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**'"PHARMACY COUNSELLING": A STUDY OF THE  
PHARMACIST/PATIENT ENCOUNTER  
USING CONVERSATION ANALYSIS'**

**by Alison Pilnick, BPharm, MA, MRPharmS.**

Thesis submitted to the University of Nottingham  
for the degree of Doctor of Philosophy, May, 1997



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## ABSTRACT

Pharmacy as a profession is changing rapidly in the UK. Over recent years, the increased utilization of ready-prepared drugs has led to a decline in the need for the traditional skills of formulation, while computerization has resulted in a situation where much of the routine dispensing work can be undertaken by less qualified personnel. The decline in the traditional aspects of pharmacy has been matched by the emergence of a much greater advisory role. Pharmacy practice researchers have been drawn to support these developments by investigating related areas, but the common factor linking this research is its focus on clinical as opposed to communication issues. Rather than investigating the nature of face-to-face interaction between pharmacists and clients as a topic in itself, researchers instead have been largely concerned with patient/health care system interactions as a function of drug therapy. Those few studies that have focused exclusively on communication have done so from a quantitative, social psychology framework, thus ignoring the two way, reactive nature of the interaction process.

This study, using data collected from patients' and carers' consultations with pharmacists in a hospital paediatric oncology outpatient clinic, uses the sociological methodology of Conversation Analysis (CA) in order to analyze the encounters which take place. In so doing, it aims to shed some light upon what is actually involved in the process of "patient counselling" in this setting. The body of CA literature which considers advice-giving in health care settings provides the starting point for a consideration of the ways in which pharmacists give advice in this setting, and how this is responded to. The aims are thus twofold: to enlarge the methodological

resources of PPR, and also to begin an examination of the communicative competencies required of pharmacists in this setting.

## INTRODUCTION

Pharmacy as a profession is changing rapidly in the UK. Over recent years, the traditional role of the pharmacist as simply a formulator and dispenser of medicines has evolved to encompass a far greater range of tasks and activities. A key part of this development has been the concept of the 'extended role', which emphasises the contribution that pharmacists can make in four key areas: the management of prescribed medicines; the management of chronic conditions; the management of common ailments; and the promotion and support of healthy lifestyles (RPSGB, 1996a). Since pharmacists are highly trained health care professionals, easily accessible on every high street and in hospitals, the evolution of this 'extended role' has arisen primarily as a response by the profession, and by the Government, to a perceived underuse of the skills and the potential of pharmacists. In particular, the White Paper 'Promoting Better Health' (Secretaries of State, 1987) encouraged the preventative and health promoting activities of community pharmacists. It also, for the first time, provided set fees for such services as the development and maintenance of patient medication records, and other services such as the provision of pharmaceutical advice to residential homes. Such developments make clear that the evolution of the 'extended role' also has a commercial and financial dimension, as a response to changing market conditions (Mays, 1994). In this sense the changes may be alternatively described as a 'survival strategy' for pharmacists, who with the advent of computerization and the increased numbers of ready prepared drugs, had seen the erosion of a large part of their traditional skill base.

This message of survival is conveyed by the Royal Pharmaceutical Society of Great Britain in its consultative document, 'Pharmacy in a New Age' (RPSGB, 1996a)



which describes how pharmacists need to find new and effective ways of bringing their skills to bear where they are needed. A number of forces for change are identified, including government concern to get the best value for money from investment in healthcare, a trend towards a greater power for consumers, and a change in the hospital sector which has resulted in shifts in the location of care. Since today's health service increasingly focuses on outcomes, taking responsibility for these outcomes is described as the "acid test" in evaluating whether individual healthcare professions have something to offer. Thus, a future is envisaged in which pharmacists are better integrated into healthcare teams, collaborate more closely with each other, and make their patient services more accessible.

At the heart of all these developments, and of the extended role itself, is the provision of **advice** to patients or clients, specifically concerning sensible and effective ways of using medicines, and more generally in terms of health promotion and lifestyle. It is now well recognised that pharmacists act as health advisers to the general public; this extension of the primary health care role was explicitly recommended by the Nuffield Committee of Enquiry into pharmacy (1986) and is continuously being pursued by the profession. Both the Royal Pharmaceutical Society and the Department of Health have sought to encourage community pharmacists to acknowledge the breadth of their contribution and to seek new ways of providing advice and support to people about their health and about the safe and effective use of medicines. The Code of Ethics for pharmacists, published by the Royal Pharmaceutical Society and containing the legal and ethical requirements for professional practice, discusses this specifically under the heading of "Counselling/Information and Advice". It states that

"A pharmacist must seek to ensure that the patient or his agent understands sufficient information and advice to enable safe and effective use of medicines. This must include seeking to ensure that the directions on the labels of dispensed products are understood." (RPSGB, 1996b, p100). Further, under a section headed "Standards for Relationships with Patients and the Public", it is stated that "The pharmacist should be prepared and available at all times to give advice on general health matters" (RPSGB, 1996b, p102).

The description of these activities as patient "counselling" is a common one in the professional literature, and is frequently used by pharmacists themselves to describe their advising and informing activities. However, since the British Association for Counselling defines counselling as "Giving clients an opportunity to explore, discover and clarify ways of living more resourcefully and towards greater well being", whilst the Code of Ethics defines it as "The discussion of medicines and treatment, and the giving of advice in a professional context", it is unclear what relationship the activities which pharmacists carry out bear to the general perceptions of counselling held by the public. As Rees (1996) contends, it is perhaps more accurate to say that "pharmacists act as facilitators rather than counsellors, facilitating an individual's ability to take and use medicines correctly and knowledgeably" (Rees, 1996, p200).

Whatever the terminology which is used, these activities of "pharmacy counselling", and the increased importance which is attached to them, have had a far reaching impact on both research and training. Mays (1994) suggests that "the existence of and

promotion of the 'extended role' have further compelled a recognition within a profession trained in the natural sciences that pharmacy is an applied science which takes place in a social context through specific organisational tasks which are part of an ever changing health care delivery system (Harding, Nettleton and Taylor, 1990). This in turn has prompted the realisation that pharmacists would benefit from some training in social, behavioural and managerial sciences, all of which are relevant to pharmacy practice research" (Mays, 1994, p10). The Nuffield Report (1986) also drew attention to health services research in pharmacy, noting that "It is in the area of HSR that the greatest weaknesses are to be found. There is too little information available, relatively weak structures and very little funding" (Nuffield, 1986, Appendix 1).

This is not to say, however, that there has been a complete lack of research into the professional activities of the pharmacist, or as the profession terms it, 'Pharmacy Practice Research' (PPR). Just as the role of the pharmacist has developed, so pharmacy practice researchers have been drawn to support these developments by investigating related areas, encompassing the factors which influence people's decisions to seek advice from health care professionals in the first place, and more particularly the extent to which this guidance or advice is complied with. Much of this research, however, which will be considered in detail in the following chapter, has concentrated on the search for simple correlations between 'inputs' and 'outputs', with evaluation of the pharmacist's advice giving resting on the patient's correct or otherwise completion of a medication 'sequence' at a later date. There is also a tendency in such studies for non-compliant behaviour on the part of the patient to be

viewed as irrational, or as the result of some sort of failure.

Another common theme in PPR studies has been a focus on attitudes, so that pharmacists and others are asked for their views on aspects of patient counselling. Understandable as this is, in the sense that it is often easier to ask people what they think rather than to do work which observes and records what they actually do, such studies shed little light on the interactional process of patient counselling itself. Mays (1994), in his review of the pharmacy practice research literature, notes that this is a particular "gap" or "blindspot" of PPR, and suggests that there is a great need for "observational studies of pharmacist client relations in order to identify the dynamics of different types of interaction. Hitherto, the literature on GP-patient relationships has been the only source of insight for PPR in this area" (Mays, 1994, p25).

Thus, the common factor which may be described as linking all this research which has attempted to address the activity of "patient counselling" is its focus on clinical as opposed to communication issues. However, if the pharmacist is to be promoted as a health adviser, these skills are of the utmost concern. Clients rank the interpersonal skills of their pharmacists highly in terms of desirable features of consultations (Tuckett et al, 1985), yet until recently pharmacy students have received no training in communication and counselling. Very little attention has been paid to face-to-face interaction between pharmacists and clients as an issue in itself; researchers have instead been concerned with patient/health care system interactions as a function of drug therapy. Those few studies which have had communication between pharmacists and clients as their specific focus have almost exclusively

employed a quantitative, social psychology framework. This quantitative approach to the study of communication, as can be seen in studies such as those by Morrow, Hargie, Donnelly et al (1993) and Smith and Salkind (1990a), depends on developing a categorisation system, and then coding and counting occurrences of a particular type. As a result, in Morrow et al's study, in order to consider the questioning skills dimension of behaviour by community pharmacists, questions are divided by "types" and "functions" and the results discuss such variables as "Number of questions asked by the pharmacist per minute". In this way, communication is broken down into discrete components, and the practical suggestions arising from such studies are limited to lists of specific requirements which are said to constitute 'good communication practice'. Instructions are thus given for the optimum distance between pharmacist and client, the amount of eye contact that should occur, when the pharmacist should touch the client etc. These rigid and inflexible guidelines ignore the two way nature of the interaction process, and the fact that just as the pharmacist can influence the client's responses and reactions, so the client may influence the pharmacist. In particular, the reactive nature of advice giving as a process is ignored.

The discussion thus far has focused largely on the adoption of the 'extended role' as it relates to community pharmacists, and indeed much of the published PPR is also community based. However, for those pharmacists employed in the hospital sector, the adoption of this extended role has been more complex. The role of medical doctors is constantly changing as science changes, so that over recent years some of the duties that were once the sole preserve of the physician have become allocated to

other members of the healthcare team, such as nurses, midwives and pharmacists (Selya, 1988). This has been met with some resistance on the part of the physician, particularly where pharmacy is concerned, and there has been considerable debate about the professional status of pharmacy and the relationship between pharmacists and the medical profession. As a result, although the role of pharmacists as medication advisers to other professionals in the hospital settings has been actively developed for many years, there has been less recognition of their possible role as advisers directly to patients (Leach, 1993).

The potential importance of a direct patient care role for pharmacists in hospital is significant. The changing management and power structure within hospitals is having various effects on hospital pharmacy, but is likely to afford opportunities to work closely with specific clinical directorates, as in the case of this study setting. More specifically, medical treatments are changing in ways which are limiting inpatient admissions to short and specific periods of active intervention or assessment. This process is driven by various factors: the rising cost of caring for inpatients, the belief that patients may respond better in familiar settings, and the preferences of patients themselves for home rather than hospital care. All of these factors contrive to expand the pharmaceutical needs of patients, and hence the role for the pharmacist in their care. However, the research literature in this area is distinguished by its scarcity; the few studies that have been published with regard to the pharmacist as giver of direct patient care are largely concerned with audit of clinical outcomes, or specifically distributive and clinical services. Issues such as drug policies, patient monitoring, medication preparation and delivery have taken precedence over communication issues

and particularly the issues involved in face-to-face interaction. However, "patient counselling" and the way in which it relates to compliance is a fundamental issue if the goal of minimising inpatient stays and maximising home care is to be achieved to its fullest extent; poor drug compliance is likely to result in rehospitalisation.

The treatment of cancer is a particular area where the rethinking of treatment strategies has placed increasing importance on home therapy. The greater openness with which the condition is now acknowledged (McIntosh, 1974), and the development of increasingly sophisticated therapeutic regimes, have made it possible for the large proportion of a patient's treatment to be provided on an outpatient basis. Where children are involved, the strong critiques of the social and psychological consequences of prolonged hospitalisation which were published by Stacey and her colleagues in the early 1970s have led to a particular determination to minimise the use of inpatient treatments. Psychological evidence clearly showed that the separation in hospital of young children from their parents results in a degree of emotional disturbance which may be long lasting and which has a possibility of affecting the rate of physical recovery of the child patients. Although this may be minimised by unrestricted visiting and parent(s) 'sleeping in' at the hospital, it is obviously desirable to restrict these stays solely for procedures which cannot be carried out by community personnel, and for emergency treatment. Given the relatively small number of specialist paediatric oncology units in the UK, hospitalisation may be geographically remote from the patient's home, making this a particularly salient issue.

The particular nature of their illness means that paediatric oncology patients receive a large amount of input over a long period of time from a considerable number of medical professionals. In addition, the long term and often complex drug regimes prescribed for these patients create specific opportunities for pharmacists to play an advisory role in their care, both on an inpatient and outpatient basis. A study showing that some one-in-five children with Acute Lymphoblastic Leukaemia failed to comply fully with oral chemotherapy (Davies et al, 1993) underlines the need for further consideration of this area, and for re-evaluation of the problem of non-compliance away from the traditional "deficit" model.

Whilst these issues have been somewhat neglected by pharmacy practice researchers, they have been all too familiar to medical sociologists since the 1970's, and have had a considerable impact on the sort of research which they do. Stimson's (1974) critique of the model of patients in medical studies of compliance resulted in a shift in objective to searching for the 'good' reasons people might have for using medicines in ways other than in accordance with instructions. Divergence from these instructions had traditionally been seen as irrational in the light of medical rationality, with the blame for 'default' lying with the patient. The ideal image of the patient employed in these studies was generally a passive, obedient and unquestioning recipient of medical instructions; the research thus became concerned with finding out what there was about a patient that made him or her a 'defaulter'. Stimson argued that this was a consideration of the problem from the point of view of the medical profession, suggesting instead an approach from the perspective of the patient. In this way the focus shifts to the social context in which illnesses are lived and treated, and a more



active view of patients is entailed. Expectations of the doctor, evaluations of the doctor's action and the ability to make personal treatment decisions are reasons which people may have for not following advice or for using medicines in unintended ways, rather than assuming ignorance or illogicality. In this sense almost anyone can become a 'defaulter' at some time.

This broadening of the concept of non-compliance, and the acceptance of the involvement of a larger range of factors than had been traditionally considered, led to a wider use of qualitative methodologies in this area. A further consequence was the move towards more naturalistic studies of such situations. Strong's (1979) work on 'the ceremonial order of the clinic' focused on the relationships between doctors, patients and their parents which evolved in the course of consultations in paediatric clinics, although this was rarely linked to issues of compliance. Other researchers have given greater emphasis to this issue, for example Silverman (1987) who approaches the subject of both doctor/patient and doctor/parent communication from an interactionist perspective. The design of the research is aimed at elucidating actors' meanings and interpretations, and identifying contextual effects. A common theme employed in the analysis is the concept of 'discourse of the social', which considers the situated nature and consequences of an appeal to the social or everyday realm by participants. An extension of this idea of 'discourse of the social' informs Silverman's considerations of compliance, in which he challenges the notion of consumerist medicine as a liberating concept for the patient. He suggests instead that if the clinical reality of an illness becomes incorporated into a social discourse, there may also be an element of coercion present, which provides an implicit method for the doctor to

ascertain compliance with the initial medically chosen course of action. This coercion is compounded by the resulting demedicalisation of the patient. In this sense a social perspective seeming to offer a totally unrestricted form of communication may evolve instead into a totally unrestricted form of surveillance, in which the medical gaze can roam freely.

Thus, the consideration of compliance as a factor linked to the doctor/patient interaction has been recognised in a fairly limited and local sense; unfortunately, this is not true of the pharmacist/patient interaction, in either the community or the hospital setting. Of all the health related professions pharmacy has probably received the least attention from social scientists; any research that has been carried out has focused largely on the dualistic occupational role which arises in community pharmacy (Denzin and Mettlin, 1968) and the possible resultant conflict between business and professionalism. In terms of the pharmacist/patient interaction, however, it is suggested that, whilst the majority of PPR employs quantitative methodologies, qualitative data could have a valuable role in determining a broader picture of patient behaviour through communication issues. Drawing together the issues discussed thus far, it is suggested in this study that the social science methodologies of both the traditional ethnographic approach, and more particularly Conversation Analysis (CA) could be used in PPR to produce a more precise and detailed account of many aspects of the interactional management of the pharmacist/patient encounter. Generally, little ethnographic work has been involved in CA; this is beginning to change as the advantages of combining both a structural and contextual approach are appreciated, although this is still a contentious area. However, given the researcher's pre-existing

'ethnographic' knowledge as a member of staff in the study site, and her presence while the consultations were recorded, this resource has been used secondarily to the CA analysis, in an attempt to further illuminate some activities and interactional references.

As part of the broader methods of Ethnomethodology, Conversation Analysis (CA) seeks to reveal the universal members' methods involved in social life, such as organised turn taking in talk. The aim is thus to establish what the participants to an interaction are themselves attending to and orienting to, ie what it is about an interaction that is important for them. In particular, the existence of a large body of CA literature on 'institutional talk' in general, and more specifically, considerable analysis of medical professional/client encounters, is especially pertinent for this study. In CA terms, the data collected for this study (tape recordings of naturally occurring consultations between pharmacists, patients and their carers at a weekly hospital paediatric oncology outpatient clinic) represent institutional interactions, the institutional element referring to the fact that the participants' professional identities are somehow made relevant to the activities in which they are engaged. This large body of relevant work, and in particular the published work on the professional/client interaction in terms of counselling and advice giving, provides the background against which this analysis is set.

Since so little is known about the actual process of face-to-face interaction between pharmacists and their clients, this study is intended largely as an *exploration* of the "patient counselling" process in this setting, in order to consider the ways in which

pharmacists manage their activities of advising or informing, and the ways in which clients respond to these. The collected audio tapes were transcribed in detail, and the analysis itself was carried out on a turn-by-turn basis, informed by the procedures described in the Methodology section of this thesis. The lack of other relevant work on the pharmacist/client encounter was in one sense advantageous, in that there could be no *a priori* specification of fixed issues to be considered at the expense of others that might subsequently arise. Instead, the analysis was guided by several analytic themes, which were as follows:

The first concerns the nature, scope and significance of talk directed at the pharmacist and initiated by the patient or carer during the encounters, considering in particular whether patients or carers set their own agendas for the activities of advising and "counselling", and how far their talk is responsive to that of the pharmacist. Since these are long term patients, this issue of the 'control' of the encounter in turn raises issues of patient knowledgeability and how this relates to, or even impinges on, the pharmacist's area of expertise.

The second theme is the activities of pharmacists with regard to the actual activity of "patient counselling", both in terms of how this is delivered and how it is responded to by the patient or carer. Advice giving is an imprecise and variable activity, and the actual two way dynamics of this as it relates to the activities of the pharmacist has received little or no attention in the PPR literature. There is, however, a significant body of CA work on advice giving in health care settings, which provides a starting point for the exploration of this area.

The third theme is concerned with the way in which pharmacist/patient talk may be influenced by the trajectory of a patient's medical career, bearing in mind once again that some of the patients and carers involved in this study have a considerable degree of experience with medical (and pharmacy) services. Evidently, this is also linked in to the issues of knowledge and competence described above, and this knowledge and competence in turn has implications for the delivery and acceptance of advice. In many ways, these issues of competence are prevalent throughout the encounters, and are often explicit in the talk.

In addition to these three main themes, some consideration was given to the fact that the study setting is a *paediatric* oncology clinic, and hence the consultations that occur with pharmacists are often multiparty. All of the patients attending the clinic are aged 16 or under, while the majority fall into the younger half of this category. Thus, the extent to which they are involved in these encounters, and the special problems which may result interactionally, were also given some brief consideration.

The analysis presented here begins by attempting to consider the overall structure of the pharmacist/patient/carer encounter in this setting, and to consider how this is related to the tasks, requirements and expectations of both parties. Following this, more detailed consideration is given to the process of "patient counselling" in the paediatric oncology clinic, both in an attempt to explicate what this activity actually involves here, and to suggest that some of the strategies employed by pharmacists within the clinic may, on occasion, be more successful than others. Advice giving is

potentially a delicate activity, since it denotes the existence of an expert/non-expert relationship; this analysis gives consideration to some of the particular problems in this setting. Finally, issues of knowledge and expertise (of patients, carers, pharmacists and other clinic staff), and the implications that these have for the management of the encounters, are considered.

This discussion began by considering the development of the 'extended role' for pharmacists, and suggested that there is now a potential conflict between the training which undergraduate pharmacy students receive and the expected competencies of the profession which they are preparing to enter. Although specific training recommendations are beyond the scope of an exploratory study such as this, it is hoped that in the processes of describing and analysing the actual process of patient counselling in this setting, some light will be shed on the skills which pharmacists require to carry out this activity. Some of the CA work discussed above which considers advice giving in health care settings has begun to draw conclusions about "better" and "worse" ways for these sequences to proceed. Evidently, such findings in pharmacy data would have important implications for the training of pharmacists in general, and particularly in terms of the extended role. Taking into account all the factors discussed, it would seem that if pharmacy is to sustain its extended role in the hospital setting, and capitalise further on opportunities for professionalisation, closer examination of the counselling role is needed. Pharmacy is a science based profession, but it is still a profession, and education for future practitioners needs to be linked more closely to the work a pharmacist is actually required to do. The threat of deprofessionalisation exists partly because, although pharmacists can see their links

to broader health care, this is often less obvious to the general public; increased emphasis on the provision of professional advice could go some way towards remedying this. The modern pharmacist needs a level of expertise in the social and behavioural sciences, as well as excellent communication skills. Much health services research talks about 'quality of care', using a variety of ways to measure this. It is suggested here that a key part of quality in terms of patients' perceptions is how care is delivered, and that a fundamental part of this is the provision of advice and information.

## **Chapter 1**

### **"PHARMACY COUNSELLING":- A REVIEW OF THE LITERATURE**



A simple summary of the changing professional requirements of the pharmacist would suggest that the 'extended role' is seen as the way forward, if not the salvation, for the profession. Clearly, successful adoption of this 'extended role' depends on pharmacists developing and refining their communicative skills. However, the research which has been carried out in this area appears to yield little insight into either the nature of the interaction process itself, or the best ways of providing communication skills training for pharmacists. As Mays pointed out in his 1994 review of health services research in pharmacy, whilst the move towards an extended role for pharmacists has generated a considerable proportion of practice research studies, including those looking at provision of advice to patients (Boylan, 1978;Phelan and Jepson, 1980) , there has been little by way of identification or evaluation of how well pharmacists perform in these extended roles (Mays, 1994). What actually exists is a large body of related literature examining topics such as pharmacists' beliefs and attitudes towards patient counselling, and the reasons why pharmacists require communication skills training. Communication is considered primarily from a clinical standpoint, as a function of drug therapy or compliance, and rarely as a topic in its own right.

This is all the more surprising since there appears to be a common theme running through some pharmacy practice research studies which suggests that pharmacists as a group of health professionals are in particular need of improving their communicative competencies. In 1979 Baldwin , McCroskey and Knutson went so far as to suggest a phenomenon known as "Communication Apprehension" (CA) as a contributing factor predisposing pharmacists to avoid communication. CA is defined

as "an individual's level of fear or anxiety associated with either real or anticipated communication with another person or persons". Applying the CA criteria to students in US Schools of Pharmacy, it was concluded that at least 1 in 5, and possibly as high as 1 in 3 pharmacy students had a tendency to avoid communication, and that systematic desensitization via an intensive skills training programme was the required treatment. (Berger, Baldwin et al, 1983, p95). Describing the format such training could take, Berger and McCroskey (1982) discuss the possibility that "pharmacy schools may attract a larger proportion of the CA people than the population as a whole... Perhaps many students perceive that, at this time, pharmacy is a profession where they won't have to communicate very often. Both hospital and community pharmacies certainly present many "attractive" physical barriers for high CA people" (Berger and McCroskey, 1982, p136). Thus it appears that pharmacy as a profession faces a double difficulty as far as the adoption of the extended role is concerned; it is not only pharmacists' communicative competencies that need to be addressed but also their underlying attitudes.

In a similar vein, Hargie and Morrow's study of the effects of a microtraining programme on the attitudes and behaviour of practising pharmacists uses a personality scale to establish that "pharmacists generally are one of the most introverted groups within the health professions" (Hargie and Morrow, 1989, p201). (The upside of this, however, is that they are also found to be generally less neurotic!). The authors' justification for the use of this scale is that not only do attitudes to a training programme affect learning, but that they also translate into performance in the outside world. The outcome of this relationship between personality and performance is that

extroverts, as measured on a personality scale, tend to react more positively both to training and to real life situations requiring communication skills.

This perceived relationship between pharmacist personality and patient counselling abilities appears to provide the theory behind the multitude of studies examining pharmacist/patient communication from an attitudinal perspective. This is explicitly described in a study by Kirking (1984) which, in setting itself up as a rigorous investigation as to why counselling does or does not take place, states "while the relationship between attitudes and behaviour has long been of interest to psychologists... the study of this relationship as it applies to pharmacists' activities, specifically counseling behavior, has been extremely limited" (Kirking 1984 p 50). In common with other studies of this type, a self-reporting methodology is used where pharmacists are asked to fill out a free response questionnaire, in this case based on Fishbein and Ajzen's (1975) theories on attitudes, behaviour and subjective norms. (The subjective norm factor is described by Kirking (1984, p51) as "a measure of a person's perception of what others believe he or she should do with regard to a particular behavior" and it is suggested that this may provide an explanation for individual pharmacists' patient counselling activities). In order to determine their level of counselling, pharmacists were asked to estimate " For the new prescriptions that you currently receive, on approximately what percent do you counsel patients?".

From these self-reports it was concluded that counselling takes place with approximately 40% of new prescriptions, most commonly involving discussion about the name of the medication, its purpose and the prescribed dosage. These were

reported as generally brief sessions, initiated by the pharmacists in about two thirds of the cases, and patients were not often asked if they had any questions about the therapy. Attitude and subjective norm measures were found to correlate significantly with the percentage of counselling reported.

In addition Kirking considered several situational and demographic variables in order to establish whether they held any influence over counselling activity. Some of these factors, such as location, type of practice (chain store or independent), prescription workload, and the type of position held by the pharmacist (employee, manager etc) were found to correlate with counselling activities, but attitude was still held to be the primary explanatory variable for the level of counselling which occurred.

Similar, although often less detailed, self-reporting attitudinal studies have been carried out in various locations with varying results. A study by Ortiz, Walker and Thomas (1992), consisting of a questionnaire distributed to 1361 Australian community pharmacists and containing a scale based on a set of opinion and belief statements, was also grounded in the premise that varied role orientations can cause variations in levels of professional behaviour such as patient counselling. The results are described as suggesting that pharmacists' orientations appear to reflect overall positive support for patient counselling behaviours, although not all pharmacists shared the same level of behavioral expectations when it came to the advisory role. The (seemingly self-evident) conclusion is drawn that the pharmacist who underestimates patients' needs for information about their medication may be less likely to engage in patient care activities like counselling. This is echoed in the US

questionnaire study reported by Schommer and Wiederholt (1994), which concludes that pharmacists use their judgement of patients' familiarity with medicines, and a perceived seriousness of potential consequences, in order to determine the importance of each element of patient counselling. It would seem that these results give credence to the suggestion that patient counselling is still the exception, in particular therapeutic circumstances, rather than the rule.

Other self-reporting studies have also considered the secondary element of Kirking's analysis; the impact of situational and demographic variables as predictors of counselling levels. Canadian questionnaire studies conducted by Laurier and others (1989;1992), in addition to reporting that a mean of 28 minutes were spent on counselling in an average 3 hour period in a pharmacy, concluded that gender and year of qualification as well as prescription workload were variables related to the time spent counselling. Recently qualified females were suggested as the group of pharmacists likely to spend most time on counselling related activities.

Assuming for the moment a simple link between attitude and behaviour, British self-reporting studies have produced favourable results. Asked to rate various activities on a Likert scale which were both important and satisfying, British pharmacists scored counselling and counter prescribing high on both counts (Moore, Hassell and Noyce, 1993). In a postal questionnaire devised by Bond et al (1993) and sent to 20% of pharmacists in Scotland, over half of the pharmacists thought their advice giving role had changed since the publication of the Nuffield Report in 1987, and nearly all reported that they would like to see this role extended further, by increased

deregulation of medicines. This suggests a theoretical willingness, at least, to become more involved in advice-giving.

However, a problem with all of the aforementioned attitudinal studies is that it is only theoretical activities and attitudes which are being measured; self-reporting by pharmacists of their own activities provides the data from which these conclusions are drawn. The comparative study of the counselling activities of Dutch and Swedish pharmacists carried out by Blom et al (1989;1993) suggests that self-reporting methodologies result in much higher estimates of levels of counselling, an insinuation which is easy to believe but, the authors maintain, hard to overcome. Other methods of studying verbal communication in community pharmacies are also considered to have their drawbacks regarding the training of "fake patients", recall, classification systems etc. This problem was also considered by Ortiz, Walker and Thomas (1989) who went on to conclude that direct observation was the most reliable survey method, and that the behavioral influence that it might bring about did not appear to be great.

Blom et al, however, go on to use a self-reporting postal questionnaire, and conclude a significant weak correlation can be found between pharmacists' beliefs and behaviour. As far as the accuracy of this is concerned, they conclude that "Pharmacists' beliefs may be based upon an ideal situation which does not present any barriers against communicating with patients" (Blom et al, 1989 p61). Whilst this may be true, it is of little practical help in terms of identifying competencies or developing training programmes. It is Laurier and Poston's contention that even if inaccurate, "self-perceptions are important since they are likely to be linked to the motivation of

pharmacists to change their practices or not " (Laurier and Poston, 1992, p110), but it is also hard to see how such idealised attitudes can be translated into behaviour in the day to day realities of pharmacy practice.

Despite these limitations, only a handful of attitudinal studies appear to have attempted to utilize any secondary measures in an attempt to establish whether, or exactly how, attitudes are transformed into behaviour. One such study (Mason and Svarstad, 1984) utilizes a "shopper" or "fake patient" methodology, in order to describe the extent to which 40 rural community pharmacists engage in 5 dimensions of counselling for 2 specific drug products. Initially, in-depth interviews were carried out to explore the sample pharmacists' views and attitudes; this was followed at a later date by a fake shopper presenting a prescription. Each shopper was trained to note conversation and other activities that occurred in the pharmacy during the encounter, and to record this on tape and on written forms immediately after leaving the pharmacy. 5 dimensions of behaviour were focused upon:- written instructions, verbal instructions, interaction time, approachability and interviewing behaviour; all of these were subsequently scored and counted. The study results suggest a significant relationship between the attitudes held towards counselling by these practitioners and their actual counselling behaviours.

A similar British study focusing specifically on vitamins and minerals utilized the same methodology in the reverse order, although the results here are considered mainly in terms of appropriateness of preparations recommended, and the focus is upon attitudes to sales rather than advice (McGuinness, Rathbone and Trevean, 1990).

However, the drawbacks of using fake patient techniques are well documented (and will be considered in more detail later) and it is questionable how much information they afford with regard to everyday, 'natural' patient encounters. For the sake of comparability such investigations often require the "shopper" to adhere strictly to a particular protocol, which can affect the nature of the interaction significantly. In the study by Mason and Svarstad, for example, the study protocol indicated a passive role for the observer, answering questions but not initiating conversation.

One method of avoiding possible bias from any of the sources mentioned above is to combine self-reporting with observation by a neutral, non-involved observer. Smith and Salkind's study of the factors influencing the extent of the pharmacist's advisory role in Greater London (1990) makes use of such an observer, whilst making the point that the more commonly used methods designed to investigate levels of counselling have not only led to considerable variation in findings but also seriously limited their generalisability. The objective of this study was to establish the extent to which community pharmacists in London gave advice on health and the use of drugs; to examine any variation with time of day, week and year, demographic location and clientele or business characteristics; and to assess pharmacists' attitudes to advisory roles. Self-reporting questionnaires were used to classify pharmacists into 3 attitudinal groups, and samples from each of these were then selected for 4 separate 3 hour periods of observational research. Data were collected on all consultations which took place, and no relationship was found between pharmacists' attitudes to advice and the amount of advice requested or given. Other factors, such as location, day of the week etc were found to have an influence, suggesting that time and/or



business pressures were the major factor determining whether or not a patient received medication counselling.

This widespread use of the attitudinal survey has not been limited to the perceptions of the pharmacist with regard to the advisory role. Several studies have considered the relationship between attitudes of customers or patients and the adoption of the extended role, ranging from simple surveys of consumer satisfaction (Sarriff, 1994) to more detailed investigations attempting to establish the factors influencing where customers seek advice. Morrow, Hargie and Woodman's (1993) survey of 261 members of the public's perceptions of pharmacist counselling attempted to quantify not just consumer satisfaction, but also how practice should move to meet desired customer standards. Quality of advice was considered in terms of the percentage of respondents who replied that they were "often" or "always" satisfied with its' adequacy, and a figure of 72% was reported. In terms of the language used by the pharmacist, almost 50% of respondents found it to be very easily understood. 13% of respondents, however, reported that they did not want any involvement with the pharmacist in terms of advice giving. The authors concluded that "Although the NPA's 'Ask your Pharmacist' campaign placed the onus on the customer actively to seek advice, these findings indicate that a substantial proportion (48%) of the public would welcome the pharmacist being proactive in this regard" (Morrow, Hargie and Woodman, 1993 p26). An earlier US survey by Montsanto and Mason (1989) had reported similar levels of satisfaction, whilst raising the seemingly forgotten issue that medication advice is only one of the services the public expect to be available from pharmacists. The implication appears to be that customers do not place the same

importance on pharmacy counselling as do researchers. Nevertheless, the conclusion drawn is similar to Morrow et al's; that pharmacists should make themselves available and encourage consulting in order to capitalize upon this.

An interesting perspective on this lack of pro-active pharmacist counselling the two previous studies describe is found in research by Carroll and Gagnon (1983), and is also raised to a lesser degree in the "fake shopper" study by Mason and Svarstad. In a self-reporting mail survey of 300 households which asked for respondents to provide details of age, income, education and drug expenditure as well as their perceptions of pharmacists' performances as drug consultants, it was concluded that pharmacists believe certain types of patients need more counselling than others. Carroll and Gagnon's results implied that pharmacists are significantly more likely to counsel patients who have lower educational attainment, and/or higher drug expenditures. Speculating about the basis for this, the authors suggest that high spenders are more likely to be involved in multidrug therapy, and hence have an increased possibility of drug interactions, whilst people with low educational attainment are considered more likely to need extra explanation. Interestingly, however, there is little evidence that non-compliance has a significant relationship with demographic status (Carroll and Gagnon, 1983), and other such studies have found conflicting results (Wiederholt, Clarridge and Svarstad, 1992).

Returning to the public's perceptions, and patterns, of advice seeking from pharmacists, there has been some attempt in the practice research literature to examine why clients may be reluctant to seek advice. Taylor's (1994) study, focusing

exclusively on non-prescription medication, observed customers purchasing products without advice and then distributed questionnaires to these "self-selectors" to establish their reasons for not asking for assistance. The majority of the respondents replied that they had used the product before, or had already received advice elsewhere, with only 6 out of 151 indicating that they had in fact wanted advice but that the pharmacist had seemed too busy. However, as the author concedes, these reported reasons for not asking for advice apply to a specific purchase rather than purchasing behaviour in general. A more general investigation by Smith (1990a), in attempting to identify which factors were important to clients when seeking the advice of a pharmacist, involved the distribution of questionnaires to people seeking advice in a random sample of pharmacies. Personal characteristics, such as approachability, interest and concern were found to be the most important in terms of advice seeking, along with the convenience of the pharmacy. Despite this, 25% of respondents did report that at some time they had felt they didn't want to trouble the pharmacist.

Another dimension to this apparent reluctance to seek advice is raised by Smith and Salkind (1988), in their study of the views of pharmacists and clients on the need for specific areas for counselling and advice in community pharmacies. 45.5% of clients surveyed claimed at some time to have felt there was insufficient privacy for them to seek or receive advice. The authors concluded that quality of advice applies not only to clinical output, but also to a suitable environment.

However, it is not only the personal characteristics of the pharmacist and the geography of the pharmacy itself which may have an effect on people's advice

seeking behaviour. One of the few social science based studies into the advisory role of the pharmacist (Cunningham Burley and Maclean, 1987; 1988) begins by underlining the fact that despite the multitude of studies, there has been "little attempt to relate the actual and potential role of the chemist to the beliefs, practices and needs of the public" (Cunningham-Burley and Maclean, 1987 p371). The study looks at the lay perspectives of 54 mothers with at least one child aged under 5 in order to elucidate their responses to minor illnesses in their children and their use of pharmacists. By means of in-depth interviews and "health diaries" kept by the mothers, it was found that chemists (the terminology the study uses) were located in between lay and professional help.

Although the use of the pharmacist and of proprietary medicines were seen to be important elements in self-care, it was found that individual experience and a particular relationship between a doctor and a patient can be major factors in the decision making process involved in illness behaviour (Cunningham-Burley and Maclean, 1988). Thus the pharmacist was seen both as a preliminary to a doctor, and as an alternative for self-limiting episodes. This conclusion, that there is no unitary "lay view" of the role of the pharmacist, can be seen as somewhat problematic for pharmacy practice, as it implies that there are many different expectations which may be brought to the pharmacist/patient consultation. Indeed, this is to an extent a problem with all the research discussed so far, as , whilst it may give an insight into when and why people seek advice from pharmacists, and if and how these pharmacists respond, it does not tell us much about the interactions and consultations that have led to the formation of the attitudes reported, or the outcome of these, and

so cannot offer any practical suggestions for improved communication.

The same is true of the considerable number of American studies which examine the effects of mandatory counselling regulations. Some of these have examined the effect of an already existing counselling regulation by means of questionnaires (Robinson and McKenzie, 1984) or comparative studies (Ross et al, 1981). Others, in states where counselling is not yet mandatory but regulations are being considered have encouraged pharmacists to view counselling as a marketing tool (Smith, D.L, 1990), or a strategy for financial gain (Gore and Madhavan, 1994; Culbertson et al, 1988). Where mandatory counselling has been found not to reach the required level, investigators have suggested that patient payment method (Raisch, 1993a) and particularly workload (Raisch, 1993b) are underlying factors. Related to this, Reutzel's (1994) study of the compatibility of the retail setting concluded that patient based activities can sometimes result in the loss of other business, but can also result in patronage gains. In other words, patient based and consumer models of practice can be complementary. Whilst there are no plans to introduce a mandatory counselling requirement to the UK, these latter findings are still salient as dispensing workload has also been identified in British pharmacies as a factor limiting patient counselling activities (Savage, 1993). However, it is worth noting that mandatory counselling requirements only extend to a statement of what advice is necessary, and not how this should be delivered.

Aside from attitudinal studies, perhaps the largest body of pharmacy practice research on the advisory role can be described as having its focus on communication as a

function of drug therapy. Many of the studies falling into this category are outcome focused, using as end measures assessment of patient knowledge, compliance, or even in some cases pharmacokinetic variables. Others have sought to quantify the amount and type of advice given in relation to particular drug products, and some have gone on to try and assess the quality of this advice. Unfortunately, many of these studies involve either a designated patient group with a particular medication regimen, or else the use of a specific counselling protocol, both of which severely limit their general relevance. It is tempting to agree with Tett, Higgins and Armour's conclusion to their review of literature on the impact of pharmacist interventions on medication management in the elderly, that "there are a lack of well-designed studies to determine the effects of individualised counselling and advice" (Tett, Higgins and Armour, 1993, p83).

Throughout this section of the literature, counselling tends to be viewed as important primarily in order to increase the patient's motivation to use his or her drugs in the proper way. In terms of compliance, Fisher suggests that this is "a concept used to measure failures of patients in meeting their therapeutic goals" (Fisher 1992, p261). He goes on to put forward a theoretical model for pharmacist/patient interaction consisting of 6 steps: message sent; message received; patient comprehends message; patient retains message; message is accepted or believed; and finally patient complies. It is suggested that pharmacist interventions are best done by means of consultations which work through the steps of the above model. Little practical advice is provided in order to achieve this, however; for example there are no indications given of how the pharmacist can be sure each step is complete before moving on to the next. In

addition the model is unable to predict when compliance will occur, and suggests the checking of tablet containers in order to ascertain this.

This search for outcome measures in order to substantiate theory proves problematic in many medication-centred studies. Some, such as Cantrill and Clark's (1992) hospital discharge study, have attempted to avoid the issue by instead assessing (indirectly) patients' information needs. This was done by determining the number of medication changes that occur during a hospital admission, along with the number of medication "problems". (There is no indication that these are problems in the experience of the patient, and they are seemingly determined by in isolation by "experienced clinical pharmacists".) Patients deemed to be in need of information, for example those to be discharged on new therapies, were then counselled by means of a 10 point counselling checklist. The majority of these points concern administrative details such as name, date of discharge etc, but the counselling requirement consisted of the purpose and indication for each drug, the frequency and timing of doses, any special precautions to be taken or side effects to be expected, and storage information. This was followed by an opportunity for the patient to ask questions and finally by a comprehension check, where the patient is asked to state the purpose and dosage of each prescribed drug.

Other, similar studies describing the "targeting" of specific patient groups can be found in the literature, without any indications of whether they were deemed to be successful. Both McGinty, Chase and Mercer (1988) and Roth (1982) studied joint pharmacy/nursing programmes, looking at the nature of pharmacists' communications

and, in the case of Roth, attempting to establish whether nurses saw pharmacists as important and relevant sources of drug information for patients. This is particularly relevant in a hospital environment where, due to logistics, nurses often carry out a large amount of the discharge counselling, calling on pharmacists to answer particular queries or provide specific counselling when required. No formal evaluation of either study is provided, although the feedback is reported as "favourable" by McGinty, Chase and Mercer.

Elderly patients were the target group for Opdycke et al (1992), who, looking solely at pharmacist initiated counselling for patients deemed "therapeutically complex", reported the identification of inadequate knowledge and noncompliance via use of a strict programme protocol. The theoretical approach to this study is again stressed, but there is still a lack of evaluation of the programme, and little information is provided about how medication problems were identified and who they were actually a problem for. The assumption in all these cases appears to be that since the patients were initially assessed as in need of advice, the advice must therefore be beneficial.

It is clear, however, from those studies which do attempt to provide an outcome measure, that the success or failure of a counselling programme is not an easy phenomenon to demonstrate. Patient knowledge, as assessed by post-counselling interviews or questionnaires, appears to be the most commonly used method. Several programmes report pre-testing of patients, followed by counselling and finally by a further knowledge test, although the time elapsing before such a second test varies widely from study to study. In Worionnecki et al's (1982) hospital based study of



neurology patients the time interval between the two multiple choice tests provided was 8 weeks, and the mean scores of those allocated to the counselled group were reported improved by 26.2 percentage points. This was in contrast to the control, non-advised group whose scores showed no improvement.

By contrast, Hammarlund, Ostrom and Kethley's secondary assessment of the effects of counselling on drug knowledge in the elderly took place almost two years later, although intermittent counselling was provided in this time. Success in this case was measured in terms of the number of medication problems per person, and the number of prescriptions they were currently using, since counselling was seen primarily as an effective means of reducing drug consumption and adverse drug reactions (Hammarlund, Ostrom and Kethley, (1985). Other studies have carried out post-counselling assessments immediately (Cromdos and Allen, 1992; Winfield and Owen,1990) in order to compare different modalities of discharge counselling; Cromdos and Allen's study compared a group receiving discharge counselling only to those who received it in addition to counselling throughout hospitalization and concluded that the latter was a preferable strategy in terms of patient knowledge. It was conceded, however, that the time pressures of a busy hospital conspire to make this an ideal but practically unattainable strategy. It is also interesting to note that although the responses received from the test group were significantly better than the control, both actually demonstrated a fairly low level of recall.

The results of all these studies generally provide support for patient counselling, or more correctly, specific education programmes, on the grounds that they improve

knowledge. This appears to be the case for many other patient groups, including paediatric asthmatics in a hospital clinic assessed by questionnaire (Hunter and Bryant, 1994), elderly patients discharged from hospital after acute episodes of illness in the US (Sherburne et al, 1988), or in Britain (Goodyer and Greene, 1988), and patients using antibiotics (Williams and Livingstone, 1991) or OTCs (Rantucci and Segal, 1986) in the community. Exceptions to this apparent confirmation of a large and unmet need for pharmacist counselling are rare. Of the hospital studies, only one was found which falls into this category; Wandless and Whitmore's (1981) study of compliance in elderly patients attending a day hospital. In this case, however, the apparent failure of the counselling programme is attributed to the study design, so that despite apparent random allocation to either the counselled or uncounselled group, patients in the counselled group were making fewer medication errors than those in the control group even before they received instruction from the pharmacist. There is thus no evidence that those in the counselled group complied better with their treatment as a result of the study.

In the community setting fewer studies of this nature appear to have been carried out in general, but inconclusive results are reported by Winfield and Owen (1990), who in attempting to assess whether verbal counselling on the use of antibiotics backed up by an information leaflet was preferable to verbal counselling alone, found that knowledge levels in general were too high to permit demonstration of any effect for the leaflets.

