cross cultural interactions requires more than just a focus on practitioners. Pharmacists describe a need to refocus 'competence' on communicative practice and suggest that, although the availability of language support in the pharmacy is important this is insufficient in enabling longer term solutions.

10.1.6 A very special service

In Chapters Eight and Nine I discussed two other particular aspects of independent pharmacy practice that make creative, tailored exchanges possible: Time and practical specialism.

Time is rarely dealt with in a holistic manner in pharmacy research; instead it tends to be apportioned to 'meaningful interactions' surrounding the provision of services. The offer of time however is critical to independent pharmacy as a differentiating feature, crucially enabling pharmacists to be accessible and attentive.

As pharmacy personhoods rely heavily on these values time is reified in the pharmacy. It is either discussed as something pharmacists have more of and have more control over or as a resource that is precious and running out. Throughout pharmacists' accounts and throughout my observation work the idea of time was used strategically as an important persuasive device. The rhetorical use of 'more time' and 'accessible time' is most common in describing the practicalities of engagement with customers. Pharmacists suggested that pharmacy time is in danger of being changed forever in the face of the new contract and in doing so this

changes the nature of pharmacy interactions and hence the values of independence. This idea of threatened time has therefore become a metaphor for the pharmacists' dilemma and the difficulties they face.

Immediacy of access, both physical, and as a result emotional, is a particularly important and from what I observed very successful aspect of independent community pharmacy (in spite of the pharmacists' struggle with interrupted time). This accessibility however is particularly perceived to be under threat from the evolution of consultation based services.

Running out of time or lack of time is often discussed in relation to services pharmacists are unwilling to engage with such as public health messaging or in relation to aspects of practice that they struggle with such as providing advice alongside prescriptions. The failure of pharmacists to capitalise on a supposed expanse of available time in these advice giving situations challenges their rhetoric of engagement and their abilities in relationship building, hence their failure to manage time can be used against them. Meanwhile the dominant rhetoric has failed to persuade pharmacists of the advantages of a new way of managing time in the pharmacy. The advantages presented by the new mode of practice as yet do not compensate for the potential loss of traditional pharmacy values.

Deploying time as part of the performance of pharmacy is also an important persuasive act aimed at persuading customers and therefore influencing 'bottom-up' power relationships. I found that in spite of an observed failure to maximise the use of time in advice giving surrounding medicines and health, pharmacists did utilise time to create informal spaces for 'non clinical advice giving' and in 'sorting out' problems. These informal services are of

particular significance in differentiating the role of the independent from the multiple and rely on the exercise of autonomy and the use of professional judgement.

Anderson (2006) describes how the pharmacist's remit has moved from bespoke medicines to 'off the peg'. Independents however are trying to hold on to the bespoke nature of practice through the way they service customers. This study shows that independent pharmacists were very good at exploiting their potential as specialist-generalists. In using language skills or stock decisions to grow special interests within the pharmacy offering, pharmacists create a distinctive practice. This demonstrates well how small pharmacies can survive by becoming 'destinations', places people will choose to go out of their way to visit in order to access particular services or stock. The rhetorical play on the idea of specialism is used to contrast their services with the multiples and their 'one size fits all' approach. The pharmacists felt that the flexibility possible through having autonomy over practical decision making was critical in enabling them to provide a personal and individual service. Much like the single handed GPs in Green's study it was felt that the ability to provide an individualistic approach was lacking in other areas of the health service today (Green 1996).

Good (2010) describes how patients who don't fit into the 'medical machine' may pose a particular problem in an environment where 'co-operative patients' are needed. As the pressure on the NHS places more demands on the public as well as healthcare professionals and requires a great responsibility in managing personal wellbeing, the independent pharmacy remains a place where those with socially complex problems can command more attention. In fact, for the independent pharmacy socially complex problems actually represent an opportunity rather than a threat. Pharmacists argue that this level of consideration is often neglected, but deeply appreciated. For these customers, most of whom who are unlikely to be

able to access private healthcare, the pharmacy is the only place they can go where there is some movement to accommodate them personally. As one pharmacist put it, the only time when somebody is going to be able to say, 'right we'll do this just for you'. Looking beyond the pharmacy they can enable customers to secure health and social benefits and equip them with the skills with which to operate successfully within the NHS system. While patient centredness is central to the 'modern' pharmacy however the type of 'bespoke practice' independent pharmacists provide is not always held in the highest regard and indeed at times may be viewed as involving morally questionable/ unthinkingly paternalistic rule breaking, rather than a positive exercise of professional judgement (for example as discussed by Benson et al. (2009) in relation to pharmacy in general). Nonetheless, in terms of the 'web of possibilities' that the pharmacists work within, it is in this aspect of practice that they are able to show their potential and their ability to maximise the value of autonomy (Lukes 2005: 68-69).

10.2 Implications

In this final section I wanted to outline the possible implications of this study for future research but also looking towards pharmacy practice and policy.

In conducting this study I have highlighted the dearth of research concerning the figure of the pharmacist within anthropology, in spite of the role they play at the frontline of care. In terms of an 'anthropology of the pharmacy' therefore I raised the need to understand the position of the protagonists who deal with (and in) medicines as well as medicines themselves. Given the increasing calls on staff to take on extra responsibility within the pharmacy it should also be

noted that even less attention is paid to these figures who operate in a poorly defined space and without the level of professional training and representative voice of the pharmacist. The fact that all but one of the pharmacists represented here were from ethnic minority groups also raises the need to consider the pharmacy within the context of research that seeks to understand the position of minority healthcare professionals within the provision of care and the potential inequities that persist in the delivery of care.

The rhetoric culture approach taken sheds some light on the strategies independent pharmacists use to describe a place for themselves in the world and demonstrates how that this space is contested. This research suggested however that the role of the independent pharmacist is neither easily definable nor defendable and a greater understanding through a contextualised, contingent anthropological approach would be especially valuable in further exploring the complexities of pharmacy life. The role of independence however is also under-examined more generally within pharmacy practice research and the term 'independent' is potentially being used very differently by pharmacists, policy makers and researchers. A clearer understanding of how this term is used could lead to better tailoring of support, training and service implementation.

As I write the *Pharmaceutical Journal* is running an article which calls for community pharmacy to 'work together to stake a claim' in a new GP commissioning world. 'Bridges need to be built with other healthcare professionals' the article suggests and competition between pharmacies for goods and services needs to be addressed (Burke 2011). To this latter point in particular the questions this research has raised regarding the potential status of independent pharmacy and the relationship between the services it provides versus the multiples are of particular importance. Pharmacy practice recommendations rarely make any

distinction between the offer or potential of independent pharmacy as opposed to the service provided by the multiples or discuss how the differences in service could be used in dissimilar but complementary ways. This study supports findings by Bush et al. (2009) who concluded that

> *'A mixed market in community pharmacy maybe required to maintain a comprehensive range of pharmacy-based public health services and, in turn, provide maximum benefit to all patients'.*
>
> *Bush et al. (2009)*

It is also important to try to understand these differences in more depth as powerful corporations are becoming increasingly dominant voices and major employers of community pharmacists. Alongside this investigation into the influence of branding on professionality and pharmacy ethics is needed to shed light on the differences reported in this study.

In the introduction to this thesis I outlined the current interest in the role pharmacy can play in attempting to address health inequalities, in particular through the potential to reach out to 'hard-to-reach' groups in the inner city. In situating my study in a particular environment I explored the potential for investigating these practitioners in terms of their relationship to marginal, urban communities. The places I visited in East and South-East London do have their own special circumstances but nonetheless these urban places bear comparison to other inner city locations, especially within Great Britain. They reveal familiar challenges relating to the urban population, including diversity and deprivation, and distinctive business challenges particular to inner city locations including the extreme and overtly competitive landscape. The pharmacists' experience of this situation suggests that 'urban pharmacy', deserves special consideration, highlighting means of meeting these challenges that reside in the provision of nuanced, personalised care.

The provision of cross cultural care was a particular discussion point raised within these findings. Further research is called for in order to investigate the daily reality of practice, how notions of ethnicity and cultural similarity/difference are being used/exploited by pharmacists, staff and their customers, encouraging reflection and appraisal of the realities of maintaining a small business in a hyperdiverse community. In practice the pharmacists in this study also highlighted the failure of current services based on the provision of language support and training in communication skills. In particular, written information was criticised for being too general to be appropriate for everyday needs. Pharmacists wanted more help in addressing labelling in particular and called for programmes that did not only focus on 'arming' the practitioners to deal with cross cultural interactions but which also sought to educate and empower customers.

This study also discussed the fact that the therapeutic relationships pharmacists construct as part of this role challenge conventional expectations of healthcare/practitioner relations within biomedical models. In policy terms this study raises concerns over the direction pharmacy is taking in repositioning the pharmacy user as a patient and calls for a critical assessment of what might be lost in pursuing this focus to the exclusion of the 'customer' from all but non-pharmaceutical transactions. In the light of the recent focus on the development of the pharmacists role it is important to examine how relationships on a personal level are currently created and valued in order to inform this discussion and to ensure that in the drive to move 'forward' existing skill sets are not ignored.