Unfortunately, as is pointed out by Williams and Livingstone (1992), patient

knowledge does not necessarily equate with compliance; the accuracy of information given to researchers is only strictly a measure of knowledge of an intended regimen and the patient's memory or recall of this. Outcome with respect to patient knowledge is not necessarily related to clinical outcome.

One method which has been used in pharmacy practice research and which in effect bypasses this problem of establishing the link between knowledge and behaviour is to measure the impact of pharmacist counselling in terms of clinical improvement of a specific condition or by use of pharmacokinetic and pharmacodynamic variables. The basis for these studies appears to be that if clinical progress in terms of disease pathology etc is made after pharmacy counselling, this implies an improved adherence to the prescribed medication regimen. Obviously such clinical indicators are more easily accessible for some medical conditions than others, which perhaps accounts for the popularity of this technique in assessing the compliance of asthma patients. Pulmonary function tests and peak flow meter readings are relatively easy to collect and interpret as success indicators, and this is the method used by DeTullio and Corson (1987) and Hindle et al (1992) in order to conclude that instruction by a clinical pharmacist resulted in increased patient understanding and better use of prescribed inhalers. In assessing asthma patients who have been prescribed inhalers there is also the opportunity to assess technique both pre and post counselling; this is generally done by breaking down the use of an inhaler into "steps" and assessing the correct or otherwise completion of these at a later date (DeTullio and Corson, 1987; Scott et al, 1988; Roberts et al 1982). This is important in a clinical sense since amelioration of the condition does not only depend on a willingness to comply by

using the inhaler at the correct times, but also on using it in the correct manner to ensure adequate drug delivery to the lungs. Here again then, it proves difficult to separate out advice and compliance from other confounding factors. In addition there are methodological questions which have been raised in terms of the validity and reliability of the rating systems used (Gray et al,1994).

For conditions other than asthma attempts to measure clinical improvement have centred around "indicators of adverse outcome" (Koecheler, Sfeir and Wilson, 1990). These indicators included scenarios such as calling out a physician at night, or rehospitalisation. For this study, in the US, patients were recruited by their medication types, for example if their treatment was known to have side effects or a potential for interaction with other drugs. At the end of the study period none of these indicators were found to apply to patients who had been counselled by pharmacists. Similar studies have been carried out in Great Britain, including such measures as number of days unable to work and number of visits made to the GP (John et al, 1993), with the conclusion that the results "reflect a consistent trend in favour of patient counselling by a pharmacist".

As has already been discussed, the specific nature of many of these studies precludes generalization of the effects of counselling to a wider population. Research with similar patient groups tends to recur:- the elderly in particular seem to be regarded as a group in particular need of counselling. Certainly, multidrug therapy is more common in elderly patients, bringing with it an increased likelihood of drug interactions and adverse effects, but there is also possibly a perception that elderly

people are more likely to be confused, have communication difficulties and/or more problems in adhering to a prescribed drug regimen. Asthma is also a very specific condition with a unique mode of therapy, and many of the particular counselling requirements that appear to be established here have little salience for other groups of patients. Even the use of "indicators of adverse outcome" has limitations, not least because it depends on an individual's propensity to reattend the GP's surgery, take time off work, etc.

There are some pharmacy practice studies in existence which have tried to take a more general view of advice as a function of drug therapy, looking at a wider cross section of patients and situations. The simplest of these have taken the form of surveys, such as the Schering report, which noted that more than 70% of patients felt that counselling by a pharmacist helped them in taking their medications (Ukens, 1994). Similarly, a Malaysian survey of 500 patients in order to assess the extent of pharmacists' involvement in the education of patients on drug use reported a 72% satisfaction level (Alkhawajah and Eferakeya, 1992). This survey went on to examine the types and items of communication that the respondents reported their pharmacists provided, and found that these were largely dosage instructions. Similar results were obtained in Great Britain by Hayes and Livingstone (1990), who found that only 10% of pharmacists counselled more than 50% of their patients on prescribed medicines, and that this counselling consisted mostly of the name and/or class of drug, the dosage schedule, and any additional warnings.

Medication advice given by pharmacists has also been considered in terms of OTC

medication purchases and self medication by consumers. Again, some of these studies are simple quantitative measures of mean levels of advice giving in relation to OTC purchases; Fisher, Corrigan and Henman (1991) found a mean level of 23.3% in an observational study of pharmacies in Dublin. The range of levels of advice actually discovered, however, extended from 0% in one pharmacy to 80% in another. Advice was considered to have been given when staff, either voluntarily or in response to a customer query, recommended a medicine, counselled on the medicine, or counselled on the condition for which the medication was purchased. Thus general health related matters or enquiries which were not in conjunction with OTC purchases were excluded from the study. In a similar Canadian observational study of OTC purchasers only 11% were reported to receive advice whilst in the pharmacy, and an assessment of the quality of these interactions was deemed to be beyond the scope of the study (Taylor and Suveges, 1994). Another study by the same authors placed customers into two groups, self selectors and advice receivers, and found that of the total sample of 413 patients only 2 were offered advice by a pharmacist (Taylor and Suveges, 1992). It is suggested that these findings provide a reference point for future discussion on whether pharmacists should increase their involvement in the sale of these products, and it would certainly appear from these results that the "extended role" is virtually non-existent in some aspects of practice.

Other studies have examined advice in terms of the level of referrals to primary care services (Marklund, Karlsson and Bengtsson, 1990; Smith, 1990b, 1993), or more commonly have focused on particular categories of OTC products to establish whether advice giving is more commonplace with some types of preparations than others. In

New Zealand, Shaw and Trevean (1983) found that the level of advice given to customers purchasing cough and cold products, and dermatological products was the greatest, although it is not clear why this should be so. It is possible that pharmacists feel that the former group, for example, have a high potential for interaction with prescribed drug therapies such as treatments for high blood pressure or diabetes. Interestingly, Smith and Salkind's observational research in Greater London pharmacies categorised recorded consultations into groups of symptoms presented by patients, and found that people most commonly sought advice for upper respiratory tract symptoms including coughs and colds. The second most common presentations in the consultations studied were skin symptoms (Smith and Salkind, 1990a), so it may be that the advice offered by pharmacists in these areas results from the frequency of related queries in general, and a perceived need for client education.

Another approach to studying drug-related advice provided by pharmacists has been taken by Nichol et al (1992a; 1992b), in a study to determine the extent to which provision of information on OTC medicines can promote change in consumer purchasing behaviour. 309 interventions in 1 pharmacy resulted in nearly half of the clients purchasing a different product than they had anticipated when entering the store, suggesting that a pharmacist's advice on appropriateness and efficacy of therapy is not only valued but necessary (Nichol et al 1992a). However, these were not the only criteria used to decide on a purchase, as cost and availability of generic brands were also found to be significant (Nichol et al 1992b).

Surprisingly, none of the studies discussed thus far have given much space to

considering the quality of advice given by pharmacists, or attempted to assess this directly as opposed to by measuring patient satisfaction. For the most part there seems to exist in pharmacy practice research literature an idea that patient satisfaction is only achieved through a good quality of advice giving, and so if satisfaction is reported then counselling can be assumed acceptable by default. Examples are Osborne and Dodds' (1993) study entitled "The quality and quantity of drug related information provided to hospital inpatients and its effect on seamless care", where the quality element is determined by exactly this method, and Blom and Rens' (1989) study of OTC purchases followed up by home interviews to determine patient satisfaction.

More objective attempts to assess quality, albeit from a clinical viewpoint, have focused on the accuracy of the information provided and its usefulness to patient care. Several of these studies have used a panel of 'experts', commonly other pharmacists, to subsequently assess the advice given to a patient or client (Nelson et al 1978; Watkins and Norwood 1978; Krska, Greenwood and Howitt, 1993). Some of these studies have chosen to employ a "fake patient" methodology, most notably the Consumers' Association surveys (1985; 1991), and have been vehemently criticised for this, on grounds of both ethics and accuracy, by the RPSGB. The latter of the two surveys in particular produced damning results, and concluded that the quality of advice given to 5 fake patients asking for help on common problems (and assessed at a later date) fell short of the requirements of the professional code of ethics (Consumers' Association 1991). Pharmacists were criticised for the frequent sale of inappropriate remedies and for failing to make necessary referrals to other health care



professionals. The suggestion is that poor quality of advice is not necessarily linked to inadequate knowledge of appropriate treatments, but to a lack of communication with the patient. However, as was raised earlier, communication skills are difficult to assess in an encounter where one party has a strictly pre-determined passive role to play and only specific information to offer, as such consultations are not necessarily representative of the day to day counselling activities of a pharmacist. Some commentators have suggested that the high street availability and business nature of the pharmacy result in a much more evenly balanced encounter between patient and pharmacist than with any other group of health professionals, with the client, as a consumer, feeling more able to take the initiative and direct the encounter (Wilson, Robinson and Ellis, 1989). In these circumstances, the passive roles assigned to fake patients seem increasingly inappropriate.

Concern at the numerous studies using simulated patients, almost without exception showing inadequate communication with patients and a lack of appropriate advice, has led some pharmacy practice researchers to conduct their own studies using alternative methods. As Krska, Greenwood and Howitt assert in the introduction to their "audit" of advice, "Clearly both the quality of advice given and the appropriateness of the products recommended are linked to questioning of the patient" (Krska, Greenwood and Howitt 1994 p93), (and are therefore liable to be disrupted in experimental type setting using a researcher). Instead, they look at the application of audit methodology to the provision of advice in response to symptoms (Krska 1994) :- peer audit is seen as doubly beneficial because of the opportunity it also provides for interaction with fellow pharmacists. Volunteer pharmacists were recruited to the study, provided with

details of a scenario which could present in a community pharmacy, and then asked to supply (in writing) appropriate advice. A consensus was reached, and a pharmacist posing as a patient was then sent out to the recruited pharmacists to present the scenarios in person. Once advice had been given, the "patient" identified herself, and the advice exchange was discussed. The report concludes that "the communication skills of the pharmacy staff were adequate on most occasions" (Krska, Greenwood and Howitt, p95), but that inadequate questioning was the factor most likely to result in inadequate advice. It is unclear why a pharmacist fake patient is seen as less likely to disrupt the normal interactional process than a non-pharmacist, but at least ethically the advising pharmacists involved had all agreed to participate in some kind of advice giving study, and were involved in the assessment of their performances.

Direct observation is the final method which has been used to assess quality of advice given by pharmacists, and has the advantage of avoiding the use of any type of fake patients. Despite this, there has in actual fact been very little direct observational research on what pharmacists do in their attempts to tell people about their medications; Berado, Kimberlin and Barnett (1989), in their observational study of community pharmacists, suggest that this is partly because of logistical difficulties and partly due to a lack of training for observational research amongst pharmacists. Whilst not all pharmacy practice researchers are pharmacists, the majority certainly are, and their educational background perhaps means that they find it easier to survey pharmacists' attitudes and perceptions, or to ask what counselling they usually provide, or to ask consumers where they obtain their information from. Berado, Kimberlin and Barnett's study aimed to develop 2 observation instruments to measure

the quality of pharmacy consultation services. These instruments consisted of an activity summary sheet, recording whether the pharmacist was involved in sales, dispensing etc, and a behavioural summary sheet which recorded the amount and type of information conveyed. The second part of this behavioural summary focused on the 'general atmosphere' created by the pharmacist; his or her style of presentation and manner of speaking, while the third and fourth parts were related to drug therapy and contained a list of possible points of information the pharmacist could ask for or provide.

In order to test these instruments for reliability and validity expert judges were involved and paired field observations carried out, establishing satisfactory agreement coefficients. Disappointingly, however, the reported results are confined to the percentage of patients receiving counselling as judged by these methods before and after a pharmacist education workshop. No discussion of the "quality" variables, such as attitude, or questioning behaviour, is presented in the paper so it is difficult to assess the value of the method in these terms. What is apparent is that these observation instruments are largely confined to recording the function of the pharmacist in isolation, despite the two way nature of the consultation process.

Naturalistic observation is also the technique used by Smith in her study of the quality of advice given to clients presenting at community pharmacies with a cough (Smith, 1992); however, the need to develop an accurate recording instrument which dominates Berado et al's study was bypassed in this case by tape-recording all the consultations that occurred. This study is also framed as a response to fake patient

investigations; as the author states , "Previous studies into the advisory role of community pharmacists have investigated the responses of pharmacists in particular scenarios in which researchers have posed as clients. These studies have provided information on certain aspects of pharmacists' responses in certain situations but they have not shown in a comprehensive way how pharmacists deal with the variety of presentations which arise in the course of their work." (Smith, 1992, p68). There have also been differences over what is constituted as a consultation with a pharmacist, and this study provides its definition as "Occasions on which either the client requested advice from the pharmacist about a minor ailment, or asked the pharmacist for a suitable product for their symptoms" (Smith, 1992, p68).

The consultations thus collected were transcribed and a coding frame devised to allow analysis. This analysis focused on how pharmacists established classification of a client's cough (eg dry, chesty etc), and the items of information then supplied by the pharmacist. The mean number of questions per consultation and the mean length of consultations were also established, and it was concluded that "In many cases information helpful in assessing the possible seriousness of symptoms was not collected. Asking more questions would increase the opportunities for clients to provide more information and open up the discussion to explore the wider health implications and appropriate health education" (Smith 1992 pp70-71). How these questions might be brought into discussion, or indeed how the number of questions that are asked in the encounters are raised, is not considered; from this point of view, whilst the methodology and focus of the study are unusual and interesting, the information it actually yields in interactional terms is limited. The design of the study

and the refusal to use fake patients also raises the question of research ethics; recordings of all consultations with the pharmacist took place with "a notice placed in a prominent place to inform the clients of the study and assuring them they could be excluded if they wished." (Smith, 1992 p69). No-one is reported as asking to be excluded, which is perhaps not surprising given that the tape recorder was already running. It seems likely that it is much more difficult for clients to withdraw their consent from something that has already started than to refuse to participate in the first place. If further naturalistic studies are to be carried out in a community setting then this is an important consideration.

All of the studies discussed thus far have considered communication only as it relates to other variables of the pharmacist/patient encounter: how it is influenced by attitudes; how it may be utilized as a marketing strategy; and how it can affect drug therapy, choice of product or clinical outcome. In addition, apart from attitudinal surveys of customers, most of the reported research has focused solely on the pharmacist in this communication process. Very few studies would seem to have directly studied the actual nature of the pharmacist/patient interaction during counselling. The rest of this chapter will be given over to discussing those which have appeared in the literature.

Most of these communication-centred studies focus on verbal interaction, although Ranelli's study, published in a social science journal, is the exception. (Ranelli, 1979). In the course of this research, subjects were shown different slides depicting a pharmacist in a neighbourhood pharmacy setting. Subjects were given a 5 point

modified Likert scale on which to record their impressions of the likeability, advice potential etc of the (same) pharmacist in each slide. Greater positive attitudes were found when the pharmacist appeared closer, in an eye level position, and when he was not screened by any object such as a counter. Ranelli, concluding that what the pharmacist does is as significant as what he says, suggested that posture, orientation and distance were the most significant factors in inferring positive or negative characteristics. Related to this, Taylor and Greer (1993), reviewing the literature existing on the "availability, accessibility and approachability" of pharmacists, echoed Mason and Svarstad's (1984) findings that approachable behaviour was largely governed by expression, speaking rate, tone of voice and general manner.

Perhaps the most significant approach to examining communication as it relates to pharmacists, however, is seen in the work produced by Morrow and Hargie. Their approach is strongly rooted in the social psychology tradition, breaking down communication into core skills. An article in *The Pharmaceutical Journal*, intended as a practical guide for pharmacists, describes these core skills;- friendliness and warmth, for example the use of the customer's name; non-verbal skills related to distance, eye-contact, touch and nods; explaining skills; questioning and listening skills; and influencing and persuading skills. It is suggested that this latter category can successfully take the form of moral appeals, as in "You have a duty to your unborn baby to stop smoking" . These skills should be combined, the authors state, with confident delivery which contains few hesitations or expressed doubts, and the use of intensifiers , eg "definitely", "absolutely", since these "help to underline the power and status of the pharmacist in terms of specialised knowledge and expertise."

(Morrow and Hargie, 1994, p312). Simple interactional techniques suggested to aid this theory include placing the most important points at the beginning or end of an encounter, and checking for patient understanding at the conclusion. The issue of 'open' and 'closed' questions is also raised, and pharmacists are encouraged to ask more open questions and to increase patient participation by pausing both after the question and after the patient's initial response.

These recommendations have grown out of extensive research and training programmes with pharmacists, with an emphasis on methods which involve asking pharmacists and others for their views on what constitutes 'good counselling'. Thus their investigation into "core situations and difficulties in pharmacy practice" (Morrow and Hargie, 1992) was conducted according to an 'expert systems' approach, in which subjects (pharmacists) were required to formulate and identify component elements of the field of enquiry under analysis. In practical terms, this meant that pharmacists were first required to identify situations in a pharmacy where they felt that counselling would be indicated, and secondly to identify the most common difficulties that these situations presented. These were compiled, and each participant was then given the full list and asked to rank both the 15 most important situations and the 15 most common difficulties. Certain issues appeared to be consistently regarded by pharmacists as important in the counselling of patients, and training of the type described was then targeted at these issues. In particular pharmacists reported having to deal with patients' confusion, worry and anxiety, but feeling ill equipped to do so; as the authors conclude, "Social and behavioral issues are recognised as important at the patient interface" (Morrow and Hargie, 1992,

p204).

A further study describes the use of similar techniques in order to identify effective patient

skills more clearly in pharmacist/patient consultations (Morrow, Hargie and Woodman, 1993). This describes the use of an approach in which 25 'experienced professionals', who had all participated in post-qualification training, recorded and viewed a range of videotaped interactions involving themselves and their patients. Each pharmacist was asked to provide 20 consultations, and these were then analyzed in depth, both individually and in groups. The aim of this analysis was to identify in detail what the pharmacists regarded as the constituents of effective and ineffective performances. In the sense that this is behaviour analysis by those involved in the process, it is termed a constitutive ethnography methodology, although it is doubtful whether the use of this term in these circumstances would be recognised by sociologists. Patient consent to be recorded in this study was established in the same manner as for Smith's tape-recordings of consultations (Smith, 1992a), by means of a poster displayed in the pharmacy inviting requests for exclusion.

As far as the details of the analysis were concerned, each individual was first asked to select 5 effective and 5 ineffective episodes from their own interactions. In groups of 3, 1 effective and 1 ineffective interaction was then chosen for each member, keeping the focus on communication rather than dispensing issues. Good individual actions within interactions were then identified for each pharmacist, along with areas where it was felt issues could have been dealt with differently.



These instances were compiled, similar instances of behaviour were classified into categories and the categories labelled. Category labels included "Questioning", "Listening" and "Non-verbal communication", with sub-categories, such as sympathy and interest in the listening group, also delineated. Pharmacists were then asked to complete a 6 point Likert scale regarding the extent to which each of these behaviours were essential for pharmacist/patient communication, both in a situation specific and a general sense. Thus the list of core skills were arrived at, which were intended to "validate and delineate the content of communication skills training programmes for pharmacists" (Morrow, Hargie and Woodman, 1993a, pp12-13).

Specific aspects of these core skills have also been investigated in greater depth by the same authors, in particular questioning behaviour by pharmacists during consultations (Morrow, Hargie, Donnelly, et al 1993). In an analysis of video recorded community pharmacist/client interactions it was reported that over 98% of the questions pharmacists asked were closed, over two thirds of which were of the variety requiring a yes/no answer. 24% of questions were described as leading in nature, and almost all of these were classified as 'subtle leads', although it is not clear from the text exactly how this distinction was made. Client questioning of the pharmacist was also considered within the scope of the study, in terms of the mean number of questions asked per consultation; this was found to be 2.5 per encounter as opposed to 4 by pharmacists.

The methods of analysis used to arrive at these results once again consisted of coding, categorisation and counting of questions. The emphasis of the study, however, is

clearly upon how the questions were posed:- constructions as distinct from content, whereas other investigators have generally been concerned with the product as the endpoint. This focus is also present in Smith's (1992b) study; whilst other of her assessments of community pharmacists have considered quality of advice from an information viewpoint (Smith, 1992a), this study examines the process in terms of questioning behaviour and information giving.

In addition to the calculation of variables such as mean number of questions per minute and the number of pieces of information supplied, an analysis of the questioning and information exchange was also carried out in order to "investigate the extent to which the communication style of the pharmacists would allow clients to express and pharmacists to respond to client concerns." (Smith, 1992b, p251). A 2 part nature was identified to many of the consultations where in the first part the pharmacist asked questions (usually regarding symptoms) and the client supplied information; once this process was over the pharmacist assumed an information giving role and the consultation focused around products. A further investigation of the symptom versus product orientation of the consultations found that the primary issue was the symptoms of the patient. As in the previous study of questioning behaviour (Morrow et al 1993b), these conclusions were dependent upon a categorising and coding framework of analysis. Smith's conclusions, however, differ slightly from Morrow et al's assertion of "core skills", stating that "Though there can be no 'blueprint' for a good or bad consultation, different techniques may be better for achieving given objectives, such as the recognition and willingness to discuss underlying problems, some focus on the symptoms and attention to the client's

concerns" (Smith, 1992b, p255). In association with other authors Smith has proposed a tool for assessing quality of care as an entirety in community pharmacies , encompassing both questioning and drug-related characteristics derived by an external panel (Smith, Salkind and Jolly, 1990). Based on generalisability theory, this aims to establish the quality of advice requested by clients and volunteered by pharmacists in the ordinary course of their work.

Despite the general paucity of literature concerning the pharmacist/patient interaction, it appears that few researchers have chosen to look beyond this in grounding their studies. The only such study identified in this review was that by Wilson, Robinson and Ellis (1989), which focuses on the possible ways in which existing studies of doctor/patient communication might provide a useful initial framework for investigation. Important differences are noted between the two professions:- customers may frequently present prescriptions or ask for advice on behalf of a third party in a community pharmacy, whereas doctors usually see their patients in person, for example. Another significant factor is that customers have easier access to pharmacists, and an ability to use several pharmacies if they so desire or if they are unsatisfied with an encounter. It is suggested that as a result customers may perceive themselves as having more control over their interactions with pharmacists than with GPs.

Bearing these differences in mind, two complete studies were carried out using this background, aiming to research directly upon the effectiveness of pharmacist/customer communications. Using methods which have been employed in doctor/patient studies,

the initial phase consists of tape recorded observations; incidents were then coded into categories such as "basic transactions", "extended transactions" etc. The second phase, immediate post-counselling interviews with clients, assessed patient recall of information against audio-tapes: the hypothesis under test is that recall is improved when customers actively participate in information exchanges. Recall is measured in terms of the number of items of information forgotten by the customer, and equal weighting is given to all items of instruction offered. The customer is not asked which items they feel to be the most important, and so no correlation can be made between this and recall. Thus, despite the background of doctor/patient interaction, little consideration is given to the client's participation in the encounter beyond the discussions of questions formulated or items of information offered which are also presented by Smith (1992b) and Morrow et al (1993). It would seem that the criticism levelled at pharmacy practice research by Ranelli in 1990 is still applicable; he suggests that the emphasis of many studies has been to reinforce the position of pharmacists as information rich sources and little attention has been paid to patients. Equally, there is no sense of what relevance any of these findings have to participants' own understandings of the encounter.

It is clear then, that of the pharmacy practice research studies which have specifically considered communication as a topic in itself, most have employed simple social and behavioral psychology as tools of analysis. Social psychology has traditionally had a positivistic reliance on experiments as its main research method, and categorization, coding and counting of occurrences have formed the backbone of this methodology. These influences are clear from the terminology used; in Morrow et al's study of

questioning behaviour (1993b) questions are divided into "types" and "functions" in order to arrive at such variables as "Number of questions asked by the pharmacist per minute". Similarly, the analysis of Wilson, Robinson and Ellis (1989) depends on division of consultations into "basic" and "extended" transactions. It is evident that categorisation is the key feature of this type of quantitative approach to the study of communication. Critics have suggested, however, that this method leads to a preoccupation with the establishment of scoring systems (Hopper, 1989). Hopper also suggests that social psychology filters society through a variety of simplifying processes; from interaction, to transcript of words, to tabulations of instances of coded categories, to numerical specifications suitable for hypothesis testing. Handling responses and deciding on the status they can be assigned is not an easy task, necessitating decisions as to whether a particular response counts as an instance of some analytic category. It has been questioned (Wooton, 1975) whether categorisation can ever do justice to, for example, a particular point of view expressed. There are many possible ways of categorising groups of people, sets of beliefs etc and therefore the ever present possibility of alternative categorisation.

Potter and Weatherell (1987) raise a number of specific objections to the simple social psychology model as a means of studying communication. These are as follows:

i) Restriction. A subject's reaction to a situation must be constrained in that responses must fit into pre-ordained categories. Put simply, subjects cannot just believe, feel or act in any way for the purposes of analysis; the response must be selected from the options incorporated into the experiment. Most studies measure

response once only, at one particular time. This strategy is designed to reduce the variability of interpretation of a response, but Potter and Weatherell suggest that it is obscuring an important feature of communication in the process; that beliefs, responses etc can change. Here they are taken to be members of relatively enduring categories; for example non-compliance is often taken to be a static problem, attributable to a specific group of people indefinitely.

ii) Categorisation as simplification. Open ended discourse is subject to content analysis:- the generation of categories which can be reliably coded and imposed over the data for the purposes of hypothesis testing. In order to achieve reliability these categories must be relatively simple to operate, and so risk losing the subtlety of a situation where participants may be constructively using their language to produce different sorts of effects throughout. Even two coders trained in the same way can persistently repeat the same confusions and categorise together different sorts of utterances.

iii) Attitudes. Studies assume that people filling in an attitude scale are performing a neutral act of expressing a mental state. However, there is at least a possibility that they are producing a specific response for the purposes of the context at hand. Given a different purpose, or a different context, different attitudes may be adopted by the participant. A level of satisfaction with pharmacist advice giving, for example, may be expressed differently to a researcher than a friend, and differently again dependent on the last encounter with the pharmacist.

iv) Selective reading. Numerically transformed versions of accounts can serve to sustain a particular model by virtue of the researcher making selections which simply mirror his or her prior expectations. Even a small amount of additional information can throw into question what may appear to be a reasonable interpretation of a person's utterance.

v) Underlying logic. The logic of techniques such as attitude measurement is that scales are used to compare various participants' attitudes to the same object. This presupposes that the object is a simple, already present entity, and ignores the close interdependence of descriptive and evaluative language. Some terms which we use come ready evaluated, with the evaluation an implicit component of the term itself. Potter and Weatherell use the examples of "terrorist" and "hijacker" to illustrate this, but the principle can equally be extended to cover terms such as "pharmacist" and "patient", which also incorporate sets of expectations to a degree. Even if language is presupposed as an idealised realm beyond conflict, the path between attitudes and behaviour which appears to inform so many pharmacy practice research studies is indirect and muddled (Fishbein and Ajzen, 1975). More fundamentally, talk has an action orientation which cannot be measured by using these techniques. As a result, the recommendations made from these studies are limited to discrete and specific components to be incorporated into a seemingly static interaction process. The fact that interaction is not a static process, and that this poses serious problems for the wholesale incorporation of these suggestions, is ignored.

It seems then, that in order to overcome these objections, alternative approaches to

studying the pharmacist/patient interaction need to be considered. As far as such approaches exist, some of the methodologies used in the other social sciences have tried to get at the action orientation of talk, and to avoid the cognitive reductionism inherent in the simple social psychology which informs much pharmacy practice research. These approaches, and the advantages they may have for identifying the dynamics of the pharmacist/patient interaction, will now be considered in more detail. Specifically, the literature discussed in this review appears to contain many generalised presumptions about 'what pharmacists should do' in the course of their work. However, adequate professional practice is dependent on everyday contingencies, and patient counselling itself is utterly contingent on the two-way interactional process with the patient. These factors alone suggest that the burgeoning ethnomethodological literature is likely to have particular uses in an analysis of the pharmacist/patient encounter.



**Chapter 2**  
**METHODOLOGY**

As has been detailed in the previous chapter, it is evident that significant problems of method and measurement arise when researchers seek to study social action. These problems have been fundamental to the development of sociology as a discipline; as Cicourel states, "A basic goal of sociology is the search for and measurement of invariant properties of social action within the context of a changing social order" (Cicourel, 1964, p197). In terms of pharmacy practice research, it is easy to see how the vast majority of studies have been influenced by the natural science paradigm, with their positivistic focus on quantifiable and statistically valid results. However, in some senses this concern for substantive results seems to have somewhat obscured the fact that results can only ever be as good as the methods (and the theory informing those methods) that are used to find and interpret them. Cicourel cites Schutz, who notes, "The world of nature, as explored by the natural scientist, does not mean anything to the molecules, atoms and electrons therein. The observational field of the social scientist, however, namely the social reality, has a specific meaning and relevance structure for the human beings living, acting and thinking therein" (Schutz 1954 p266-7). Despite their proposed focus on communication, then, the majority of studies concerning pharmacy counselling fail to take sufficient account of this fundamental difference.

For sociology, on the other hand, this problem of how the individual is able to anticipate or make sense of the perspective of the other during the course of

communication has played a pivotal role in the development of social theory. As George Herbert Mead explicitly noted, communication involves the conveyance of *meaning* (Mead 1932 pp83-84). In consideration of this, however, Cicourel proposes that Mead's notions "presuppose that meanings, their generation, transmission and understanding, according to some set of standards, are matters which can be accepted as self-evident" (Cicourel 1964 pp197-8). Elaborating on this, he observes that whilst it is clear that throughout the course of interaction meanings are communicated continuously, their properties are ill-defined, and provide no explanation for how an individual goes about the business of making sense of his or her own environment in a socially acceptable manner. Evidently, this produces a further problem for the study of interaction, since it is dangerous for the researcher to assume that both s/he and the subject are sharing the same subjective meaning structures for assigning significance to an event or object. This in turn presents the problem of how any such differences may be reconciled or recovered for standard processes of measurement. As Cicourel concludes, "Because of their dependence for stability on the actor's perception and interpretation of them, the measurement of the stated features of everyday life (even after assuming that social institutions and ecological arrangements delimit the forms of collective life) and especially, the unstated conditions of everyday life are sufficiently indeterminate to raise serious questions about the measurement systems now in use" (Cicourel 1964 p221). There is a note of caution, then, for the observer who fails to take account of what Cicourel calls the elements of "common-sense" acts in everyday life, since he or she is using an implicit model of the actor which is "confounded by the fact that his observations and inferences interact, in unknown ways, with his own biographical situation within the social world." The

distribution of responses to questionnaires, for example, is only half the picture, and the 'meaning' of this distribution relies upon common-sense knowledge which includes the actor's typification of the world as it is founded in his own biographical situation. Thus respondents to the kind of questionnaires discussed in the previous chapter are likely to have different conceptions of what constitutes a 'satisfactory' pharmacy service, or indeed what the activity of 'patient counselling' involves. To report that a certain percentage of respondents found their pharmacy services 'satisfactory' tells us nothing about these conceptions, or the criteria which respondents have used when making these assessments for the particular purpose of answering a questionnaire.

Addressing questionnaires specifically, Cicourel goes on to consider "the evils of data reduction" (Cicourel 1964 p106), pointing out that in order to use a questionnaire to test a hypothesis, every subject's response pattern would need to be predictable on theoretical grounds. In addition, each type of respondent would have to have an identical understanding of the questions contained. In order for this to occur, "The question and response would have to reflect the kinds of typicality that the actor uses to manage his daily world, be conducted in the everyday language he is familiar with, and evoke replies which are not altered by the idiosyncrasies of occasional expressions, particular relevance structures, a pretence of agreement, or the particular biographical circumstances of the respondent, unless such properties are variable conditions in the research design" (Cicourel 1964 p110). In terms of questionnaires that seek to measure values and attitudes (as is the case with much pharmacy practice research), his argument anticipates that of Potter and Weatherell's, discussed in the

previous chapter: that by imposing a deterministic "grid" or fixed choice structure, these tend to ignore the emergent, ever-altering (and thus problematic) character of everyday life. The notion of underlying stable attitudes is at best shaky, and at worst results in data which is nothing more than a "frozen" slice of an artificial or hypothetical situation. This occurs primarily because the concept of attitude in itself is not a quantifiable one; the quantification arises solely as a result of a particular theoretical framework. Fundamentally, it is perhaps meaningless to speak of attitudes at all, since we cannot know other people's minds.

In a similar manner, interviewing as a research strategy is fraught with difficulty, in that either the researcher or the actual questions have the potential to misinterpret or be misinterpreted. With this in mind, it is difficult to contend that even similar interview results are either accurate, in the sense that they are establishing both what the researcher intended to establish and what the interviewee intended to be established, or more fundamentally, that they approximate some (identical) true value.

Turning to consider how these problems may be overcome for the practical purposes of research, Cicourel suggests that "recent work has shown that the analysis of speech, gestures, and physical appearance can be important research tools for studying social solidarity, social distance, role distance, authority relationships and general sociological organisation" (Cicourel 1964 p188). Singling out speech from this list, several of the methodologies used in the social sciences have attempted to get at

the action orientation of talk implied here. By so doing, they aim to avoid the cognitive reductionism criticised by Cicourel that is inherent in much pharmacy practice research, influenced as the majority of it is in terms of a fairly simple social psychology paradigm. Of specific interest, particularly in terms of the research setting for this project, is Conversation Analysis, or CA. This is sometimes included under, or confused with, the umbrella term of Discourse Analysis (DA). Levinson (1983), however, defines DA as a series of attempts to extend the techniques successful in linguistics beyond the unit of the sentence and into conversation. In this sense it is rule governed, and so closer to the social psychology model than CA. A further approach, 'Critical' Discourse Analysis, uses literary theory in order to explicate speech as if it were text.

Ethnomethodology has been a strong influence in the development of CA; the former has its foundations in the idea that language is inseparably involved with the processes of reasoning and thinking. Language is considered an active practice, used like a tool in order to get things done. Ethnomethodologists consider that mainstream sociologists (and social psychologists) have failed to show any awareness of members' possessions of social competence, treating them as 'social dopes'. It follows that as far as both ethnomethodology and CA are concerned, the number of questions asked by a pharmacist per minute, for example, does not just happen, but is actively created by participants to the encounter.

Ethnomethodology itself developed, as Heritage (1995) describes, not as a means to tackle specific issues of language, meaning or communication, but instead as a

general approach to the study of social interaction. To quote from another Heritage source, "the research culminating in ethnomethodology can be perspicuously viewed as the product of a consistent attempt to recast the analysis of social organization and social conduct...In the context of the theory of action, what is self evident is that the actors treat their own and one another's actions as the intelligible products of knowledgeable subjects whose talk and conduct is more than a conditioned babble. It is self-evident too that these same actors believe themselves to be, and treat one another as, confronted by real choices in conduct for which, unless 'excused', the chooser will be held accountable as the agent of his or her actions" (Heritage 1984 p129-30).

In particular, the ethnomethodological approach developed as a critique of the Parsonian exposition of social interaction. In simple terms Parsons (who was perhaps the most influential English language sociologist of the twentieth century) had focused his writings around how the practicalities of everyday life could be absorbed into a general scheme for explanation. Taking a concern for general synthetic theory from the positivistic tradition of sociologists such as Durkheim, he sought to combine this with a more Weberian, idealist approach which gave scope to the importance of ideas, values and culture. According to the structural-functionalist approach to sociology, all societies have to satisfy some functional pre-requisites, which are in effect a set of pre-conditions for the possibility of society. These pre-conditions are twofold: firstly relating to physical survival, and secondly relating to the survival of society itself through time, incorporating such factors as skills, knowledge and maintenance of boundaries. These boundaries, however, recognise that societies are subject to

environmental pressures, and social systems therefore change to accommodate this (Parsons 1991). Expanding on this line of thought, Parsons developed the notion of the "Action Frame of Reference", in which the starting point for analysis is that interaction is framed by the orientation of actors to their situation. Actors thus orient to the specific context in which some sort of interaction is occurring in terms of a framework of ideas. The social situation is seen to contain three sorts of object: social, physical and cultural; and within this environment motivation to act occurs either as a search for rewards or pleasures, or as an attempt to avoid deprivation or sanctions. Although there is not room here for anything other than the most perfunctory treatment of Parsons' work (although some of his work on the sociology of medicine will be discussed in the following chapters), what is important is that he placed massive weight on the role of normative values, linking personality based dispositions on one hand with social institutions on the other. In this sense his is a highly deterministic view of social action; although actors may think they have choices, and their experiences are that they have choices, effectively these are determined for them. In simplistic terms, and particularly in his later work, Parsons' theory concentrates on roles and systems, rather than people and actions.

However, such a simplistic treatment of Parsons perhaps neglects to consider that what he set out to do in 'The Social System' (1991) was to describe a voluntaristic theory of social action, since rationalistic and positivistic theories could not simultaneously explain social order and rational action, and therefore could not arrive at a satisfactory theory of values, culture and meaning. To quote from the Preface to 'The Social System', "Without an adequate theory of the nonrational aspects of



action, sociology would never develop a satisfactory understanding of the meanings which actors attach to social action" (Parsons, 1991, pxxix). Social order is deemed possible if actors share a culture of common values, which unites them together to share and perform co-operative activities. It follows that action is meaningful because rational actors have available to them common values which define action, and that these general values bind social actors together in the social system.

It is perhaps at the beginning of 'The Social System' that Parsons' concern with the perspective of the actor is at its most explicit. As he states at the outset, "The most elementary components of any action system then may be reduced to the actor and his situation" (Parsons, 1991, p7). Likewise, "Action is a process in the actor-situation system which has motivational significance to the individual actor, or in the case of a collective, its component individuals" (Parsons, 1991, p4). The ways in which actors ascribe significance to their actions and the actions of others is also considered, so that "Part of ego's expectations, in many cases the most crucial part, consists in the probable reaction of alter to ego's possible action, a reaction which comes to be anticipated in advance and thus to affect ego's own choices" (Parsons, 1991, p5). In this sense then, the social system is considered to be essentially a network of interactive relationships, and the significance attached to individual actors and their interactions with others is perhaps not so far removed from the Ethnomethodological stance. However, Parsons' main concern with 'The Social System' as a sociological work was to develop a general sociology of values, and he explicitly notes that the book "Is intended as a theoretical work in a strict sense" (Parsons, 1991, p3). It seems that in the construction of this theory, then, the

perspective of the actor which is stated so clearly at the beginning becomes somewhat marginalised as the theory is developed. To use a final quote from Parsons, "A social system is a mode of organisation of action elements which relate to the persistence or ordered process of change of the interactive patterns of a plurality of individual actors. Regardless of the enormous variability in degrees of stability and structural integration of these interaction patterns, of their static character or involvement in processes of structural development or change, it is necessary for the present type of theoretical analysis to develop a scheme for the explicit analysis of the structure of such systems" (Parsons, 1991, p24). The development of this 'scheme' thus begins to shift the focus away from individual actors, and towards roles and systems.

Returning, then, to Heritage, he summarises Parsons' theory of social action as follows; "that social action is to be understood as the causal product of internalized moral norms and rules that are engaged by relevant social contexts and function as drivers of context". It follows that co-ordination of action is possible because the actors share a common body of norms and rules which are brought to bear by a shared recognition of their joint social situation. In turn, this common recognition results from "a shared system of determinate cultural representations and symbols that provide for agreement among the actors about the nature of the objects, events and actions that make up any common setting of action" (Heritage 1995 p392).

As Heritage notes, and as has been alluded to here, this view of action is essentially *motivational*. The concentration on social norms as 'drivers of action' means that

there is little, if any, explicit consideration of how the producers of social action are *knowledgeable* in their own right. The perspective of the actor, as someone who manages to achieve shared understandings through the use of situated, common sense reasoning, is virtually (although as has been noted, not entirely) absent. Thus it is clear why critics of Parsons have summarised this approach as treating the actor as a 'judgemental dope', for whom situations are unproblematic, and conduct is produced wholly as a result of internalized norms. No account is taken of how social actors make joint sense of their situations. As Heritage also points out, there is a sense in which Parsons' theory is static, in that it assumes that the circumstances of the actors are unaltered by their actions.

These two perceived flaws in the work of Parsons provide the central tenets of ethnomethodology; that actors, having a "common-sense knowledge" of their situations, are continually creating, maintaining or altering the social situations in which they are placed through the actions they perform. Thus the situation is not seen to contain actions in the way Parsons suggests; rather situations are created through their constituent actors and actions. The development of ethnomethodology as a theoretical standpoint, then, represents a shift towards the acknowledgement of human agency as fundamental to the study of social interaction. According to Lynch (1993) "Ethnomethodology can be described briefly as a way to investigate the genealogical relationship between social practices and accounts of those practices" (Lynch, 1993, p1).

In developing the ethnomethodological approach, Garfinkel addressed the deficiencies of the Parsonian perspective by drawing on Schutz's analysis of the typified and approximate character of common sense knowledge and representations. Through what Garfinkel calls the 'documentary method of interpretation', objects etc are assimilated into social categories by actors in social situations. Thus the basic idea is that we will approach any given situation, object or event with a set of assumptions about what we will find and what is going on, and will then look for evidence to confirm our assumptions. Famously, by means of a series of what have come to be known as "Breaching experiments", Garfinkel demonstrated that the use of common-sense knowledge, along with these background assumptions, is fundamental to the maintenance of shared understandings. These experiments engineered events which ran counter to actors' expectations and assumptions; for example in a game of noughts and crosses the 'experimenting' player would, in his or her turn, rub out their opponent's mark and replace it with their own. Some opponents became angry, whilst others in turn began to play by the new 'rules', in their turn rubbing out the experimenter's mark. From these experiments Garfinkel drew two main conclusions; firstly that our basic capacity to understand social interaction depends on public, intersubjectively available rules, and secondly that social rules may not function in the way which Parsons had suggested, ie internalization. "Common-sense knowledge", and "background assumptions" are essential to the maintenance of understanding. As the 'breaching' shows, these understandings are achieved and sustained on a moment by moment, turn by turn basis. They underline the persistent and unremitting effort that we have to make to achieve shared understanding, which in the course of ordinary interaction is largely tacit or invisible. Garfinkel uses the

term 'trust' to describe the alliance which maintains this reciprocity of perspective, which inevitably involves our expectations that others will see the world as we do.

Additionally, Heritage observes that Garfinkel questioned "conceptions of language and symbolization which have as their basis the assumed primacy of the representational function, stressing instead the multiple relevancies and the inherent reflexivity and contextuality that sign functions possess" (Heritage 1995 p392). In courses of action, social actors will necessarily interpret them as elements of the actions that they partially constitute. Thus, in summary of ethnomethodology's position, "A shared social world, with its immense variegation of social objects and events, is jointly constructed and recognized through, and thus ultimately rests on, a shared base of procedures of tactical reasoning that operationalize and particularize socially distributed corpora of inexact knowledge" (Heritage 1995 p393).

Garfinkel's work, and with it the development of ethnomethodology, can thus be seen to incorporate three distinct, basic themes. His book, 'Studies in Ethnomethodology'(1967) served to introduce the basic policies and objectives of ethnomethodology. The first is that the knowledge we use to navigate the social world is primarily social in origin, rather than resulting from internalized norms. Only a very small part of our knowledge actually originates in personal experience. Secondly, our knowledge of the world is stored in a form that is approximate: there is a vast gap between what we can in principle perceive and what we can in any explicit sense know. Finally, the issue of mutual understanding or intersubjectivity

is central to any analysis of social activity which takes account of the actors' knowledge basis. In terms of analysis, the persistence and prevalence of these shared methods of reasoning are fundamental. In addition to their function as a basis for understanding actions, they also function as a resource for the production of actions. Actors draw (albeit tacitly) on them so as to produce actions that will be intelligible and accountable (or 'recognizable-describable' as Garfinkel would put it) in a particular context. The result of this is that these 'members' methods' are readily available to the analyst, since the results of their application permeate natural social interaction. Expanding on this, Lynch notes that Garfinkel was not proposing to develop 'taxonomies' of ordinary methods, but that for Garfinkel, " "methods" include the entire range of lay and professional practices through which social order is produced. By conceiving of these methods as subject matter, Garfinkel was proposing an encompassing approach to the study of social actions" (Lynch, 1993, p6). Where Parsons retained the judgemental position of an 'idealized scientific observer', in contrast to this, "Garfinkel decided to make a topic of commonsense knowledge of social structures without first setting up a scientific counterpoint to that knowledge" (Lynch, 1993, pp9-10). In this sense, as Lynch describes, ethnomethodology is not only a 'method' for establishing the assumptions, tacit knowledge, behavioural norms and expectancies through which participants constitute routine interaction, but also a perspective from which to begin investigation of the "tacit research practices used in "conventional" social science" (Lynch, 1993, p11).

As discussed earlier, of particular relevance to any kind of study of communication

has been the development of the distinct branch of ethnomethodology known as Conversation Analysis, or CA. Talk is a resource readily available to the analyst, and with it the way that actors or members constitute their activities, roles and identities through talk. Thus, over the past 20 years, CA has developed into a prominent form of ethnomethodological work. As its name suggests, CA emerged from the underlying initiatives of ethnomethodology primarily as the study of methods of conversational action. As Heritage puts it, "Nourished by Goffman's (1964, 67, 71, 83) conception of the 'interaction order' as an autonomous domain of investigation, conversational interaction began to be conceptualized as a social institution in its own right whose normative organization and empirical regularities could be addressed using the sorts of basic observational techniques that a naturalist might use in studying animals or plants (Sacks 1984) " (Heritage 1995 p393-4). The inception of CA as a distinct methodology was closely linked with the tendency for ordinary language descriptions, and the attendant procedures of memorizing, categorizing or coding to marginally interpret, portray as ideal or to restrict and reduce the specifics of what they attempt to depict. In such a way the investigation becomes one step removed from the actual event, blurring the precise realities of social interaction. Throughout a range of methods commonly employed in the social sciences, including interviewing, questionnaires, observational methods and experimental methods involving manipulation of behaviour, the specific details of the interaction are lost in the analysis. It is for these reasons that CA is distinctive in its commitment to the use of naturally occurring data which confers a twofold advantage; firstly that each detail of the talk may be retained for analysis, and secondly that naturally occurring data can provide the researcher with an infinite resource containing an immense range of

interactional variations. These variations allow for systematic and critical comparisons which may then be used to develop analyses. Thus, a basic CA assumption is that ordinary (or mundane) conversation represents a fundamental domain for the analysis of members' methods, or the practices that they use to make sense of, and to make sensible contribution to, an ongoing interaction. The recording of naturally occurring data has an additional advantage, in that, as Sacks (1992) stresses, it is a resource that can be analyzed, re-analyzed, and made available to others for their analysis. The use of highly detailed transcripts of interaction, which will be discussed further in the following chapter, enables dissemination and publication of any analysis to and for a wider audience.

As Heritage contends, "CA (like other ethnomethodology) is concerned with the analysis of the *competencies* which underlie ordinary social activities. Specifically, it is directed at describing and explicating the competencies which ordinary speakers use and rely on when they engage in intelligible, conversational interaction. At its most basic, the objective is to describe the procedures and expectations in terms of which speakers produce their own behaviour and interpret the behaviour of others" (Heritage 1984 p241).

Rather than starting with an *a priori* set of theoretical specifications, CA has eschewed the construction of idealised theories in favour of the empirical identification of diverse structures of actual, real-life practices. Heritage describes this as the shift from 'the structure of action' (Parsons' (1937) idealised and conceptually



simplified model) to the 'structures of action' (Atkinson and Heritage, 1984) which are particularised and multiple. Within this approach there thus exists a considerable freedom of theoretical manoeuvre which allows a multidimensional perspective on the task of conceptualising conversational action. (Heritage, 1984). At the root of this perspective, however, are three fundamental assumptions. The first is that interaction is structurally organised, informed by organisations of practices to which the participants are oriented. Heritage (1995) uses the example of 'an interruption' to illustrate this: the recognition of an interruption presupposes a set of structured turn-taking procedures to occur in conversation. It is only after these structural features of, in this case, turn-taking and interruption are defined that it becomes meaningful or relevant to attribute the effects of other factors such as class, gender or race. As Heritage puts it, the "organization of practices, rather than being dependent on the motivational, psychological or sociological characteristics of the participants, are the medium through which these characteristics manifest themselves" (Heritage 1995 p396).

The second assumption is that contributions to interaction are contextually oriented. In doing a particular current action speakers normally project and require the relevance of a 'next', or range of possible next actions to be done by a subsequent speaker (Schegloff 1972). An example of this is that a question from one party projects the relevance of an answer from another. Additionally, in designing a turn at talk, this turn is usually addressed by the speaker to preceding talk. Heritage (1995) observes that speakers design their talk in ways that exploit or capitalize upon this basic positioning. It follows that, in the production of their next action,

subsequent speakers demonstrate an understanding of a prior action in a variety of ways. In turn, these actions may be (tacitly) confirmed by the prior speaker, or can become the objects of 'third turn repair' in which misunderstandings are exposed (Schegloff 1992a). In CA terms, these processes are the resulting product of a common set of shared, structured procedures: as Heritage (1995) summarises, these encompass the grasp of a 'next' action that the current action projects, the production of that utterance or action by the subsequent speaker, and then the interpretation of the second's action by the first.

The third fundamental assumption which is pivotal to the conversation analytic perspective is that no detail of an interaction can be dismissed *a priori* as unimportant, irrelevant, or without meaning. Thus, for example, pauses, perturbations and other such 'minor' details (which are commonly 'cleaned up' out of other methods of analysis and which may appear to be of minimal importance in terms of an interaction) are also subject to analysis by way of being part of a speaker's actual activities. To ignore or dismiss these would be to gloss or idealise the specifics of a particular interaction.

A further primary principle of CA can be drawn out from the second assumption discussed above, which asserts that contributions to interaction are contextually oriented. The natural extension of this principle is that the significance of any speaker's utterance is *doubly* contextual, ie it is both context-shaped and context-renewing. In other words, it is impossible to adequately interpret a speaker's

utterance except by reference to the context in which it occurs (and especially the immediately preceding actions). Hearers use and rely on this developing context to interpret the utterances of others, and speakers attend to it in the design of what they say. In this sense talk is context-shaping; its context-renewing character arises since, as every current action will form the immediate context for the next, it will inevitably contribute to the framework by means of which, and in terms of which, the next action will be understood. (Heritage 1984).

In terms of the actual analytic procedures of CA, the process is strongly data-driven, centring around observations arising from the data. The analyst, as a competent language user him or herself, becomes engaged in an inductive search for instances of a particular practice or phenomenon contained in the data. Just as no detail of interaction is dismissed *a priori*, so there is a bias against any *a priori* speculation concerning possible orientations and motives of speakers, with the analyst instead concentrating on the detailed examination of conversationalists' actual actions (Heritage 1984). A major component in this analysis procedure is deviant case analysis; having established a general pattern, this involves looking at the cases where this general pattern is departed from, and if or how participants orient to any such departures. As Heritage (1995) notes, this "pattern and deviant case analysis has yielded strong results; not only in terms of structural features such as turn-taking and repair but also involving the organization of gaze (Goodwin 1981), gesture (Goodwin 1986) and conduct in institutional settings (Heritage and Greatbatch 1991)". (Heritage, 1995, p399)

In summary, then, CA is primarily concerned with the ways in which utterances accomplish particular actions by virtue of their placement and participation within sequences of action. Sequences and turns of interaction are thus the primary units of analysis, for example questions and answers, invitations and acceptance or refusal, etc (Heritage 1995). CA has developed a generic approach to handle this, in the notion of the 'adjacency pair' (Schegloff and Sacks, 1973). This provides a normative framework for a next action which is accountably implemented, for example the acceptance of an invitation. In such cases the conditional relevance of a second action to a first (Schegloff 1968) allows speakers to find that specific conversational responses, such as the answer to a question, are both notably and accountably absent. The *accountability* of this permits speakers to solicit, comment upon or draw inferences from the 'missing' action. In some senses, this concept of the adjacency pair can appear over-simplistic; an answer, for example, may not directly ensue from a question; instead the second speaker may request clarification of the question. However, this notion serves to illustrate how linked actions are what Heritage describes as "the basic building blocks" of intersubjectivity. (Heritage 1995 p256); returning to notions of meaning it displays how, on a multiplicity of levels, the meaning of what a speaker says is found in the subsequent speaker's response. Returning also to Garfinkel, it becomes clear how mutual understanding is displayed 'incarnately' in the sequentially organized details of interaction, and also how it is available as a resource for analysis.

Attempting to summarise this notion of accountability, Lynch (1993) notes that social activities are orderly, and that this orderliness is both observable and ordinary. This

orderliness is also oriented (he uses the example of a pedestrian's glance to 'display' her orientation to 'crossing the street'). This 'orientedly ordinary observable orderliness' is in turn rational, in the sense that orderly social activities make sense to those who know how to produce and appreciate them. Just as these features can be described, so deviations from this orderliness are available both to the other parties to an interaction, and to the analyst, and it is here that the notion of 'accountability' becomes most apparent.

There is a note of caution to be sounded here, however: as Heritage (1995) makes clear, the second speaker's analysis of prior turns is presented indirectly, and must therefore be inferred. Clearly, there exists the possibility that the second speaker may be deliberately or intentionally disattentive to an utterance, or may at least interactionally reject or minimize any response. To quote from Schegloff and Sacks (1973 p297), "If it cannot be made to happen next, its happening is not merely delayed but may never come about". Thus, as Heritage makes explicit, talk occurring at the 'conversational surface' cannot simply be treated as an unproblematic representation of the speakers' understandings or intentions, but instead is a starting point for interpretative and analytic work (Heritage 1995). For both ethnomethodology and CA, talk is considered a form of "glossing" (Wootton, 1975), by which it is meant that the analysis of meaning cannot be exhausted by simple analysis of words spoken. The CA approach thus also deals with some of the problems of the underlying logic of the social psychology model as discussed by Potter and Weatherell and raised in the previous chapter.

An area of some contention is whether statistics have a place in CA. As discussed by Cicourel, and as Schegloff (1993) asserts, even the most basic forms of quantitative measures require analytically defensible specifications of the 'variables' under analysis. Thus all possible environments in which a particular action might occur would need to be known in order to make reliable and valid statements concerning the frequency of a particular type of utterance. However, as has already been considered, intentions may be expressed or concealed in and through the operation of conversational procedures, and thus, as Heritage puts it, "the circle is closed" (Heritage 1995 p402). The general view, then, is seemingly that statistical analysis of CA findings should be treated with caution, and that if such techniques are employed they are more likely to be successful in terms of well defined elements of talk and a limited range of goals. A minority of CA studies have employed quantitative procedures (for example Heritage and Greatbatch's (1986) study of applause generation in political oratory), but these have restricted their focus to fairly specific features of interaction.

The notion of context for CA is also somewhat problematic. Heritage (1984) observes that the notion of context that has so far been discussed is an exceptionally immediate and local one. One of the major issues for CA has been how such a notion of context enables the researcher to look at events taking place in, or informed by, a wider context such as a social institution. Levinson (1979) suggests that we can often understand a particular sequence of talk (his example is a question and answer session involving a teacher and pupils in a school) by reference to the institutional context. However, the question then arises of when and how it is appropriate to draw on these

assumptions. Heritage (1984) suggests that the orthodox response is that we (as well as the speakers) bring knowledge about an institutional context to the talk, and that both we and they then use this as a resource in interpretation. In this sense though, the context of interpretation is treated as somehow exogenous to the talk. Quoting from Heritage, if we instead begin to think of context as something endogenously generated or created in and through talk, then "It is through the specific, detailed and local design of turns and sequences that 'institutional' contexts are observably and reportably- ie accountably - brought into being. It is within these local sequences of talk, and only here, that these institutions are ultimately and accountably talked into being" (Heritage 1984 p283). In this way, like any other states of affairs, institutional contexts are created on a turn-by-turn basis. Thus, as Lynch describes, instead of viewing context as an array of factors that surround an event and define its meaning and significance, context and event are treated together. To quote from Lynch, "...the very terms we use to identify what is going on- that is, the way we characterize the events, participants, and actions- already imply the relevance of context" (Lynch, 1991, p29). Since members themselves commonly have no difficulty in seeing 'what is going on' in a particular situation, ethnomethodology aims to describe how members manage to produce (and recognise) contextually relevant actions and utterances

Pollner (1991) uses the term (endogenous) reflexivity to describe how the sense of a question etc is "achieved" in the setting in which it occurs. This concept of reflexivity is fundamental to both ethnomethodology and CA; Lynch (1993) describes how if sociological descriptions are endogenous to the fields of action investigated by

professional sociologists, then such descriptions are reflexive to the settings in which they originate. (An example to illustrate this comes from Garfinkel's work with jurors; so that what jurors determined was reflexive to their way of determining it, and likewise their descriptions and arguments were reflexively rooted in their deliberations.<sup>1</sup>

What is particularly relevant for pharmacy practice research is that much CA research has been carried out in institutional settings, in an attempt to discover how these institutional contexts are created in and through talk. A considerable body of published work has focused on variations from mundane conversational practices, and how these variations may partly constitute the institutional character of particular forms of institutional interaction. The obvious difficulty here concerns the temptation to attribute features of an interaction haphazardly to its context (Schegloff 1992b). The 'problem of relevance' persists; that if it is to be claimed that some interaction is institutional in character, then the relevance of the institutional context (and its associated roles, tasks and identities) must be shown to be demonstrable in the details of the members' conduct. Such an example would be formal turn-taking in a court room (Atkinson and Drew 1979); if participants organize their turn-taking in a distinctive way that is fitted to the roles and associated tasks of the setting, then it is clear that they are also oriented to the institutional context. Institutional settings often

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<sup>1</sup> In this discussion Lynch also considers Garfinkel's use of the term 'indexicality', describing it as "the most obvious throwaway term in Garfinkel's text" (Lynch, 1993, p17). He cites the use of indexical expressions such as 'What are you doing here', and notes that there are both many things that 'here' can refer to, and many reasons why 'here' may be chosen rather than a more specific descriptor. He concludes by suggesting that what is in fact important is that members manage to make adequate sense and adequate reference with the linguistic and other devices at hand.



involve strongly defined social roles, and CA work has attempted to characterise the ways in which these broad variety of roles and their associated tasks are managed through talk in these settings. All this work has its basis in the recognition that the creation and maintenance of institutional roles is ultimately realised through specific sequences of conversational action. Fundamentally, CA takes account of the two-way nature of the interaction, accepting that the lay person may have an effect on the professional's orientation, as well as vice versa. This is something which other modes of studying communication either do not or cannot take into account.

A central theme of institutional interaction study has been the development of asymmetrical relationships between participants (Drew and Heritage, 1992). Accepting the common existence of 'standard' patterns in institutional encounters, it is clear that these are likely to owe much to the direction and initiative of the institutional professional. He or she is likely to participate in many such interactions in a day, whereas for the client it may be a unique situation. In the case of paediatric oncology patients and their carers, some long term patients will have received a great deal of care from pharmacists, and thus experienced many face-to-face interactions; the effect that the trajectory of a patient's career has on the encounters may be significant. Another source of asymmetry is related to the direct relationship between status and role and the rights and obligations of discourse in many forms of institutional interaction. The predominantly question-and-answer pattern found in medical encounters, for example, may make it difficult for the lay party to take the initiative over what is talked about. There is an important asymmetry between the professional and lay perspectives and so also between capacities to direct the

interaction in desired and organisationally relevant ways. More fundamental than all these are the asymmetries of knowledge and the right to knowledge in many institutional interactions. Studies of the doctor/patient relationship commonly describe an asymmetry of knowledge that allows the doctor control of the conversation by using a biological model of disease which undermines the patient's own experience and understanding (Silverman, 1987).

Fundamentally, however, it is suggested that the asymmetries between (for example) doctors and patients are not exclusively a product of the physician's abstract power; rather than being imposed this asymmetry is interactively achieved by both participants. As Maynard (1991) describes, patients contribute to the asymmetric status by compliance with the physician's speech acts, for example the transformation of locally based accounts into institutionalised categories of disease. This is compounded by, for example, withholding any reply after an assessment is provided by the doctor. In addition Maynard states that the rigidity of the consultation as a problem-solving exercise removes some of the contingency that is inherent in ordinary conversation, so that the clinical discourse then appears by comparison more predictable and manipulated. Though systematically the participants are using very different forms of knowledge and making references to the institutional context of a diagnostic action, they show an orientation to social structural relationships that reinforce the clinic's authority. The sequential relations that do occur in this context are more rigid, and it is through eliciting problem proposals in the beginning turns of sequences that clinicians provide for the relevance of displaying an authoritative view of the patient. Therefore, although the relationships between speakers are

demonstrably asymmetrical, this asymmetry is of a particular and specified kind.

It seems clear from the large body of related CA work, then, that some degree of asymmetry permeates most institutional encounters (although perhaps a case can be made for its necessity, in organisational terms, in some instances). However, it has been suggested that the standard against which this is measured, the tacit acceptance of equal participation in ordinary conversation, results in an oversimplified view of asymmetry. In ordinary conversation the roles of initiator and responder are still present, and more weight may be given to some people's interventions than others, for example the gender imbalances of power and dominance in interactions recorded by Zimmerman and West (1975). This asymmetry may change as the topic focus shifts, but if participation were to be aggregated over the course of an encounter a substantial overall effect may still be likely. In addition, just as a pharmacist may fail to respond to a particular utterance from a patient for whatever reason, and choose to direct the conversation differently, this option is also open in everyday speech. Jefferson and Lee's (1992) work on "troubles telling" illustrates this, for example if the co-participant in a troubles telling does not move into alignment as a troubles recipient. Paradoxically, complete dismissal is rarely an option open to the 'service provider' where the focus of the encounter is constituted as 'a problem to be solved'; there is instead the lesser power to classify items as non-essential matter. In these limited senses a case can be made for the occurrence of asymmetrical relations in ordinary conversation also; this draws on Maynard's view that the asymmetry in a given interaction is of a particular and specified kind pertaining to the situation in hand.

As is evident from the above discussion, much of this research on 'institutional talk' has taken place in broadly medical settings, considering for example doctor-patient interaction (eg Heath 1992), Health Visiting (Heritage and Sefi 1992) and HIV/AIDS counselling (Silverman 1992). Of particular relevance for this project, the latter two of these studies focus specifically on the process of advice-giving by health professionals. Evidently, these settings are less formal than a courtroom, and hence more fluid in terms of pinpointing institutional role-based identities. However, orientations may still be found "in a complex of non-recursive interactional practices that vary in form and frequency" (Heritage 1995 p409). Thus, systematic aspects of organization and turn design, for example in terms of openings, delivery of advice or information etc, are emerging as fundamental to the ways in which the 'institutional character' of these settings is created and managed.

In summary then, this study is intended to explore the applications of CA to the study of professional/client interaction in the context of pharmacy practice. The aim is twofold; firstly to enlarge the methodological resources of pharmacy practice research and to address some of the deficiencies of previous studies in terms of their treatment of "pharmacy counselling", and secondly to investigate the nature of face-to-face interaction between pharmacists and clients, about which very little is known. The tendency of previous approaches to gloss or idealize the specifics of what they depict has resulted in a loss of the finer features of the event under investigation. For this reason, and as discussed here, CA is distinctive in its commitment to the use of naturally occurring interaction, and an avoidance of idealized theoretical and empirical treatments of research material. The approach therefore has strong

advantages in the study of such an imprecise and variable subject matter as advice giving, in that the details of the interaction are maintained. The existence of a wide body of CA literature on medical encounters in general, and more specifically, advice giving by health care professionals, provides a fundamental basis for this analysis.

**Chapter 3**  
**METHODS**

The study was based in a paediatric oncology clinic, which sees patients up to the age of sixteen and with a diagnosis of cancer or leukaemia. The clinic is part of a large teaching hospital, with a medical school attached. Data for the study were collected in two phases, both before and after the reorganisation of specific clinic procedures. The organisational differences that this change resulted in will be discussed later in this chapter, both in terms of the effects this had on data collection and the differences this change of environment appeared to make to the activities of the pharmacists under study.

For the initial phase, consent for the study to take place was obtained firstly from the District Pharmaceutical officer, and secondly from the principal pharmacist within the hospital. The principal pharmacist made the initial approach to the medical consultant whose patients would be involved if the study went ahead; he agreed in principle to the proposals but asked that it be discussed further at the weekly multi-disciplinary team meeting held by the paediatric oncology department. Those present at this meeting (including doctors, nurses, pharmacists and a playleader) also consented to the general theme of the study but raised questions as to how patient and/or carer consent would be obtained. It was later decided that, at a further team meeting, a much more detailed presentation of the research would be given; staff members at this included in addition social workers and a clinical psychologist. Consent was given by all these groups for the study to commence immediately upon production of patient information leaflets stating the basic aims and objectives of the research. As the

research would not interfere directly with the patients' normal courses of treatment, it was not felt necessary by anyone involved to bring the proposal before the hospital ethics committee. Copies of the finished leaflet (see Appendix) were approved by the medical consultant, and in order to ensure as many staff and patients as possible were aware of the study, numerous copies were placed around the paediatric oncology ward and the pharmacy department.

In this initial data collection phase, a total of 21 audiotaped recordings of consultations between pharmacists, patients and their carers were collected. 13 of these were obtained during a weekly Wednesday afternoon clinic when patients who are receiving maintenance therapy are offered a routine opportunity for counselling by pharmacists. The remaining 8 were obtained during ordinary pharmacist rounds in a ward setting, and consisted of consultations between pharmacists and those patients who had temporarily been admitted to hospital, in the large majority of cases due either to an infection or for the administration of a particular chemotherapy regime. The researcher was present whilst all these recordings were made, and in all cases consent from the carer(s), and the patient where appropriate, was first sought by either the researcher herself or the pharmacist responsible for the counselling. At the end of the consultation a patient information leaflet was given to the participants, along with the opportunity to ask any further questions about the study. In addition to the tape recordings, notes were also made of any significant non-verbal aspects of the encounter.

The data were collected over a period of a month, and as a result of this time span,



three different pharmacists (1 male and 2 female) were involved in the consultations. Of the 21 patients taking part, the large majority (15) had a diagnosis of acute lymphoblastic leukaemia (ALL): the diagnoses of the remainder were 3 children with Non-Hodgkin's lymphoma, one child with an osteosarcoma, one child with a neuroblastoma and one child with an orbital rhabdomyosarcoma. The treatment regimes of the children were also varied, with the simplest being a single tablet every morning, and the most complex involving 7 drugs in various dosage forms. The most common regime, UKALL XI (for maintenance therapy in patients with ALL) required a combination of up to 4 drugs on certain days with as few as one on others. The period which had elapsed since the children were started on treatment ranged from one month to over two years; in one case it was not possible to determine this exactly due to transfer from another hospital. The youngest patient involved in the study was aged 2 years, and the eldest 16 years; 12 were male and 9 were female.

The clinic consultations between these patients (the majority of whom were accompanied by one or both carers) and a pharmacist took place within the Pharmacy Department. Having been seen by one of the clinic doctors, the clinic attenders would bring their patient records to the pharmacist, who would then dispense sufficient medication to last until their next visit. In addition to the dispensing function, these consultations were intended to provide the opportunity for the patient or carer to raise any issues or request information with regard to their treatment. Dispensing for the oncology clinic was carried out separately from other outpatient dispensing in order to allow for this: although the pharmacy department in the study site does have an area for outpatient counselling, a separate area was used for dealing with those

attending the oncology clinic. Consultations thus took place in an area which was not used by other patients, although it was used by other hospital staff who had queries, wanted to order specific supplies or medication etc. Due to constraints on space there was a very limited amount of seating in this area, and this was often taken up by waiting patients. In practice this usually meant that families had to stand whilst they received their medication and spoke to the pharmacist. The tape recorder was positioned in this area, on the counter that the pharmacists used to prepare and hand over the dispensed medication.

For those consultations occurring actually on the paediatric oncology ward, tape recording was more problematic due to the level of background activity and noise. It was often necessary to position the tape recorder opportunistically on various pieces of equipment such as intravenous drip stands, meal trays, etc. However, the attendant noises of a paediatric ward in a busy hospital meant that portions of some of these ward consultations were virtually unintelligible and could only be transcribed in the barest detail.

The second period of data collection occurred just over a year after the first, again over a period of a month. By this time several changes had occurred to the running of the clinic, the most pertinent for this study being the relocation of the clinic pharmacist. Under the new paediatric oncology clinic arrangements the pharmacist is present in a room adjacent to the doctor's consulting rooms, with a waiting room to one side. This means that patients and their carers are able to collect their medication, and speak to the pharmacist, immediately after they have been seen by

one of the medical staff. The proximity of doctor to pharmacist thus means there is no need for those attending the clinic to make a special (and reasonably lengthy) journey to the Pharmacy Department, carrying their patient records. Again, the proposal to collect data (which was identical to the first) was discussed at a multi-disciplinary team meeting, and again the consent of all the staff who might be involved was obtained. For this second period of data collection, however, there appeared to be a stronger feeling that the proposal should be lodged with the hospital ethics committee, and this was taken on board.

The actual application to the hospital ethics committee was not without problems, in that the documentation required to support the application was often irrelevant to this kind of non-invasive (in the clinical sense) study. The committee guidelines are drawn from the Royal College of Physician's recommendations with regard to medical research involving human subjects. Its objectives are stated thus: "to maintain ethical standards of practice in research, to protect subjects' rights, and to provide reassurance to the public that this is being done". However, the documentation required for a submission appears to have been stipulated largely with reference to clinical trials of either novel drugs or novel uses for established drugs. Requirements such as the "Ward drug and study summary sheet", which included such questions as "If blood samples are to be taken, what is the total blood loss for patient/subject, and over what period of time?", were obviously irrelevant for an observation and recording based study which aimed for minimal interference with the day to day activities of the clinic. The resulting problem was that the completed application

actually contained very little information about the nature of the study or the methods which would be used to carry out the research at all.

A solution to this was finally found in that it was agreed by a member of the committee that an extended "research protocol" should be allowed to accompany the application, giving a description of the aims and objectives of the study, as well as an outline of the methods. There was also found to be a difficult issue in the area of consent; clinical drug trials require written consent from participants and this requirement has thus been set for all studies by the ethics committee. It is also stipulated that subjects should be allowed adequate time to consider a proposal before being asked to give their written consent, with a period of 24 hours being the minimum 'consideration time' which is generally acceptable. After some discussion it was eventually agreed that verbal consent would be negotiated individually from each carer and/or patient prior to any recording, and that the requirement for written consent would be waived. This was considered to be a reasonable strategy given the non-invasive nature of the study. In addition, in order to study interactions that were as natural as possible, and for the researcher to have minimal effect on this, a primary concern was to cause as little disruption to the normal clinic practices as possible. There was a third, practical dimension to this decision, in that the clinic is held weekly, and so some patients were unlikely to be seen again for some time after a consent form was issued. Following these negotiations the proposal was approved, and permission given for the second period of data collection to begin.

In this second period of data collection, under the new clinic arrangements, 24

recordings of consultations between pharmacists, patients and their carers were obtained. All of these 24 patients, who ranged in age from 3 years to 15 years, had a diagnosis of ALL (Acute Lymphoblastic Leukaemia). 9 of these patients were female, and 15 were male. The time which had elapsed since the commencement of treatment ranged from 2 months to over 4 years (this latter case involved a patient who had undergone one course of chemotherapy, had relapsed and was then started on a new treatment regime). Three pharmacists were involved in the running of the clinic over this period, of whom two were female and one was male.

The sample of patients involved in the study was not selected in any deliberate manner, consisting in both cases of all those patients in attendance at four consecutive weekly clinics. In addition, the first sample contained those who were present on the ward on two consecutive days in the fourth week when only two (previously recorded) patients were due to attend the clinic. Although not specifically selected for representativeness the sample is nevertheless a reasonable indicator of the population seen by pharmacists in terms of frequency of types of disease states and treatment regimes. Representativeness was not considered an issue in this study for two reasons; firstly that it was largely considered an exploration of the pharmacist/patient encounter in terms of both the findings and the feasibility of the techniques involved, and secondly that given the ethical issues and practical difficulties involved in the negotiation of consent in this area, the possibility of an unrepresentative sample is difficult to exclude completely. However, a sample bias would only be a problem if refusal and unusual behaviour were closely associated, for example in terms of non-compliance. There is no reason to suppose that they are, and the issue may not be too

important in a project which is mainly intended to explore the potential of a methodology with respect to pharmacy practice and to demonstrate the sorts of findings it can produce, rather than to make a conclusive statement.

There are evidently some difficult ethical issues involved in this study, given that it involves dealing with children and young people, some of whom were likely to die in the course of the project. This did create some practical difficulties in the negotiation of consent to involvement, which had to be obtained very carefully so that no-one felt under any pressure to have their consultation recorded when they did not wish to do so. Having previously been employed as a pharmacist within the clinic, the researcher was familiar with most of the staff and some of the patients and their carers. It is difficult to ascertain what effect this may have had on the negotiation of consent: certainly the researcher was at great pains to stress that this was a quite separate project from her previous employment and that no-one would be "letting her down" or causing any problems in any way by refusing to participate. In the majority of cases this consent was obtained from the carer; where it was felt possible to obtain informed consent from the patient this was done also. However, there were a number of complicating factors in obtaining consent from the patient aside from those of perceived comprehension of the request. Chemotherapy drugs often leave patients feeling lethargic, sick, or somewhat dazed, and any consent given under these conditions is perhaps open to question. In general, then, the request for consent operated on the principle of guardianship used throughout the hospital environment, albeit with a sensitivity to the understanding of the patient.

With these kinds of procedures in place, there was also the possibility that the negotiation of consent would serve to heighten the salience of the subsequent counselling. The researcher's previous first-hand experience of clinic activities would lead her to suggest that this was not, in actual fact, the case; apart from two consultations where attention was drawn to the tape recorder (in both instances by way of a joke), clinic business appeared to carry on as near to normal that any differences were undetectable. Pharmacists did not appear to give any more advice or information than they would usually do, and patients and carers did not noticeably seem to ask for any more information or explanation.

The negotiation of consent prior to the commencement of the consultations did, however, result in a slight analytic disadvantage. The introduction of the researcher was generally made by the clinic pharmacist, often after the exchange of initial greeting sequences with the patient and/or carer. Since recording did not commence until consent had been agreed, the majority of the opening sequences of the interactions have been lost. However, since the focus of the study was intended to be broadly around issues of advice-giving, ethical issues were thought to be the more significant in this case. Likewise, ethical issues were behind the decision not to approach any patients who had just received a diagnosis for consent to participate. In the event such an opportunity did not present itself during the period of data collection; in any case it was felt that the scope of this particular study would not justify such recordings.

The final issue of importance with respect to consent to participate in this study is

confidentiality. All participants were assured that the only persons with access to the tape recordings would be the researcher and her two academic supervisors. If the tapes were to be used in a broader academic context, or if any published work were produced, assurances were given that the identities of the participants would be protected.

It seems pertinent here to discuss some of the differences that were immediately evident in analyzing the data collected from the new clinic setting in relation to the old. The most notable interactional feature is that there is a much greater incorporation of the child into the encounter. When, as was often the case under the old arrangements, patients and carers were forced to stand to receive their medication children were often far below the eye level of the pharmacist and the carer(s), which made it difficult for a three way interaction to occur. However, in the new consulting room the seating is arranged around a dispensing table for the pharmacist. In practice most children who are old enough to have some understanding of the encounter occupy a position *between* the pharmacist and their carer(s), and thus participate to a much greater degree. To some extent there has been a refocusing of the interaction, with the child as a central participant. This appears to hold true even if patients play little verbal part in the consultation; remarks or questions are addressed with reference to them if not directly to them.

A second point is that there is a general increase in the length of time that the clinic attenders spend with the pharmacist. It seems highly likely that the new arrangements create less pressure for both parties to deal with any issues or problems speedily;



there is less awareness of the "queue" of other patients waiting to be seen, and no chance of medical staff from other departments interrupting in order to obtain urgent materials for operating theatres, etc. The provision of a toy box has meant that where children are not themselves either able to or interested in participating in the encounter, they are less likely to prevent their carers from spending a length of time in discussion.

In addition to improving the opportunities for communication between pharmacists and families, the new facilities have also created opportunities for face-to-face doctor/pharmacist interactions. The proximity of the rooms means that a doctor will sometimes come into the pharmacist's room with a patient, in order to discuss or help explain a particular course of treatment. The opportunity for doctors to ask advice about doses, regimes etc has also been increased; before this was largely only possible by telephone. This also has advantages for the pharmacist in that if there are any perceived errors in prescribing, matters can be clarified immediately and without inconvenience to the patient. In this respect the arrangements have opened up a channel of communication that previously had not existed to any great degree.

Other preliminary observations are that the arrangement allows the pharmacist to develop a greater rapport with the families. This is partly due to the increased privacy (although the entire clinic operates an "open door" policy) and to the more relaxed atmosphere. However, it is also helped by the fact that the pharmacist generally knows in which order people will be seen, and is able to prepare for this accordingly.

A final point is that as the pharmacist is no longer situated in the pharmacy, any alterations to prescriptions (due to blood count results, nausea etc) have to be made within the consultation room. This can be difficult as families will often continue their questions while the pharmacist is calculating, measuring, etc. This tends to mean that there is little eye-contact on the part of the pharmacist while this is accomplished, and it often results in the drugs becoming the visual focus for all parties, sometimes even after the task has been completed. Under the old arrangements the pharmacist would generally have asked a technician to carry out the dispensing, in order to remain with the patient and/or their carer. It is difficult to see how this could practically be overcome in the rearranged clinic.

The observations listed above are largely of a fairly conventional ethnographic nature, resulting from direct observation of the clinic and the production of field notes. This approach, with the researcher seeking to immerse herself as fully as possible in the activities under investigation whilst keeping careful records of the activities occurring, provided a starting point for the analysis. The majority of the analysis, however, relied upon the audiotaped recordings of the pharmacist/patient/carer encounters, and employed a standard conversation analytic approach.

The first stage in this analysis was to undertake detailed transcription of all 45 consultations, using the standard method of CA notation developed by Gail Jefferson (see Appendix). This was a somewhat lengthy process, and, as noted, proved to be particularly difficult with the recordings from the paediatric oncology ward, owing to the level of background noise. Simplified versions of these transcripts are contained

in the Appendix: Transcripts 1-13 are of recordings made within the "old" clinic arrangements; Transcripts 14-21 are of ward-based recordings; and Transcripts 22 onwards are of recordings from the "new" clinic. Throughout this process of transcription, the researcher kept a notebook of any interesting or unusual issues that arose during the listening and transcribing process.

As Heritage (1995) notes, this kind of transcribed data is a valuable support for memory, and a convenient means of handling large volumes of data. It also makes the recovery of particular segments of talk considerably easier. However, just as recorded data is an approximation to an interaction itself as a lived reality for the participants, so transcripts are an approximation to recorded data. Throughout the analysis, then, the transcripts were used as an accompaniment, rather than as a substitute, for the actual recordings; the majority of the analytic work was carried out using both simultaneously.

The analysis was carried out on a turn-by-turn basis, informed by the procedures described in the previous chapter. There was no *a priori* specification of fixed issues to be considered at the expense of others that might arise; instead the analysis was guided by several analytic themes. Some of these had arisen out of a previous, brief examination of sections of the first body of data for a Master's dissertation. Conventional ethnography, however, had played a much larger part in this analysis. The aim for this study was to produce a much more detailed and precise account of aspects of the interactional management of pharmacist/patient/carer encounters within the clinic. With this in mind, the themes that guided the search through the data can

be broken down into three broad areas, as follows. The first of these is the nature, scope and significance of talk directed at the pharmacist, considering in particular how far the patients or carers set their own agenda and raise topics of their own during the consultation and how far their talk is responsive to that of the pharmacist. This in turn raises issues of patient knowledgeability and pharmacist expertise, and the ways in which these are reconciled.

The second theme is the activities of the pharmacist with regard to the delivery of advice or information, and the manner in which this delivery is received by the patient or carer. There is a significant body of CA work on advice-giving in health care settings, and some of this begins to draw conclusions about "better" and "worse" ways for these sequences to proceed. Evidently, such findings would have important implications for the training of health care professionals in general, and specifically for pharmacists in terms of the "extended role".

The third area concerns the way in which pharmacist/patient talk may be influenced by the trajectory of the patient's medical career, particularly in the light of previous contact with pharmacy services. This links back in many ways to the first theme, raising as it does issues of knowledgeability and competence. Evidently, these issues of knowledgeability and competence also have implications for the delivery and acceptance of advice, and as such are an important component of the analysis throughout. In addition to these three main themes, some consideration was given to the special problems implicit in paediatric medicine with particular regard to the multi-party nature of the interaction. The salience of this is particularly apparent in

the contrast between data from the "old" and "new" clinic, in that the patient was often excluded by circumstance from consultations in the former.

The data were also analyzed in relation to other published work using a CA paradigm. As stated previously, there is a large body of published work considering institutional interaction in general, and more specifically, considerable analysis of professional/client encounters. In CA terms the data collected here represent institutional interactions, the institutional element referring to the fact that the participants' professional identities are somehow made relevant to the activities in which they are engaged. This large body of relevant work, and in particular the published work on the professional/client interaction in terms of counselling and advice-giving, provided the background against which the analysis was set. The analysis presented here begins with an attempt to establish a loose, overall structure for the encounters, in order to try and establish 'what pharmacists do' in these consultations. This is followed by a more detailed and specific consideration of some of the issues and themes discussed above.

## **Chapter 4**

### **THE ORGANISATION OF THE PHARMACIST/PATIENT/CARER ENCOUNTER:- A PUTATIVE STRUCTURE.**

The particular nature of their illness means that paediatric oncology patients receive a large amount of medical input over a long period from considerable numbers of health care professionals. Moreover, the long term and often complex drug regimes prescribed for these patients create specific opportunities for pharmacists to play an advisory role in their care both on an inpatient and outpatient basis. In the hospital where the recordings were made, pharmacy care for inpatients is managed on the basis of a daily ward round and a weekly meeting with the other members of the paediatric oncology team, made up of doctors, nurses, social workers, psychologists etc. On discharge patients attend a weekly outpatient clinic, where they are first seen by medical staff and then collect their prescribed medication from the pharmacist, giving them an opportunity to bring into discussion any questions or problems arising from their therapy.

Although this general arrangement has been in operation for several years, during the course of the study a significant change was made to the organisation of the pharmacist/patient consultations. In the past, medication was collected (and any advice was given) from the pharmacy itself, albeit in a designated area away from other patients. Under the new system the pharmacist has been allocated a room within the clinic suite, adjacent to the medical consulting room, so that patients and their families move directly from one to the other and are afforded significantly more privacy. The major interactional differences that have been observed under these "new" clinic arrangements, however, have been discussed at length elsewhere. In terms of the overarching organisational structure of the consultations that will be

suggested here, both sets of recordings of the talk between pharmacists, patients and their carers (under the "old" and "new" arrangements) will be considered together.

Sacks, Schegloff and Jefferson (1974) distinguish two types of talk, institutional talk and informal talk, or "ordinary conversation". Dingwall (1980) takes this analysis further by making distinctions between three types of speech systems; mundane conversation, orchestrated encounters and pre-allocated encounters. Whilst the first of these is concerned with talk in which the elements are relatively invariant between occasions, but at the same time capable of allowing the modifications which establish the character of a particular situation, the remaining two terms pertain to institutional interactions. The importance of such exchanges is underlined by Drew and Heritage's assertion that "talk in interaction is the principal means through which lay persons pursue various goals and the central medium through which the daily working activities of many professionals and organisational representatives are conducted." (Drew and Heritage 1992, p3).

Institutional interactions may take place face-to-face or over the phone, although the latter is more common in community pharmacy; likewise they may or may not occur within a particular designated physical setting such as a clinic. The institutional element of the interaction, then, refers to the fact that the participants' institutional or professional identities are somehow made relevant to the work activities in which they are engaged. An institutional interaction consists of conduct that is in various ways affected or constrained by the participants' orientation to social institutions, whether as their representatives or as their clients. Since sentences and utterances are



designed and shaped to occur in particular sequential and social contexts, their sense as actions is at least in part derived from such contexts. Particularly, utterances are interpreted by means of whether and to what extent they conform to the expectations attached to the setting in which they occur. Mundane conversation is used as the benchmark against which institutional talk may be recognised.

This distinction between institutional talk and mundane conversation, as will become apparent, is not a hard and fast one. Central to all speech is the right to speak and receive attention, and the orderly characteristic of social interaction depends on this. Under normal circumstances only one party talks at a time, and others orient to what is being said. In this way the focus of attention is established, and the possibility of being nominated as next speaker normally ensures its continuance. Various distributive procedures of this sort are used to manage speech exchanges, which largely take place in encounters; the mutual relevance of a particular encounter leads us to include some matters and exclude others. Returning to Dingwall's terms both mundane conversation and the essentially role centred orchestrated encounter depend on a working consensus of the nature of the occasion, but he asserts that it is fundamental to both the latter and the rule-centred pre-allocated encounter that one party has the fundamental right to determine when the other party or parties may speak or receive attention, and what they may speak about. This is clearly the case in medical consultations where a specific goal has to be reached, ie diagnosis and management. The shared purpose of the encounter and the problems in maintaining a shared orientation to it are important considerations in the perceived asymmetrical nature of institutional interactions; many institutional encounters have strict rules of

topic relevance and a specific agenda which must reach a specific kind of solution. In terms of considering the structure of the encounters presented here, the issues may be more complex, particularly as a result of the uniqueness of the setting; paediatric oncology is the only medical specialty in the study hospital where a pharmacist is routinely present at clinic. In this respect, it is possible that patients may not know in advance what will be held to be thematically relevant, at least partly as a result of confusion concerning the role of the hospital pharmacist. However, it would be expected that the structure of the consultations would still exhibit two other properties of institutional talk (Drew and Heritage, 1992): the involvement of special constraints on what one or both of the parties will treat as an allowable contribution to the exchange; and the association with frameworks and procedures that are particular to a specific institutional context. In this way, institutional interaction implicitly involves a reduction and specialisation of the available set of conversational options.

This reduction and specialisation of conversational options appear to result in the localised production of a broad framework of interactional events that are more or less adhered to in the course of the pharmacist/patient consultations recorded. This putative sequence of interaction will shortly be considered , component by component, with reference to a single , "typical" case. It is worth noting, however, that such a sequential organisation is not limited to institutional interaction alone, although the explications of loose, 'overall structures' of particular types of encounter have been a focal area of early work on institutional interaction (eg Byrne and Long, 1976; Maynard, 1984). Jefferson (1988), considering the sequential organisation of troubles telling in ordinary conversation, describes a series of recurrent, positioned

elements as comprising a "candidate" troubles telling sequence. The shape and trajectory of this sequence was considered to be well formed in some conversations and distorted in others, such that the array of these elements in the sequence is described as "vague orderly" (Jefferson 1988, p419).

Although many of the conversations recorded were long and multi-faceted, they were not amorphous, and as such appeared to present a general shape. Series of utterance types appeared to 'belong' in various positions within this vague shape, thus providing evidence for troubles-telling as a sequential phenomenon made up of a 'sequence' of components. A candidate sequence was thus composed in which talk moved between the two opposed relevancies of the participants attending to the trouble, and attending to business as usual. This candidate sequence in its roughest sense consists of 6 segments: A) Approach, B) Arrival, C) Delivery, D) Work-up, E) Close-Implicature and F) Exit. In this sense Approach refers to the approach towards the troubles telling element of the conversation, and Arrival indicates the announcement of the trouble.

The Approach segment was found to consist of several elements. The first of these, Initiation, may either involve an Inquiry, or a Noticing. In the case of an Inquiry, if a co-participant is aware of the presence (or possible presence) of a trouble, he or she may initiate talk about the trouble by inquiring into its current status. (One of the examples Jefferson gives from her data is "How's your foot?"). The second possible element, a Noticing, may occur even if the co-participant has no prior knowledge of a trouble. Despite this lack of knowledge, they may still be prompted by something in the talk to notice a trouble possibility, for example by the sound of someone's

voice.

However, as Jefferson notes, "troubles talk is so arranged that a co-participant need not know about the presence of a trouble to effectively initiate talk about it...for example...a conversational "How are you" can stand as a first component in a troubles talk package, the trouble emerging in response to such an inquiry" (Jefferson 1988, p241). This kind of opening can make space for a "Trouble premonitor", for example a downgraded conventional response or an improvement marker as response to an inquiry. Thus, instead of "fine", an item like "better" can serve to orient a co-participant to either the presence of a trouble *or* the continuing state of a trouble.

Alternative to these strategies is another kind of premonitor, what Jefferson calls a "lead-up". A lead-up may either indicate the presence of something possibly 'troubling' or actually begin to explicate the nature of a trouble. Whilst this lead-up may be used in response to an inquiry, as Jefferson notes, it is a more common occurrence where talk about a trouble is being initiated by the troubles teller. An example of the former from Jefferson's data is: "What's new with you?" "Oh I went to the dentist", where the lead-up occurs in response to the initial inquiry: an example of the second is (as the first speaker finishes a story):

"So I have to say..." "The next time you see me I'm gonna be looking like hell you know why?".