I discussed how these particular pharmacists, operating on the margins of the profession are able to challenge the dominant rhetorical framework and provide creative solutions to practice within a socially complex setting. In raising these issues however I also touched on

the difficulties pharmacists are experiencing in managing particular elements of practice. Although this study did not focus on service delivery it highlighted the ongoing problem of advice giving in the pharmacy, the perceived threat to pharmacy time (and hence value) from consultation based services and rejection of public health messaging. The former concerns represent what might be seen as a depressing reiteration of previous findings although this study did highlight areas of particular and valuable success that lie outside the formal situation. In returning to these themes however the failure of the dominant rhetoric to persuade pharmacists of the benefits of change perhaps exposes weaknesses within the strategies employed in engaging pharmacists and in dealing with change on the ground. In relation to public health messaging this research raised particular concerns regarding the ability and/or desire of pharmacists to effective implement some aspects of the new contract.

In conclusion, as pharmacist 15 summed up, this research highlights the figure of the independent pharmacist and in exploring the construction of pharmacists' personhoods reveals a particular 'way of being ' that makes a valuable contribution to the delivery of care that should not be overlooked;

> It is a very different thing, sometimes even though it doesn't look like it. You might say Boots, local pharmacy, what's the difference? But there is a difference, (..) it is important to the people. It is definitely important to the people.
>
> **Pharmacist 15**

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Appendix 1.

Ethical approval, London School of Hygiene and Tropical Medicine

LONDON SCHOOL OF HYGIENE
& TROPICAL MEDICINE

ETHICS COMMITTEE

APPROVAL FORM
Application number: 5348

Name of Principal Investigator	Kathryn Duckett
Department	Public Health and Policy
Head of Department	Professor Anne Mills

Title: Pharmacy practice in a multi-ethnic community: the perspective of ethnic minority independent community pharmacists in East London

This application is approved by the Committee.

Chair of the Ethics Committee . T. W. Meade .....

Date .....27 August 2008.....

Approval is dependent on local ethical approval having been received.

Any subsequent changes to the application must be submitted to the Committee via an E2 amendment form.

Appendix 2.

Consent and participant information forms.

Examples of the following are shown overleaf:

- Participant information sheet interview
- Participant information sheet observation
- Consent for interview
- Consent for observation

Participant Information Sheet: Interview

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information.

Study Title

Pharmacy practice in a multiethnic community: the perspective of independent community pharmacists in East London

Investigators

Principal Investigator: Kathryn Duckett

Supervisor: Dr Stuart Anderson

Contact Details: London School of Hygiene and Tropical Medicine, Keppel St, London

What is the purpose of the research?

This research is being carried out as part of a dissertation for an ESRC (Economic and Social Sciences Research Council) sponsored PhD thesis in Public Health Services Research at London School of Hygiene and Tropical Medicine (LSHTM).

The study does not involve any local NHS trust or other Pharmacy professional or regulatory bodies and has not been sponsored or commissioned by any such body.

The study has been approved by the LSHTM ethics committee

Why have I been chosen?

The study involves independent community pharmacists it is anticipated that 24 pharmacists in total will be interviewed during the course of the study. Pharmacists are chosen 'opportunistically' in other words the investigator selected your pharmacy purely on the basis of being in the area of study and from information available in the public domain regarding the status of the pharmacy. No formal selection procedures have been used and no other information was accessed regarding you personally or this pharmacy in particular.

Do I have to take part?

Participation is entirely voluntary and you may discontinue participation at any time. There will be no pressure exerted on you to continue with the research following your decision to discontinue.

What will happen during the research?

The research will take the form of an informal interview/ discussion based on some pre-prepared questions around the topic area. The interview will probably take around one and a half hours (I will discuss with you the amount of time you are able to commit at the beginning of the research in order to fit around your availability). The interviews will be recorded on a Dictaphone purely so that I am able to listen back to the discussion at a later date. I might also take some notes during the discussion.

If at any time questions make you feel uncomfortable or you feel you do not wish to answer the questions please inform me and please remember you can withdraw from the study at any point.

Will my taking part in this study be kept confidential?

I will ensure compliance with legal requirements in relation to the storage and use of personal data as set down by the Data Protection Act 1998. Records of the research will only be accessed by me as the principal investigator named here and data, once analyzed, will be disposed of in a secure manner.