However, all of these approaches do not *automatically* or *necessarily* lead into troubles telling, since they are ambiguous as to their troubles implicativeness in the

sense that they may receive troubles disattentive responses from co-participants. "How are you?" "oh, surviving", for example, may still receive the response "That's good". Nevertheless, this ambiguity can also provide " an opportunity for a co-participant to exhibit receptiveness to the possible trouble premonitory work being done. A recipient of a possible troubles premonitor will exhibit that he or she is tracking the item as on the way to further talk, as not in itself assessable... or dismissable by reference to other matters...Rather a recipient produces a "continuer", an item that expects and is ready to receive further talk" (Jefferson 1988 p423).

These kinds of premonitor responses (eg from Jefferson's data "Wendy and I have been really having problems" "M-hm") display an alertness to further talk, and are seemingly specifically attentive to the ambiguous character of prior utterances. What they do not do is to commit themselves to hearing a trouble as underway, since it is possible that a trouble is not in fact underway; as Jefferson indicates, they are "Neutral" with respect to occasioning troubles talk. This, she suggests, is as a result of the pressure towards 'business as usual' to which participants are demonstrably oriented. This becomes clear as troubles talk is entered, where there is a contrast between the strong alignment displayed with business as usual, and an ambiguous alignment with trouble.

The next segment of a troubles telling, the Arrival, is divided by Jefferson into "Announcement" and "Announcement Response". In terms of the first, a troubles teller regularly moves from an approach device to an announcement of the trouble, regardless of whether the response to this has been neutral, disattentive or even

silence (as in the previously quoted example from Jefferson's data:

J: "The next time you see me I'm gonna be looking like hell you know why?"

(0.7)

J: "Cause every damn one of these teeth coming out" )

This kind of announcement is recurrently followed by an utterance which marks arrival at the trouble which has been approached. These "Announcement Responses" are further divided into 2 types. The first both marks arrival and elicits further talk on the 'troubles topic' but does not necessarily place the co-participant in alignment as a troubles recipient, eg (from Jefferson's data):

L: "His mother's real low"

E: "Oh really"

The second, by displaying "empathy", aligns (or commits) the co-participant as a troubles recipient, eg (again from Jefferson):

S: "We got burgled yesterday"

D: "Nah no"

Following either of these announcement response types, there is the interactional opportunity for the troubles teller to move into actual 'Delivery' of the trouble. It is clear, however, that before this can occur a substantial amount of interactional work is required of the participants, in order to arrive at this position.

Delivery obviously consists of exposition of the trouble to the co-participant; this is followed by a Work-up containing activities such as diagnoses, prognoses, reports of relevant experiences etc. Close-implicature provides a device for moving out of the troubles talk, by way of optimistic projections etc, and the conversation in which a trouble was talked about is then Exited. Within all these segments smaller sub-segments, or elements, can be identified and found to recur.

However, and despite the apparently smooth progression such sequential ordering would appear on paper to provide, in the actual talk recorded by Jefferson there was not one single instance in which this candidate sequence was found to be present element by element, or even segment by segment, in order. The sequential order which existed did so in only very gross terms; whilst within troubles talk it was possible to identify sequential components, these did not actually *occur* in talk in a consecutive fashion. Nevertheless, the "dimly defined" shape remained.

If, as these results suggest, particular aspects of mundane conversation can be shown to involve a reduction and specialisation of the available set of conversational options, how then does the structure of institutional talk differ from this? Zimmerman, in his study of the interactional organisation of calls for emergency assistance (1992), suggests that in an institutional setting, as far as a practitioner is concerned, the intended effect of a standard ordering of work tasks (along with organisational procedures and policies) is to make the handling of the task as routine as possible. Thus practitioners routinely deploy not only particular interactional strategies, but also particular conversational machinery. This "task of work" (in the narrowest sense) orientation is missing from mundane conversation<sup>2</sup>. Clearly, however, there is a task to be accomplished both for the emergency call taker:- to collect and codify information speedily and with accuracy in order to despatch the appropriate emergency service; and for the clinic pharmacist:- to enable the patient to understand and utilise their prescribed drug therapy with the minimum distress or discomfort.

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<sup>2</sup>Clearly, however, mundane conversation may be used to accomplish tasks of its own, for example to establish someone's wellbeing, to arrange a meeting etc. 'Work' is thus used here in its narrow, occupational sense.

Within this, both are actually engaged in two simultaneous tasks:- firstly talking and listening; and secondly, for the call taker the codifying of data, and for the pharmacist, preparing and handing over the medicines (dispensing).

In both cases, the former is the vehicle for the latter: in the case of the pharmacist there is a clear relationship between the dual purposes of the encounter; the task of talking and listening, and the handing over of a particular medication. Particularly, the medication itself may be used as a resource to facilitate talk, through both displaying and explaining an object (for example a bottle of tablets) simultaneously. Without access to video data, these visual aspects become somewhat problematic with regard to their incorporation into the analysis, and the main focus of the analysis presented here will be the **talk** of pharmacists and their clients. However, where the accompanying field notes or explicit references in the talk allow, the ways in which these two activities interrelate will also be considered.

Thus the real "work" of the call, as Zimmerman indicates, consists of participants coping with both call processing requirements, which are broadly the same in each case, and also the variable circumstances particular to that call. Likewise, for every clinic patient the pharmacist has routine dispensing duties to attend to, as well as particular and personal advice or information giving. In practice, these opposing requirements are dealt with through the use of frequently employed sequential strategies. In both cases, alignment towards the interactional task appears to be sometimes easily achieved, and sometimes greatly tests the interactional skill of the



participants.

Building on the idea that talk oriented to institutional settings usually involves repetitive occasions, Zimmerman goes further to suggest that within a range of variation, these occasions will exhibit similar structures to those he proposes for the emergency assistance call. The sequence he describes is as follows:

Pre-beginning  
Opening/Identification/Acknowledgement  
Request  
Interrogative series  
Response  
Closing

In this sequence, the pre-beginning provides participants with the interactional space to establish, as Schegloff describes it, "the kind of call this is." (Schegloff 1979). The interaction then moves on to a reduced version of the "core opening sequences" observed for mundane telephone calls; a *summons/answer* sequence, an *identification/recognition* sequence that establishes the identities of the caller and answerer, and an *acknowledgement* sequence. The *greetings* sequence, and the *how-are-you* sequence found in mundane calls are absent, presumably due to their lack of relevance in essentially anonymous encounters (Whalen and Zimmerman, 1987; Whalen, Zimmerman and Whalen, 1988).

Following the acknowledgement of the call-taker's opening, callers go on to produce a second component of the sequence, which constitutes the reason for the call; a *request* for assistance. In order to determine further the precise nature and location

of the incident, and thus the appropriate emergency assistance, this is succeeded by an *interrogative* series on the part of the call taker. Once this has been *responded* to by the client, the remaining 'work' of the call consists of despatching the necessary service as soon as possible, and so the participants move to a (generally succinct) *closing* sequence.

However, as will now be considered with reference to a single case from the clinic data, the interactional organisation of the pharmacist/patient/carer encounter appears to exhibit an amalgamation of features from both Jefferson's troubles-telling sequence and Zimmerman's emergency assistance calls sequence. The transcript used to illustrate this, reproduced in full below, is taken from a recording made under the old clinic arrangements, and the participants are the patient, aged 16 years (C), the pharmacist (Ph), and a pharmacy technician (T). Recordings in all cases began immediately after consent to participate in the study had been elicited; in some cases this has resulted in incomplete recording of the opening sequence of an encounter. In this case, the name of the patient has been called by the pharmacist, and he has moved from the waiting area to the counselling area.

#### **Transcript 12:-gg/op/be**

- 1.Ph: Right (.) first of all I'm sorry but we haven't got any blisters (0.6) they're all
2. stuck somewhere between here and America
3. (.)
- 4.C: (looking at mouthwash) I wanted the green one
5. (0.5)
- 6.Ph: You want the green one do you not like the (0.5) red one?

7. (.)

8.C: Mmmm

9. (0.6)

10.Ph: Right (.) I'll have a word with the technician and we'll get that changed for

11. you th[en

12.C: ['ow long will it (.) will that be?

13. (0.5)

14.Ph: Be about two or three minutes=

15.C: =Alright I'll have t[hat then

16.Ph: [Just let me check we've got some up here just hold

17. on a minute (goes to check)

18. (2.2)

19.C: (into tape recorder) Hello

20. (1.5)

21.T: You want the gree::n one (0.1) right

22. (0.9)

23.Ph: Won't be long(1.5)(C bangs on taperecorder)oy(laughs)(1.2)Right(o.5)Uh:hm

24. (.)do you want me to explain your tablets cos they're not [in blisters to you

25.C: [No:o I know what  
to do

26. (0.5)

27.Ph: You know what to do with them all (1.2) Right so you've got all those for

28. your mynaptopurine (1.1) [Two of them

29.C: [What do I do take (0.5) two of them and what d' ya  
call it one of them each?

31.(0.6)

32.Ph: Hold on (.) you take two of the 10mg each morn[ing (0.2)=

33.C: [Yeah

34.Ph: =that's two of the little ones[ (0.5) two of the 50mg=

35.C: [yeah

36.Ph: =(0.7) 't's two of those (.) and one of the half tablets it's already

37. halved (1.5) o[kay?

38.C: [Yeah yeah=yeah=ye'

39.Ph: so that makes you a total of 145mg

40. (0.2)

41.C: Oh (0.4) Why didn't you just say that

42. (1.0)

43.Ph. Pardon?

44.C: Why didn't you just say that I would have remembered that

45.Ph: OK Right (.) Well (1.0) and you've got your methotrex[ate

46.C: [Yeah

47. = y[eah

48.Ph: [That's [Wednesday mornings (0.6) Yeah (1.1) your=

49.C: [Three of them Yeah

50.Ph: =prednisolone (.) that's not to be taken until the 7th of July (0.9) yeah  
because you're having another injection then aren't you (0.6) and  
there's twelve in there for you (0.9) and your co-trimoxazole same as  
usual (0.4) twice a day

53. [Mondays Wednesdays Friday (0.7) okay? (0.9) we=  
 54.C: [Mondays Wednesdays Fridays  
 55.Ph: =should have blisters for next time you come (1.5) Can I get round to that lot (9.2) (Puts in bag)  
 57.C: Who wanted to tape this anyway?  
 58. (0.9)  
 59.Ph: She's doing a (0.5) a Phd (uhhh ) (0.5) to become a doctor (0.3) and ~~shows~~ to know all about the role of the pharmacist (0.9) I can give you a leaflet ~~but~~ it if you want one (0.7) Want on[e?  
 62.C: [No(.).I don't like student doctors to be honest wi' ya=  
 63.Ph: =Oh she's not a student doctor she's a pharmacist she's a qualified pharmacist  
 64.C: Oh right [yeah  
 65.Ph: [and then she's doing something else (0.7) Do you want to take ~~sat~~ and I'll give you your Corsodyl when it's ready it won't be long

Present: Patient aged 16 years (C), Pharmacist (Ph), Pharmacy Technician (T)  
 Start of treatment: 10/91  
 ALL

The first thing that is apparent here is that there is a lack of a pre-beginning segment of the opening sequence. This is in contrast to pharmacist/client encounters in community pharmacy, when the first question asked of a client who has walked in and requested to see the pharmacist is usually along the lines of "How can I help you?". This has an evident relation to the kind of "Which service would you like?" found in British emergency calls, as it gives the 'recipient' of the encounter (pharmacist or call-taker) an opening into the kind of information that is necessary for the interaction to proceed in each case.

The lack of this segment here can presumably be accounted for by the fact that both parties to the initial interaction *know* to a greater or lesser degree why they are there

and what the encounter will consist of. Zimmerman's emergency assistance calls analysis provides for this segment as "a machinery for regulating access to, and shaping the trajectory of, conversational encounters of all sorts" (Zimmerman 1992 p342). Thus the opening sequence in general establishes an alignment of identities which provide a particular footing for the call, the relevance of which is continued until an alternative alignment is brought about by the participants. However, since this sort of consultation is a routine and regular occurrence for most of the patients seen by a pharmacist at clinic, the process of striving for a common footing is somewhat redundant. Most of the patients have received outpatient treatment for a matter of months or years, whilst even those who are making initial visits to clinic will have spent some length of time as an inpatient, having daily experience of consultations with a pharmacist. In this sense there is no interactional requirement to establish an alignment of identities; the alignment that exists is pre-established. This is not to say, however, that the 'routine' which exists does not have to be re-established; even routine is (or can be) an interactional achievement, achieved again and again (Schegloff, 1986). In this sense a common footing of some sort still has to be achieved; the difference is that both participants are party to the fact that it has been done before and will be done again.

Although not present on the transcript, an opening sequence of some description is, however, present in this interaction. This appears to be of a similar nature to Zimmerman's *opening/identification/acknowledgement* sequence, although the form it occurs in is closer to *opening/recognition/acknowledgement*. This may in part be due to the fact that Zimmerman's data consists of telephone calls, whereas what is

occurring in the clinic is face to face interaction. However, since recognition as opposed to identification is also possible over the telephone, this issue highlights the fact that these are **not** essentially anonymous encounters; even when the pharmacist does not recognise the patient, they will be in possession of documentation (clinic records) telling them who the patient is. Parenthetically, when clients make telephone enquiries for advice in community pharmacy, they rarely identify themselves and are rarely asked to do so. For those asking about 'delicate' matters the anonymity is an important factor in their request, and for those making other requests there are other issues which take precedence, for example any medication they may be taking, their age, or their symptoms. The identification component in this case is an ethical requirement for the pharmacist, before he or she is able to hand over medication. In some consultations this does take the form of an *identification* question; here, however, the (long-standing) patient is known to the pharmacist and it is formulated as a recognition. Identification of the pharmacist occurs only rarely, and then as a courtesy rather than as an entry gaining strategy. Entry for the pharmacist is already gained in these encounters in the sense that it is the patient who comes to see **them**, and so there is no need for the type of identification sequence which can be seen in the work of other health professionals such as health visitors (Dingwall and Robinson, 1990).

In many cases, although not in this particular example, this opening is followed by a *greeting* or *how-are-you* sequence, of the type identified by Zimmerman as being absent from emergency assistance calls. The inclusion of such a sequence in the consultations is in many ways unsurprising: firstly (as noted) these are **not** essentially

anonymous encounters, and patients and families may have built up close relationships with a pharmacist over the years of treatment; and secondly there is none of the attendant urgency which pervades Zimmerman's study data. What is more noteworthy is that this sequence is rarely used in order to approach the raising of a particular problem on the part of the patient or carer, which is one function it serves in Jefferson's description of a troubles-telling; the *how-are-you* component is generally treated as a courtesy enquiry and responded to as such. The possible reasons for this are considered in more detail in the following chapter. What is important to note here is that any raising of problems tends to occur at a much later point in the consultation, prior to closure.

This *general enquiry* segment is usually followed by an *approach* to advice or information giving on the part of the pharmacist. This is sometimes formulated as a reason or justification for the advice to follow, as in this case.

1.Ph: Right (.) first of all I'm sorry but we haven't got any blisters(0.6)

'Blisters' refers to the packaging commonly used for paediatric chemotherapy outpatients; they are plastic containers divided into compartments for daily dosages, with each daily compartment subdivided into different time markers, eg breakfast, lunch and bedtime. In this way all medication is supplied ready counted and each dose is ready prepared. The patient merely peels off the top of the appropriate section of the carton and removes the tablets as required. The system is intended to save patients the difficulty of counting out several doses from many different bottles; it also enables

patients to check whether they have in fact taken a particular dose, which is impossible with bottled tablets. The patient involved in this encounter is nearing the end of his treatment, having had years of blister therapy, and so it would be reasonable for the pharmacist to presume he would have a level of familiarity and competence with the blister pack. Thus in this case, the *approach* to advice giving about medication dosage consists of a reason why on this occasion this advice is necessary.

In terms of the interactional structure of the encounter, the pharmacist's use of "first of all" as an opener (Line 1) is interesting, in that it suggests she is consciously setting up some kind of agenda for the work of the consultation, of which this is the first component. Her use of "we" in "we haven't got any blisters" (Line 1) underlines the institutional status of this interaction, invoking the authority of the hospital at large. This is seen again in Lines 10-11:

10.Ph:Right (.) I'll have a word with the technician and we'll get that

11.Ph:changed for you [then

-in the use of the impersonal term 'technician' and the statement "we'll get that changed".

The *approach* to advice-giving, in whatever way it is framed, facilitates *arrival* at advice giving by the pharmacist. In this transcript, this eventually occurs at Line 23-24, having been delayed by the patient's request for a different variety of mouthwash:



23.Ph:Uhhm (.)

24.Ph:do you want me to explain your tablets cos they're not [in blisters to you

25.C: [No I know what to do

A variety of devices appear to be used by pharmacists to achieve this arrival into advice-giving; here it is formulated as a question "Do you want me to explain?" but in other instances it is produced as a statement, eg

#### Transcript 15

1.Ph: (Name)? OK (.) I'll go through it all with you

or on some occasions it is dispensed with altogether, so that the encounter moves directly from an approach to advice giving to the *delivery*, eg:

#### Transcript 14

1.Ph:Hi, I've just got some Septrin here for him. you'll need to give him 7.5ml

These arrivals at advice giving will form the focus of the next chapter. In general (and however it is presented), this arrival formulation of an intent to give advice is allowed to stand unchallenged, and is *accepted* by the patient; in some cases, however, it is immediately *rejected* by the patient or carer. The rejection in this instance occurs at Line 25:

23.Ph:uhhm (.)

24.Ph:do you want me to explain your tablets cos they're not [in blisters to you

25.C: [No I know what to do

Thus, despite the previous sequence of an *approach* to advice giving followed by an offer of advice as part of the *arrival* segment, the intention is immediately rejected. Interestingly, the patient's overlapping assertion that the advice is redundant (Line 25) occurs at a point before he has heard the re-asserted justification for this advice (Line 24). This would also give credence to the suggestion that in the ordinary course of events this patient is competent in the administration of his own drugs; the overlap can be seen as a motivated interruption to head off the pharmacist and prevent unnecessary advice giving. In other circumstances, this would probably be allowed to stand; here, however, it places the pharmacist in a difficult position. As the lack of blister packaging is a new problem, she knows it is unlikely that the patient actually does know "what to do". Following the initial rejection of this advice, then, a *rearrival* at advice giving must be negotiated in an attempt to realign the patient. In this case, this is dealt with by use of a statement reiterating patient knowledge (line 27):

27.Ph: You know what to do with them all (1.2)

This is followed by a pause which gives the patient an opportunity to confirm or disconfirm the proposition. This can be seen as an understanding check, which produces a formulation of the client's position for him to accept or reject. When no response is received from the client, the pharmacist appears to take this as a negative answer, and proceeds to *deliver* the information (Lines 27-28):

27.Ph: You know what to do with them all(1.2) Right so you've got all those for  
28.Ph: your mercaptopurine(1.1) Two of [them

29.C:

[What do I do take(0.5)two of them and

what d'ya 30.C:call it one of them each?

The type of disjointing to the preferred order of the interaction that results in this segment is described by Jefferson and Lee (1981) as interactional asynchrony; the co-participants can be characterised as improperly aligning to the categories crucial to the orderly progression of the overall sequence. For Jefferson and Lee's purposes, this occurs when a co-participant doesn't move into the expected role of a 'troubles-recipient'; here it occurs when the patient does not initially move into the role of an 'advice-recipient'. This problem is to an extent overcome in line 29, however; the patient's question "What do I do?" actively corroborates and facilitates the advice giving which the pharmacist begins, although it does so belatedly. Despite this, it is still not delivered as a straight admission of ignorance, as the patient goes on to produce his own candidate statement of what he should do with his tablets. This could be viewed as either checking his understanding of the instructions ("Take two of those" (line 29) follows the pharmacist's utterance "Two of them" (line 28)), or as exhibiting the knowledge which he failed to exhibit when given the opportunity in line 27. In the event this candidate statement is partly wrong, and the pharmacist goes on to deliver full dosage instructions to the patient (lines 32 onwards). The interactional difficulties created by these initial exchanges give some indication of the delicacy of the next stage in the sequence, the *response to advice or information*, as far as the recipient is concerned. Advice causes problematic implications about the knowledge or competence of the intended recipient; Heritage and Sefi's (1992) study of interactions between health visitors and mothers suggested that the mothers tended to minimize the extent to which they acknowledge that advice has been informative, as

a possible means of preserving their competence. Certainly the acknowledgement here is minimal; although the advice is not overtly rejected in its second presentation, the client criticises the method by which it is given (Line 41):

41.C:oh(0.4) Why didn't you just say that(1.0)

This provides for the possibility that the client's apparent ignorance is as a result of the advice-giving technique which has been employed, rather than as a phenomenon in itself. Grudging acceptance, or "unmarked acknowledgement" (Heritage and Sefi 1992) appears to be a recurrent feature of these pharmacist patient encounters, although not generally to the extent shown here. The pharmacist's response to this once again underlines the institutional nature of the interaction, and the restrictions this generally places on the behaviour of the participants. Judging by the tone of the response, the pharmacist appears somewhat surprised at the client's utterance in line 41, suggesting that such bluntly delivered criticism is not a frequent occurrence. Despite this, it is dealt with perfunctorily but without a shift in position by the pharmacist (line 45), who then goes on to proceed with the dosage information.

45.Ph:OK Right (.) Well (1.0) and you've got your methotrexate

Throughout this delivery stage, what the pharmacist tells the client is presented as factual and framed as information, rather than as something in which the patient has

a choice. This presentation of advice/information, the basis for any distinctions between the two and the outcome of these will be considered in detail later. It is interesting to note, however, the use of phrases such as "same as usual" (line 52), which imply that there is one definitive course of action for each patient to take in terms of the chemotherapy regimen. Despite the interactional difficulties which are apparent in this encounter, both in the initial approach to advice giving and in the subsequent delivery of advice which is criticised by the patient, the pharmacist in this case manages to achieve advice giving without explicitly contradicting the patient. This is important in terms of the orientation to patients' and carers' knowledge and competence which pervades these encounters and which will be discussed at length as a phenomenon in its own right. Dealing with long term patients, as these clinic attenders are, introduces an extra element of delicacy into the advice giving process, and the ways in which this is managed can have important implications for the subsequent smooth running of the encounters. Although the difficulties in this encounter are apparent to the analyst, achieving a 'realignment' (in this case twice) is necessary for the consultation to proceed, and it eventually does proceed relatively smoothly in the sense that the pharmacist is able to complete her informing sequence, handing over the medication simultaneously, whilst receiving the interactionally necessary acknowledgements for these activities from the patient.

Another important point is that throughout the *delivery* stage, dispensing tasks have been carried out by the pharmacist alongside the verbal tasks. Throughout the encounters, these tasks begin at the point where *acceptance* of advice giving is achieved. Interestingly, they are also sometimes used to signal the end of the *delivery*

phase and a move into *close implicature*; when all the bottles or blisters have been handed over to the patient alongside the verbal explanations, the routine work of the encounter is done for the pharmacist. This appears to be what the pharmacist in this case is working towards in line 55:

55.Ph:Can I just get round to that lot ((Puts in bag))

as she places the medication in a bag for the patient to take away: however she is interrupted by the patient's query about the reason for the presence of the tape recorder. It appears that these pharmacist/patient/carer consultations do not always present a natural or specific endpoint which is clear to both parties (in contrast with, for example, prescription writing in the GP/patient encounter), often necessitating a rather heavy-handed close implicature by the pharmacist. In this case, the encounter is only being temporarily closed, until such time as the patient's preferred mouthwash can be prepared; nevertheless it still requires the pharmacist to suggest a course of action to the client (Line 65-66):

65.Ph:[and then she's doing something else (.) Do you want to take a seat

In other consultations, where a final closure is being sought, utterances such as "Right then" or "OK that's everything" serve this purpose. It is immediately after this point, once imminent closure has become apparent to the patient/carer, that any questions left unresolved by the explanations imparted are commonly raised by them. Failing this, an *exit* is produced, commonly focused around when the patient is due

to return to clinic and ending with a "See you then" type statement.

The sequence that can be seen to more or less exist in the consultation reproduced here, and indeed in the other recordings, then, appears to be as follows: (Items in brackets indicate the 'contingency plans' brought into action when the flow of the 'standard' sequence is disturbed.)

**Opening/Identification/Recognition/Acknowledgement**  
**Greeting/How are you**  
**Approach to advice giving**  
**Arrival at advice giving**  
**Acceptance/Rejection of Intention**  
**(Rearrival)**  
**Delivery of advice/information**  
**Response to advice/information**  
**Close implicature**  
**(Questions/Reclose implicature)**  
**Exit**

However, as in Jefferson's troubles telling sequence, not all of these segments are present in every encounter, and in some encounters they are subject to disorder. Accordingly, this candidate pharmacist/patient/carer sequence is treated as a template, rather than as a complete description of the interactions, and this template is subject to disordering and disruption in the actual consultations. Jefferson and Lee (1981) describe this formulation as reminiscent of the 'ideal types' proposed by Weber for the study of social organization: where both their template and the one presented here differ from this notion is that they are not pre-formulated. Instead, they are grounded in and constructed from the data under inspection. Since CA insists on describing and analyzing actually occurring events "in the very details of their

occurrence" (Jefferson and Lee, 1981: p 401), the notion of a 'template' or 'model' in this sense is somewhat problematic; the intention here is to use it simply as a tool to begin the analysis of 'what pharmacists do' in this setting. The 'overall structure' presented here is thus intended as a starting point for the analysis which will follow.

As in troubles-telling, it appears to be mis-alignments that are largely responsible for creating interactional difficulties; for the process to move beyond the fourth stage of the template presented above depends on the co-participant aligning as an advice recipient. Thus a much looser overall structure is suggested than for Zimmerman's emergency assistance calls, with the irregularities occurring most noticeably around the area of advice giving. The following chapters will deal with the analysis of these 'advice giving' segments in more detail.



## Chapter 5

**"I'M NOT GOING TO SAY ANYTHING TO YOU BECAUSE YOU'VE HAD IT ALL BEFORE..." :- A PROVISIONAL TYPOLOGY OF METHODS OF ARRIVAL AT ADVICE GIVING**

The data presented in this chapter are concerned with the *initiation* of advice giving by pharmacists in the paediatric oncology clinic. Responses to this advice from patients or carers will be given only a perfunctory consideration here, as functions of the initiation sequence, and will be considered in more detail in the next chapter. The main focus of the analysis of these 'arrivals' into advice giving will here be concerned with the wide variety of strategies employed by pharmacists in the delivery of advice and information. Recurrent findings of other research concerned with advice delivery (eg Heritage and Sefi, 1992; Silverman, 1992) suggest that health professionals in a range of environments employ a range of different strategies and methods of advice delivery, in order to get their clients to align with, or to themselves participate in the advice giving. This body of research, encompassing such settings as Health Visiting and HIV counselling, is an important resource, and in drawing on it many of the methods identified in these settings are also found to occur in the oncology clinic. The aim of this chapter, however, is to set out the strategies used to **gain entry** into advice giving in this setting (with only a brief consideration of how these relate to those reported elsewhere), and alongside this, to reflect upon how the strategies used here are related to particular constraints or contingencies that arise in this setting.

The organisational set up of the paediatric oncology clinic creates an opportunity for pharmacists to meet regularly with patients and their carers to discuss chemotherapy regimes.

This frequency of contact with the patient and/or carer creates a particular set of contingencies that have a clear impact upon the interactions occurring in the clinic. Since chemotherapy patients will all have had a period of inpatient treatment at the time of diagnosis, and since the role of this particular clinic is to monitor *maintenance* therapy, the 'lay' parties involved in these interactions all have some degree of experience both with chemotherapy regimes and with pharmacy services. There is, therefore, an omnipresent issue of patient knowledgeableability which pervades these consultations; 'lay' knowledge encompasses both experience and practice, and may overlap or impinge to a greater or lesser degree on the 'professional knowledge' of the pharmacist. Throughout the encounters, as will be illustrated here, there are issues arising which clearly demonstrate patient knowledgeableability as an oriented-to feature of action. This knowledge in turn ties into issues of identity, and institutional and contextual relevance. The trajectory of a patient's medical or illness is an important factor here; whilst some patients have had prior treatment but are new clinic attenders, others have been attending the clinic for several years.

Even in the briefest of the consultations collected here, there is a theoretical opportunity for pharmacists to respond to requests for information, and to offer suggestions to help decrease the discomfort of side effects of therapy. In the consultations recorded, these issues concerning general therapeutic information occur routinely throughout. There are also many incidences of more specific orientations, where the pharmacist appears to be focusing on defined and personal issues revolving around dosage and administration. Most of this "advice" appears to be initiated by the professional, often prior to any clear indication that it is in fact desired by the

client. This is interesting for two main reasons; the first is that as has already been alluded to, these are not 'pre-allocated' encounters in the sense of, for example, courtroom interaction (Atkinson, 1982). Heritage and Greatbatch (1991), in their work on news interviews, draw a contrast between types of "formal" interaction which differ from ordinary conversation (in terms of turn-taking procedures etc) and those which do not. The clinic encounters presented here would seem to fall into the latter category (since there are no specific rules about who may speak when or in what manner), yet the way in which the majority of the interactions are organised is such that the pharmacist ends up in the role of the initiator.

Secondly, (and seemingly relatedly) pharmacists are bound by a Code of Ethics that requires them to ensure clients know how to take their medication safely and effectively. This, however, can place them in direct contrast with the contingencies of ordinary conversation, which generally require that a person does not attempt to tell another person something that they already know. The difficulty for pharmacists is that they may not know the extent of a patient's knowledge beforehand, and so the initiation of advice sequences, particularly in the context of long-term patients, can be a delicate operation. Whilst knowing or not knowing about the administration of drugs may not be culturally defined as delicate in the same way as knowing about how to care for your baby or knowing about the transmission of HIV, it should be borne in mind that these are long term patients who can expect to receive medication for a period of at least two years. Thus, whilst not knowing how to administer a one-off course of antibiotics for a child, for example, may not be perceived as an accountable issue of competence, the ongoing nature of chemotherapy medication (and

the attendant issues of, for example, knowing when to administer anti-sickness drugs in order to relieve side effects) appears to bring a different dimension to these encounters. Additionally, since these are potentially very sick children indeed, it is suggested that the parental 'obligation' to care for a child becomes heightened under these circumstances. Despite the potential delicacy of the interactions, however, pharmacists rarely refer to the Code of Ethics requirement or justify their questioning or advice giving, in the sense of "I have to go through this with you because...".

This issue of the difficulties involved in telling someone what they may already know becomes even more salient in respect of the fact that in the entire data, there is only one example of a **mother initiated** approach to advice, occurring some way into an encounter where the pharmacist has been focusing attention on the child:

**Transcript 23:- ds/nc/op (simplified transcript)**

1. Ph: Can I just check we've got the right chart there (.) (name)(.) s'that right?
2. M: Say yes (0.2) [(name) that's me (.) yes
3. C: [Yes
4. Ph: Right (1.6) ((looking at chart))
5. M: Two weeks this week
6. Ph: Right (0.3 ) (well) we've only done one week (.) just to ruin it so I'll just change that  
- add another week in (0.4)
7. Ph: 'cos he only had a week last week didn't [he
8. M: [Yes yes
9. Ph: But his counts are fine (.) so we'll just add those in (1.8)
10. M: ((to child)) You're too much trouble aren't you throwing [everybody out ((laughs))
11. Ph: [ (( laughs))
12. C: Yeah ((laughs))
13. M: Dr (name)'s sorted him out today though huhh (.) he showed you your tickle spots didn't he (name)
14. Ph: ((laughs))

((Child tries to tickle mother))

15. M: No (.) I'm not ticklish there
16. C: ohhhh (0.5) Can I have a high one
17. M: He wants a special place where I tickled him round there (must be a tickle spot)
18. Ph: I've got a tickly spot there ((points)) (. ) It'll never go away (.) it'll always be ticklish ( )
19. M: What have they done another 100% (.) I never even looked
20. Ph: He's on ((looks at chart)) 100% yes cos he had one week of 100% last week() another 2 (0.6) and then if he -your-  
- if his count's alright (.) in 2 weeks (.)he'll have one more week of 100% and then go up to 125 ( )

Examining this encounter, no explicit advice or information is given to the mother prior to her question at line 19. In fact, at line 5, the mother prompts the pharmacist, who she has seen inspecting the drug card, as to the number of days medication her son is due to receive. In response to this, the pharmacist states that she has only prepared one week's chemotherapy, on the basis that this was what the child had received at the last visit. The pharmacist's utterance following this in line 9, however, is interesting; a possible interpretation of "but his counts are fine" would be in the sense that, if this is so ('counts' being white blood cell counts upon which dosages are ultimately based) there are no new medical or dosage issues to be raised or discussed here. Whilst the pharmacist is counting out the extra tablets the child becomes the focus of attention for the mother, but it is following the pharmacist's contribution to their discussion at line 18 that the mother initiates a question concerning the dosage regime. The formulation of this, "What have they done another 100%", with its secondary part "I never even looked", is interesting in that it both proposes an answer to the question and provides a reason for why the information is

necessary. In particular, "I never even looked" works to suggest that the mother would have been able to glean this information for herself from the drug card, unproblematically. In this sense it is a fairly weak solicitation of advice; what it does is to make relevant the kind of response that the pharmacist gives, which concerns dosage details. The response from the pharmacist following this, however, does not solely attend this finite question, but heralds the beginning of a detailed explanation of the likely subsequent course of events.

It may be salient to note here that this is a patient who had been attending the clinic for 4 years at the time this consultation was recorded, and it may be considered reasonable to suppose, as a result of this, that his mother was assumed to be familiar with the medication regimes and dosages involved in his treatment. Significantly, however, the pharmacist does not appear to know either the patient or carer by sight, and opens the consultation (in line 1) by checking the patient's identity. The date at which this patient's treatment began is information contained on the drug charts the pharmacists use in these clinics, so it is likely that the pharmacist is aware of this fact; nevertheless, it is still curious, particularly in the light of the data to follow, that no attempt is made to establish any kind of knowledge basis with the mother. It is interesting also that the mother's approach is made some way into the encounter; in terms of the general structure of the consultations discussed previously pharmacists tend to place the details of a medication regimen at the beginning of the "advice-giving" segment, immediately after the greeting sequence. When that does not occur in this case, the mother requests the information for herself and this request forms the approach to advice giving that is usually negotiated by the pharmacist.

This instance where the mother orchestrates the approach into advice giving is unique in the data. However, there are also a small number of consultations where there appears to be a lack of any advice or information element produced by the pharmacist, and this goes unchallenged by the patient or carer. Thus the encounter is treated in a similar way to a **basic business transaction**, so that the medication is handed over as any other commodity would be, without any explanation or clearly defined opportunity for explanation. This type of approach is illustrated in the extract below:

**Transcript 32:- ml/nc/op (simplified transcript)**

1. Ph:Right (0.6)
2. Ph:Coming back in a week's time (0.3) Right (0.2) have you got plenty of Septrin at home? (.) or (.) [uhhh
3. F: [We have (.) uh hh better take some more
4. Ph: There's your blister =
5. F: =Ta  
(1.0)
6. Ph: There you go (.) There's another bottle for you
7. F: Oh alright (.) thank you
8. Ph: Have fun (.) See you

Whilst this approach involves no details, it is delivered in a manner which assumes patient competence; "There's your blister" in line 4, and "There's another bottle for you" in line 6 are presented as self explanatory statements, and this presentation is apparently accepted by the father. The talk serves to invoke a sense of a long-term and ongoing relationship, for example "Have you got plenty of Septrin at home?" implies previous visits on which this drug has been supplied. Aside from the drug



name, there is little in this sequence to overtly suggest that it is occurring in a pharmacy clinic, or that the participants are a pharmacist and the father of a patient. While the talk is evidently task-oriented and topic specific, the pharmacist's role is narrowly defined in the encounter, in terms of simply handing over the medication. The result is that, although this is an asymmetrical encounter along the lines of those that commonly occur between a service provider and a recipient, it is hard (jargon excepted) to find anything which locates the talk specifically as a 'medical' encounter, involving specific identities. It seems that it is largely in the advice giving segment of the interaction that the particular roles of pharmacist and patient, as opposed to a general service provider/recipient distinction, become explicit.

What does remain here, however, is a clear sense of an ongoing relationship, as illustrated by the pharmacist's utterance in line 2, "Coming back in a week's time". This appears to be a statement on the part of the pharmacist rather than a question, and as such it is allowed to stand without comment by the father. The records for this patient show that he had been attending the clinic for just under a year at the point at which this recording was made; again (as with the previous extract), it might be assumed that there would be little routine advice which could be given by a pharmacist to a patient of such long standing. However, as the rest of this chapter will serve to illustrate, it is unusual that these issues of knowledge and competence are assumed from the outset in the clinic setting; more typically they are explicitly negotiated by the participants. This negotiation does not just occur at the arrivals into advice giving which will be considered here, but throughout the entire encounters.

It may seem unusual to have dealt with these anomalous cases from the outset; however, it is hoped that by so doing, the delicacy of the 'entry into advice' problem which is considered below will be highlighted. Both of the previous encounters from which extracts have been presented appear to run smoothly, and with little difficulty for either party. However, they also run contrary to the Code of Ethics, in the sense that they are based on assumed knowledge. Where pharmacist-initiated advice giving is apparent, issues of knowledge and competence are of paramount importance in the unfolding of the interaction.

As has been mentioned earlier, (parent initiated and "business transaction" formulations aside) the large majority of the arrivals at advice giving are in fact initiated by pharmacists, who employ a variety of conversational strategies in bringing this about. The remainder of this chapter will seek to identify these strategies and to consider their implications in terms of the way they constitute patients or carers.

### **The "Unilateral" approach**

The most basic of these strategies is one identified by Heritage and Sefi (1992) in their Health Visiting data. This approach involves delivering advice without first establishing whether the client is knowledgeable about the issue in question; this contrasts with the previous approach which assumes client knowledge without establishing it. Once again, the consultation below which illustrates this strategy involves a patient who has been attending the clinic for a significant length of time (2 years); following an opening summons/answer exchange where the patient's carer is required to identify herself the pharmacist moves straight into the business at hand.

### Transcript 5:- eg/op/be (simplified transcript)

1. Ph:(Name)?
2. M: hello
3. Ph: Right OK(0.3) (There's) There's your mercaptopurine(0.2)
4. M: yeah
5. Ph: and they've already been halved for you so you're taking j-just one
6. Ph: to be given each morning( )

In line 5, then, in terms of the talk, the pharmacist begins to deliver the dosage details immediately after the opening sequence, without first establishing whether the carer may already be aware of these details. In actual fact there are other activities occurring simultaneously in this encounter; as the pharmacist states "There's your mercaptopurine" a bottle is handed over to the patient. This action may be seen in some way to legitimate or justify the "advice" (instructions about the dosage of this particular drug) which follows. In this sense, the sequence is perhaps not as 'unilateral' as those described in Health Visiting or HIV counselling, since the bottle acts as a resource (for announcing or introducing the topic) and thus somewhat softens the production of this sequence. This factual set-up and unilateral delivery occur across a range of consultations, but within this framework a different phrasing of approaches can appear to constitute more or less patient knowledge, and provide opportunities for differing degrees of patient input. In the extract above, for example, the pharmacist uses a drug name, mercaptopurine, without any further explanation around this; the implication is that the mother will be familiar with this terminology, and her acknowledgement in line 4 appears to confirm this. In the extract below, however, the pharmacist neither pauses for acknowledgement nor allows for the possibility that this may be redundant advice, until the first significant opportunity

occurs for the mother's entry into the consultation at line 5.

**Transcript 6:- ar/op/be (simplified transcript)**

1. Ph: Prescription for (name)?((M approaches))I've got some Septrin for him here=
2. M: =Yeah
3. Ph: and you're to give him 7.5ml (.) on Mondays Wednesdays and [Fridays
4. M: [Right
5. Ph: and you're starting this Friday ok?(0.4) and again we've got some sunblock
6. Ph: for him as well(0.2)
7. M: Right

Once again, drug names are used seemingly unproblematically by the pharmacist (and acknowledged by the mother). As the pharmacist proceeds with the dosage details in line 3, the mother's acknowledgement occurs in overlap with the final part of the instructions, which goes some way to suggesting that this is not new information for her. Interestingly, the pause in line 5 where the pharmacist appears to seek acknowledgement for the entire segment of details concerning the administration of the Septrin goes unfilled, the mother does not provide any acknowledgement here, and neither does she state that this is redundant information. After this pause the pharmacist shifts topic slightly, moving on to the next item, the sunblock. This utterance, and the mother's acknowledgement of it, concludes the 'advice-giving' segment of this encounter; the rest of the consultation from line 8 on is concerned with co-ordinating the date for the next clinic appointment. In some ways this advice giving segment is somewhat contradictory; although explicit instructions for the actual

oral medication are delivered unilaterally, no explanation or instructions are provided for the sunblock. This has actually been supplied because some chemotherapy medications can cause a hypersensitivity to sunlight; however it appears to be presumed that the mother (whose child has attended the clinic for 6 months) will be aware of this and know how to use it. Speculatively, the way in which the lack of advice regarding this potentially more complex matter contrasts with the details provided for a straightforward drug administration regimen may illustrate some kind of distinction made by the pharmacist between 'drug' and 'non-drug' items; although there is detailed consideration of oral medication in the Code of Ethics there does not seem to be any recommendation regarding sunblock!

The extract above, then, provides little opportunity for any negotiation as to whether the information imparted is necessary prior to its delivery; nor does it explicitly invite participation from the patient or carer. In other instances of this 'unilateral' approach, the delivery is followed by a specific opportunity for the client to align or become drawn into the process, albeit after some details have already been delivered. In the instance below, the pharmacist has been discussing the date of the next clinic visit with the patient's elder brother, and the move to handing over medication does not occur until line 13.

**Transcript 25:- sc/nc/op (simplified transcript)**

8. Ph: Alright yeah(.) I've given you seven days anyway =  
9. B: Yeah  
10. Ph: Because it's-  
-it works out easier(.)but you'll get a new lot on Monday (0.6)  
11. Ph: D'you want some of the Septrin? (0.5)

12. B: Yeah (0.4) better take some just in case
13. Ph: Yeah (.) well there's that one and that's 7.5ml =
14. B: = Mmmhmm
15. Ph: twice a day on Monday Wednesday and Friday(.) is that alright?(0.5)Do you want a bag

Here the brother (in line 15) is explicitly invited, by use of a tag question, to raise any difficulties with the dosage administration (or indeed, potentially, any other question). In this sense the delivery of advice here could be said to be 'client centred' rather than 'delivery centred', in view of the fact that the extent to which the advice is delivered (although not the initial advice) is made more negotiable. This opportunity is also provided to a lesser extent in the following extract.

**Transcript 34:- nq/nc/op**

12. Ph:Right then (0.4) There's the mercaptopurine (0.7 ) Yeah (.) no problem there
13. (0.4) It's all ready for you (0.3) 5mls and (.) 5mls of each (.)
14. M:Yeah (.) yes that's [methotrexate is it yeah
15. Ph: [every day

Here, however, the pharmacist does not continuously use drug names when referring to the medication; after naming the first drug he displays an orientation to the second ("5mls of each"), but merely indicates bottles and discusses dosage. Interestingly it is the mother who properly names the drug, although the pharmacist does not respond to her naming. This demonstration of knowledge (and the apparent misalignment of the following information which will be discussed in the next chapter) in fact seems to pass unnoticed by the pharmacist, who has begun to proceed with further dosage instructions. The use of "no problem here", however, as a possible problem-elicitor,

marks this as a routine encounter involving the handing over of familiar items to be used as they always have been used; this seems somewhat at odds with the way in which the details are delivered. Nevertheless, it illustrates how unilateral delivery can be coupled with a process of explicitly looking and checking as to whether there is any reason for things to be problematic. However, the fact that they are deemed not to be does not, as here, necessarily prevent the delivery of routine details.

Just as there is some degree of orientation to perceived competence in this extract, "Unilateral" delivery may also be further softened by more explicitly attending to this. In the transcript below, the pharmacist packages information in statements and questions which presuppose the possibility of patient knowledge, but nevertheless provide the opportunity to continue to deliver the dosage details unilaterally.

**Transcript 40:- kb/nc/op (simplified transcript)**

5. Ph: Well you're still on that low dose-  
-You know you're on three point-  
-I don't know whether  
you know you're on 3.75ml (0.3)
6. C: I think [I am
7. Ph: [Which is smaller than you uusually are
8. C: Yeah

This formulation credits the patient with some prior knowledge of the dosage regime ( "You know you're on three point.." which is then amended to "I don't know whether you know") and, perhaps as a result of this, is delivered more tentatively than is usual in the "unilateral" approach. This may be related to the fact that the

patient, who is an 8 year old girl who began attending clinic 4 months ago, has come to collect her medications alone; whilst it may have been assumed that her carer(s) would be aware of the specific dosage, the same assumption is not made of her. However, an implied level of competence is built in to the following unilateral delivery, also involving a (14 year old) patient who attends with her mother, but who responds to the pharmacist's utterance herself. (The extract begins at the point at which the pharmacist has finished inspecting the drug card, following a discussion about summer holidays).

**Transcript 29 :- kj/nc/op (simplified transcript)**

10. Ph: Yeah (.) Just what we expected by the looks of it (.) 75% (.) coming back in 2 weeks (0.3)  
11. C: Yes  
(Pharmacist checks blister pack))

Here again, the use of the statement "just what we expected" in line 10 appears to tie back to the kind of 'no problems there' formulation found in transcript 34 previously, marking this as a routine encounter. The slight pauses provide a possible opening for confirmation of each item in the list presented by the pharmacist; however, the patient waits for completion of the list before responding. Although this encounter is explicitly treated as routine, the manner in which the information is delivered serves to illustrate that it *could* have been different (and in so doing perhaps provides some kind of justification for the fact that the details are still provided). This kind of orientation to the fact that something *may* be different or distinctive on a particular occasion appears to be a common feature of the consultations within the clinic; the unusual factor is perhaps that advice or information then often appears to



be given regardless of whether any distinctive element is present. Some of the interactional problems which might be associated with this kind of format will be discussed in more detail in the following chapter. Briefly, however, it is evident that this unilateral approach is not tailored to the understanding of a particular patient or carer, and thus runs the risk of providing information that is redundant and which may even be regarded as an attack on the recipient's competence. In addition, it can leave us uncertain about the nature of the recipient's response:- although what is stated by the pharmacist may be acknowledged and thus appears to be accepted there is no clear demonstration of understanding or intention to act upon it.

### **"Announcements" or "Statements of intention"**

There are also apparent in the corpus of data a set of alternative strategies which pharmacists use, which address the issue of giving redundant advice to a greater or lesser degree. An alternative approach, identified in this data, is the use of **announcements**, ie announcing that advice giving is about to take place. This kind of announcement of an **intention to give advice** prior to the actual delivery occurs in the extract below.

### **Transcript 7:- dc/op/be (simplified transcript)**

1. Ph: (name)? (0.8) ok [I'll go through it all with you
2. M: [Yes
3. M: It's alright(.) I know it already

This kind of prefacing or contextualising the delivery of advice does not necessarily preclude the subsequent production of a unilateral delivery. What it does theoretically

provide is an opportunity for the dismissal or rejection of advice before it is produced. In this particular case the advice is resisted; interactionally, however, this may be quite difficult for the patient or carer to achieve diplomatically. This kind of prefacing also has the potential to be problematic in that, if, as here, the preface is unspecific, ("I'll go through it all with you"), the patient or carer may be unsure precisely what they are rejecting.

Additionally, if the overt function of such statements is not to provide an opportunity for the patient or carer to reject the advice, then this raises the question of what the announcement does do. As will be considered throughout this chapter, some of the strategies identified here project advice or information sequences more strongly than others. A unilateral delivery both projects and delivers information simultaneously, although this may be softened by the handing over of medication in order to topicalise this information. Since, as here, dismissal of **announced** advice is hearable as a kind of 'interruption' of the progression towards the actual advice, it may be assumed that the strategy of announcing forthcoming advice is interactionally a fairly strong projection that (some) advice will follow regardless. In this sense, an announcement-as-arrival may serve to provide space in the encounter for a prolonged action of informing by the pharmacist.

It is perhaps only theoretically then, that this formulation really does give the carer the opportunity to reject advice which is considered to be redundant. Should such rejection successfully occur however, some of the problems highlighted by the unilateral approach are still present here, in that the issue of the recipient's actual

understanding and specific commitment to future action remain unresolved. The same is true of the 'understanding' that can be gleaned from client responses, if a subsequent unilateral delivery ensues. Again, within this general "statement of intention" framework, different strategies are employed; the use of "with you" in line 1 above implies a collaborative process as opposed to a unilateral one. The following extract suggests that this is a process which may be deliberately employed by pharmacists, as (in line 8) the "for you" is immediately substituted for "with":

**Transcript 4 :-sc/op/be (simplified transcript)**

1. Ph: (name)?(1.2)[Hi
2. M: [hello
3. Ph: Well firstly we've got to apologise for the bottles but there's been
4. Ph: a delay with the [blisters(0.5)
5. M: [oh
6. Ph: [so that's why we've
7. M: [Yeah so long as it tells you what's(0.2)
8. Ph: Yes we've put everything on for you(.)just let me go through it for(.) with you
9. Ph: Right () the mercaptopurine
10. M: Yeah

In addition, the way in which this statement is phrased:- "**Just** let me go through it..." (line 8) means that it would be difficult for the mother to refuse, despite her earlier statement (line 7) to the effect that as long as there are dosage instructions on the bottles she will be able to manage without a blister pack. Again, unilateral delivery of advice details occurs here after the warrant for the advice. However, this encounter appears to be tailored to particular local contingencies, namely the lack of all-in-one blister packaging; the implication is that the details are necessary because

of this situation. Thus, although this type of arrival device appears on the surface to offer a chance for the recipient to refuse the explanation, in practice the actual formulations used by the pharmacists can make this problematic.

In the extract above, in contrast with those discussed previously, there is some attempt on the part of the pharmacist to **establish the relevance** of the advice giving at the very beginning of the consultation; this particular case involves a different presentation of the medication from that which the clinic usually supplies, and this is stated at the outset. A similar strategy is used in the following encounter, where the pharmacist explicitly sets out to establish whether a particular body of information is known to the patient or carer:

**Transcript 11:- sg/op/be (simplified transcript)**

1. Ph: Prescription for (name)? (0.3) No? ((patient and carer approach))
2. Ph: Right.(.)(name)'s not had maintenance therapy before  
has he? (0.5)
3. M: No
4. Ph: Right (.) I'll explain it all(0.3) First of all(.) whenever we do the  
blister
5. Ph: cards we always get them done at the back 'cos they (0.2) get done in  
6. preference then [so you don't hang around for so long(.)
7. M: [Right
8. Ph: Right he's got to have(.) his mercaptopurine (.) (find the tablets for you
9. Ph: 45mg a day (.)so you need to give this each morning(.)it's one half a
10. tablet(.) We've already halved the tablets for you there=
11. M: =Mmmhmm

In line 2, the question "(name)'s not had maintenance therapy before has he?" establishes the patient as a first time clinic attender, thus setting the stage for the

relevance of what is to come in terms of the patient's medical career. When the mother confirms this, the pharmacist states her intention to give full details ("I'll explain it all"), and then proceeds to do so. Once again, the delivery which follows this statement is classifiable as unilateral; having been constituted as someone whose child has not had maintenance therapy before the carer's necessity for this advice is presumed. The go ahead to do this is thus *officially* based on the lack of knowledge of the mother. It is worth noting briefly that that the initial part of the informing segment, in lines 4-6, is framed in terms of the routine way in which 'we' at the clinic always do things.

An interesting variation on this "statement of intent" device is the use of a **statement implying that no advice will be given**. In a sense this is the counterpart to the above approach, where an explanation is presumed necessary unless the patient explicitly states otherwise. In this "statement of no advice" format the pharmacist presupposes knowledge on the part of the patient whilst at the same time allowing an opportunity for this (presumed redundant) advice to be requested, eg:

### **Transcript 30: nq/nc/op (simplified transcript)**

1. Ph: ((indicating tape recorder)) It's a bit official isn't it (0.4 ) I'm not going to say anything to you really because you've had it all before haven't you?
  2. F: No (0.2) the missus usually does this
  3. Ph: Oh right (0.2) It's what we were expecting (.) 50%
  4. F: Yeah
- ( )

In this case, knowledge on the part of the father is presumed by the pharmacist in his

opening statement, and this projected non-delivery in fact creates problems since, although the patient has been attending the clinic for over a year, and there are no unpredicted changes to the medication on this occasion, it is the patient's mother who usually attends. In this case the pharmacist does go on to deliver some advice when this becomes apparent; although the 'preferred' answer in terms of the question design might be to agree with the pharmacist's assessment (Pomerantz, 1984), the formulation does provide the opportunity to disagree. Similar problems arise with the use of this type of formulation in the extract below, where once again the presumption of knowledge leads to interactional complications.

**Transcript 33:- jb/nc/op (simplified transcript)**

1. Ph: Same as usual=
2. M: =Right (0.2)you
3. Ph: Right (0.4) There's nothing for me
4. M: Nothing
5. Ph: Yeah (.) Same as normal (.) Two weeks worth is it?
6. M: Yeah
7. Ph: Two weeks' worth (0.3)
8. M: I think he's gone up [to 150
9. Ph: [150% yeah=
10. M: =Yeah

The pharmacist begins (in line 1) by setting up this encounter as routine and without any 'new' business to discuss, suggesting it is the "same as usual", and the mother of the patient initially appears to align with this. The same assessment is reiterated by the pharmacist in line 3, "There's nothing for me", which presumably means there is no new information to be imparted. The mother's "Nothing" at line 4 is perhaps the first potential challenge to this projected state of affairs. However, it is not until

the pharmacist has restated the sameness of the consultation once again that the mother explicitly challenges it; even then her challenge (in line 8) is produced in a tentative, subjective manner, in terms of what she 'thinks' rather than knows. This serves to highlight the delicacy of the disaligning process. Interestingly, the pharmacist does not explicitly acknowledge having misinterpreted the situation, but simply agrees with the mother's assessment. This extract highlights one of the major drawbacks with this approach, in that it may well be harder for a patient or carer to request advice that they are not "supposed" to need than to accept redundant details. In addition, if a patient or carer accepts the initial statement that no advice will be given without later challenging this, the issue of their actual understanding is never made explicit or resolved.

#### **Questioning (a) "Do you need advice?"**

Although the different ways of arriving at advice giving discussed so far constitute a significant number of those consultations recorded, in the majority of the encounters an entry into advice giving is brought about by **questioning**. These questions fall into various types; an obvious way of resolving the issue that people may be unwilling to ask for advice of their own accord, whilst still avoiding some of the interactional problems seen earlier, is to begin by **asking the client whether he or she is in need of advice**. Evidently, this strategy also establishes the relevance for advice giving in a more direct manner which provides an obvious opportunity for acceptance or declination, as below.

#### **Transcript 2 :-kj/op/be (simplified transcript)**

1. Ph: Prescription for (Name)(0.3)Hiya(.)It's(name)'s first time having blisters

- isn't it?
2. M: Yes=
  3. Ph: = Do you want me to just explain it(0.3)[this is a really simple one for her
  4. M: [Yes if you would

In this extract the pharmacist's opening utterance "It's (name)'s first time having blisters isn't it?" projects a confirmation from the mother which is subsequently produced. However, it also works to establish an interactional context for the advice giving, and is then immediately followed by the offer of advice. This offer is accepted immediately by the mother (although perhaps the statement that this is a 'simple' blister works to suggest that a lengthy explanation is not in the offing). The contrast between 'Do you want me to explain' in this case, against the statement of intention type arrival 'I'll go through it all with you' seen previously is significant. Whilst the former provides an explicit opportunity for requesting an explanation (or indeed a specific *sort* of explanation), the latter is far less negotiable, and interactionally more difficult for the patient or carer to resist or downgrade. In the consultations recorded here, asking whether someone *requires* an explanation appears equally likely to be accepted or rejected. In this sense, such a question, whilst it projects the relevance of subsequent advice giving, projects the actual activity far less strongly than either the unilateral or statement of intention approach. This can of course cause problems in terms of stated versus actual competence of the patient or carer; these will be considered in more detail in the following chapter, but the extract below gives a brief illustration.

**Transcript 12:- gg/op/be**



17.Ph:Uhhm do you want me to explain your tablets cos they're not

18.Ph:[in blisters to you

19.C: [No I know what to do

Built into the pharmacist's question in lines 17-18 is an account for why the advice is necessary on this occasion; however, since the question is positioned before the account the patient's answer overlaps with this. This highlights the major interactional problem in terms of this strategy; that carers or patients who assert that projected advice is redundant may be unaware of gaps in their knowledge. These gaps may not be apparent to the pharmacist, who as a result may curtail the delivery of advice that is in fact needed. Even if these gaps are apparent to the pharmacist, as in this case where the patient's medication has been repackaged in an unfamiliar manner and so it is unlikely that he actually does know "what to do", it is interactionally difficult to try to persist in advice giving to someone who has explicitly declined it.

### **Questioning (b): "General" Questions**

Related to this is the problem that the patient may not actually know what it is they need to know; this becomes even more acute when an opening question is framed in a more **general** way. This is what occurs in the consultation below, at line 10.

### **Transcript 20:-lt/E38/ta (simplified transcript)**

10. Ph: Do you know about the medication that (.) he's going to be having?

11. M: Yes she=

12. Ph: =You do (0.5)

13. M: (Name) told us about it

The question that the pharmacist asks here, "Do you know about the medication that

he's going to be having?" is a very broad question, although it does explicitly project the possibility of subsequent advice or information. As such it contrasts with the questions seen in previous encounters, such as "This is (name's) first time having blisters isn't it", which contain a built in assumption and a discernably preferred answer. It is not clear from this exchange what, if anything, the pharmacist has actually found out about the mother's knowledge or if anything remains that she needs, or would like to know.

In theory, perhaps, this **general opening** is intended to allow the patient or carer to delineate any problem areas, but again, the patient or carer may not know how to respond to this. The recurring problem is that for a patient to formulate an information seeking response requires a certain amount of knowledge in itself of what is appropriate. If this basic knowledge is not present, no response at all may be forthcoming, as in the extract below:

**Transcript 35:- kb/nc/op (simplified transcript)**

1. Ph:Right (0.3) How's the medicine going?  
(1.6)
2. Ph:Yeah (0.4) I've got five days' worth already made up so:oo( )

The opening of this consultation, then, contains a presupposition that not only does the patient or carer know the details of their treatment but that they also have an assessment of this treatment. Certainly, "How's the medicine going?" is a question which establishes the relevance of discussing the medication, and perhaps provides a peg to latch any further advice on to. (It may also work to establish the relevance

of the pharmacist as the person to talk to about 'the medicine' at this time). However, it is a difficult question for which to provide an answer which will itself be considered relevant without any further information.

There are, however, important differences to note between this encounter and the extract from transcript 20 reproduced above. Whilst the opening question in transcript 20, "Do you know about the medication that he's going to be having?", explicitly projects the possibility of the production of an informing sequence, the question here has a different object. "Do you know about the medication that he's going to be having?" explicitly addresses the mother's state of knowledge, whereas "How's the medicine going?" may be seen to address more general issues of well being and coping, and does not carry with it any projection of advice other than a possible topicalisation of 'the medicine' as an issue to be talked about. It may, then, be useful to subdivide this "general questioning" strategy into two categories: firstly general questioning which is clearly related to the medication, as in transcript 20; and secondly "How are things?" type questions which do not carry with them this explicit focus, and to which transcript 35 and the remaining examples in this section belong. The extent to which this latter category actually projects an informing or advising segment is, clearly, not as great.

There is also a problem that, as in general conversation, a question of the "How are you" type may just be treated as a courtesy enquiry to which only affirmative responses are interactionally acceptable. As Sacks (1975) notes, 'How are you' is a sequentially implicative question which may invoke the roles of troubles teller and troubles recipient. Thus, 'fine' may be the answer to 'how are you' because the

answerer does not wish to share their troubles with the questioner. Equally, the questioner may not wish to be a troubles recipient, since 'how are you' also serves a greeting type function. Sacks concludes that 'fine, thank you' is the correct conventional answer unless there is reason to believe that the person asking **really** wants to know the state of one's health. It seems plausible that this is what is occurring in the following 2 encounters.

**Transcript 21:-sg/E38/ta**

1. Ph:How are things then? (1.0)
2. M: OK

and

**Transcript 19:-io/E38/ta**

1. Ph:How are you getting on then? (0.6)
2. M: OK thank [you
3. Ph: [Yeah (.) OK (.)

In other medical settings, such as GP/patient encounters 'How are you' may be heard in 2 ways: both in terms of social enquiry and as a task oriented question concerning the problem which has led to the consultation (Frankel, 1995). In this setting, its treatment seems closer to the former way, in the sense that although a child with cancer or leukaemia cannot in any real sense said to be 'OK', this fact is already known to all the involved parties, and is indeed a prerequisite for attendance at the clinic. However, this type of general questioning may display an orientation to

relevance in the sense that pharmacists appear to continually attend to the possibilities of any new circumstances or problems; 'How are you' type questions may be intended as a non-specific method of allowing the patient to raise these.

However, as previously discussed, in the general overall structure of the consultations the raising of specific problems by patients or carers tends to take place at the very end of the advice giving segment, immediately prior to closure. This appears to occur regardless of any initial response made to this kind of "How are you" enquiry. Thus, whilst this set up may be more successful with more experienced patients who are familiar with the kind of problems pharmacists would be able, or expected to deal with, it can create potential difficulties for new patients. Additionally, the enquiry may not serve any purpose with those experienced patients who are aware that the end of the encounter generally provides them with an opportunity to raise their problems.

**Questioning (c): "Is that what you were expecting?"**

A third variation on the questioning-as-arrival-into-advice approach is to ask if an item is **what the patient was expecting**; the assumption apparently being that if so then there will be no problems with other details such as dosage etc, as below.

**Transcript 43:- nq/nc/op (simplified transcript)**

1. Ph: Right (0.3)now is it what we expect (0.4) 100% (0.4) 2 weeks (0.5) Yes?
2. M: Yeah (.) Yeah

Once again, the orientation to patient knowledge is clear here; the pharmacist's

utterance "Is it what we expect" followed by a search for confirmation appears to constitute the patient or carer as someone with an expectation of the therapy. This kind of strategy is advice projecting in the sense that, if a client states that the medication is **not** what they were expecting, the presupposition is that some kind of explanation will be necessary. However, a patient or carer's agreement with the expectation does not appear to preclude subsequent advice giving; this will be discussed in detail in the following chapter. In any case, this strategy appears to be more commonly used further on in the consultation after the dosage information etc has been given to see if a problem indicative response is then forthcoming, eg:

#### **Transcript 39:- kj/nc/op (basic transcript)**

- 1.Ph: Let's concentrate a bit
- 2.M: We've had to wait (.) new surface area
- 3.Ph: Yes ( ) been increased slightly hasn't it
- 4.M: Yeah
- 5.Ph: Yeah( )it doesn't make a difference to the tablets for now( )but we'll (.)
6. increase the tablets next time ( ) more than likely they won't change
7. much at all anyway =
- 8.M: =Right ( ) So you're not going to change them this [time
- 9.Ph: [No ( ) just a tiny change (.)
- 10.Ph: It's gone up from 1.53 to 1.56 (.) the change that makes in the tablets
- 11.is so tiny ( ) it makes no odds ( )
12. Just a little change but we'll ( ) we'll have it done for next time
13. ( )
- 14.Ph: So it's 100% for 2 weeks then is it?
- 15.M: Yeah
- 16.Ph: Does that sound like what you were expecting?
- 17.M: yeah
18. ((Doctor enters room))

Once again, the mother is clearly oriented to here as someone with an expectation of her daughter's therapy (line 16). The sense of normal routine, and the way that this

ties into an ongoing relationship with the pharmacist, and an established knowledge basis, is invoked by the talk in this manner. Clearly then, this type of questioning, at whatever stage it is used, displays sensitivity to parental competence, and serves to reduce any explicit gap of competence between the pharmacist and the patient or carer. However, once again there is a problem in that the recipient is required to have a prior expectation in order to know whether a situation differs from it.

### **The "Collaborative" approach**

The most successful way in which pharmacists appear to avoid such problems is by asking a series of questions which enable them to check the extent of a patient's knowledge whilst simultaneously delivering advice in an indirect form; for example as a series of propositions which can be confirmed or disconfirmed. This "collaborative" strategy is used in the extract below in order to bring into discussion what turns out to be a particularly complex method of drug administration:

#### **Transcript 15: jm/e38/ta (simplified transcript)**

1. Ph: The magnesium glycerophosphate(.) the nurse was saying that you're ~~rdm~~
2. Ph: giving them now is that right? ( )
3. M: Yes
4. Ph: Right(.) are you alright with them (.) just half a tablet?( )
5. M: Yeah(.) I just dissolve it and put it down the nasal tube

The use of a collaborative, stepwise strategy is identified by Silverman (1992) in his work on HIV counselling; however, the factual, precise nature of the information

presented in the oncology clinic means that the exact nature of the collaboration across the 2 settings differs somewhat. This will be considered in terms of client responses in the next chapter. Nevertheless, in a general sense, this method of advice giving appears to produce responses from recipients which are more indicative of involvement with the process. This is clearly illustrated in the extract above at line 4 where the mother becomes actively involved in the discussion of the administration of the prescribed drug. The pharmacist here packages specific details in a question form, in a stepwise progressive manner (lines 1-2 initially, and then line 4). The questions are presented in such a way that they invoke filling a gap in knowledge for the pharmacist, in the sense that 'I need to know something from you the patient'. However, whilst this method tends to draw patients and carers into the advice giving process, in more complex cases it can be time consuming. The possibility of a failure to establish relevance is also present, in which case it is conceivable that the advice giving segment would come off as a unilateral sequence.

Despite this, as the examples below show, it potentially provides the best management of the consultations of any of the strategies outlined, in the sense that it can be adapted to take into account the competencies and knowledge that are made apparent through it. Issues of competence are thus dealt with to the extent that patients/carers are given an opportunity to actually display rather than assert their competence, and specific problems can then be isolated and dealt with. However, this collaborative stance can also be problematic in the sense that a display of understanding may be encouraged by the design of the turn (eg "Are you alright with them, **just** half a tablet?"). This may be compounded by the fact that that the strategy also presupposes



a great deal of knowledge on the part of the patient or carer from the outset. The extract above illustrates the collaborative approach in specific relation to a particular kind of treatment, and elicits a response from the mother which *demonstrates* her knowledge and competence. However, where there is less specificity, the response may be less satisfactory in terms of the demonstration of knowledge. This is illustrated in the extract below.

**Transcript 16:-lsm/E38/ta (simplified transcript)**

1. Ph: You know his tablets (.) are they going into his line now or is he taking them?()
2. M: No he's taking them in (.) in a drink
3. Ph: In a drink (.) he's alright with it in a mixture?(0.3)
4. Ph: [He's OK with that?
5. M: [Yeah

In this case the pharmacist has to reformulate a question (line 4) in order to elicit a response from the mother of the patient, and in contrast with the previous extract the response which is obtained does not demonstrate competence at administration but merely asserts there are no problems. In a sense this may be due to the framing of the question by the pharmacist; in this extract the pharmacist makes the carer's competence at administration less directly questionable. As with transcript 15, these questions are presumably designed to address whether there are any administrative problems with the drug (since if the patient is taking his tablets in a drink the mother will be required to crush and dissolve them). However, the focus of transcript 15 is clearly on any difficulties the mother may have with a particular method of drug administration. In the extract above the explicit focus is on the patient, and his well

being ("He's alright with it in a mixture") and as such any attempt to establish competence is indirect. The delay in the mother's answer to this perhaps serves to make this a less satisfactory answer than in the previous case; however, it is a perfectly adequate response to the question which has been asked. The sequence below, in which the collaborative approach is used to try and establish whether the medications a patient has been receiving in hospital will cause problems for home administration elicits a response of a similar order.

**Transcript 18:- m/E38/ta (simplified transcript)**

1. Ph: You know when you have your tablets (.) your sickness tablets(.) Wha-
2. Ph: -do you have them at home at all or not?(0.5)
3. C: Uhhh [Yeah [Yellow ones
4. F: [He has some don't [you (0.3) half(.) half
5. Ph: You have half a one?(.) Are you alright with those (.) you can take them
6. Ph: alright (.) you've got no problems? (0.4)
7. F: He prefers the tablets to the (uhhh fluid) Don't you? (0.3)
8. C: Yeah

Once again the pharmacist establishes what she is doing in terms of things she needs to know from the patient ("Do you have them at home at all or not?" in line 2). The set up also assumes knowledge on the part of the patient and his father, in the respect that they need to know which 'the sickness tablets' are in order to provide an answer to the question. The pharmacist then moves on, again by means of a series of questions, to attempt to *establish* whether there are any problems. Once again, however, the use of a general question may be problematic, in the sense that it presumes the father is aware of what kind of problems there might be. In this way it is easy to see how this kind of collaborative approach may or may not deliver the

required information, depending on the level of specificity with which the pharmacist imbues the question. In actual fact, the response given here is the required one, since the pharmacist's concern is that the child (who is aged 7) may have difficulty in swallowing the tablets; it is usual hospital policy to provide children under the age of 12 with syrups or mixtures. Here then, the pharmacist does establish that the respective medications are being administered correctly, without either directly challenging competence or doing so indirectly by providing redundant information. The case below achieves a similar goal in relation to pain control:

**Transcript 14:-ps/E38/ta (Simplified transcript)**

1. Ph: So(.) are you having any problems with [the morphine?
2. M: [the morphine (.) Oh no (.)
3. M: no he (.) tends to (.) you know (0.3) The other it takes too(0.3) I-  
-you know(.)
4. M: if he's in a lot of pain he can't do his physio work(0.5)
5. Ph: Right(.) [OK
6. M: [But you know(.) it seems to control it(.) at least he gets you
7. M: know sleep at night [which you don't very often get()
8. Ph: [he gets (.) yeah ((laughs))
9. Ph: it means [you get a decent night's sleep as well ((laughs))
10. M: [he hasn't got to ( ) yeah (.) yeah(.) Yes
11. Ph: And he's not having much breakthrough at all is he? (0.3) I mean he's not
12. Ph: having much of the liquid at all?()
13. M: No [ no no (.) That's right (.) it's just morphine
14. Ph: [He's alright with what he's on then(0.4) Right

The pharmacist's opening utterance here succinctly establishes relevance and contextualises the topic for discussion, in this case again the administration of a particular drug (morphine) with which it can be problematic to obtain continuous pain control. Having isolated this particular drug as the topic for discussion, the

pharmacist further narrows this down in lines 11-12, where 'breakthrough' refers to breakthrough pain, and 'the liquid' is what should be administered if such pain did occur<sup>3</sup>.

By using this collaborative approach then, the patient or carer is encouraged to take an active part in the advice giving process, so that a course of action is apparently negotiated between the two parties rather than imposed by the pharmacist. This course of action may not just be related to dosage and administration competence; the approach also provides the scope to topicalise more general issues of well being such as adequate pain relief, nausea, etc, as are seen in the latter examples of this strategy. The extent to which this collaborative strategy may be seen to project advice is debateable, since in the smooth running of these types of encounters there is a 'discussion' rather than an 'informing' feel. Nevertheless, this strategy is able to address (to a greater extent than any of the others shown), the actual practices that patients or carers use to manage their therapy, as opposed to the dosage details that will theoretically enable them to do this. As a result of this, the responses received by the pharmacist have the potential to give the clearest indications seen in any of the consultations with regard to understanding and commitment to future action.

Seven different methods of negotiating arrival into advice giving have been outlined

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<sup>3</sup>Morphine is an analgesic drug with a relatively long period between administration and full effect. The difficulty of using this in paediatrics is that dosing is by necessity begun cautiously, in an attempt to arrive at an optimum dose which will provide satisfactory pain relief without unnecessary sedation. However, once a dose has 'worn off' and the patient is once again in pain, a subsequent intravenous dose would not take effect for some time. Oral preparations are therefore used to prevent this 'breakthrough pain' during the dosage titration period.

here, along with a brief discussion of the potential advantages and drawbacks of each method. Thus the range of conversational arrival devices used by pharmacists in these consultations appears to be as follows:

- 1. Patient/carer initiated**
- 2. "Business transaction" (where no advice or information is forthcoming)**
- 3. "Unilateral"**
- 4. Statement of intention to give advice**
- 5. Statement that no advice will be given**
- 6. Questioning:**
  - a) "Do you want me to explain?"
  - b) General questioning/ "How are things?"
  - c) "Is it what you're expecting?"
- 7. Collaborative**

It must be stressed that these names are not necessarily considered as being employed by the members of the interaction themselves, but are intended merely as a means of distinguishing the different ways in which advice giving is brought about in the consultations. In other words, although it is assumed that these 'strategies' would be recognisable to the members of the interactions, the terminology used to describe them is that of the analyst. However, this chapter and the one which follows aim to illustrate that there are members' distinctions to be observed between these different strategies, both in terms of the ways in which they are set up and the ways in which they are responded to. Thus, while the terminology employed here is intended merely as a way of marking these distinctions, the actual process distinctions themselves correspond to those observed and oriented to by the members.

In summary here, it is hoped that the consideration of these processes has underlined the delicate and potentially problematic nature of the 'entry into advice giving' stage

of the pharmacist/client encounter in this setting. The issues of knowledge and competence that pervade these interactions are continually, and demonstrably, oriented to by the participants at this stage. However, attempting to find out 'what people know' can in itself be an implication that there is something that they do not know, and so the ways in which a patient or carer's state of knowledge is elicited can be problematic. Unilateral encounters, for example, can appear to run quite smoothly, but not much information is gained (or allowance made) with regard to patient expertise. Part of the problem is that a minimal response is perfectly adequate in the context of this type of delivery, which does not allow pharmacists to know whether the patient or carer is willing or able to act on the information provided. When more complex strategies, such as the collaborative approach, are used, however, there is greater potential for misunderstanding unless relevance is clearly established from the outset. In a practical sense, these perceived differences between the formats appear to be most important in terms of the responses that are received from clients and the implications of these, which is what will be considered next.

## **Chapter 6**

### **"PATIENT COUNSELLING" BY PHARMACISTS: ADVICE, INFORMATION OR INSTRUCTION?**

'Patient counselling' by pharmacists is a diverse and ill-defined activity. It may, in practice, range from simply stating the dosage of a drug as it is handed over to the client, through to counter prescribing for common ailments, to giving advice with regard to lifestyle and health promotion issues, for example smoking cessation, cholesterol testing and contraception. As far as the terminology is concerned, 'counselling' is how these range of activities are described by the profession; whether these activities bear any resemblance to the more general notion of 'counselling' which may be held by the public is debateable. In terms of the adoption of the 'extended role' which is seen as a the way forward for pharmacy as a profession, patient counselling has a central part to play. In a sense this part is two-fold: not only is it hoped that as a result clients will be equipped with the resources to use any medications more safely and effectively, but also that the perception of the pharmacist as the 'first port of call' for general advice on medicines and health will become commonplace.

This chapter aims to consider the process of 'patient counselling' by pharmacists in detail, by examining the ways in which they set up these sequences and the ways in which patients or clients respond. However, since this is data collected in a hospital setting, there are some important points to note. The first is that, unlike in community pharmacy, the pharmacist in the oncology clinic already knows *why* all these patients are here. Whilst a community pharmacist may literally be called upon to give advice on any vaguely medically related matter, and will often have no preconception as to why a particular client may wish to see them, hospital pharmacists' consultations with



oncology clinic patients have a much more clearly defined framework. The large majority of patient counselling in this setting is concerned with hospital initiated chemotherapy regimes and any adjunct medication; where this agenda is broadened this is usually accounted for in terms of how other medications or lifestyle factors may affect the chemotherapy regime. The second point, as has been raised in the previous chapter, is that the majority of these clinic attenders are long term patients, and even those that are new to the clinic have had some degree of experience with medical (and pharmaceutical) services during their inpatient treatment. The issues of knowledge and competence that this raises are particularly problematic in terms of advice giving or instructing. Whilst advice giving itself is a delicate enough activity, advice giving to persons who may already have a great deal of knowledge about their situation has the potential to be even more delicate. The fact that these are paediatric consultations adds further complications; in the majority of cases the patients attend clinic with a parent or carer who is the main focus of the interaction with the pharmacist. Heritage and Lindström (forthcoming), in their analysis of Health Visitors' interactions with the mothers of new babies, note that there are particular moral themes running through their data. These include the parental *obligation* of looking after young children, and the attendant desire to demonstrate that this obligation is being properly fulfilled. In addition, Heritage and Lindström's data deals with largely healthy young children: it is reasonable to suppose that this obligation may be somewhat intensified when a child is very sick indeed<sup>4</sup>.

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<sup>4</sup>It has previously been suggested that the administration of a child's medication is a less 'morally laden' activity than 'looking after' a baby. However, in the case of a serious chronic illness such as leukaemia, it seems reasonable to assume that this general obligation of 'looking after' a child, and hence the activities that this necessarily involves, becomes heightened.

By its very nature, advice giving as an activity denotes an expert-novice relationship. To quote from observations about the Health Visiting data which seem equally applicable here, "While the mothers may have particular outlooks and beliefs about how their children should be looked after, they are confronted by medical professionals who have socially sanctioned rights to "know better" about how their obligations should be discharged" (Heritage and Lindström, forthcoming). Again, where a sick child is concerned, it seems that the rights of medical professionals are socially sanctioned to an even greater extent. Elaborating further on their data, Heritage and Lindström state that "In these visits it is also clear that, to a greater or lesser extent, the mothers see their knowledge, competence and vigilance in baby care as an object of evaluation, and, moreover, by a person with officially accredited competencies to judge their conduct." (Heritage and Lindström, forthcoming). Likewise, the issue of compliance and competence with what can be a highly complicated therapeutic regime may perhaps be seen to be at issue in the pharmacist-patient encounters presented here.

Expanding this discussion a little, Pollner (1987) describes how there are certain things in the world that we take for granted in such a way that if they do not happen in that way we assume that our mind is at fault because we know what the reality is. Quoting from Pollner, "Given our mundane assumptions about the world, persons and perceptions, contradictory experiences of the world - reality disjunctures, as we shall call them - are puzzling events... For practitioners of mundane reason, reality disjunctures are potentially explainable by formulating one or another (and perhaps both) of the competing versions of reality as the product of an exceptional method of

observation, experience or reportage" (Pollner, 1987, p69).

In this way, one of the competing versions of reality may be identified as a product of a 'defective' apparatus, such as poor vision, or a distortive psychological mechanism such as hallucination or imagination. However, the determination of which of the parties to a disjuncture is a 'deficient witness of reality' may be problematic, in the sense that just as one party may say that another has misheard, so the second party may say the same to the first. Resolution, as Pollner describes, thus "often involves a 'politics of experience' in which a group's or individual's experiences (or claims) about reality are dismissed or discounted in favour of what will be regarded as the official or accredited version of reality" (Pollner, 1987, p70).

These definite versions of what the world is like may be derived from commonsense knowledge about the sorts of events which occur in the real world. Pollner uses the example of 'fuzzy road signs' as an illustration; since we know that road signs are typically painted so as to be 'unfuzzy', if we see a fuzzy sign then we conclude that it must be our sight that is at fault. Returning to the data at hand, it is perhaps true to say that in the same way we cannot challenge the advice of health visitors or other health professionals, because to do so calls doubt on our civil status as people who are aware of and acknowledge their warrant to advise. To challenge such advice may be treated as constituting evidence that the challenger does not form part of the same moral universe as 'responsible and reasonable' citizens. In the oncology clinic setting, involving as it does long-term patients and their carers, the acceptance of advice thus invokes not only this 'moral' dimension, but also issues of competence and how this

may be judged.

Accordingly, this chapter will begin by reconsidering the advice giving 'strategies' identified in the previous chapter, concentrating this time on the responses which are received from the patients or carers. As the previous chapter has attempted to illustrate, the ways in which pharmacists attempt to negotiate an entry into the advice giving or informing segment of their consultations is interactionally a very delicate matter, and this delicacy is heightened by the knowledge and competencies that are frequently possessed by the patients and/or carers attending the clinic. This chapter will first attempt to consider the 'entry' strategies outlined previously in terms of patient or client responses to them, and to discuss how these responses equate with the pharmacist's end goal of ensuring that the clinic attenders are in a position of being able to comply with their medication as prescribed. For the moment, the terms 'advice', 'information' and 'instruction' will be used interchangeably, and the term 'pharmacy counselling' will be used as a broader descriptor which covers all three activities. However, what this chapter will then try to do is to consider the differences between these terms as far as the participants are concerned, by drawing on the wider literature which has considered these distinctions and the implications they may have in terms of client responses and/or involvement.

The first strategy for 'entry into advice giving' identified in the previous chapter is one which is unique in the data; a **mother initiated** approach to advice. As has been noted, this approach actually occurs some way in to the consultation, following a period when the pharmacist has been focusing attention on the child.

**Transcript 23:- ds/nc/op (simplified transcript)**

- 1.Ph: Can I just check we've got the right chart there (.) (name)(.) s'that right?  
2.M: Say yes (0.2) [(name) that's me (.) yes  
3.C: [Yes  
4.Ph: Right (1.6) ((looking at chart))  
5.M: Two weeks this week  
6.Ph: Right (0.3) (well) we've only done one week (.) just to ruin it so I'll just change that  
- add another week in (0.4)  
7.Ph: 'cos he only had a week last week didn't [he  
8.M: [Yes yes  
9.Ph: But his counts are fine (.) so we'll just add those in(1.8)  
10.M: ((to child)) You're too much trouble aren't you throwing  
[everybody out ((laughs))  
11.Ph: [ (( laughs))  
12. C: Yeah ((laughs))  
13.M: Dr (name)'s sorted him out today though huhh (.) he showed you your tickle spots didn't he (name)  
14.Ph: ((laughs))

((Child tries to tickle mother))

- 15.M: No (.) I'm not ticklish there  
16.C: ohhhh (0.5) Can I have a high one  
17.M: He wants a special place where I tickled him round there (must be a tickle spot)  
18.Ph: I've got a tickly spot there ((points)) (.) It'll never go away (.) it'll always be ticklish ( )  
19.M: What have they done another 100% (.) I never even looked  
20.Ph: He's on ((looks at chart)) 100% yes cos he had one week of 100% last week ( ) another 2 (0.6) and then if he -your-  
- if his count's alright (.) in 2 weeks (.)he'll have one more week of 100% and then go up to 125 (0.3)  
21.M: Well you're not (.) cos you've been you've been ((unclear)) with his chemo so (0.2)  
22.Ph: Oh right he's coming in for his injections  
23.M: Yes he's had four weeks of tablets  
24.Ph: Yeah  
25.M: ((to child)) (...) At least he hasn't got to come back next week (0.3) It's ages since you had 2 weeks (name)  
26.Ph: ((laughs))  
27.M: ages and ages  
28.Ph: Right then (.) that's it (.) oops

((Unclear exchange between child and mother:- child is asking for money for a drink))

29.Ph: Do you need any Septrin? =

30.M: = Yes please (.) Yes

31.Ph: 5mls? of that one((shows bottle))that's the right one isn't it (0.2)  
[is that the aniseedy one

32.M: [Yes

33.C: [Yes yes

34.Ph: Is that one nice (.) do you prefer that one (.) right

(15 lines at end of consultation, in which pharmacist discusses holiday plans, omitted)

At line 19, then, the mother initiates the advice giving segment of this encounter by asking what "they" (presumably the clinic doctors) have done. Interestingly, this is not a "what do I do?" question, but rather a question about what has been done, and in this case could perhaps be more accurately described as a mother initiated approach to **information**. In this sense it may be interpreted as referring to chemotherapy regimes in a more general sense, rather than specific dosage instructions, and this is certainly the way in which it is treated by the pharmacist. In line 20, then, the pharmacist begins to deliver information about the regime; this information is not limited to answering the mother's question about what is occurring on this occasion, but goes on to suggest the likely course of subsequent events. In actual fact, this prediction is wrong, and is immediately corrected by the mother in the subsequent turn (line 21). Although the correction is done explicitly and with little apparent difficulty, the mother's lexical choice perhaps serves to soften this somewhat. "Well, you're not", which is ostensibly addressed to her child, and the utterance which follows, has the effect of suggesting that while the pharmacist is right in general terms, this child is a 'special' case. The apparent interactional ease with which information is then traded by the pharmacist and mother is perhaps a result of this delineation, avoiding as it does any loss of 'face'. Furthermore, the basic dosage

information which is offered towards the close of this extract (line 31) is delivered by the pharmacist in a much more tentative, questioning fashion than is commonly seen in these consultations, and an agreement rather than an acknowledgement is sought for this utterance. Speculatively, it may be that a *specific* request for information by a patient or carer allows them to subsequently obtain a more 'competent' position within the encounter, since the request itself may necessarily display some degree of knowledge. However, since this is the sole incidence of this type of mother initiated approach within the consultations collected here, it is difficult to draw any firm conclusions.

Almost paradoxically, the 'uniqueness' of this consultation in the corpus of data may be alternatively explained by recourse to Heritage and Lindström's (forthcoming) Health Visiting data. As they note, "Any request for advice constitutes an admission of uncertainty about an appropriate course of action. Such a request may, further, imply or display that its producer lacks knowledge or competence concerning the issue at hand or is unable to cope with a problem without external assistance. By the same token, it constitutes the recipient of the request as the knowledgeable, competent and authoritative party in the exchange. Concerns with these issues of knowledgeability and the 'face' considerations they may raise, may be compounded when the requested advice concerns a baby for whom a mother has a direct responsibility to care in a knowledgeable and competent way, and when the person to whom the request is made may be viewed as someone who stands in judgement on her knowledge and competence in this matter" (Heritage and Lindström, forthcoming).

Whilst pharmacists may not be seen as acting in 'surveillance' of a mother's behaviour to the same extent as Health Visitors, some of the general sentiments of this observation may nonetheless be applicable here. It should be noted that Heritage and Lindström are talking specifically about **advice** in this context, and it has already been noted that what the mother's initial request is seeking here may be more accurately described as information. Nevertheless, the issue of 'being seen to lack knowledge' appears to be important here. This is perhaps most evident in the framing of the initial question (line 19) and its attendant justification for the lack of knowledge. (It is also interesting that the 'they' in this utterance serves to distance both the mother and the pharmacist from any changes that have been made). The manner in which the subsequent information from the pharmacist is received certainly does serve to minimise its usefulness; unfortunately there are no examples of 'correct' responses to such mother initiated approaches which can be compared in terms of response.

The second strategy identified for entry into advice giving is the **basic business transaction**, of which an example is reproduced below (although, as will be seen, it is perhaps paradoxical to term this a strategy for entry into advice, since the pharmacist does not attempt to initiate any kind of advising or informing sequence).

**Transcript 32:- ml/nc/op**

1.Ph:Right (0.6)

2.Ph:Coming back in a week's time (0.3) Right (0.2) have you got plenty of Septrin at home? (.)

or (.) [uhhh

3.F: [We have (.) uh hh better take some more

4.Ph: There's your blister=

5.F: =Ta



(1.0)

6.Ph: There you go (.) There's another bottle for you

7.F: Oh alright (.) thank you

8.Ph: Have fun (.) See you

This approach, delivered in a manner which presupposes patient competence, provides little opportunity for any interactional contribution from the father of the patient other than acknowledgements for the two items of medication which are handed over. The question in line 2, "have you got plenty of Septrin at home", is concerned with matters of supply rather than administration, and is received and treated as such by the father. Thus, although competence with this medication is assumed on the part of the father by the pharmacist, it is never explicitly brought into question or demonstrated. Although theoretically there is some opportunity for the father to raise any questions he might have regarding his son's chemotherapy regime (for example the pause after line 5), this may be problematised by the issues discussed at the beginning of this chapter. If to ask for advice is in itself a delicate activity, framed as it is in this setting by issues of knowledge and competence, then to ask for advice when one is not apparently expected to need it is doubly delicate. Here, since the pharmacist does not inquire as to whether there are any problems, the implication is presumably that there should not be any. However, this issue is never explicitly resolved, and in this sense we (and the pharmacist) are ultimately left unclear as to the actual degree of understanding which exists.