The confidential and anonymous treatment of participants' data is considered the norm for the conduct of research. As a researcher I must recognise your entitlement to privacy and must accord you your rights to confidentiality and anonymity, unless you specifically and willingly waive that right. You will be asked in the consent form if you agree to be anonymously quoted. This means that in the final presentation of material something you say may be written up verbatim and referenced for example 'Pharmacist X said:...'

It is my responsibility as the researcher to ensure that data in the form of any publication does not directly or indirectly lead to a breach of agreed confidentiality and anonymity.

Following assessment and grading by examiners in LSHTM, the finished thesis will be held by LSHTM libraries available on request for consultation.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the study, it is hoped that this work will contribute to furthering the development of the role of pharmacy within primary health care services in the UK.

Will I be debriefed at the end of the research?

Should you wish to receive a summary of findings and any subsequent work relating to this study then this can be provided for your interest. If you wish you can be provided with a copy of the transcript of your interview.

What will happen to the results of the research study?

It is hoped that the conclusions from this study will form the basis of further, more extensive research on the role of pharmacy and the training of pharmacists.

The results of this study may be used in publications in appropriate outlets including pharmacy journals, at conferences and in other discussion forums.

Participant Information Sheet: Observation

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information.

Study Title
Pharmacy practice in a multiethnic community: the perspective of independent community pharmacists in East London

Investigators

Principal Investigator: Kathryn Duckett

Supervisor: Dr Stuart Anderson

Contact Details: London School of Hygiene and Tropical Medicine, Keppel St, London

What is the purpose of the research?

This research is being carried out as part of a dissertation for an ESRC (Economic and Social Sciences Research Council) sponsored PhD thesis in Public Health Services Research at London School of Hygiene and Tropical Medicine (LSHTM). The study does not involve any local NHS trust or other Pharmacy professional or regulatory bodies and has not been sponsored or commissioned by any such body.

The study has been approved by the LSHTM ethics committee

Why have I been chosen?

The study involves independent community pharmacists it is anticipated that 20 pharmacists in total will be interviewed during the course of the study. Pharmacists are chosen 'opportunistically' in other words the I selected your pharmacy purely on the basis of being in the area of study and from information available in the public domain regarding the status of the pharmacy. No formal selection procedures have been used and no other information was accessed regarding you personally or this pharmacy in particular.

Do I have to take part?

Participation is entirely voluntary and you may discontinue participation at any time. There will be no pressure exerted on you to continue with the research following your decision to discontinue.

What will happen during the research?

During the observation work the researcher will be present within the pharmacy in order to collect notes on: communication with customers, use of space, time within the pharmacy and the pharmacy environment.

It is anticipated that I will visit the pharmacy on average 5 times a week throughout a 4-6 week period for sessions lasting for approximately 4-5hours each in order to gain a good understanding of daily life within the pharmacy. These times will be agreed with you to fit with your requirements prior to commencing the research and reviewed as the research progresses to ensure you are comfortable with the arrangements made. You will be able to agree with me as to how best to handle my presence

within the pharmacy. It is anticipated however that when conducting research she will be sitting on a chair close to but not behind the counter where transactions can be overheard but such that customers who request a 'private' discussion are not compromised. If at any stage my presence is found to be disruptive to the pharmacy then observation will cease.

Systematic recording of observations in the field will be made, comprising logs of intended and actual daily activities, a personal diary and methodological and descriptive field notes of observation and analysis including descriptions of what is seen and experienced and also perceptions and interpretations of events.

Will my taking part in this study be kept confidential?

I will ensure compliance with legal requirements in relation to the storage and use of personal data as set down by the Data Protection Act 1998. Records of the research will only be accessed by me as the principal investigator named here and data, once analyzed, will be disposed of in a secure manner.

The confidential and anonymous treatment of participants' data is considered the norm for the conduct of research. The researcher must recognise your entitlement to privacy and must accord you your rights to confidentiality and anonymity, unless you specifically and willingly waive that right. You will be asked in the consent form if you agree to be anonymously quoted. This means that in the final presentation of material something you say may be written up verbatim and referenced for example 'Pharmacist X said:...'

It is my responsibility as the researcher to ensure that data in the form of any publication does not directly or indirectly lead to a breach of agreed confidentiality and anonymity. Following assessment and grading by examiners in LSHTM, the finished thesis will be held by LSHTM libraries available on request for consultation.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the study, it is hoped that this work will contribute to furthering the development of the role of pharmacy within primary health care services in the UK.

Will I be debriefed at the end of the research?