As has been noted previously, these interactions which assume knowledge and competence to this degree are unusual in this corpus of data, which may at least partly be accounted for by the requirements of the Code of Ethics to which

pharmacists subscribe. More usually, some attempt is made to either establish the extent of a patient or carer's knowledge, or to supply advice or information which is deemed to be relevant. The most basic example of the latter strategy can be found in the 'unilateral' approach to advice giving which occurs in the data, and which is illustrated in the encounter below:

**Transcript 5:- eg/op/be (simplified transcript)**

- 1.Ph:(Name)?
- 2.M: hello
- 3.Ph: Right OK(0.3) (Theres) There's your mercaptopurine(0.2)
- 4.M: yeah=
- 5.Ph: =and they've already been halved for you so you're taking j-just one
- 6.Ph: to be given each morning(0.2)
- 7.M: Right
- 8.Ph: and two of those to make the full 45mg [so
- 9.M : [Right so she has
- 10.M: one of them and two of them each morning(0.5)
- 11.Ph: That's right(.)[and the methotrexate just on Wednesdays
- 12.M: [Mmmhmm
- 13.M: Yeah=
- 14.Ph: =OK (1.0)
- 15.M: So that's one(0.2) that's one big'un and one little 'un?
- 16.Ph: That's right(.) one of each
- 17.M: That's great(.) Thanks a lot

Here, then, after establishing the identity of the patient, the pharmacist immediately begins to describe the dosage instructions for the supplied medication. Acknowledgement is sought for each component of these instructions (for example, the pharmacist does not proceed with the next component until she has received the mother's utterance in line 7.) The mother's next acknowledgement, in lines 9-10, takes the form of a resummary of the pharmacist's instructions to that point; this is in turn verified by the pharmacist, who then goes on to introduce the dosage details for the next drug. Following the pause by the pharmacist in line 14, the mother

actually goes on to produce the dosage instructions for this drug herself ("That's one big'un and one little 'un" in line 15"); this candidate statement is correct and is reinforced by the pharmacist.

This encounter then despite its 'unilateral' set up for the delivery of information, leaves us in no doubt at all that the mother has the necessary knowledge to manage the correct medication for her child. Her initial resumption, and her subsequent statement (produced whilst examining the drug bottles), make her understanding clear. However, this understanding is interactionally volunteered by the mother rather than sought by the pharmacist; what the pharmacist explicitly seeks is merely an acknowledgement for her utterances. Evidently, then, such a unilateral set up does not always result in such satisfactory results. Since this approach does not explicitly invite extended participation from the patient or carer, the issue of whether what the pharmacist is imparting is necessary information, together with the issue of the patient or carer's actual knowledge, can remain unresolved. This kind of situation is apparent in the extract below:

**Transcript 6:- ar/op/be (simplified transcript)**

- 1.Ph: Prescription for (name)? ((M approaches)) I've got some Septrin for him here =
- 2.M: =Yeah
- 3.Ph: and you're to give him 7.5ml (.) on Mondays Wednesdays and [Fridays
- 4.M: [Right
- 5.Ph: and you're starting this Friday ok?(0.4) and again we've got some sunblock
- 6.Ph: for him as well(0.2)
- 7.M: Right
- (0.3)
- 8.Ph: When are you due to come back?
- 9.M: Next Wednesday
- 10.Ph: Next Wednesday(0.2) that's fine (0.4) There you go ((puts medication in bag))
- 11.Ph: Thank you very much
- 12.M: 'Bye

Here, the dosage instructions are delivered in a virtually identical manner, and the mother's contributions are limited to the (interactionally required) acknowledgement tokens of "Yeah" and "Right". Her understanding of the details are thus never made explicit; although the pharmacist's utterance in line 5, ending as it does with the question "OK?" is apparently enquiring whether there are any problems with the segment of information previously imparted, this utterance is not taken up by the mother. There is of course the opportunity for repair initiation by a client who has not understood any given details, although it is becoming clear from the data presented thus far that this is rarely used. Thus no 'overt' difficulties are displayed with the mother's understanding. In addition, it has been suggested here that one of the problems with this approach is that the delivery of unsolicited or redundant information may be perceived as an attack on the recipient's competence<sup>5</sup>. Considering the mother's acknowledgement "Right" in line 4, it is interesting to note that this is produced before the completion of the pharmacist's utterance, and as such may be interpreted as an attempt to demonstrate that she knows what is coming next and is in a position to predict the imminent completion of this set of instructions.

Some of the "softer" instances of unilateral entries into advice giving identified in the previous chapter compensate for this problem of constituting competence to some degree, as can be seen in the consultation reproduced below. However, by its nature,

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<sup>5</sup> Although it is difficult to display this in the transcripts presented here, there is sometimes a tangible note of irritation in the acknowledgements of patients or carers who are in receipt of extended, unrequested information regarding dosage details.

this kind of unilateral approach means that the initial advising or informing segment is delivered regardless, and only subsequent details may be tailored to the patient or carer.

**Transcript 25:- sc/nc/op (simplified transcript)**

- 1.Ph: ((Taking drug card from patient)) Thanks  
(2.3)  
2.Ph: Great (.) I don't have to change anything  
3.B: Yeah (.) I don't think so  
4.Ph: No (.) the count's fine  
5.B: Mmmhmm  
(0.6 )  
6.Ph: And you're coming back in a week  
7.B: Monday  
8.Ph: Alright yeah(.) I've given you seven days anyway  
9.B: Yeah  
10.Ph: Because it's-  
                  - it it works out easier (.) but you'll get a new lot on Monday (0.6)  
11.Ph: D'you want some of the Septrin (0.5)  
12.B: Yeah (.) better take some just in case  
13.Ph: Yeah (0.4) well there's that one and that's 7.5ml =  
14.B: = Mmmhmm  
15.Ph: twice a day on Monday Wednesday and Friday (.) is that alright? (0.5) Do  
          you want a bag (Child's name)  
16.C: No thank you  
17.Ph: No [OK  
18.B:       [Alright then ((laughs))  
19.Ph: ((Laughs))  
20.B: Bye  
21.Ph: Bye

In this instance, the informing segment of the encounter is prefaced by a discussion about administrative arrangements and the child's actual condition ("Count's fine") in line 4. The unilateral delivery of the dosage details does not occur until line 13, and is followed in line 15 with the tag question "Is that alright?". Coming as this does at the end of a more general discussion, as well as immediately following the dosage instructions, it may be that this question is intended to provide a more general

opening for further information rather than to simply seek acknowledgement for the previous instruction. In this sense, although the initial information is not made negotiable, the extent to which further information is delivered is. Despite this, no response is forthcoming from the carer (although it is possible that there was some non-verbal signal, for example a nod). Placed as this informing segment is towards the end of the encounter, the previous utterances of the pharmacist have certainly already constituted the carer as someone with some degree of knowledge about clinic jargon and procedures. However, once again the actual understanding of the carer, as demonstrated by his responses, remains unclear. The lack of any kind of repair utterances, or alternatively any extended responses, means that any assessment of understanding must be made on an implicit rather than an explicit basis.

Even within this unilateral format, however, (offering the limited opportunities that it does for invited client participation), patients or carers may try to display their knowledge, possibly to pre-empt further advice giving. Such a display of knowledge is produced at the commencement of the advice-segment in the encounter below.

**Transcript 34:- nq/nc/op (simplified transcript)**

1.Ph: everything goes quiet once the tape goes on

2.M: ((laughs)) Yeah (0.2) I'm not gonna say [yeah ((laughs))

3.Ph: [I make sure I say all my things first  
( )

((Dietician who has been using room previously enters and there is a discussion about the removal of her equipment))

4.D: Do you want me to (0.3)

5.Ph: If possible yeah (.) On a Wednesday afternoon we use this room for dispensing the (0.1) chemotherapy =

6.D: = Oh right (.) Sorry (.) Nobody uhhh (.) told me ((laughs)) let me just take (.) can we just [take

- 7.Ph: [Yeah I'll-  
-I'll leave- I'll leave it with you (.) I'm uhhh getting by as we  
are
- 8.D: Alright let me just [uhhh
- 9.Ph: [Can I just get to that corner ( ) I'll be out your [uhhh
- 10.D: [Yeah sure
- 11.Ph:-I'll keep right out of your way  
(2.3)
- 12.Ph: Right then (0.4) There's the mercaptopurine (0.7) Yeah (.) no problem there  
(.) It's all ready for you (0.3) 5mls and (.) 5mls of each (.)
- 13.M: Yeah (.) yes that's [methotrexate is it yeah
- 14.Ph: [every day
- 15.Ph: Methotrexate just on a Thursday morning
- 16.M: Yeah (.) Yeah
- 17.Ph: Do you want a bag for them (.) [I've got one here
- 18.M: [Please (.) Yes please

(End of consultation, in which the mother jokes about the amount of medication the child is taking and how she manages to "get them down 'im", omitted.)

Here, then, the pharmacist begins the informing segment (and indeed, recommences conversation with the mother), by delivering the dosage details of the first drug, mercaptopurine (lines 12-13). Towards the end of this utterance, however, there is an orientation to a second bottle of medication; having stated the mercaptopurine dose as "5mls" the pharmacist adds "5mls of each". In the subsequent turn the mother acknowledges this; she also goes on to identify the second drug which has not been named by the pharmacist. However, the pharmacist overlaps with this display of knowledge and proceeds to give further, unsolicited information about the dosage frequency of the first drug ("every day") and the second (weekly on Thursdays). This utterance also appears to be misaligned with the mother's, in that while she is referring to a drug, the pharmacist anticipates her interruption as referring to the frequency of administration. The mother's response to this unrequested information is confined to an acknowledgement token, and there is no suggestion from her

response that she has been told anything new or newsworthy. Parenthetically, it is also interesting to note again the use of the statement "no problem there" by the pharmacist, followed by a pause. Theoretically this provides an opportunity for the mother to contribute to the informing agenda; despite the fact that this is not taken up (and the assumption is thus that the mother is in agreement with this assessment), the pharmacist goes on to deliver dosage details regardless. Interactionally, as has been noted, it may be difficult to raise any problems when the presupposition is that there are none to be raised. Thus, this kind of "no problem" statement is bound up with competency in the sense that it appears to carry the presumption that as these are ordinary or routine circumstances, the patient already possesses the necessary knowledge. Paradoxically, this does not prevent the actual delivery of the dosage details. This may be one way in which pharmacists deal with the potential delicacy of the professional requirements of the Code of Ethics, by both constituting knowledge and then proceeding to give information as though it is a shared resource. This idea is perhaps illustrated more clearly in the extract below.

**Transcript 29 :- kj/nc/op (simplified transcript)**

(7 lines omitted in which mother remarks that she had expected to see a different pharmacist; the pharmacist who is present explains that due to holidays, he has been "dumped" with the job).

8.Ph: Yeah "he doesn't mind" (0.2) Mind you they forgot to mention that

9.Ph: I would-

-I'd still be doing my own things as well (0.1) so it's (.) a bit busy

((looks at drug card))

10.Ph: Yeah (.) Just what we expected by the looks of it (.) 75% (.) coming back in  
2 weeks

11.C: Yes



((Pharmacist checks blister pack))

12.M: Are they all there?

13.Ph: Yeah

14.M: Good

15.Ph: Unless any escape before I get the lid on

(1.6)

16.Ph: Have you had a vincristine or is that next week? (.)

17.Ph: That's next [week isn't it (0.3) Oh yeah (.) next time you come

18.M: [Two weeks (.) yeah

19.C: Next time I come

((Pharmacist puts medication in bag))

20.M: Can we have some EMLA please?

21.Ph: Yeah (.) sure

((hands over cream))

22.Ph: There you go (0.2 That's everything isn't [it

23.M: [Have you got any brown bags?

24.Ph: Uhhhm ( ) Yes I have ((hands over bag)) There you go

25.M: Thank you

26.Ph: See you

27.M: [Bye

28.C: [Bye

In line 10, here, the pharmacist's statement "Just what we expected..." displays an orientation to competence (the pause for acknowledgement apparently serving to constitute the patient as part of this "we"). The subsequent dosage information is subsequently delivered in a unilateral fashion ("75%(.) coming back in 2 weeks"), but the set-up is such that this information takes on the characteristics of something that is already known by *both* parties. Thus, the medication details are delivered in a manner which, although it may be producing redundant information, is unlikely to be constituted as an attack on the recipients' competencies. The acknowledgement by the patient in line 11 may be seen as much as an acknowledgement that this was what she was expecting as of the subsequent details. These two utterances constitute the only advising or informing segment of this encounter; the remainder is taken up with

administrative details and a request by the mother for an adjunct medication, EMLA cream<sup>6</sup>.

Summarising this unilateral approach to advice or information, there appear to be a number of important issues. Firstly, as the examples here have attempted to show, although this approach may attend to competency to a greater or lesser degree, it is not specifically tailored to individual competencies. Thus, although the extent of an informing segment may be made negotiable, the initial information is not. Even where competence is explicitly invoked, dosage details are not withheld, but are instead produced as if they are already shared by both parties. Thus, the pharmacist runs the risk of at best providing information which is redundant, and which at worst may be regarded as an attack on the patient or carer's competence in the continued administration of their chemotherapy regime<sup>7</sup>.

In addition, since the only interactional *requirement* of a recipient to these kind of unilateral sequences is a response token (and even such a minimal response is not always actively pursued by the pharmacist), the nature of the responses that are produced tell us little, explicitly, about understanding or uptake of this information.

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<sup>6</sup>EMLA cream is an anaesthetic cream used to prepare the skin for injections such as the vincristine which the patient has stated she is due to receive on her next visit. Although this cream is commonly used with smaller children in the clinic, it would not be clinic policy to offer it to a 13 year old.

<sup>7</sup> Hypothetically, it may be that dosage details of a chemotherapy regime are oriented to on the one hand as something so important, and on the other hand so technical, that they must be repeated on each clinic visit. Perakyla suggests a comparison between the announcement of safety instructions on aeroplanes, where passengers are not asked beforehand if they 'need' this information. However, in the oncology clinic there is also the moral dimension of 'correct' drug administration which has been discussed, which adds complications in that clients seem sometimes to be both 'expected to know' and 'expected to listen'.

Interactionally, a minimal acknowledgement may be all that is required for the sequence to proceed; however, it sheds little light on the degree of the patient's knowledge or indeed their intention to act on the information that they have been given.

Some of the 'problems' attendant on this approach are similar to those discussed previously with regard to the mother-initiated instance of advice giving. As Heritage and Lindstrom note, corresponding issues occur in the Health Visitor data whether advice giving is requested or whether it is volunteered unrequested: "The volunteering of advice may carry with it an assertion of the very same implications about the relative authority and competence of the advice giver and advice recipient that are acknowledged in contexts where the recipient requests advice. And such implications may be the more unwelcome because they are produced by persons whose claims - to knowledge and to rights to judge- may be effectively unchallengeable" (Heritage and Lindström, forthcoming). Thus, despite the apparently smooth manner in which unilateral advice giving appears to proceed interactionally, it has deep implications for the constitution of knowledge and competence of the patient as a property to be assessed by the pharmacist.

In terms of the strategies employed by pharmacists which attempt to provide some kind of grounding for the information to follow, or to explicitly address the issue of giving redundant advice to a greater or lesser degree, perhaps the most basic of these is an announcement, or a **statement of intention** to give advice. This kind of advice-

prefacing is illustrated in the example below.

**Transcript 7: dc/op/be (simplified transcript)**

- 1.Ph: (name)? (0.8) ok [I'll go through it all with you
- 2.M: [Yes
- 3.M: It's alright(.) I know it already
- 4.Ph: Oh(.) yeah(.) I apologise for the bottles but we've had a bit of a delay with the
- 5.Ph: blisters so we've had to put them in [bottles for today
- 6.M : [oh right
- 7.Ph: OK?
- 8.M: yeah(0.2)
- 9.Ph: But all the labels have been (.)have sort of got all the instructions on(0.3)
- 10.M: yeah
- 11.Ph: But I'll just go through it(0.3)the methotrexate(0.2)is those two ((indicates))
- 12.Ph: and you're giving two of the 10mg on Wednesday(.)
- 13.Ph:[the 23rd and the 30th and you're giving one of those(.)
- 14.M: [Yeah(.) and the same with that?
- 15.M: Yeah
- 16.Ph: on the Wednesday (0.3) the mercaptopurine(.)right(.)you've got 3 strengths
- 17.Ph: to make up the total dose that you need
- 18.M:(mmmhmm)
- 19.Ph: and you're giving one of the 50mg uhhh starting tomorrow morning(.)
- 20.M: Yeah
- 21.Ph: and you're giving one of those tablets they've already been halved [so you
- 22.M: [yeah
- 23.Ph: only have to give him one half in the morning(.)
- 24.M: mmmm
- 25.Ph: and three of the 10mg(.) the lower strength
- 26.M: Yeah
- 27.Ph: OK(0.3)
- 28.Ph: The Septrin you're giving one twice a day on Mondays Wednesdays and Fridays
- 29.Ph: and starting on this Friday(0.2)
- 30.M: yeah
- 31.Ph: and the prednisolone (.) it's a 4 day course (.) uhhhm you have to take 9 tablets a
- 32.Ph: day so if you give it like(.)morning midday and evening to give him sort of 9 a
- 33.Ph: tablets a day and it's just the 4 days' worth of those(0.2)
- 34.M: Yeah
- 35.Ph: and he's starting those tomorrow(.)
- 36.M: That's it(0.3)
- 37.Ph: OK(.) is everything(0.4) so when are you due to come back?
- 38.M: uhhh 28th
- 39.Ph: Yeah ((puts medication in bag)) There you go then thank you very much()
- 40.Ph: Bye

41.M: Bye

This is an interesting extract in that in this setting, as in Health Visiting, patients or carers almost never *explicitly* reject either the production of advice or advice itself as redundant. However, "I'll go through it all with you" (line 1) as produced here is a broad statement, which may be heard as attributing no prior knowledge to the mother. Here this offer is reformulated both following the initial rejection and subsequent to an explanation for why this advice may be necessary on this occasion. Once again the reformulation is produced as a statement of intent ("But I'll just go through it" in line 11), and dosage details are subsequently delivered in a unilateral fashion. As has been discussed in the previous chapter, such a statement does not necessarily constitute an offer which may be declined so much as an intention; however, if an advice giving segment were to be intercepted here the same problems of demonstrable versus asserted competence would remain unresolved. What is also clear from this extract is that a statement of intention type arrival into advice giving does not preclude a subsequent unilateral delivery of this advice. This is, in fact, what ensues on this occasion, and the mother's responses are indicative of this.

Considering the mother's responses in detail, these are largely confined to minimal (in some cases barely audible) response tokens such as "Mmhhm" and "yeah". There are two exceptions to this; in the initial segment of dosage details (lines 11-16), the mother attempts to pre-empt the instructions for the second bottle of methotrexate, by asking "Yeah, and the same with that" in line 14. The second extended response occurs at the conclusion of all the dosage details, in line 36, where she states "That's it". It is unclear from the tape, however, whether this is in recognition of the fact that

all the medications she knows her child to take have been described to her, or whether this is a response to some non-verbal cue such as all the bottles having been handed to her.

Thus, although this type of arrival device may appear on the surface to offer a chance for the recipient to refuse the explanation, in practice the somewhat categorical formulations used by pharmacists may make this difficult. The difficulty is, in essence, linked to the extent to which pharmacists attempt to **establish the relevance** of advice giving, since once a recipient is provided with a justification for why advice is necessary on a particular occasion, it is, interactionally, both easier to accept and harder to decline. At the same time, such justifications, which generally revolve around the peculiarity of a particular prescription or circumstance, serve to minimise the possibility that the produced advice may be heard as an attack on competence. This is evident in both of the extracts reproduced below, for different reasons.

#### **Transcript 4 :-sc/op/be (simplified transcript)**

- 1.Ph: (name)?(1.2)[Hi
- 2.M: [hello
- 3.Ph: Well firstly we've got to apologise for the bottles but there's been
- 4.Ph: a delay with the [blisters(0.5)
- 5.M: [oh
- 6.Ph: [so that's why we've
- 7.M: [Yeah so long as it tells you what's(0.2)
- 8.Ph: Yes we've put everything on for you(.)just let me go through it for(.) with you
- 9.Ph: Right (0.3) the mercaptopurine
- 10.M: Yeah
- 11.Ph: 50mg(.) they've already been halved (.)
- 12.M: oh yeah
13. Ph: so you're just giving one each morning starting tomorrow(0.3)
14. M: Right
- 15.Ph: OK?(.) and they're 10mg so you're giving 4 each morning()
- 16.M: yeah
- 17.Ph: starting tomorrow(.) so that'll make up the total dose that he needs

18.M: Right  
19.Ph: OK(.) the methotrexate(.) you're only giving on Wednesdays(.) and of the 2.5mg you're giving three  
20.P: Are they the Wednesday tablets?  
21.Ph: that's right(0.2) they're just Wednesdays  
22.P: I wondered why I got them for [like that  
23.M: [Just on a Wednesday then  
24.Ph: That's right  
25.M: Right  
26.Ph: and they've got the dates on there for you [23rd and the 30th  
27.M: [right(.) right  
28.Ph: uh-hh and the (.) one of the 10mgs to make up the total dose(0.2) [And the=  
29.M: [Yeah  
30.Ph: =Septrin(.) you're giving twice a day on Mondays Wednesdays and [Fridays() starting this Friday OK?  
31.M: [Fridays right (.) can you just mark that with a 1(0.2)  
32.M: just put a mark on it with a 1 and we'll know to give him one of them(0.3)  
33.M: Four of them is it?=  
34.Ph: =yeah  
35.M: I'll put on there (.) one of those(.)four of them  
36.Ph: No there's 3 of those  
37.M: 3(.) put a 3 then  
38.Ph: It says three there as well if you forget but I'll put it in numbers as well  
39.M: 4(.) and that's 1(.) and they have been halved in the bottle(0.4)  
40.Ph: and one of those(0.2)  
41.M: And one of these(.) but that's=  
42.Ph: = Yeah(.) do you understand?  
43.M: yeah(.) I understand that one(.) Yeah yeah that's it  
44.Ph: OK and when are you actually due to come back?  
45.M: Uh-hh(.) the 30th  
46.Ph: In two weeks' time (.) yeah that's right  
47. P: Am I having these ones of a night time?  
48.M: [No() these all start tomorrow don't they  
49.Ph: [No() You're having them on Wednesdays your mam will know when to give them to you  
50. P: I know but it's Wednesday today (.) am I having [them?  
51. M: [no  
52.Ph: [no you're not having  
53.Ph: them today you're starting next week(0.2) OK (.) I'll put them in a bag for you.

((4 lines at end omitted))

In this case, then, the pharmacist begins the encounter by stating that, as there are no blister packs, the medication will be supplied in individual bottles. The mother's

response to this, in line 7 ("Yeah so long as it tells you what's...") is apparently a suggestion that as long as the dosage details are written on each bottle, then this will not be problematic for her. Despite this possible attempt to pre-empt any further instruction, which is in essence a turn at talk which does not make relevant further advice, the pharmacist produces a statement of intention in line 8 ("Just let me go through it"), and proceeds to deliver the dosage details. Parenthetically, this utterance in line 7 may also have a dual function as 'an acceptance of an apology' produced by the pharmacist for the lack of blisters, and in this sense is both retrospective and prospective.

In the initial segment of this encounter (down to line 20), the mother provides basic acknowledgements to each segment of the pharmacist's talk. At line 20, the patient himself interrupts to ask a question about his medication, and for the next few lines becomes the focus of the encounter for both his mother and the pharmacist. From line 26 the pharmacist continues with the delivery of the dosage instructions, until these are complete at line 30. At this point, the mother begins to ask for additional help in co-ordinating the dosage, by asking that the pharmacist mark all the bottles with the number of tablets that are to be given in each dose. (This is despite the fact that all the bottles already have printed dosage labels attached, to which the pharmacist alludes in line 38). It becomes apparent then, that had the mother actually changed the character of the informing segment of this encounter, by stating (at line 7) that the lack of blisters would be fine if all the bottles were labelled, the dosage instructions may in fact have been problematic for her. The end section of this encounter is largely taken up with the additional labelling of these bottles (and some





22.M: Uhh well I do-  
- have to dissolve everything=  
23.Ph: =you have to dissolve everything anyway [Right  
24.M: [laughs  
25.Ph: with the tablets(0.3)  
26.Ph: Right with his Septrin then it's 7.5ml(.) marked on the syringe on there  
27.Ph: you've used one [of those before haven't you to be given twice a day  
28.M: [yes  
29.Ph: Mondays wednesdays and Fridays(.) that's two weeks [so  
30.M: [Mmm  
31.M: do I start that today(.)  
32.Ph: Uhhm start it (.) if you give him a dose tonight if you want and then Friday(.)  
33.Ph: and then carry on Monday Wednesday Friday like that(.)  
34.M: [Mmm  
35.Ph: [OK?(0.6)  
36.M: OK.  
37.Ph: You are coming back in two weeks aren't you(.) That's right (laughs)

(Pharmacist puts medicines in bag)

38.C: Can I put these in?  
39.Ph: Yeah(.) course you can(.) Thank you()  
40.Ph: There you go then (indistinct) [see you  
41.M: [Bye

The relevance for the advice on this occasion is that this is the first time that the patient has attended the clinic, and following the identification sequence, this is the first question that the pharmacist asks the patient's mother. Having established these circumstances, then, the statement "I'll explain it all" by the pharmacist in line 4 takes on the character of a necessity rather than a threat to competence. Following some general information on the organisation of the clinic, the pharmacist begins to give the dosage instructions; the amount of detail in these is clearly greater than in many consultations with more long term patients, and contains an orientation to the fact that this is a "new" patient. Thus the tablets are not only named but described ("small round ones" in line 12), there is an attempt to relate this medication to what the child has been receiving as an inpatient ("his methotrexate which he's been having

weekly") in line 15, and the pharmacist asks about the preference of the child (and mother) in relation to dosage forms (lines 20-21). There is also a check that the mother knows how to use the oral syringe which has been supplied with the Septrin (line 27). Throughout this encounter the mother provides acknowledgements for the items of information she is offered, and at line 31 produces a question about when one medicine should be started. At the conclusion of this information, the pharmacist asks a general question, "ok?" (line 35), and pauses until an acknowledgement, presumably for the entire informing segment, is received.

It can be seen then, from both this and the previous extract, that the statement of intention device can be a useful one in terms of allowing the pharmacist the interactional space to give a prolonged informing sequence to the patient or carer. However, the smooth acceptance of such an intention may be contingent upon establishing the relevance of this advice previously, since this projected relevance helps to bypass the issue of competence to a large degree. Where no such relevance is established, it is easy to see how and why a patient or carer in this setting may respond to a statement such as "I'll go through it all with you" so defensively.

Turning to consider the **questioning** strategies identified in the previous chapter, it is evident that these also establish the relevance for advice giving to some extent, whilst providing a more obvious opportunity for acceptance or declination. This is evident in the transcript below, which again deals with a first time clinic attender.

## Transcript 2 :-kj/op/be (simplified transcript)

- 1.Ph: Prescription for (Name)(0.3) Hiya (.) It's (name)'s first time having blisters isn't it?
2. M: Yes=
- 3.Ph: = Do you want me to just explain it(0.3) [this is a really simple one for her
- 4.M: [Yes if you would
5. Ph: ((to child)) Do you want to come and have a listen?()
- 6.Ph: Right(.) what we do is date each day that you have them and what time OK(.)
- 7.Ph: you're just having the mercap  
-mercaptopurine at the moment aren't you so you've
- 8.Ph: just got one tablet in each one.
- 9.M: Right
- 10.Ph: As you get to have more tablets(.) when she gets into the next stage of the chemotherapy what we do is
- 11.Ph: we put all the tablets for the morning or all the tablets for the evening in a  
12.Ph: specific one(.) [with the day and date on just to make it easier
- 13.M : [I see
- 14.Ph: and I'll just show you how they peel off actually (.) it's alright that one's not
- 15.Ph: needed(0.2)They should tear (.) but it's easier probably if you just peel it all back(.)
- 16.Ph: and the tablet's popped in there [so you can actually see there's a morning
- 17.M: [oh right great
- 18.Ph: lunchtime and evening dose OK?(0.5)
- 19.M: So she's just got every morning [tomorrow morning
- 20.Ph: [ Yes if she takes those either just be-  
we:ll it's best
- 21.Ph: just before breakfast with mercaptopurine(.) and then when's (name) when are you coming back in again?
- 22.M:[Monday
- 23.P: [monday
- 24.Ph: Right(.) I didn't know if she was coming Monday or Tuesday with it being a Bank Holiday so you'll have an extra tablet(.)
- 25.Ph: if you just give it back to the ward that'll be fine
- 26.M: Right
27. Ph: Can I take those() put them in a little bag so you know what you've got
28. M: Thank you very much

In this case the "Do you want me to just explain?" offer is enthusiastically taken up by the mother, providing the pharmacist with the interactional space to give a detailed explanation, not only of the dosage details on this occasion, but also of the blister packaging itself, and how this will work for future prescriptions. The mother's

responses to this information (which she has, in effect, asked for) are rather more extended than basic acknowledgements, for example "I see" in line 13, and "Oh right great" in line 17. In line 19 she goes on to resummarise the dosage advice she has been given by the pharmacist, thus clearly displaying her understanding.

However, although this strategy provides avenues for personalisation and specificity of advice (or the theoretical opportunity for an advice sequence to be rejected as redundant), the issue of stated versus actual competence may still be problematic here. Particularly, the rejection of an offer of an 'explanation' implies that the patient or carer has some knowledge of what that explanation will contain, and is thus in a position to *know* it is redundant. In the extract below, an offer of advice at lines 23-24 is initially rejected, and only subsequently accepted after its reformulation at line 27-28.

#### Transcript 12:-gg/op/be

- 1.Ph: Right (.) first of all I'm sorry but we haven't got any blisters (0.6) they're all stuck somewhere between here and America  
(.)
- C: (looking at mouthwash) I wanted the green one  
(0.5)
- Ph: You want the green one do you not like the (0.5) red one?  
(.)
- C: Mmmm  
(0.6)
- Ph: Right (.) I'll have a word with the technician and we'll get that changed for you th[en
- C: [ow long will it (.) will that be?  
(0.5)
- Ph: Be about two or three minutes=  
C: =Alright I'll have t[hat then  
Ph: [Just let me check we've got some up here just hold on a  
minute (goes to check)  
(2.2)
- C: (into tape recorder) Hello

- (1.5)  
T: You want the gree::n one (0.1) right  
(0.9)  
23.Ph: Won't be long (1.5) (C bangs on tape recorder) oy (laughs) (1.2) Right (0.5)  
Uh:hm (.) do you want me to explain your tablets cos they're not [in blisters  
to you  
25.C: [No:o I  
know what to do  
(0.5)  
27.Ph: You know what to do with them all (1.2) Right so you've got all those ~~four~~  
mercaptapurine (1.1) [Two of them  
29.C: [What do I do take (0.5) two of them and what d' ya  
call it one of them each?  
(0.6)  
Ph: Hold on (.) you take two of the 10mg each morn[ing (0.2)=  
C: [Yeah  
Ph: =that's two of the little ones[ (0.5) two of the 50mg=  
C: [yeah  
Ph: =(0.7) 't's two of those (.) and one of the half tablets it's already  
halved (1.5) o[kay?  
C: [Yeah yeah=yeah=ye'  
Ph: so that makes you a total of 145mg

Since this encounter has already been dealt with in detail in the chapter describing the overall structure of these encounters, only the initial segment will be reconsidered here. The patient's initial rejection of the explanation in line 25 places the pharmacist in a difficult position, since (as the lack of blisters is a one-off occurrence) it is unlikely that the patient actually does know 'what to do'. Having tried again to establish this fact, but receiving no response to this (line 27), the pharmacist begins to deliver the dosage instructions anyway; this action is to an extent facilitated by the patient's subsequent question "What do I do...?" in line 29. What this encounter illustrates then, is that asking the initial question does not guarantee the 'right' answer from a patient or carer, and that the renegotiation of an acceptance for the projected information may be interactionally difficult following an initial refusal.

This issue ties in to the problems described with "General" questions in the previous chapter, in the sense that the patient may not know what it is they need to know (or that the pharmacist feels they should know) unless this is explicitly stated. In the transcript below, the pharmacist has to persist with information-finding activities despite the mother's initial assertion, because this initial assertion tells him nothing about the mother's actual knowledge.

**Transcript 20:- It/E38/ta (simplified transcript)**

((Initial 9 lines, where pharmacist explains that he is not the "usual" pharmacist, but is covering for someone on sick leave, omitted))

10.Ph: Do you know about the medication that (.) he's going to be having?

11.M: Yes she =

12.Ph: = You do

13.M: (name) told us [about

14.Ph: [Yeah fairly strong sort of [ anti sickness tablets

15.M: [Yeah

16.Ph: just in case (..unclear...)

17.M: ((to child)) Yeah please (.) thank you (.) No let go of the gun( ) (...)

18.C: (...unclear)

19.Ph: OK that's fine

20.M: Alright?

21.Ph: Yeah (.) Bye

Thus, in line 14, the pharmacist goes on to tell the mother of the patient about 'the medication that he's going to be having' (despite her assertion that someone else (a nurse) has already told them), largely because it is unclear exactly what they have already been told or know. Interactionally, there is no need for the mother to volunteer this information, subsequent to her response that she has received some information from the nurse. It should be noted, however, that the design of the pharmacist's turn in line 14 accommodates the mother's previous turn, by

acknowledging it before going on to give details about the medication. In this way, perhaps, the response avoids any potential misalignment.

Where "How are things" type questions are used as openers, this issue of needing some knowledge to determine what will be a relevant contribution to the encounter becomes even more acute. In the examples of this type from the previous chapter, at worst no initial response, and at best a non-committal one, is forthcoming from the patient or carer. The latter situation is found in the extract below.

#### **Transcript 21:-sg/E38/ta (simplified transcript)**

((Intravenous drip alarm is bleeping throughout))

1.Ph: How are things then? (1.0)

2.M: OK

3.C: OK

4.M: ((to child)) Come here (0.8)

5.Ph: Have you had the blister packs from us yet? (.)

6.C: [ ( ...unclear)

7.M: [ I don't know uhhhh

8.Ph: The blister packs that we provide you haven't had them yet? (0.4)

9.Ph: Well sometime in the future you'll start to get all your tablets (.) in (.)

10.Ph: Uhhh packs which are specially made out for each day's dosages (.) that'll happen

11.Ph: sometime in the future (.)

12.M: Yeah

13.Ph: It makes it a lot easier for you you know (.) just to administer (.)

14.Ph: each day's drugs or (.) you know (.) you know which day you have got to give which

15.Ph: drugs (.) So we'll tell you all about that when it happens which shouldn't be too (.)

16.Ph: far in the future (.) Right (0.7)

17.M: ((to child- alarm is continuing to bleep) (...Unclear..) If you leave it

18.M: the nurses will come and do it(0.6)

19.Ph: That's fine (.) [OK (.) That's fine

20.M: [Alright

It is worth noting again that there appear to be two issues involved in these



pharmacist/patient/carer consultations: the general state of health of the child and the child's medication. As a general rule, pharmacists do not appear to bring up the former unless it is raised by the patient or carer first, although they will join in enthusiastically (if non-committally) with reports of progress or improvement that are made. It may be that when a pharmacist attempts to move towards the direction of advice giving with the kind of question seen above, the patient or carer is unsure to which of these two variables the question relates. "How are things then?" could just as easily be interpreted as a general question regarding the progress of the child, (and thus not usually a topic pharmacists raise for discussion), as it could be interpreted as specific to the drug treatment. In this sense it fails to achieve a topicalisation of drug administration issues, and the pharmacist is forced to ask another question (at line 5) in order to proceed with the information that he wishes to deliver. (Parenthetically, the mother seems a little bewildered by why this information should be delivered now, and barely responds to its production).

The final variant of the questioning arrival strategy identified in the previous chapter is the "Is that what you were expecting" type question. This differs from the kind of "Just what we were expecting" statements described in terms of a unilateral delivery earlier, in that it both explicitly constitutes the patient or carer as someone with an expectation and provides a clear interactional opportunity for them to agree or disagree with this. In the example below, in line 1 the pharmacist actively pursues an answer from the mother as to whether her expectations correspond with her own; this being the case there is evidently little need for any further explanation. Interestingly, this expectation is initially formulated in terms of the actual regime

rather than specific dosages, and so in terms of the prescription rather than administration. It seems to be assumed that if the carer has an expectation of the prescription, then the dosage details will also be non-problematic, the dosage information that is given here ("4mg" in line 3) is notably truncated.

**Transcript 43:- nq/nc/op (simplified transcript)**

1.Ph: Right (0.3) now is it what we expect (0.4) 100% (0.4) 2 weeks (0.5) Yes?

2.M: Yeah (.) Yeah

3.Ph: 4mg (.) He's had the vincristine (.) ((begins to prepare tablets))  
Right (.)

4.M: What are those in there?

5.Ph: What?

6.M: In there (.) They're not his tablets are they?

7.Ph: Yea:ahhh

8.M: He has syrup

((7 lines omitted in which pharmacist tries to establish how the mistake has been made))

15.Ph: Let me do the Prednisolone

16.M: He has that in tablets (.) all (0.2)

17.Ph: Yea:ahhh (.) Yeah ( ) Hello ((to another child who enters and then leaves))  
(0.6) So the prednisolone is 6 (.) each day

18.M: Yes

19.Ph: (30) and you can start that tonight (.) and then give the next dose tomorrow morning (.)

20.M: How many shall I give him tonight then?

21.Ph: Give him 6 tonight=

22.M: =6 tonight

23.Ph: [It's best to start straight away

24.M: [Right

((End of consultation, in which pharmacist accompanies mother to main pharmacy department in order to dispense medications as syrups, omitted)).

Owing to the circumstances of this encounter, and the fact that the end portion went unrecorded, it is difficult to draw any firm conclusions with regard to the subsequent nature of the advice giving. However, some dosage information is supplied with the

one medication (prednisolone) which the child does receive in tablet form, and the mother asks a specific question with regard to this in line 20. Hypothetically, it may be that the orientation to the mother's perceived competence here makes it less 'delicate' for her to subsequently request information, in the sense that this is one thing that she is unclear about amongst many that she is not. It is important to note however, that this kind of approach device *requires* an initial expectation of the patient or carer in order for them to know whether what is occurring on a particular occasion is different from this. Nevertheless, this kind of strategy displays sensitivity to parental knowledge by serving to reduce any explicit gap of competence between the pharmacist and the patient or carer.

The final 'arrival into advice' strategy identified in the previous chapter is the **collaborative** approach. More complex than the other strategies discussed, and thus potentially more difficult for the pharmacist to bring about successfully, this type of strategy nevertheless provides a means for explicitly negotiating issues of knowledge and competence. At the same time, the responses to these sequences which are received from patients or carers are potentially the most indicative of active involvement in the counselling process. Two of the consultations which were identified as involving this 'collaborative approach' in the previous chapter will be considered in detail here with a focus on patient or carer responses, in an attempt to illustrate how these sequences are brought about.

In the case below, having greeted the patient and her mother, the pharmacist begins by asking a series of questions about the particular medication the child is receiving.

Specific details are packaged in a question form, in a stepwise progressive manner (lines 1-2 initially, and then line 4), and the response received from the mother (in line 5) clearly *displays* her competence, by virtue of stating her actions with the medication.

**Transcript 15:- jm/E38/ta (simplified transcript)**

- 1.Ph: The magnesium glycerophosphate(.) the nurse was saying that you're giving
  - 2.Ph: them now is that right?(0.3)
  - 3.M: Yes
  - 4.Ph: Right(.) are you alright with them (.) just half a tablet?(0.2)
  - 5.M: Yeah(.) I just dissolve it and put it down the nasal tube
  - 6.Ph: That's OK then (0.2) Is she going to be on them for much longer?(0.6)
  - 7.Ph: She's not is she?
  - 8.M: No idea(.) no one's said to me(0.5)
  - 9.Ph: Mmmm (.) it's just that somebody's written "two more days".() I don't know
  - 10.Ph: what that's about (0.7)
  - 11.Ph: (to child) Hello (.) you're looking a bit fed up.
  - 12.M: She's got a tantrum() she keeps putting that (unclear...) [((laughs))
  - 13.Ph: [((laughs))
  - 14.Ph: Do you know if she's having her chemo today?
  - 15.M: Hopefully =
  - 16.Ph: =Hopefully they are giving it today(.) [right (0.5)
  - 17.M: [yeah
  - 18.Ph:The ondansetron (.) do you give it as a liquid or? (0.2)
  - 19.M: They usually put it through a line
  - 20.Ph: Oh right(.) (That's OK then)
- ((Both laugh at child who has put bedpan on head))
- 21.Ph: Right that's it then (.) Bye
  - 22.M: Thanks(.) Bye

As previously noted, in the course of this encounter the pharmacist packages her questions in such a way that they invoke filling a gap in knowledge for her, in the sense of "These are things I need to know from you". Thus, in line 14, "Do you know if she's having her chemo today?" is (in terms of the actual filling of a

knowledge gap for the pharmacist) an unnecessary question, since she is holding in her hand a drug card that states that the chemotherapy is due to start today. It seems more likely that this is an attempt to topicalise any issues or problems that the mother may wish to raise regarding the chemotherapy medication. The pharmacist's final question, in line 18, is, like the first, directed at establishing the mother's competence with the administration of a particular drug (ondansetron). This question actively invites a response from the mother which will make explicit her administration strategy. Once again, the mother *displays* her understanding in her response, by stating that 'they' (in this case the nurses) are giving this particular drug intravenously. Thus, the responses received from the mother of the patient in this encounter are extended, clearly display rather than assert competence, and are indicative of an active involvement in the advice giving process.

A similar kind of set up can be seen to produce similar results in the consultation reproduced below.

**Transcript 14:- ps/E38/ta (simplified transcript)**

- 1.Ph: So(.) are you having any problems with [the morphine?
- 2.M: [the morphine () Oh no (.)
- 3.M: no he () tends to (.) you know(0.3)The other it takes too(0.3) I-  
-You know(.)
- 4.M: if he's in a lot of pain he can't do his physio work(0.5)
- 5.Ph: Right(.) [OK
- 6.M: [But you know(.) it seems to control it(.) at least he gets you know
- 7.M: sleep at night [which you don't very often get()
- 8.Ph: [he gets (.) yeah ((laughs))
- 9.Ph: it means [you get a decent night's sleep as well ((laughs))
- 10.M: [he hasn't got to (0.3 ) yeah (.) yeah(.) Yes
- 11.Ph: And he's not having much breakthrough at all is he? (0.3) I mean he's not
- 12.Ph: having much of the liquid at all?(0.2)

13.M: No [ no no (.) That's right (.) it's just morphine  
14.Ph: [He's alright with what he's on then(0.4) Right  
15.Ph: The other thing is (.) is he OK?() he's alright with tablets and everything isn't  
he?(0.2)  
16.M: Yeah (.) yeah  
17.Ph: And his lactulose (.) is he going to the loo alright?(0.2)  
18.M: [yes  
19.Ph: [Because morphine can cause a bit of constipation sometimes(.)  
20.M: Yeah well they did give us some medicine for that which he takes(0.2)  
21.M: but I've cut it down to once a day because he does [go easily  
22.Ph: [Yeah he's  
23.Ph: alright with [that?  
24.M: [so yeah(.) I didn't want to cause him to have you know(0.2)  
25.M: [diarrhoea or anything (.) yeah  
26.Ph: [To go to the loo all day  
27.M: so yeah(.) he just has it once a day  
28.Ph: And when are you going home?  
29.M: Uhhhm I'm not sure() I think they're trying to get us home for the weekend.  
30.Ph: Right.((Exchange of patient's address follows in order to dispense Rx))  
31.Ph: That's great(.) thanks very much  
32.M: Thank you

Once again, the pharmacist begins by establishing relevance and identifying a particular topic for discussion (the administration of a particular drug, morphine, which as noted previously, can prove problematic in paediatric patients). Interestingly here, the mother does not initially respond to this question as one about administration, but talks generally about the drug in comparison to "the other", the analgesic that her child was receiving previously, and how it has contributed to the general well being of her child. By means of further stepwise questions (in lines 11 and 12), the pharmacist specifies more directly the issue with which she is concerned, namely whether the dose of morphine that has been prescribed is sufficient to obviate the need for any other analgesia. The mother's response to this (in line 13) makes it clear that she has understood the aim of this question, stating that it is "just morphine" that her child is receiving.

Following a check that the patient is able to swallow tablets (line 15), the pharmacist then topicalises an issue related to the morphine administration. Knowing from the drug card that the patient has been prescribed a laxative (lactulose), she asks a question about this (in line 17); this question is followed by her explanation for asking it (line 19). The mother's response to this not only displays her understanding, but also sets out the practices which she has developed to deal with this, ie tailoring the dosage of the medication herself. This discussion of her actions is followed by her own explanation: "I didn't want to cause him to have you know ( ) diarrhoea or anything", with which assessment the pharmacist joins in and collaborates. The final segment of the interaction (line 28 onwards) is taken up with the pharmacist establishing the necessary administrative details to dispense the patient's medication ready for his imminent discharge from hospital.