Should you wish to receive a summary of findings and any subsequent work relating to this study then this can be provided for your interest. If you would like a brief summary of results for your pharmacy in particular this can also be provided

What will happen to the results of the research study?

It is hoped that the conclusions from this study will form the basis of further, more extensive research on the role of pharmacy and the training of pharmacists.

The results of this study may be used in publications in appropriate outlets including pharmacy journals, at conferences and in other discussion forums.

CONFIDENTIAL

Informed Consent Form: Interview

Principal Investigator: Kathryn Duckett

London School of Hygiene and Tropical Medicine, Keppel Street, London

Title: Pharmacy practice in a multiethnic community: the perspective of independent community pharmacists in East London

	Please circle as appropriate	
Have you read and fully understood the Participant Information Sheet?	**YES**	**NO**
Have you had the opportunity to ask questions about the study?	**YES**	**NO**
Have you received satisfactory answers to all your questions?	**YES**	**NO**
Do you understand that you are free to withdraw from the study without penalty, at any stage?	**YES**	**NO**
Do you agree to the audio taping of the interviews conducted solely for the use of the principal researcher in analyzing the results of this study?	**YES**	**NO**
Do you agree with the publication of the results of this study in an appropriate outlet/s on the understanding that the researcher complies with the stated anonymity, confidentiality and data protection measures?	**YES**	**NO**
Do you agree to being anonymously quoted within the research? **(See participant information sheet)**	**YES**	**NO**
Do you agree to take part in this study	**YES**	**NO**

Signed:.....

Date:.....

Full Name in Capitals:.....

CONFIDENTIAL

Informed Consent Form: Observation

Principal Investigator: Kathryn Duckett

London School of Hygiene and Tropical Medicine, Keppel Street, London

Title: Pharmacy practice in a multiethnic community: the perspective of independent community pharmacists in East London

	Please circle as appropriate	
Have you read and fully understood the Participant Information Sheet?	**YES**	**NO**
Have you had the opportunity to ask questions about the study?	**YES**	**NO**
Have you received satisfactory answers to all your questions?	**YES**	**NO**
Do you understand that you are free to withdraw from the study without penalty, at any stage?	**YES**	**NO**
Do you agree with the publication of the results of this study in an appropriate outlet/s on the understanding that the researcher complies with the stated anonymity, confidentiality and data protection measures?	**YES**	**NO**
Do you agree to being anonymously quoted within the research? **(See participant information sheet)**	**YES**	**NO**
Do you agree to take part in this study?	**YES**	**NO**

Signed:.....

Date:.....

Full Name in Capitals:.....

Appendix 3.

Customer information sheet

Customer information

What is the research that is taking place in my pharmacy?

This research is concerned with better understanding the work of independent community pharmacists. By observing the pharmacist at work in your pharmacy the research hopes to get a good idea of the services offered within the pharmacy, how the pharmacist's time is used and how the pharmacist carries out consultations with his customers. It is important to be able to watch what happens on an ordinary everyday basis as well as speaking directly to the pharmacists themselves although interviews are also being carried out with pharmacists as a separate exercise.

While your discussion with the pharmacist might be observed as part of this work you are not the subject of the research.

Why this pharmacy?

Pharmacists are chosen 'opportunistically' for this study, in other words the investigator selected your pharmacy purely on the basis of being in the area of study and from information available in the public domain regarding the status of the pharmacy.

Will anything I say be recorded?

The researcher might make notes about the kind of information you were looking if you have a conversation with the pharmacist or the products you were interested in buying when you came to the shop but will **NOT** write down any information about you in particular, including any reference to your name, address or any other personal information. **NO** audio or video recording equipment is being used. There will be **NO** reference to what you said in any study which could be traced back to you or even back to this particular pharmacy or the pharmacist we are studying. The pharmacist being observed has agreed to take part in this study only on the understanding that his anonymity and confidentiality are preserved.

What is the research being carried out for?

This research is being carried out as part of a dissertation for an Economic and Social Sciences Research Council (ESRC) sponsored PhD thesis in Public Health Services Research at London School of Hygiene and Tropical Medicine (LSHTM).

Following assessment and grading by examiners in LSHTM, the finished thesis will be held by LSHTM libraries available on request for consultation.

The study has been approved by the LSHTM ethics committee

What will happen to the results of the research study?

It is hoped that the conclusions from this study will form the basis of further, more extensive research on the role of pharmacy and the training of pharmacists. The results of this study may be used in publications in appropriate outlets including pharmacy journals, at conferences and in other discussion forums.