Not only does the mother in this encounter actively demonstrate her competence with regard to dosage and administration, but she also shares her 'coping' practices with the pharmacist. She is evidently actively involved in the consultation, and the apparent result is that a course of action is apparently negotiated between both parties, rather than imposed by one on the other. It is in this sense that this kind of collaborative strategy may be described as the most 'successful' of all those identified, in terms of both achieving the end goal of the pharmacist and overcoming the attendant difficulties of patient or carer knowledgeability and competence.

So far, little consideration has been given to the choices which pharmacists make in selecting one or other of these advising or informing strategies, or the reasons why

one approach may be used in a particular situation or to deal with particular contingencies. Examining the data as a whole, there do seem to be some identifiable features which appear to invoke the relevance of one particular 'advice strategy' over another. The 'collaborative' strategy, for example, appears to be particularly relevant in cases where the administration of chemotherapy drugs involves a non-routine practice or practices. By contrast, the 'unilateral' approach seems to occur where dosage details are routine, and where they may have been imparted to the patient or carer on many previous occasions. 'Statements of intent' in this setting appear largely to relate to particular contingencies, such as the lack of blister packaging or the fact that a patient is receiving maintenance therapy for the first time. However, these are intended as preliminary observations rather than firm conclusions, as an attempt to begin to consider whether there are some relevant features of a consultation that make one advice giving 'strategy' more useful or applicable than another.

Having reconsidered the advice giving strategies outlined in the previous chapter in terms of client responses, the second half of this chapter will attempt to evaluate these in terms of the wider CA literature, and particularly in terms of the distinctions that have been made there between advice and information. As can be seen from the consultations presented thus far, "patient counselling" by pharmacists in this setting is an activity that largely consists of making statements to clients or patients about what should be done or how one should act in the future, for example the way in which a particular drug should be administered. As such, it is possible that it may be set up in a normative, non-normative or directive fashion. Likewise, it may be produced and treated as advice or information by the participants without this



distinction being problematic in the interaction. In health education terms, however, the perceived technical differences between the two formats can be construed as a problem, particularly with regard to instigating behavioural change. In addition, requesting advice may be seen as an admission of uncertainty regarding a particular course of action in a way that requesting general information is not. As such, issues surrounding the broad activity of "counselling" in a health care setting have been the focus of several widely circulated CA analyses.

In considering advice and information, these analyses have made clear distinctions between the two. Heritage and Sefi (1992), in their work on Health Visiting, suggest that information is put across in a factual, or non-normative framework, eg "Babies need x number of feeds a day" whereas advice has a normative, almost moral dimension describing certain courses of action, eg "If it were my baby I would...". Their definition of advice is deliberately broad, and focuses on the Health Visitor 'forwarding' or promoting a possible future course of action. Based on this, Silverman and others have gone on to draw further distinctions between advice and information, using data collected from HIV counselling sessions. These distinctions have centred around the perceptions of members and observers, alongside the identification of specific features of advice giving. Thus he suggests that non-specific, non-personalised talk is likely to be produced and treated as information, as in the extract below:

eg (Silverman, Perakyla and Bor, 1992)

173 C: as far as sex is concerned it means keeping to the safer

174 sex guidelines  
175 P:[hmm  
176 C:[for two reasons (0.5) firstly to try and prevent them  
177 passing it on to anyone else  
178 P: hmm

Here the counsellor is seen by Silverman to be producing information rather than advice; the form of delivery is non-specific and non-personal. The patient is also seen to be treating the utterances as information by confining himself to minimal response tokens and thus avoiding any direct implication in future lines of action suggested by the counsellor.

Conversely, advice is personal and specific; Silverman states that "there is a clear correlation between the way in which an advice sequence is set up and the response which it generates" (Silverman, Bor, Miller, et al 1992 p178) , so that the uptake of advice is much greater where problems are specified in a stepwise manner. Advice can thus be recipient designed, avoiding the problems of blame attribution for lack of knowledge. Successful as these factors appear to be in promoting the uptake of items presented to a recipient, the distinction being made here between advice and information seems at least in part to be pre-defined. Accounting for the differences between degree of uptake in a number of consultations, Silverman et al state that "The answer seems to be that in the Information-Delivery Format, unlike the Advice-Giving Format, patients are only interactionally required to give response tokens or unmarked acknowledgements." (Silverman, Bor, Miller, et al, 1992 p184). Thus it seems that rather than describing what the clients are actually orienting to, the differences are largely denoted by form, from impersonal, unsuccessful information

through to personal, stepwise, successful advice. In other words, each of these forms are reasonably and plausibly shown to receive different types of response, and these types of response are then proposed to display a particular understanding of the prior utterance, for example that it was information. However, it is unclear what relationship these interpretations have to those of the participants themselves.

Other analysts considering this problem have made different distinctions to those suggested by Silverman. Returning to Heritage and Sefi, in their work on Health Visiting, minimal response tokens on the part of the recipient are assumed to represent unmarked acknowledgement of *advice*;

eg: Heritage and Sefi 1992

- 1 HV: 'hh No always be ve:ry ve:ry qui:et at
- 2 ni:gh[t. 'hh
- 3 M: [Mm
- 4 (.)
- 5 HV: Always uhm (0.4) on-have a dim li:ght,
- 6 M: Yeh.

and for Robinson and Dingwall (1990) , also looking at Health Visiting, these kind of responses imply simply that the client does not know how to respond to the preceding turn. Considering these different interpretations, it is hard to see interactionally how Heritage and Sefi's response-as-unmarked-acknowledgement-of-advice differs from Silverman's response-as-receipt-of-information. It seems plausible that the presence of these minimal reprise tokens does not necessarily indicate that something is being heard as information or advice, but simply that however it is being heard there is a lack of stated commitment to any action based upon it.

These kind of considerations highlight serious problems with analyses working with a priori definitions based on the form of delivery. They also raise the issue of how textbook and technical definitions of advice relate to the vernacular definitions used by members. As suggested earlier, a common perception is that information does not necessarily have any implication for what a client goes on to do in the future, and so to this extent, in terms of counselling, there is a difficulty. However, since within a counselling session of any kind the only indication that someone has any commitment to act on something is given by their response, it is to the responses of clients we should look for any meaningful distinctions.

Accordingly, the approach used to analyze the data presented here draws on Heritage and Sefi's concept of normative and non-normative dimensions of information delivery. In so doing, it tries to consider any distinctions as a members' phenomenon, in terms of how utterances are set up and responded to. In other words, the basis for the analysis is that the only valid distinction that can be made between "information" and "advice" is a members' distinction.

In the data from the pharmacy paediatric oncology outpatient clinic, it can be seen that pharmacists tend to set up all their consultations as non-normative, or even directive<sup>8</sup>, eg

**6/ar/op/be**

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<sup>8</sup> Non-normative in the sense that there is no apparent presentation of either 'better' or 'worse' alternatives and so no explicit involvement of any moral dimension; directive in the sense that items are set up as factual instructions to be obeyed as they stand.

- 1.Ph: Prescription for (name) ( ) I've got some Septrin for him here=  
 2.M: =Yeah  
 3.Ph: and you're to give him 7.5ml( ) on Mondays Wednesdays and [Fridays  
 4.M: [Right

where in line 3 the dosage instructions are produced as a statement of fact.

This factual set up probably arises from the fact that in other environments such as HIV counselling, there is more choice in better and poorer ways of behaving, as opposed to one "right" and infinite "wrong" ways of taking a particular course of medication. Since many of the clinic chemotherapy patients are longstanding, extended details are unnecessary on a lot of occasions, making it interactionally more difficult to set up the kind of normative advice sequences described by Heritage and Sefi. A statement of the "If I were you I would do this..." type is, obviously, far less appropriate to the parents of a child who has been receiving long term chemotherapy than to a new mother who has just brought her baby home from hospital. What are prevalent are utterances containing personalization and specification, two of the characteristics Silverman describes as inherent in talk likely to be constituted as advice. However, even with near-identical interactional set-ups in terms of patient specific, non-normative packaging of details, these utterances are received in a variety of ways. These range from basic response tokens, eg:

11//sg/op/be

- 8 Ph:Right he's got to have( )his mercaptopurine( ) (find the tablets for you) he  
 has  
 9 45mg a day(so you need to give this each morning( )it's one half a tablet()  
 10 we've already halved the tablets for you there=  
 11 M: =Mmmhmm

- 12 Ph:of that and two of the small one-  
-small round ones
- 13 Ph:each morning( )starting tomorrow morning( )
- 14 M: Mmmm

through to utterances where the parent resummarises the details given by the pharmacist, eg:

### **5/eg/op/be**

- 3 Ph:Right OK( )(There's)There's your mercaptopurine( )
- 4 M: Yeah
- 5 Ph:and they've already been halved for you so you're taking j-just one
- 6 Ph:to be given each morning()
- 7 M: Right
- 8 Ph:and two of those to make the full 45mg [so
- 9 M: [Right so she has
- 10 M:one of them and two of them each morning( )

(where in lines 9 and 10 the mother produces a repeat of the instructions which have been given over both the pharmacist's previous turns), and below, where, after some intervening talk, the mother produces a resummary in line 39.

### **16/lsm/e38/ta**

- 30 Ph:And then there's nystatin(.)he's supposed to hold that in his mouth
- 31 :and swallow( )the yellowy one(.)I don't think they've actually given
- 32 :him that one yet but I'm sure (name) will explain it all to you when it comes( )
- 33 M:Yeah(.) When's that going to be starting?
- 34 Ph:It looks as though he's written it up yesterday ((indicates card))
- 35 so it should start sometime today( ) It's better to use them both together()
- 36 M: ((Laughs)) It's alright if he knows he can spit it straight out but if
- 37 he knows he's got to hold it in there might be a few problems
- 38 Ph:((Laughs)) Well if you can do that after mealtimes it works more effectively
- 39 M: So basically we do that one first(.)and then that one?

In each of these cases, the responses do not openly treat the pharmacist's utterances as normative in the sense of involving choices or opinions about alternative courses of action. However, they do differ in important respects. The minimal response tokens seen in Extract 11 merely assert understanding, while the kind of summary displayed in Extracts 5 and 16 actually demonstrates this understanding. In this sense, such a summary is the strongest form of acknowledgement interactionally available to the recipient. Significantly, an action component is included in both resummaries presented here, in the sense that some kind of action is proposed for the future:

"So she has one of them and two of them each morning" and "We do that one first and then this one". This is arguably as close as it is possible to get to an interactional demonstration of both understanding and commitment to future action.

Thus far, the discussion here has been confined to the distinctions made in the literature between advice and information. However, as has already been noted at the outset, the 'counselling' done by pharmacists is of a very different order to that done, for example, by counsellors connected with a HIV testing service. In some senses, pharmacy counselling appears to bear more resemblance to conversational sequences of instruction described in the CA literature, rather than counselling in its broader sense. As Goldberg (1975) notes, "A set of instructions...is commonly broken down into its smaller component parts, each of which is delivered one-at-a-time over a series of sequentially placed turns" (Goldberg 1975, p273). The recipient is not inactive in this activity, but will commonly repeat the instruction or utter a response token such as "Okay" or "Mhmm". Returning to the example of a previous consultation which was noted for its unilateral, directive nature, it is easy to see this

kind of structure in the interaction.

### **Transcript 6:- ar/op/be**

- 1.Ph: Prescription for (name)? () I've got some Septrin for him here=
- 2.M: =Yeah
- 3.Ph: and you're to give him 7.5ml () on Mondays Wednesdays and [Fridays
- 4.M: [Right
- 5.Ph: and you're starting this Friday ok?() and again we've got some sunblock
- 6.Ph: for him as well()
- 7.M: Right
- 8.Ph: When are you due to come back?
- 9.M: Next Wednesday
- 10.Ph: Next Wednesday() that's fine () There you go ((puts medication in bag))
- 11.Ph: Thank you very much
- 12.M: 'Bye

Goldberg suggests that, besides producing an Instructional portion in uttering the instruction, the Instructor's utterance also stands as an Action, and that this Action selects some next Action for its recipient, namely a Recipient Utterance. In the sense that the Instruction Action can "trigger" a recipient action, she suggests a methodic relationship between the two utterances. This kind of "methodic relationship" appears evident in the encounter presented above (and in others, particularly in the 'dosage details' section of the interactions which occur with what has been described as the 'unilateral' approach to delivery). In the extract above, each component of the dosage details are receipted by the mother before the pharmacist proceeds to the next. In this sense, as Goldberg describes, each Instruction and its Receipt form an Utterance Pair. It follows that non-occurrence of a receipt marker is consequential to the course of the interaction, since one Instruction-Receipt pair should preferably be completed before procedure to the next. This interactional requirement for 'receipt marking' can on occasion (although not always) be seen to be actively pursued by the pharmacist, as below.



**Transcript 11:- sg/nc/op**

32 Ph: give him a dose tonight if you want and then Friday  
33 (.)and then carry on Monday Wednesday Friday like that(.)  
34 M: [mmm  
35 Ph:[Ok?  
(0.6)  
36 M: Ok

Here the pharmacist clearly elicits a response from the mother before proceeding with the interaction, and her contribution is explicitly invited by the "ok" in line 35. However, this receipt marking is not always pursued, and even when it is no response may be forthcoming, as in the example below.

**Transcript 25:- mh/nc/op**

15 Ph: Twice a day on Monday Wednesday Friday(.)Is that alright?  
(0.5)  
16 Ph: Do you want a bag?

According to Goldberg, appropriate receipt responses may include 'continuation markers' such as "Mmhhm", and repetitions or end partial repetitions of the previous utterance. It follows, therefore, that an appropriate interactional response to something which is set up and received as an instruction sequence may not tell us very much about the nature of a recipient's understanding. The sorts of resources a recipient can use to **show** rather than **claim** competence are limited; Goldberg uses the example of transformations, for example "one fourth" instead of the original "a quarter".

It should perhaps be noted that, in the case of Goldberg's data, recipients are being given instructions that they have specifically **requested**, (by means of ringing in to

a radio cookery programme). It may be that in general terms, participants to an instruction sequence take for granted the goal of an activity, in the sense that one party will tell another how to accomplish a particular task. In contrast, the aim of an advice giving sequence may be better described as one party suggesting a 'preferable' or 'possible' course of action rather than a definitive one. As has been noted, one of the characteristics of dosage instructions in this setting is that they are intended to constitute a specific and definitive type of administration, rather than suggesting a possible method. In addition, the fact that patients or carers in this setting have not (generally) asked for the delivery of these instructions may have some bearing on the minimal, and sometimes non-existent, acknowledgements that are seen here. Just as the goal of Goldberg's instruction recipients may be assumed to be, for example, the baking of a cake they have requested the recipe for, so it is reasonable to presume that the goal of patients or carers here is to complete their chemotherapy regimes as directed. However, the fact that the same instructions may be delivered to them repeatedly, and regardless of whether they have been requested, may account for some of the apparent differences in commitment by the recipients across the two settings.

It is also important to note here that the shape of the interaction does not have to be conclusively defined by the initial response of the patient. Whilst an utterance may be accepted as advice or information by a recipient, who may either assert or demonstrate understanding, the first speaker may not necessarily accept this response but may hold the second speaker to account. The important factor interactionally is whether such responses are hearable as accountably (ie deliberately or motivatedly)

disattending advice which has been offered. As has been demonstrated here, an unmarked acknowledgement is a legitimate response to an (often sustained) act of informing or instructing; while it may disattend its character as advice it does so unaccountably. Thus, the important difference is whether any disattention can be heard as accountable by the informing or advising party.

Judging by the data presented here, it does not appear that these interpretations are treated as problematic in pharmacy counselling. All of the responses, from the most minimal acknowledgement through to a resumption, are generally treated as adequate by the pharmacist (although *some* response may be actively pursued). Rarely, if ever, does a pharmacist treat a minimal acknowledgement as problematic. Of course, there are interactional difficulties in pursuing such a minimal response; it constitutes a challenge to the stated competence of the patient or carer which may, in any case, be adequate. The problem that remains is how asserted understanding relates to actual understanding, so that the pharmacist may be left in doubt as to what the patient actually knows. In other situations, however, more "third turn" activity might be expected following a minimal initial response irrespective of what it is seen to constitute. Ultimately then, the interpretation of an utterance does not just lie in the hands of the respondent, but may be actively negotiated by both participants.

This section began by suggesting that while Silverman's work offers many insights into the counselling process, there appear to be some problems with his distinction between advice and information. The kind of approach adopted here offers a different

way forward, in that it avoids imposing *a priori* definitions of advice and information. Instead, an attempt has been made to adopt a descriptive approach, explicating the practices used by the participants themselves. Whilst the majority of encounters are set up within a non-normative, or factual framework, this does not appear to be treated as problematic by the patients or their carers. Instead, within this set up clients exhibit a range of responses which show considerable variation in uptake. To an extent what Silverman's distinction seems to hinge on is that advice giving requires strong interactional uptake to persist over several turns. A lack of this uptake means, for Silverman, that an utterance has been treated as information. In terms of this approach, however, minimal uptake does not imply that an utterance has not been heard as advice; merely that it has been interactionally minimized, rejected or dismissed by the client.

It is important to note, however, that there are significant differences between the data presented in Silverman's work and the data collected and presented here. In the oncology clinic data, the clients are all already members of a particular group (cancer patients and their carers), whereas the participants in Silverman's pre-HIV test counselling sessions may or may not be a member of a particular group (HIV positive persons), or may not be at present but may be about to become so. This means that there are potentially different implications involved; for example the possibility of hearing something that is produced as a general statement about members of a class as personal by virtue of belonging to that class. Specifically, actual language can be explicit in promoting a course of action, or it can promote an action implicitly by use of factual generalisation.

However, in terms of Silverman's distinction between personalised advice and generalised information, the former relates to a specific person and the latter more generally to "people in a class". By knowing that a person is a member of a particular class, then, it may be possible to target that class generally and still produce an utterance that is heard to be personal.

Professionals in any service encounter may package details as normative or non-normative, as fact or opinion, and there are a range of responses that may be forthcoming to both approaches. Thus fact may be treated as opinion, and normative statements may receive only a very minimal acknowledgement. Unfortunately for the professional, only some of these responses will actually indicate that the client has taken on board what has been said.

As Jefferson and Lee (1992) note, in their work on troubles telling, "acceptance or rejection (of advice) may be in great part an interactional matter, produced by reference to the current talk, more or less independent of any intention to use it, or its actual subsequent use" (Jefferson and Lee, 1992, p531). Acknowledgements of advice are, as Heritage suggests, a "servo-mechanism" in Schegloff's (1988) sense of the word<sup>9</sup>. Alternative ways of talking, or in this case reacting, are often not treated by the participants to an interaction as equivalent. Interactionally, this becomes apparent when an advice recipient is 'steered' into a proper acknowledgement by the deliverer. Where this does not occur (and in this setting it occurs very rarely), the nature of the understanding of the recipient, and further the intention of the recipient

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<sup>9</sup>Shegloff describes a "virtual servo-mechanism" as a device like a thermostat which senses the current state of a relevant variable, compares it with the target value registered in another component, and initiates action to bring the former into alignment with the latter.

to act upon the content of the utterances they have received, remains unclear. It would be interesting to consider how other types of professionals deal with this dilemma.

## **Chapter 7**

### **"WHEN ARE YOU DUE TO COME BACK THEN?": EXITS FROM ADVICE GIVING AND CLOSINGS**

Having used the previous chapters to consider the process of "patient counselling" by pharmacists in this setting, and the ways in which these sequences may be set up, this chapter will have as its focus the 'exits' from advice giving and closings that occur at the end of the pharmacist/patient/carer encounter in the oncology clinic. Beginning with a general consideration of closings as an interactional phenomenon, the analysis will then move on to examine particular practices which are relevant in this setting, in an attempt to suggest both how and why these practices are used here. The institutional nature of the setting is one factor which seems highly likely to have a significant influence on the closing devices which are employed by the participants to these encounters; however, it is important to remember that these are interactions-in-a-series, where one clinic visit presupposes a next within a relatively short period of time. Additionally, the knowledge and competence of the patients or carers in this setting (which exerts a pervasive influence on the segments of the interaction described so far) appears to be a relevant issue in these terminal stages of the encounters. All of these factors, then, have implications for the exchanges which occur.

It has already been noted that the hospital pharmacist/patient interaction does not have the natural end point of, for example, a clinical diagnosis or prescription writing; equally the problem proposal which generally indicates the start of a physician/patient encounter may not be present. To a certain extent then, where the encounters end remains to be negotiated, in the sense that although they are ultimately time limited, they lack a fixed duration. This is in marked contrast to Clayman's analysis of closings focusing on live news interviews, where he suggests that "Social interactions



can be distinguished by the degree to which their temporal length is locally variable or predetermined." (Clayman 1989 p659). Live news interviews are in one sense an extreme example of how an encounter is brought to a close at a pre-specified time, but Clayman generalises the observation, stating that "Across a range of settings, interactional occasions have varying degrees of constraint placed on their overall lengths." Even casual social encounters are described as having a loosely defined normative length; Clayman gives the example of "leaving too early" to illustrate this. However, since casual social encounters are relatively flexible in this regard (which is suggested as the defining characteristic which makes them informal), where they end remains to be negotiated by the participants. In contrast, Clayman suggests that encounters in institutional settings have a comparatively rigid duration. Whilst it is true that some professional service encounters have a standard length that is substantially determined in advance this does not seem to be apparent in the oncology clinic interactions, where the overall length of consultations varies substantially. As a corollary to this, Clayman suggests that this standard length usually represents a time that the interaction should fill in addition to a time it should not extend beyond; this also does not appear to be of overwhelming relevance in the data collected and presented here, as the "business transaction" type encounters described in the previous chapter illustrate. The brief (but not seemingly abrupt) nature of encounters such as the one below, suggests that the pharmacist and carer are not orienting to any notion of a "minimum time" to be spent in consultation:

**Transcript 32:- ml/nc/op (simplified transcript)**

1. Ph:Right  
(0.6)

2. Ph: Coming back in a week's time(0.3)Right(0.2)have you got plenty of Septrin at home? (.) or (.) [uhhh
3. F: [We have (.) uhhh better take some more
4. Ph: There's your blister=
5. F: =Ta  
(1.0)
6. Ph: There you go (.) There's another bottle for you
7. F: Oh alright (.) thank you
8. Ph: Have fun (.) See you
9. F: Bye

Thus it is interesting that Clayman develops this analysis further by stating:

"Moreover, the existence of fixed boundaries is in part what gives an encounter its institutional character; it is because the encounter must end at a fixed time that the participants can 'feel' the

constraining force of the environing institution".(Clayman 1989 p662). Whilst the clinic encounters as a whole display many features which are commonly described in "institutional talk", it would be difficult to demonstrate in this data that time is a primary factor in bringing this about. There does, however, appear to be a relationship between the duration of the encounters (in terms of chronological time) and the tasks which are to be accomplished, in the sense that the encounters focus largely around the pre-determined task of handing over the medication, and hence they must last until this has been done. Thus, it is not intended to suggest that the duration of these encounters is entirely free and informal, but rather that any boundaries are task rather than time oriented.

Returning more generally to closings, Schegloff and Sacks (1974) suggest that there are two major problems in bringing an encounter to a close: firstly to do so in a way

that is recognisable as a closing, and secondly to produce a terminal exchange. In order to achieve this, a warrant is needed for preclosing; they suggest that "passing turns" such as "Well" and "OK" serve this purpose. These turns are in themselves devoid of topical content; the participants are declining to add anything of substance to the conversation. Thus, if each speaker passes a turn, they are jointly proposing that the conversational business has been exhausted, and a terminal exchange may be appropriately initiated. Such a "straightforward" closing is common in the data, as is illustrated by the extracts below:

**Transcript 38:- jb/nc/op (simplified transcript)**

98. Ph: and 2.9 of the [other (.) of the mercaptopurine  
99. M: [OK of the ( )  
100. M: Thank you  
101. Ph: And you're OK for Septrin?  
102. M: Yes  
103. Ph: Alright  
(1.6)  
104. M: Thanks very much then=  
105. Ph: =OK then  
106. M: Bye  
107. Ph: Ta-ta

In lines 102-104 above, the preceding topic (having enough Septrin) is dealt with, and both participants decline to initiate any new topics. The pharmacist's utterance at line 105, "OK then", allows the mother to respond with the first part of a terminal exchange, and in this way a move from pre-closing to closing is completed. In the above example, then, both participants align fairly immediately with the closing; in other cases the pre-closings may persist over several turns, as below:

**Transcript 37:- sk/nc/op (simplified transcript)**

47. Ph: Right so that's it (.) Do you need any more Septrin Oh no it's already in there isn't it (.) Yeah it will be
48. M: Yeah cos =
49. Ph: =That's fine  
(0.8)
50. M: Alright  
(0.5)
51. Ph: That's everything you need
52. M: Right
53. Ph: OK
54. M: Thank you then
55. Ph: See you then
56. C: Thanks a [lot
57. M: [Bye

In this case the initial "passing turn" sequence (lines 49-50) fails to lead directly into a closing; following a pause, the fact that the "core business" of the encounter is over is emphasised by the pharmacist in line 51, with the statement "That's everything you need". This is followed by a further passing turn sequence (lines 52-54), before a terminal exchange component is produced in line 55. It is perhaps a feature of the uncertain length of the encounters that there are several examples of pharmacists producing more directive variants on the commonly used pre-closing exchanges such as "Right" and "Well", as below;

**Transcript 22: kj/nc/op (simplified transcript)**

20. Ph: Right then [that's it
21. M: [Ok then
22. Ph: There [you go
23. M: [Thanks very much then
24. Ph: Thank you-  
- Oh EMLA cream
25. M: Oh EMLA cream
26. Ph: Do you want the uhhm =
27. M: =patch as well () Thanks then
28. Ph: OK [Bye

29. M: [Bye (.) Bye

In this encounter, the pharmacist's utterance "Right then that's it" (line 20) is clearly directed towards a closing and the mother immediately aligns with this intention by acknowledging the utterance and declining to introduce any further topics for discussion. Subsequently, a 'forgotten' item of medication is remembered by the pharmacist and handed over; the preclosing work having been done, however, means that the participants move directly from the handing over of this item to a terminal exchange.

These extracts underline the two part nature of closings; in terms of closings as an achievement the major problem is "How to organise the simultaneous arrival of the co-conversationalists at a point where the speakers' completion will not occasion another speaker's talk, and will not be heard as some speaker's silence" (Schegloff and Sacks, 1974, p237). Since simply ceasing to talk does not provide a solution to the problem of closing, thus ending sequences employ adjacency pair formats, since "If something cannot be made to happen next, it is not merely delayed, but is made unassured to ever happen" (Schegloff and Sacks, 1974, p240). Two utterances are needed for two reasons; firstly so that the second speaker can demonstrate an understanding of the first speaker's intentions and display a willingness to concur with this; and secondly so that the first speaker can see that the intention was understood and/or accepted. Through this use of adjacency positioning, as Schegloff and Sacks illustrate, failures and corrections can be attempted; likewise an opportunity may also be provided to raise other issues which have not thus far been dealt with, as in the second example above. Since there is no guarantee that the natural course of

conversation will provide the occasion for any particular topic to occur, so a closing exchange should not necessarily exclude the possibility of one of the participants inserting unmentioned topics or business. It may also be used to clarify matters raised earlier in the conversation, as below:

**Transcript 5: eg/op/be (simplified transcript)**

11. Ph: That's right()[and the methotrexate just on Wednesdays
12. M: [Mmmhmm
13. M: Yeah=
14. Ph: =OK
15. M: So that's one(0.2) that's one big'un and one little 'un?
16. Ph: That's right(.) one of each
17. M: That's great(.) Thanks a lot
18. Ph:Bye

Here the mother takes the opportunity to summarise and clarify (in line 15) the dosage details the pharmacist has given her over the preceding turns; once this has been achieved she initiates a terminal exchange (line 17). Thus the transition from pre-closing to closing can be seen to occur when pre-closing exchanges are accepted and treated as closing implicative by both the participants.

A further issue raised by Schegloff and Sacks with reference to closings is that of positioning, in the sense that "a pervasively relevant issue (for participants) about utterances in conversation is "Why that now"." (Schegloff and Sacks, 1974, p241) Thus some utterances may determine their character as actions largely as a result of placement considerations; the example that they use to illustrate this is that an answer

is only an answer after a question. This issue of placement considerations appears to be particularly pertinent to the clinic data with respect to the topic of future arrangements. For all of the patients and their carers, a particular visit to the oncology clinic is only one in a series of visits which may occur regularly over a period of several years, and so a regular feature of "this" encounter is a reference to the "next" visit.

Button discusses this phenomenon in terms of "how a current conversation is organised as one in a series of encounters, and how , through this specific mechanism, a relationship is achieved or re-achieved between the participants that they may then use to structure some parts of their conduct" (Button, 1991 p251). Expanding on this notion, he suggests that the conduct it is particularly relevant for is the initiation of closings in conversation. Drawing on Schegloff and Sacks' (1974) explication of how, in "bounding off" some topic for conversation, a participant may be presented with a "free turn" in which a closing may be initiated, he suggests that arrangements may be oriented to as what he calls a "special status topic" that is specifically used to place the conversation on a closing tack. Thus, in practice, by providing for a future encounter the participants may conclude that a current encounter could be appropriately terminated; secondary to this is a possible indication that further topics are unnecessary now as they can be dealt with in the future. Button also suggests that arrangements are organised so as to be the last topic in the conversation, but in the clinic data this is not necessarily the case; arrangements seem to serve a variety of functions dependent on their placement in the encounter, which are not always closing implicative.

The notion of "Why that now" as raised by Schegloff and Sacks can thus be seen to be of the utmost importance in terms of how discussions about future arrangements are set up and responded to; this is demonstrated by the occurrence of arrangements as a topic at a variety of temporal locations throughout the encounters, apparently serving a variety of (both functional and conversational) purposes. In the extract below, for example, the next visit is presented as the initial topic:

**Transcript 37:- sk/nc/op (simplified transcript)**

- 1.Ph: Right (.) Two weeks' worth (.) Is that what you were expecting?
- 2.M: Yeah=
- 3.Ph: =Coming back in 2 weeks' time
- 4.M: Yeah

((Pharmacist begins to dispense medication))

In this instance then, discussing future arrangements can be seen as a functional phenomenon, a "checking" device before any medication is dispensed (since establishing when the patient is due to come back will also establish the quantity of medicine to be dispensed). Secondary to this the formulation constitutes the carer as a person who has an expectation about medication in terms of future arrangements. A rechecking occurs in line 3, and it is only after the mother's response to this that the pharmacist begins the task of dispensing. Thus, although the topic in this case ('arrangements') is the same as in Button's discussion, in some cases the actual activity that is involved may be different. Button's analysis focuses on the actual making of arrangements between two parties; here the **functional** purpose is presumed to be checking or rechecking arrangements that have originally been made by a party other than the pharmacist.



Arrangements also appear to be used as more subtle resources in the consultations, as in the extract below where they occur after an initial general discussion about the lack of blister packaging, and represent a move into the advice giving component of the interaction (line 15):

**Transcript 13: lc/op/be (simplified transcript)**

1. Ph: Prescription for (name)?(1.6)(Name)? Anyone else down there(.) No?
2. Ph:(to other non-clinic patient) Are you being seen to by the way? (Response unclear)(.)
3. Ph: Prescription for (name)?(2.1) (sneezes) Excuse me sniffing(.)
4. Ph: I've [just had a burst of the sneezes
5. M: [It's alright (laughs)
6. Ph: Now first of all I've got to apologize we haven't got any blisters
7. Ph: at the moment =
8. M: [That's alright
9. Ph: = [They're somewhere between here and America(0.2)
10. M: Oh right!
11. Ph: I'd love to know where [ (laughs) hopefully they'll be in for
12. M: [ (laughs)
13. Ph: next time you come back =
14. M: =Right
15. Ph: (name)'s coming back in a week that's [right isn't it
16. M: [Yeah (.) Yeah (...)
17. Ph: Yeah and she's had her vincristine hasn't she(.)
18. M: yes
19. Ph: today(.) so she's got her prednisolone to go with her vincristine (.)
20. M: Yeah (0.7)
21. Ph: It's just 25mg tablets(0.6) one to be taken each morning and [night
22. M: [night yeah
23. Ph: Right that's just for 4 days(0.7) and (.) she's got her mercaptopurine here(.)
24. Ph: 2 of the 50mgs each morning starting tomorrow()

Interestingly, as this consultation develops, this arrangement is used to frame the advice within the context of a week's time scale; the prednisolone, for example (line 23) is to be taken "just for 4 days", and the advice continues in the same manner.

There are also instances in the data where the discussion of future arrangements appears to be addressing a specific problem or anticipated problem, as below:

**Transcript 2: kj/op/be (simplified transcript)**

19. M: So she's just got every morning [tomorrow morning  
20. Ph: [ Yes if she takes those either just be-  
we:ll it's best  
21. Ph: just before breakfast with mercaptopurine(.)and then when's (name) when  
are you coming back in again?  
22. M:[Monday  
23. P:[monday  
24. Ph: Right(.)I didn't know if she was coming Monday or Tuesday with it being  
a Bank Holiday so you'll have an extra tablet(.)  
25. Ph: if you just give it back to the ward that'll be fine

Here there is a potential problem with future arrangements because of a Bank Holiday; the problem is established to be an extra tablet and a solution (to "give it back to the ward") is provided by the pharmacist in line 25. In contrast, arrangements do occur at temporal locations within the data where it is hard to see that they serve any functional (as opposed to conversational) purpose; in the extract below the question is posed almost rhetorically (line 37), and indeed receives no audible reply from the carer:

**Transcript 11: sg/op/be (simplified transcript)**

33. Ph: and then carry on Monday Wednesday Friday like that()  
34. M: [Mmm  
35. Ph: [OK?  
36. M: OK.  
37. Ph: You are coming back in two weeks aren't you(.) That's right (laughs)

(Pharmacist puts medicines in bag)

38. C: Can I put these in?  
 39. Ph: Yeah(.) course you can(.) Thank you()  
 40. Ph: There you go then (indistinct) [see you  
 41. M: [Bye

Here the question occurs after two passing turns, and it is hard to see how it would have any functional use in terms of either framing advice-giving or anticipating or dealing with a specific problem. Despite this, similar formulations are found in a number of encounters; the nature of arrangements as a final topic will be considered in detail with reference to the encounter below.

**Transcript 6: ar/op/be (simplified transcript)**

1. Ph: Prescription for (name)?((M approaches))I've got some Septrin for him here=  
 2. M: =Yeah  
 3. Ph: and you're to give him 7.5ml(.)on Mondays Wednesdays and [Fridays  
 4. M: [Right  
 5. Ph: and you're starting this Friday ok?(0.4)and again we've got some sunblock  
 6. Ph: for him as well(0.2)  
 7. M: Right (0.3)  
 8. Ph: When are you due to come back?  
 9. M: Next Wednesday  
 10. Ph: Next Wednesday(0.2) that's fine(0.4)There you go ((puts medication in bag))  
 11. Ph: Thank you very much  
 12. M: 'Bye

In this consultation line 6 contains the end of the pharmacist's advice about drug dosages, etc. However, it is difficult to tell if this is heard as such by the mother; there is a significant pause after her acknowledgement in line 7 which suggests she may be waiting for further details. Unfortunately, we are not party to what else may be happening during this pause in terms of the handing over of medication or any other action by the pharmacist, which is one of the limitations of audio data obtained here.

Following on from this, line 8 can be heard as accomplishing a variety of tasks; it can be heard as closing implicative, in the sense that it is proposing the prior block of information may be complete. The utterance does not deliver any more advice in itself, although it could potentially lead to more in the sense that it is checking there is no inconsistency between the amount of drug supplied and the date of the next visit. It could also be conceivably checking the prior advice about the tablets in an indirect manner, in the sense of "Does the patient understand how many tablets they have and why?". The receipt of the patient's response with "That's fine" (line 10) goes some way to proposing that this was a real, functional checking, and that the information received has been assessed for some purpose.

Returning to considerations of positioning, however, the position of the question in line 8 is interesting in that by occurring towards the end rather than at the beginning of the consultation, it downgrades the possibility of a problem. In other words, it seems to carry a degree of expectation that there won't be a problem by virtue of its positioning. In this sense it is hearable as moving towards a closing, by projecting the possibility of exit from advice or completion. Although such statements have been suggested as differing slightly from Button's data in the sense that these are arrangements made by others, Button's notion of constituting an ongoing relationship still appears to be relevant here; once talk starts about "next time" then the presumption may be inbuilt that "this time" is over. In this way a future encounter can provide for the close of a current encounter, and it seems plausible that it is being invoked in such a manner here.

In addition, aside from issues of closing, the pharmacist would generally **know** when a patient was due to reattend the clinic before the consultation, which also raises the issue of whether pharmacists are being seen to **do** a particular activity by asking when the next appointment is. Although it is not needed in terms of doing the functional work of the encounter, it may be needed in terms of the interactional work. Thus "That's fine" (line 10) can be heard as an assessment by someone who has rights and competencies, or who is knowledgeable. The question may also do the work of **reminding** the patient when their next appointment is, or at least in this case checking that there is no confusion between the involved parties over this. Pharmacists are ethically (and increasingly, legally) held to be accountable for making sure that people know how to take their medication; this raises the issue of what is involved in being seen to do your work, both by an organisation and by a client.

Returning more specifically to closings in relation to issues of knowledge and competence, it has earlier been noted that there is not necessarily a clearly defined end point to a consultation between a hospital pharmacist and a patient or parent, and that this often makes itself apparent in the data. As the party ostensibly "in control" of the interaction, it generally falls to the pharmacist to topicalise bringing the encounter to a close. As discussed above, this may involve invoking arrangements as a resource in this respect; it also requires collaboration from the co-participant(s) to move from pre-closing to closing. However, there are also instances in the data which bypass this process of achieving alignment towards a terminal exchange by producing a forcible closing. In the example below, this is done by means of a self-explanatory

statement at line 22:

**Transcript 17: kj/E38/ta (simplified transcript)**

1. C: ((On way out of room)) My Mum's not here at the moment()
2. Ph: No it's OK (.) I shan't be here long anyway [((laughs))
3. C: [((laughs))
4. Ph: Let's see(.) Have you been alright with your tablets (name)?
5. C: Yes
6. Ph: And you haven't had any more mouthwash recently (.) have you?(0.2)
7. C: No
8. Ph: So your teeth haven't gone another strange colour?(0.2)
9. C: No
10. Ph: That's alright then(0.3) And you've not been feeling sick or anything
11. Ph: [have you that's been alright then
12. C: [No
13. Ph: Right (.) good(.) You're looking better than last time I saw you actually(.)
14. C: Yeah
15. Ph: Are you feeling better?(0.3)
16. C: Yes
17. Ph: Good (.) Let's find the card ((looks at card)) I don't know if I've got  
much to ask
18. Ph: you about these(0.3) Are you going home soon?(0.2)
19. C: Uhhh I should be going home on Saturday.
20. Ph: Saturday(.)right( )So you'll need your tablets to take home on Saturday  
[won't you
21. C: [Yeah
22. Ph: That's OK then (.) right(0.4) I can let you run away now (.) Bye
23. C: Bye

It is interesting that the only participants in this encounter are the pharmacist and the patient; the latter's initial utterance about the absence of her mother suggests that she is not accustomed to seeing the pharmacist alone. It is possible, then, that the pharmacist does not expect the patient to have any degree of knowledge about when the business of the consultation would be over; whatever the reason, a "unilateral" closing statement is produced in line 22 which gives the patient little choice but to leave. Thus the closing produced by the pharmacist in this case may be part of her

constituting the other actor in the encounter as a child. However, this unilateral slant to closings is present to a greater or lesser degree in a number of the consultations, ranging from the directive passing turns discussed earlier to the extreme example above. In the extract below, for example, it appears to be used as a method of changing the footing of the conversation away from the discussion of niceties, and back to a pharmacist/client encounter:

### Transcript 3: d/op/be (simplified transcript)

15. Ph: so just 5ml Mondays Wednesdays Fridays(0.2)
16. M: OK that's great() I've got a syringe
17. Ph: You've got a syringe right? I've got a habit of going backwards and forwards
18. Ph:[ so I thought I'd bring them with me() There you go ((hands over medication))
19. M: [I know
20. Ph: You got by quick today
21. M: I know() for a change((laughs))
22. Ph: It's nice isn't it? Right then
23. M: Thank you
24. Ph: Bye
25. M: Bye

The actual business of the encounter here is over in line 19, and an exchange of pleasantries follows: however, this is then brought to a rather abrupt end by the pharmacist in line 22; although the carer is at least given a conversational opportunity to align with this. This somewhat artificial end to the encounter is present in several of the study consultations. Parenthetically, it is possible to imagine that this kind of 'forced' closing betrays some kind of orientation to time pressures, in the sense that the pharmacist is attempting to close one encounter in order to begin another. It appears, however, that these kind of formulations appear across the data regardless

of perceived or actual pressures of time. The consultation above, for example, takes place between the pharmacist and the last clinic patient of the day, although it occurs over an hour before the end of the pharmacist's working day. Hospital policy is that if clinic duties conclude before 5pm, the clinic pharmacist returns to the main dispensary to assist there for the rest of their scheduled time. However, since this is largely an unpopular rule (general dispensing is perceived as less 'specialised' and therefore somewhat beneath the abilities of an oncology specialist), it seems unlikely that there is any haste on the part of the pharmacist to conclude an encounter for this reason. Additionally, in terms of the arrangements of the clinic itself, although a pharmacist will know how many patients are scheduled to be seen that afternoon, it is not usually known in which order they will arrive. The waiting area of the clinic is out of sight of the pharmacist's seat in the consulting room, and in any case this is not an 'exclusive' waiting area for the oncology clinic, but also contains paediatric patients waiting to see other specialists<sup>10</sup>. Thus there are few of the pressures that confront, for example, a community pharmacist who can clearly see how many people are waiting for prescriptions or the chance for a consultation.

Considering these 'forced' closings as a general phenomenon, it seems more likely that, as Goldberg (1975) notes, the end of a series of instructions is typically an achieved position rather than a natural or logically findable one. Where pharmacists set up their "counselling" as a series of instructions, the end may thus be accompanied by the use of some of the standard lexical items or phrases identified by

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<sup>10</sup>Under the 'old' clinic arrangements, it was sometimes possible for the pharmacist to see the 'next' patient whilst handing over medication to the present one, since they commonly moved to sit in the chair vacated by the patient or carer currently being "counselled".



Goldberg, such as "That's it" or "Right, that's everything". What is also significant about this kind of forced closing is that it fails to allow the discussion of any other matters which have not been covered by the pharmacist that the patient or parent may wish to raise. Accepting that pharmacists are likely to have a clear idea of the particular sets of topics to be covered in a given consultation, it is understandable that an attempt to close the conversation is made when these have been completed. However, this does not allow for the fact that the pharmacist's idea of a satisfactory solution and that of the parent or patient may not be the same; in addition there may be personalised queries or difficulties in a particular case. A sensitivity to this may be displayed by asking a general question at the end of the encounter, as below:

**Transcript 18: m/E38/ta (simplified transcript)**

22. Ph: Are you still running the drip through (.) Yeah (.) OK then (.) you're  
alright
23. Ph: with everything else aren't you? (.) There's no problems? (0.2)
24. C: [No
25. F: [No
26. Ph:[Thank you

Thus in the encounter here the pharmacist incorporates a question into her move towards closing ("There's no problems?") in order to establish whether there are any other areas the participants wish to discuss. Not only does this provide an opportunity to raise any further issues, but it also itself makes closure relevant in the sense that if there are no more issues to be discussed, then the 'business' of the encounter can be said to be comprehensively exhausted.

So far the analysis of closings has focused around the pharmacist as the "expert"

participant in these encounters; there are, however, instances of consultations where a movement out of advice and into closing is topicalised by a parent or carer. In order for the client to bring this about, the assumption must be that they have the competence to know when the advice is over. In the extract below, for example, the mother (at line 19) appears to be displaying some kind of acknowledgement that the advice-giving segment of the consultation has been concluded:

**Transcript 8: uk/op/be (simplified transcript)**

15. Ph: The Septrin (.) you're giving 3 on Mondays Wednesdays and Fridays  
you're  
16. Ph: giving 3 twice a day(0.2)  
17. M: Mmmm  
18. Ph: Ok(.)the methotrexate 2 to be given on the 23/6 which is a  
Wednesday(0.3)  
19. M: What else(.) uhhh oh that's it(.) Yeah that's it yeah(0.4)  
20. Ph: When are you actually due to come back?  
21. M: A week on Monday(.)the 28th  
22. Ph: Yeah that's right(.) that's brilliant((puts medication in bag)) OK thanks  
very much  
23. M: Thanks(.) Bye  
24. Ph: Bye

In this case then, the mother's acknowledgement of having received all of the advice is followed by the pharmacist raising arrangements as an apparently closing implicative topic; this is also the case in the following extract:

**Transcript 10: jm/op/be (simplified transcript)**

23. Ph: OK? (.) The methotrexate again there's 2 strengths to make up the  
total(.)dose  
24. Ph: she needs and that needs-  
one needs to be given on Wednesday(0.3)  
25. M: Yeah(0.2)  
26. Ph: with 2 of the 2.5 needs to be given [on Wednesday (.)  
27. M: [Yeah

27. Ph: and the Septrin you're giving one twice a day on Mondays Wednesdays  
and  
28. Ph: Fridays [starting this Friday  
29. M: [Right(.) OK (0.2) I've got that  
30. Ph: OK(.) When are you actually due to come back?  
31. M: Next Wednesday  
32. Ph: That's brilliant(.) Thanks(.) Bye  
33. M: Thanks(.) Bye

In this instance the mother is providing minimal acknowledgements to the individual segments of advice produced by the pharmacist (lines 25 and 27), but her extended response (and the nature of it) at the conclusion of the advice in line 29 suggests that she is hearing the pharmacist's prior utterance as the end of the advice as a whole rather than the end of another segment. These types of responses by patients and carers raise the question of how they are knowing that the advice is over. There are three factors which may be operating here; the first is that many of the clients have a great deal of knowledge about their treatment regimes and are therefore likely to be competent to recognise that they have received and/or discussed all the medication they were expecting to receive. The second is the existence of non-verbal cues; in general the clinic pharmacists tend to illustrate the advice about a particular medication by moving its bottle towards the patient. It thus may be possible to assume that the advice has concluded when all the bottles have been presented in this manner. Evidently, these two factors are bound up with each other in the sense that pharmacists commonly display and hand over a bottle whilst describing the dosage instructions for the medication it contains.

The third factor relates back to the way in which pharmacists set up the "advice giving" component of these encounters, which was described in the previous chapter.

Heritage and Sorjonen (1994) note that "And-prefacing" may be used as a feature of question design, in the sense that the 'and' serves to link a question to a preceding question/answer pair. They suggest that in interactions between Health Visitors and new mothers, and in similar informal medical encounters, "*and*-prefacing indicates that the question it prefaces have a routine or agenda based character" (Heritage and Sorjonen, 1994, p1). They also note that as a feature of question design this kind of set up is rarely found in mundane conversation, but is a common feature of 'institutional' interaction, "where the parties are occupied with a restricted set of tasks, or address one another as incumbents of particular social roles" (Heritage and Sorjonen, 1994, p1).

Although not always designed as questions, these 'and-prefaces' are prevalent in the data collected here with respect to dosage instructions, as can be seen in the example below which was used earlier in this chapter.

**Transcript 6:- ar/op/be (simplified transcript)**

- 1.Ph: Prescription for (name)?((M approaches)) I've got some Septrin for him here =
- 2.M: =Yeah
- 3.Ph: and you're to give him 7.5ml (.) on Mondays Wednesdays and [Fridays
- 4.M: [Right
- 5.Ph: and you're starting this Friday ok?(0.4) and again we've got some sunblock
- 6.Ph: for him as well(0.2)
- 7.M: Right (0.3)
- 8.Ph: When are you due to come back?
- 9.M: Next Wednesday
- 10.Ph: Next Wednesday(0.2) that's fine (0.4) There you go ((puts medication in bag))
- 11.Ph: Thank you very much
- 12.M: 'Bye

In this encounter, having initially announced the first medication in line 1, the

pharmacist prefaces all her utterances regarding dosage with 'and' ("and you're to give him" in line 3, "and you're starting this Friday" in line 5, "and again we've got some sunblock" also in line 5). Having sought (and largely received) acknowledgements from the mother for all these utterances, the pharmacist's final question, "When are you due to come back?" is formulated differently, and is thus detached or distanced from the previous body of instructions. In the Health Visitor data, Heritage and Sorjonen suggest that Health Visitors handle the form filling element of their task by distancing themselves from it, eg (from their data) "These details (.) I don't know why they want to know them but father's age". Pharmacists also are part of a complex chain of command in the oncology unit, albeit implementing a relatively high powered knowledge base. Even so, much of the authority for their pronouncements is attributable to (often unnamed) others. In this encounter, for example, the pharmacist states "You're to give him 7.5ml" rather than "The dose is 7.5ml" (other such examples are "He's to have..." and "They want him to..."); the implication is that these are instructions relayed from some other party, in this case the doctor. Elaborating on their data, Heritage and Sorjonen state that "In this context, *and*-prefaced questions, with their recurrent invocation of the official agenda lying behind the subsequent course of questions, can underscore that, at this point in the encounter, the nurses are "doing bureaucracy" rather than "establishing a helping relationship". By sustaining and highlighting the distinctiveness of this set of "bureaucratic" questions through *and*-prefacing...the nurses can separate themselves from the bureaucratic aspects of their visits, and thereby seek to emphasise that the more affiliative relationship with the mother as "helper" and "befriender" is central to their purposes in the encounter" (Heritage and Sorjonen,

1994, p23).

Parenthetically, it may be that this kind of issue is relevant to the sorts of 'unilateral' advice giving strategies identified and discussed in the previous chapters. Whilst pharmacists never make explicit "I have to go through this with you because..." type statements, it may be that this kind of 'and-prefaced' format serves a similar purpose to that which it does in the Health Visitor encounters, in that it marks the instruction sequences that ensue as items on a "bureaucratic" agenda. This is not to suggest a separation in these pharmacist client encounters between 'bureaucracy' and 'helping', since the latter kind of affiliative relationship is rarely, if ever, seen in this setting. However, the suggestion is that the selective use of *and*-prefacing marks not only a distinction between 'routine' and 'helping' activities, but that it also marks bureaucracy or routineness in itself.

Returning more directly to issues of closing, it may also be that this kind of 'and-prefaced' structure provides the recipients with a resource to know when the 'instructing' segment of an encounter is complete. In the example above, the pharmacist phrases her final question, and her assessment of the response to it, in a different manner; as has been noted, this serves to distance it from the preceding information. The pause that occurs before this question (in line 8) suggests that the mother of the patient is unsure as to whether there are any further dosage instructions to be included in the pharmacist's list, but the fact that the pharmacist's next utterance is not linked back to the previous in the way that her others have been makes it clear that this section of the consultation has been concluded.

It seems, then, that although these encounters lack the fixed duration of some professional/client encounters or more formal medical encounters, there are nevertheless a variety of resources available that may be drawn upon by both participants in order to establish or determine an endpoint. These include the 'passing turns' found in mundane conversation, and also incorporate the orientation to 'next time' that these encounters necessarily contain. There are also a range of non-verbal cues which may be in effect, which have to do with the positioning of medicines between the involved parties (and eventually, the 'bagging' of these for the patient to take away). Where these encounters are set up in an 'instructional' or 'unilateral' manner, the endpoint may be more problematic, since in the absence of a 'natural' closing relevant statement it is often necessary for the pharmacist to explicitly produce a move towards closing. 'And-prefacing' as a feature of these instructional sequences in a sense has a two-fold function, in that it serves to link all the 'and-prefaced' items together **and** to distance any subsequent items from these; hence the implicativeness of this structure in relation to subsequent utterances as a resource for patients or carers to establish that a sequence has reached its conclusion. Exits from advice giving and closings have largely been considered together here, since it appears that the end of the former activity provides (with the completion of the handing over of the medication) substantially for the relevance of the latter. Once again, as throughout this data, the knowledge and competence with clinic procedures possessed by the patients or carers (whether this is competence in the sense of knowing that all the required medication has been handed over, or knowing that if all the available medications have been handed over that this is in itself closing implicative) is an important factor in establishing these endpoints.

## Chapter 8

**"WHY DIDN'T YOU JUST SAY THAT?" :  
DEALING WITH ISSUES OF ASYMMETRY, KNOWLEDGE AND  
COMPETENCE.**



The existence of asymmetry in medical encounters has been discussed many times in previous research, beginning with Parsons' influential functionalist view of socially prescribed roles for physician and patient. However, as Bogoch (1994) points out, the underlying assumption of this traditional Parsonian model is one of "a disinterested professional acting on the basis of complex theoretical knowledge and the interests of the client, and a client who cannot understand or appreciate professional opinions, accepting and complying with professional diagnosis and treatment recommendations" (Bogoch, 1994; p66). Two distinct issues relating to asymmetry are raised by this Parsonian perspective; the first is the ancillary question of whether this 'mystical' professional expertise has now become more routine and accessible to an increasingly educated, 'consumerist' public. Secondly, and more fundamentally, as Maynard (1991) describes, these descriptions of the manifestations of institutional power and authority largely omit to consider how participants organise interaction in the first place. The end result is thus that communication has often been considered only as a by-product of these overarching societal structures of power and authority. However, as Maynard contends, asymmetry in the form of physician control cannot be considered as an automatic effect of institutional processes; analysis of consultations shows that both parties to the consultation constitute and enact this asymmetry throughout the interaction. In part, he suggests, these patterns develop as a way of handling the interactional difficulties the doctor/patient encounter creates.

Bloor and Horobin (1975) describe these difficulties as a "double-bind" situation for patients, in that they are expected to use their own judgement as to when it is appropriate to seek medical advice, but later to defer to the doctor's judgement when

undergoing treatment. As Heath (1992) notes, considering the process of diagnosis, "patient's accounts of their illness or behaviour, and in particular the ways in which they attempt to justify having sought professional medical help, reveal a deep sensitivity to the asymmetries in the relationship between patient and doctor" (Heath, 1992; p261). He goes on to consider how, by describing their own subjective experience of the illness, or by qualifying their version of a particular episode, patients systematically preserve, through their talk, the differential status between their own understanding of the complaint and its professional assessment, and between medical expertise and lay opinion. In conclusion, he suggests that patients display a "central concern to avoid any response which could serve to imply that the participants' versions and assessment of the condition had an equivalent status" (Heath, 1992; p262). Any response to diagnosis which challenges this asymmetry inevitably undermines the patient's grounds for seeking professional medical help in the first place.

The complex nature of the doctor/patient encounter suggested here by Heath is also the central argument used by Sharrock (1979) in his consideration of the lay/professional nature of the relationship. He criticises sociology for acting as an indictment, in the sense that by describing the professional/client relationship as "oppressive", it is both finding fault and apportioning blame. By constituting the doctor/patient relationship as a *struggle* for dominance, the implication is that each and every meeting between doctors and patients is a struggle, and that patients would have much more to say *if* they were allowed to. Subsequently then, "if the medical professional is reliant upon the way in which he structures his talk with the

patient...for his control, then he is indeed dependent on the very weakest constraints which could not contain or control anyone who genuinely wanted to raise the topic" (Sharrock 1979, p142). The conclusion implicit in this evaluation then is that , rather than struggling for dominance and losing, patients do not in actual fact really try to contest the authority of the doctor.

These notions of "interactional submission" by the patient are also found in Ten Have's (1991) consideration of the doctor/patient encounter. He highlights the twofold nature of asymmetry in such interactions, suggesting that there is firstly an asymmetry of topic, in the sense that it is the patient's condition that is under review rather than the doctor's, which leads to a secondary, associated asymmetry in terms of task distribution within the encounter. Thus, although the initiative for the encounter is likely to be the patient's, the distribution of tasks in terms of an ultimate goal of diagnosis involves quite "natural" interactional dominance by the doctor, which is enacted through questioning, investigating and decision making behaviour and complied with by the patient. The implication then, is that it takes specific and deliberate effort on the part of the patient to counter the interactional contingencies leading to asymmetry, and that this is rarely seen in practice.

Frankel (1995) observes that "in its modern guise, the (medical) interview is treated more as a *technique* used by one person to obtain information from another" (Frankel, 1995, p233). Defining interviews in general, he suggests that they are "an instance of the division of labour: The interviewee supplies the matter, the interviewer supplies the form" (Frankel 1995, p234). Where clinical interviews unfold largely through

Question and Answer exchanges, the focus "is organized around solving one or more problems. As such, much of the questioning that occurs in a clinical encounter is designed to elicit information that is complete and accurate enough for the physician to arrive at a conclusion" (Frankel, 1995, p248-9). Like Ten Have, then, he suggests that the various phases that make up a clinical encounter are regulated in terms of larger organizational tasks. However, he points out that there are particular moments in clinical encounters which represent 'windows of opportunity' for patients' talk, for example their expression of affect. In conclusion, he observes that the "act of caring and being cared for" is also a fundamental dynamic feature of clinical encounters, and that this necessarily has an effect on the patterns of talk which emerge.

Hutchby (1996), discussing power in discourse in relation to data collected from talk radio, describes how an approach informed by CA can provide an account of power as an integral feature of talk-in-interaction, so that "through focusing on such issues as how participants orient to features of a setting by designing their turns in specialised ways (eg restricting themselves either to asking questions or to giving answers) (this) can be used to address how power is produced through oriented-to features of talk" (Hutchby, 1996, p482). Thus he suggests that the ways in which participants design their interaction can, in effect, place them in relationships where "discourse strategies" of power are differentially available to each of them. Power can in this way be viewed as an "emergent feature of the oriented-to discourse practices in given settings" (Hutchby, 1996, p482).

In discussing this approach, he draws on Davis's (1988) study of power in

doctor/patient encounters, which suggests that whilst CA may be used to address power in this setting, it requires a more detailed theoretical underpinning. Hutchby rejects this argument, and goes on to illustrate, with reference to the talk radio data, *how* power can be seen as a feature of the unfolding of talk in a particular setting. Specifically, he describes how power may be seen as a "shifting distribution of resources which enable some participants locally to achieve interactional effects not available to others" (Hutchby, 1996, p481). In this setting, the distribution has to do with both the organization of activities within a call, and the asymmetrical distribution of argument resources provided by a participant's position within that argument. Second position in an argument, he suggests, represents a more powerful position, in that the second speaker is only required to attack the first speaker's contribution to produce an appropriate response, rather than setting out their own stance. It is easy to see, then, how these principles may also be applied to the Question-Answer format noted in doctor-patient interaction, where the instigation of new topics is largely undertaken by doctors, and patients are required to respond to this.

The overwhelming conclusion from this and other studies then, is that asymmetry, rather than being imposed, may be interactively achieved by both participants to an interaction, and specifically to the doctor/patient encounter. However, it is important to note that the majority of this literature is based on episodic, as opposed to long term relationships. Conversation analysts, in particular, have not tended to focus on long term interactional sequences. Nevertheless, it would seem plausible that such encounters with long term patients are likely to contain significant differences, centred around the issue of knowledgeability. As Macintyre and Oldman (1977) state, in their

work on migraine, "Those who suffer from chronic illnesses, particularly ones that doctors can do little about, develop a special knowledge of their condition. This knowledge is of a rather different order from that held by doctors, and from the point of view of the patient, it is subtly superior" (Macintyre and Oldman, 1977; p55). This superiority arises, they argue, because the patient's knowledge is personal and forged from direct experience; it is "What I know" about an ailment rather than "What is known", and is therefore constructed rather than received. These two sorts of knowledge are not, however, independent of each other, and may therefore be subject to negotiation within the interaction.

There are other suggestions in the wider sociological literature that patients with chronic illnesses are of a different order to episodic patients in terms of their interactions with the health care system. As Freidson (1973) notes, in terms of Parsons' description of the sick role, the sick person's exemption from the duties of everyday life "is temporary, and its legitimacy conditional on trying to get well" (Freidson 1973, p234). This kind of temporary exception, however, is applicable only to acute illnesses; in chronic illnesses such as cancer and leukaemia, legitimacy is not conditional on trying to get well. Indeed, as Freidson indicates, it is generally believed impossible to recover from most chronic ailments. Secondary to this, the behaviour of the sick person "comes to assume a more definite pattern when he is thought to have a chronic illness requiring long term and sustained contact with a practitioner" (Freidson, 1973 p311) in the sense that chronic patients develop some kind of organisation in their lives which is related to the (professionally defined) demands of their treatment. In other words, rather than a person's life being

organised by the disease and any associated incapacity, it is organised instead by "professional conceptions of the disease and what is needed to treat it; the disease becomes a professionally organised illness" (Freidson 1973, pp311-2). Within this organisation, however, there is still the opportunity for the patient to backslide, by for example missing appointments or failing to comply with the prescribed medication regimen.

The data presented throughout this thesis are drawn from a paediatric oncology outpatient clinic, which deals with long term cancer and leukaemia patients under the age of 16. As has already been described, these patients and their carers make regular visits to the clinic, often over a period of several years, and as such are an unusual group with respect to their knowledge of particular conditions and treatments. The data are also unusual in terms of the wider literature in that they involve pharmacist/patient, as opposed to doctor/patient, consultations. Interesting questions of status and expertise are raised by this, in the respect that in a professional sense there is some degree of separation between knowledge and status: pharmacists have claim to a specialised body of knowledge but are not generally seen as having the same status as that of a doctor. There are also distinctions to be made between these encounters and other (non physician) health professional/client interactions; where for example health visitors may need to establish with their clients 'What their visits are about', in this setting both parties to the interaction have a clear idea of why they are there. The patients and carers involved will already have had regular contact with a pharmacist during their initial inpatient admission following diagnosis, and the role of the clinic is to monitor *maintenance* therapy. As might be expected, then, a fairly

well-defined agenda (as described earlier) appears to exist for the encounters. In addition, visits to the clinic pharmacist take place immediately after a consultation with the clinic doctors, so the possibility exists that there are details arising from the former which the pharmacist has not yet been made party to. All of these factors have implications for the interactions which occur, and particularly for the ways in which issues of expertise and/or knowledgeability are managed or pre-empted.

The issue of patient knowledgeability, and the way in which it frames the consultations, is evident even in the opening sequences of the encounters. As has already been alluded to, both parties to the interaction have a clear idea of why they are there, and so the consultations routinely move from a greetings and/or identification sequence straight into the 'business' of the encounter, without any of the "pre-beginning" type exchanges described by Zimmerman (1992) which are common in institutional talk. In this situation, the 'business' consists of advice or information about prescribed medication, in terms of dosages, administration, etc. The move into this 'informing' component of the encounter is frequently framed by the pharmacist in terms of patient expectations, as below:

**37: sk/nc/op (simplified transcript)**

- 1 Ph: Right(.) Two weeks' worth (.) Is that what you were expecting?  
2 M: Yeah=  
3 Ph: =Coming back in two weeks' time  
4 M: Yeah

and

**43: nq/nc/op (simplified transcript)**



- 1 Ph: Right (.) now is it what we expect (.) 100% (.) 2 weeks (.) Y[es?  
2 M: [yeah (.)  
yeah  
3 Ph: 4mg (.) He's had the vincristine (.) ((begins to dispense tablets))

In both cases the patient or carer is constituted by the pharmacist as someone who *has* an expectation about their medication and its dosage, and any advice which is then given in the encounters is framed within these terms (For example "Are you giving 5mls?" rather than "The dose is 5mls", etc). In the second extract, the pharmacist's pursuit of an answer from the mother of the patient after the question "Is it what we expect?" reinforces the notion that she is included in this "we", and thus serves to place both parties on a more equal footing in terms of their expectations of the patient's therapy. The mother's response confirms that "100%" for "2 weeks" is indeed what she had been expecting, and the pharmacist then proceeds to dispense the medication. The use of medication records or drug cards is also an important factor in these interactions; in both cases the pharmacist refers to the card before producing the treatment summary. In fact, the pharmacist would be able to tell from these cards whether any alteration had been made to the planned treatment, and in this knowledge seeking sense the opening questions are redundant<sup>11</sup>. However, they also serve to topicalise dosage information in a manner which explicitly constitutes patient competence. In addition, the fact that these statements are quoted from a document perhaps serves to give them some kind of objectivity, in the sense that the card

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<sup>11</sup>The drug card contains a week by week description of the planned regime for a particular condition, and is therefore subject to alteration as a result of the patient's white blood cell count, nausea, general well being etc. Any such alterations are made by the doctor at the clinic visit and marked on the card. Thus, the pharmacist can tell by looking at the card if this has occurred. Additionally, it is entirely possible that a carer, due to previous experience and a firsthand knowledge of a child's condition over the previous week, may be 'expecting' a change in therapy on arrival at the clinic.

becomes the representation of the organization to which "we" (pharmacists and patients or carers) belong.

This deferral to perceived patient knowledge or competence as an opening strategy for the encounter is perhaps one method by which the pharmacist can ensure that redundant or unnecessary advice is not delivered to the patient. Contrastingly, where pharmacists try to proceed directly to the 'informing' segment of the encounter without first establishing some sort of shared footing for their advice, this may be badly received, as below:

**7: dc/op/be (simplified transcript)**

1 Ph: (name)? (.) OK (.) [I'll go through it all with you  
2 M: [Yes  
3 (0.6)  
4 It's alright (.) I know [it anyway  
5 Ph [Oh yeah

Here, the pharmacist's statement "I'll go through it all with you" allows for little or no knowledge on the part of the mother, and is immediately countered with what can be heard as a rather defensive response. Interactional difficulties such as this highlight the somewhat delicate position pharmacists dealing with long term patients such as these are placed in, in the sense that their Code of Ethics requires them to ensure that patients are familiar with the dosage instructions for their medications. This creates the obvious difficulty of either attempting to give advice to already knowledgeable patients, thereby running the risk of undermining their competence, as above, or else assuming knowledge on the part of the patient, as in the prior two extracts, and attempting to tailor any advice around this. Whilst this latter strategy is used quite

successfully in the examples above, it too can create difficulties, as below:

**30: nq/nc/op (simplified transcript)**

- 1      Ph:    ((Indicating tape recorder)) It's a bit official in't it (.) hh: (.) I'm not  
              going to  
2            say anything to you really because you've had it all before haven't  
              you?  
3            (0.5)  
4      F:      No (.) the missus usually does it=  
5      Ph      =Oh right (.) It's what we were expecting 50%

Interestingly, although the assumption the pharmacist makes in this case is proved to be wrong, and the father of the patient states that "the missus" usually attends the clinic, the pharmacist does not proceed into any kind of explanation or information for the father. Instead, the utterance in line 5, "It's what we were expecting 50%" seems to provide for the fact that "the missus" will have anticipated this dosage regimen and will be competent to deal with it, making any further explanation unnecessary.

This extract, taken from a consultation where only the father is present with the child, is particularly interesting in the light of Strong's notion of "the loving but incompetent father". Also considering interaction within a paediatric clinic, he suggests that within the clinic, fathers' qualities as regards their children are "strictly limited- or so they were treated"(Strong, 1979, p60). He notes that when mothers attended clinics by themselves, little or no reference was ever made to their partners. Conversely, when fathers attended clinics alone with their offspring this was treated as a matter of interest, and often a source of problems, by the staff. In short, "whereas mothers' competence was never openly questioned, this was almost a matter of routine for

fathers. They might not be the ideal representative for a child, but it was also made explicit that this was not a duty to be expected of a father" (Strong, 1979, p63). This perhaps sheds some light on why the pharmacist in the extract above is content to allow the absent mother's presumed competence with her child's medication to stand in the way of any further explanation to the father.

There are a small number of consultations within the body of data collected here where a father is the sole representative of the patient; as in Strong's data the consultations which take place under those circumstances appear to be of a different order to those where a mother is present. In the extract below, for example, which has already been categorised as displaying the characteristics of a "business transaction", no information is given to the father about the child's medication.

**Transcript 32:- ml/nc/op (simplified transcript)**

1. Ph:Right
2. (0.6)
3. Ph:Coming back in a week's time(0.3)Right(0.2)have you got plenty of Septrin
4. at home? (.) or (.) [uhhh
5. F: [We have (.) uhhh better take some more
6. Ph: There's your blister=
7. F: =Ta
- 8.(1.0)
9. Ph: There you go (.) There's another bottle for you
10. F: Oh alright (.) thank you
11. Ph: Have fun (.) See you

Interestingly, in answer to the pharmacist's question at line 3, "Have you got plenty of Septrin at home?", the father answers "We have", thus giving the impression that his child's medication regime is not something for which he has sole responsibility

or control. In general, the consultations involving fathers alone tend to follow this pattern; little or no advice is given by the pharmacist to the father, and the expertise of the mother is invoked by both parties to facilitate this. As Strong puts it, it seems that the medical audience have "tacitly validated mothers' authority" (Strong, 1979, p61).

This pattern does not hold true, however, for the one occasion in the data where a child is brought to clinic not by either parent, but by an elder brother. In this consultation (below), information is sought from the sibling (eg in line 8), and dosage information is offered by the pharmacist (lines 15 -17).

**Transcript 25:- sc/nc/op (simplified transcript)**

1. Ph: ((Taking drug card from patient)) Thanks
2. (2.4)
3. Ph: Great (.) I don't have to change anything
4. B: Yeah (.) I don't think so
5. Ph: No (.) the count's fine
6. B: Mmmhmm
- 7.(0.7)
8. Ph: And you're coming back in a week
9. B: Monday
10. Ph: Alright yeah(.) I've given you seven days anyway
11. B: Yeah
12. Ph: Because it's-  
- it it works out easier (.) but you'll get a new lot on Monday(0.6)
13. Ph: D'you want some of the Septrin (0.5)
14. B: Yeah (0.4) better take some just in case
15. Ph: Yeah (.) well there's that one and that's 7.5ml =
16. B: = Mmmhmm
17. Ph: twice a day on Monday Wednesday and Friday (.)is that alright(0.5) Do
18. you want a bag (Child's name)
19. C: No thank you
20. Ph: No [OK
21. B: [Alright then ((laughs))
22. Ph: ((Laughs))
23. B: Bye

24. Ph: Bye

Throughout the course of this encounter, then, the sibling is treated as someone with a degree of knowledge, able to comprehend the significance of blood counts (line 5), and to decide whether any further antibiotic supplies are needed (lines 13-14). Interestingly, at the conclusion of the clinic on this particular afternoon, the attending nurse enters into a discussion with the pharmacist about what a "sensible boy" the patient's elder sibling (who is aged 16) is, and how fond he is of his brother. It also transpires that he is a frequent representative for his brother at the clinic, making it highly plausible that his treatment as a competent and knowledgeable party is a phenomenon which has been negotiated and achieved over a period of time (and a period of evaluation!) by the clinic staff.

Returning to Strong's data, one of his other major observations with regard to the representation of children at clinics is that "not only did staff treat mothers as entirely competent to answer their questions, but mothers typically answered in the same fashion" (Strong, 1979, p61). Thus, "when a couple did attend a clinic together, staff placed fathers in a subordinate position to their spouses. Questions were asked directly to the mothers, and, though fathers sometimes added their own comments to which staff might reply, they normally returned to the mother for their next question" (Strong, 1979, p61). In the data from the oncology clinic, however, there is only one instance of a child who attends with both parents (below). In contrast to Strong's model, the father here is very much the dominant party, answering the large majority

of the pharmacist's questions (eg in line 16), and initiating topics for discussion (line 23).

**Transcript 36:- sr/nc/op (basic transcript)**

- 1.M: Have we only got one this time?
- 2.Ph: Yeah ( ) Hi [(child's name)
- 3.M: [They did it wrong
- 4.F: Can I have another patch?
- 5.Ph: Yeah sure
- 6.F: Last time they couldn't get a vein (.) on that hand so they had to transfer it to
7. ( ) [to where ( ) on the other hand ( ) I know ( )
- 8.Ph: [Oh right
- 9.Ph: There you go ( ) a spare one
- 10.C: What's that for Mummy?
- 11.F: Injection darling =
- 12.M: =For your ( ) for your magic cream
- 13.C: Have we got some Mom?
- 14.M: We've got some magic cream
- 15.Ph: Coming back next week then aren't you
- 16.F: Yeah
- 17.Ph: Just a week's worth here
- 18.F: Yeah ( ) yeah
- 19.( )
- 20.Ph: ((to child who is watching him prepare blister)) You've got lovely eyes you know
- 21.F: Come back Thursday
- 22.( )
- 23.F: It's much better now than pharmacy before ( ) I used to hate doing that
- 24.Ph: Waiting outside you mean ( ) Yeah ( ) Most people have said they like
25. it much better [this way
- 26.F: [It's a lot quicker isn't it and nearer ( ) no point in
27. waiting around there ( ) hours
- 28.Ph: Are you OK for Septrin ( ) or could you do [with some more
- 29.F: [No ( ) we need some
30. more (.) want some more =
- 31.M: =Please
- 32.Ph: No problems (.) tablets then
- 33.F: Thank you
- 34.Ph: Here we go =
- 35.M: =What's that one
- 36.Ph: This is the ( ) [aniseed one

37.F: [aniseed  
38.M: aniseed ( ) that's the [one  
39.F: [That's the one  
40.Ph: Two and a half mls of this one yeah  
41.M: Yeah  
42.Ph: Yeah ( ) That's it  
43.M: She doesn't like the other [one does she?  
44.F: [No  
45.Ph: [Thank you (name) ((to doctor who has  
46.brought in a drug card))  
47.Ph: Yeah (.) OK  
48. ( )  
49.M: Come on then  
50.Ph: See you then  
51.M: Bye

In this context, the father's use of "I" in "Can I have another patch" (line 4) is interesting; it is also the father who answers the child's question in line 10, despite the fact that it is explicitly addressed to "Mummy". From line 15 onwards, when the pharmacist begins to ask questions and check arrangements, it is also the father who provides answers or confirmations to these utterances. It subsequently becomes clear that he has been a regular attender at clinic for a long period; in line 23 his statement "It's much better now than pharmacy before, I used to hate doing that" is a reference to the new clinic consulting room arrangements ( where the pharmacist and doctor occupy adjacent rooms) brought in some months previously. The mother's first contribution to the encounter since the opening (apart from speaking to her child) comes at line 31, and serves merely to emphasise the request for more Septrin made in the prior turn by her husband. As the pharmacist begins to hand over the medication (line 32), the mother fails to recognise one of the bottles and asks "What's that one" (line 35): she is answered by both the pharmacist and her husband in unison. The overall impression gained from this consultation then, is that the father



has a greater degree of competence with (and familiarity regarding) his daughter's medication than does the mother. Even the knowledge which the mother does display about her child is confirmed with her husband, as in line 43. In contrast to what might be expected from Strong's findings, this division of expertise does not appear to be problematic for any of the participants in the encounter. However, it is difficult to draw any conclusions from this since it is the only instance in the data where both parents are present and there are thus no other consultations for comparison. Nevertheless, it is interesting to note that in both this consultation and the prior one, both the father and the elder brother are clearly regular representatives for the respective patients at the clinic. It seems at least plausible that this may account for at least some of the deviation from the pattern that might be expected.

The consultations also raise interesting issues around the use of jargon; in this case medical, technical terms. Meehan (1981), in his consideration of the use of medical terms by doctors and patients, draws on Barnlund's (1976) suggestion that the use of jargon between members of a group can increase efficiency of communication, cultivate a rapport amongst members and provide a sense of common identity. Moreover, the use of jargon in communication with outsiders is most often characterised as having *negative* effects, so that in a technical, medical sense, to assume professional ownership of such a language precludes the possibility of patient understanding. However, as is clear from these data, in this setting patients and/or carers themselves commonly use technical terms, and pharmacists appear to treat this body of knowledge as something which the patient has access to. There is little use of mitigators, qualifiers or questioning intonation around the terms, or any other interactional contingencies which might serve to suggest that the patient has limited access to this language, as the extract below clearly illustrates.

**38: jb/nc/op (simplified transcript)**

- 1      Ph:    50% then (.) for a week  
2            (0.3)  
3      M:    Yeah  
4      Ph:    Count's up again is it?  
5            (0.2)  
6      M:    No (.) it's down (.) He was on 150 last week

Here the participants are discussing the tailoring of medication dosage to the patient's white blood cell count, but considering this extract in isolation there is perhaps little to suggest it is a professional/client encounter as opposed to a discussion between two

professionals. Since jargon may be seen in this way as a claim to knowledge, this use of technical as opposed to vernacular vocabulary by both parties is one sense in which the "knowledge-based asymmetry" of the model professional/client encounter may be eroded. Significantly, on the occasions where pharmacists refrain from using technical terms, this is often countered somewhat by the patient or carer, as below:

**Transcript 38: jb/nc/op (simplified transcript)**

- 57.Ph: Does he take the (.) medicines OK?  
58.M: He doesn't like the methotrexate  
59.Ph: Oh the (.) once a week one  
60.M: Mmmmm (.) He doesn't like that very much  
61.Ph: Does it taste significantly different?  
62.M: I don't know (.) I've no [idea (.) he doesn't like steroids  
63.Ph: [He must know though  
64. (0.7)  
65.M: He doesn't like [steroids either that is (.)  
66.Ph: [Oh yeah  
67.M: but I have tried [that (.) that's horrible  
68.Ph: [That's (.) looking at this he's OK with the one he has  
69. to take every day then isn't it?  
70.M: Yeah (.) Yeah (.) and the Septrin he's alright with that as well

In this extract the pharmacist continually uses "lay" terms to describe the patient's chemotherapy regime to the mother, for example "medicines" (line 57), "the once a week one" (line 59) and "the one he has to take every day" (line 68-69). The mother responds to this by using the names of the actual drug or class of drug in response; "methotrexate" in line 58, "steroids" in line 62, and "Septrin" in line 70. Thus, although she does not actually contradict the pharmacist's terminology at any point, her utterances serve to make it perfectly clear that the use of jargon is not in any way problematic for her. In this instance then, any criticism of the pharmacist is implicit; on occasion it can become more explicit, as below. (although here the criticism is not

so much related to the terminology which is used in the course of the explanation, but rather the more general form in which the explanation is provided):

**Transcript 12:-gg/op/be (simplified transcript)**

- 23 Ph: Right (0.5) Uh:hm (.) do you want me to explain your tablets cos they're  
24 not [in blisters to you  
25 C: [No:o I know what to do  
26 (0.5)  
27 Ph: You know what to do with them all (1.2) Right so you've got all those for  
28 your mercaptopurine (1.1) [Two of them  
29 C: [What do I do take (0.5) two of them and what d'  
ya call it one of them each?  
31 (0.6)  
32 Ph:Hold on (.) you take two of the 10mg each morn[ing (0.2)=  
33 C: [Yeah  
34 Ph:=that's two of the little ones[ (0.5) two of the 50mg=  
35 C: [yeah  
36 Ph:=(0.7) 't's two of those (.) and one of the half tablets it's already  
37 halved (1.5) o[kay?  
38 C: [Yeah yeah=yeah=ye'  
39 Ph:so that makes you a total of 145mg  
40 (0.2)  
41 C: Oh (0.4) Why didn't you just say that  
42 (1.0)  
43 Ph:Pardon?  
44 C: Why didn't you just say that I would have remembered that  
45 Ph:OK Right (.) Well (1.0) and you've got your methotrex[ate  
46 C: [Yeah

In this case then, the patient is explicitly critical of the way his dosage details are presented to him by the pharmacist (" Why didn't you just say that" in line 44 is his immediate response to the conclusion of her first segment of information). In this way the patient manages to provide for the fact that his apparent ignorance (which is ostensibly assumed by his lack of response at the pause in line 27 and demonstrated by his utterance in line 29) is related to the way in which the details that have been presented to him, rather than existing as a phenomenon in itself. The pharmacist acknowledges his complaint, albeit minimally, in line 45, and then begins to proceed

with the next segment of the dosage details, concerning the methotrexate.

It is thus becoming apparent that a collaborative process of sustaining an apparently common body of knowledge does not necessarily hold firm throughout the encounters. Instead, it is continually established and re-established according to local contingencies, underlining the nature of asymmetry as an interactional achievement. The following (complete) encounter serves to illustrate more fully the ways in which pharmacists and their clinic clients move into and out of a shared footing of knowledge, or a shared orientation to the activity of the here and now.

### 13:-lc/op/be

- 1 Ph: Prescription for (name)?(1.6)(Name)? Anyone else down there(.) No?  
2 (to other non-clinic patient) Are you being seen to by the way?  
3 (Response unclear) (.)  
4 Prescription for (name)? (2.1) Excuse me sniffing(.)  
5 Ph: I've [just had a burst of the sneezes  
6 M: [It's alright (laughs)  
7 Ph: Now first of all I've got to apologize we haven't got any blisters  
8 at the moment=  
9 M: [That's alright  
10 Ph: =[They're somewhere between here and America  
11 (0.2)  
12 M: Oh right!  
13 Ph: I'd love to know where [ (laughs) hopefully they'll be in for  
14 M: [ (laughs)  
15 Ph: next time you come back=  
16 M: =Right  
17 Ph: (name)'s coming back in a week that's [right isn't it  
18 M: [Yeah (.) Yeah (...)  
19 Ph: Yeah and she's had her vincristine hasn't she  
20 (.)  
21 M: yes  
22 Ph: today(.) so she's got her prednisolone to go with her vincristine (.)  
23 M: Yeah  
24 (0.7)  
25 Ph: It's just 25mg tablets(0.6) one to be taken each morning and  
26 =[night  
27 M: [night yeah

28 Ph: Right that's just for 4 days(0.7) a:and (.) she's got her mercaptopurine  
here(.)

29 2 of the 50mgs each morning starting tomorrow

30 (0.5)

31 M: Yeah

32 (0.7)

33 Ph: and one of the halved (.)

34 [they've already been halved for you

35 M: [Oh right yeah(.)oh right yeah(.)good yeah two and a [half each  
morning=

36 Ph: [so that makes  
your 125

37 =hundred and twenty five

38 M: Right

39 (0.5)

40 Ph: Uhh (.) What's next oh the methotrexate(.) two to be taken on  
Wednesday

41 Ph: the thirtieth of the sixth the 10s () and two of the 2.5s=

42 M: =Right so that doesn't go up then it's only the

43 (0.2)

44 Ph: No (.) once you get to 100% your methotrexate doesn't increase

45 (0.2)

46 M: Right

47 Ph: You only increase your mercaptopurine (0.5) OK?

48 M: Right(.) yeah

49 (0.4 )

50 As I say it's the first time she's got=

51 Ph: =Is it the first time she's gone up that high(.) Oh right

52 that must be a good sign=

53 M: =(I don't need) the uhhh dropper for Septrin she it must be about

54 uhhh three months now (I think)

55 Ph: Oh right

56 M: She's having uhh (.) pentamidine(.)

57 Ph: instead of Septrin 'cos she didn't respond very [well to it?

58 M: [Well no we was just

59 forever going (.)right down off treatment altogether and going=

60 =[back to 50 again

61 Ph: [right

62 M: and definitely (.) well this certainly does seem to be working

63 [better

64 Ph: [seems to be working(.) excellent (unclear...)

65 Ph: Well that's a good sign anyway isn't it?

66 M: That's right

67 Ph: OK well I'll see you next week then

68 M: OK (.[...)

69 Ph: [Right(.) bye bye

70 M: Thank you

In the first part of this consultation (down to line 42), there is little interactional contribution from the mother. However, a range of technical, medical terms are used by the pharmacist, none of which are treated (by either participant) as problematic; instead they are seemingly treated as common knowledge. Although there is little in the way of asymmetry in this "knowledge-based" sense apparent in the opening of this encounter, there are nevertheless the manifestations of a different kind of asymmetry in evidence, in the sense of interactional dominance. In this particular encounter, the pharmacist begins by explaining (in lines 7-8) that the patient's medication will be presented in a different form from usual; in individual bottles rather than in a "blister" pack which contains each day's dosages already counted out and compartmentalised into the appropriate section for day, date and time of day. The packaging of the tablets in bottles in this instance renders the mother's knowledge and/or competence of administration using the blister packs redundant. Having accounted for a reason why dosage details are necessary on this occasion, the pharmacist is then able to proceed with this information, beginning at line 22. Even this informing segment, however, is framed in terms of the mother's knowledge of other events, such as when the child is next due to attend clinic (line 17), and the injection she has just been given (line 19). The pharmacist then displays each individual bottle to the mother in turn, describing the instructions for each, and the mother acknowledges each component of these instructions, for example by resummarising the pharmacist's utterance, as in line 35. This section of the encounter then, from lines 22-41, appears to proceed along the 'standard' lines of a typical lay/professional encounter, in that the talk is dominated by the pharmacist, the

mother's utterances are limited to responses or reactions to the pharmacist's talk, and there are clear distinctions between the professional and non-professional party. The interactional dominance that is apparent here manifests itself in the talk in the way in which the pharmacist initiates the topics for discussion, and thus sets the 'agenda' for the initial stages of this encounter. Interestingly, this agenda is itself explicitly invoked in the talk by the use of the statement "first of all" at line 7; this leads into the topicalisation of item-by-item instructions for the medication.

In line 42, however, the mother begins to demonstrate her knowledge, by picking up on the fact that although the rest of the dosage regimen has changed, the dose of one drug (methotrexate) has remained the same. Having solicited an explanation from the pharmacist for this (lines 42-47), she begins to account for her question, by beginning to state that this is the first time that the child has received full strength chemotherapy. She then goes on to inform the pharmacist that a dropper for Septrin (an antibiotic syrup) is not necessary, as her daughter is receiving a different (nebulised) antibiotic. The pharmacist's utterance "Oh right" in line 55 marks this as newsworthy, and she then questions the mother further about this; the explanation (line 58-60) provided by the mother is couched in technical terms and is followed by an assessment of the new therapy ("Well this certainly does seem to be working better"). This second section of the interaction, then, proceeds in a much more collaborative manner. Not only is the mother displaying knowledge that the pharmacist does not appear to be party to, but the interactional dominance by the pharmacist which characterised the first segment of the interaction has largely been



eroded. Significantly, it is the mother's initial *demonstration*<sup>12</sup> of knowledge in line 42 which heralds the move towards this more symmetrical *interactional* alignment.

This particular encounter underlines the ways in which interactional manifestations of knowledge and competence are continually negotiated by the participants in this setting, in ways that tend to minimise the asymmetry that is commonly seen in the doctor/patient encounter, both in the interactional dominance sense (related as this appears to be to the 'task' of the encounter for the pharmacist) and the knowledge-based sense. Although features of knowledge-based asymmetry are sometimes evident in the data, they are rarely sustained for any length of time; even when 'new' information is imparted by the pharmacist, the ability of the patient or carer to relate this to the knowledge they already have has a minimising effect. This body of knowledge which the patient is party to in turn has an effect on the interactional dominance commonly exhibited by the professional party in lay/professional encounters. Thus, Heath's (1992) assertion that, through talk, patients preserve the differential status between their own and professional understandings of their complaint, in order to prevent an undermining of their grounds for seeking help, does not appear to apply entirely to this data. Patients' descriptions of their conditions or treatment in this setting are frequently couched in the same terms as those used by pharmacists, and they are not hesitant to draw their own conclusions or make their own assessments as to how a particular treatment is working or how the use of a particular drug should be tailored to their circumstances. It seems, for a variety of

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<sup>12</sup>A demonstration of knowledge is not presumed to be the only purpose, or even the intended purpose of this utterance. However, just as it partly characterises a lack of knowledge, it also characterises some degree of knowledge on which the query is based.

reasons, that the 'ownership' of a long term disease such as leukaemia is greater for patients or carers than that of an episodic illness, and that this in turn has an effect on the differential status between 'lay' and 'professional' understandings.

However, whilst patients and/or carers appear to demonstrate their knowledge and competence freely throughout the encounter, even in instances where pharmacists do not appear to be orienting to this, the notion of "interactional submission" would still seem to have some relevance. As Ten Have (1991) suggests of the doctor/patient interaction, and has been suggested briefly here, to some extent this may be due to task distribution; the pharmacist may need to establish certain facts, such as the date for the next clinic attendance, any medication received that day etc, or more generally to give instructions and hand over medication, which necessitates periods of interactional dominance. The interactional dominance on the part of the pharmacist which occurs in this setting, in terms of both initiation and agenda, is thus often clearly 'justified' in the talk (through its reference to future arrangements, changes to therapy etc) and by the physical task (since the handing over of bottles is used to facilitate information sequences). The actual interactional task (advising or informing) is less clearly justified in this way because of the issues of knowledge and competence it invokes. Despite their (often apparent) knowledge, patients or carers seem prepared to accept this 'control' of the encounter by the pharmacist, to the extent that they are sometimes prepared to accept a whole package of partly unnecessary details on the initiative of the pharmacist, rather than raising specific questions themselves.

Returning to a consideration of knowledge, the access to the medical, technical

language of the clinic that is continually demonstrated by the clients appears to play a key role in achieving the more broadly symmetrical footing that appears to exist. This in turn raises the question of what can actually be seen to count as "jargon" in a particular setting, since neither of the parties in the majority of these interactions appear to treat medical, technical terms as part of a specialised vocabulary. In the context of repeated visits to institutions such as hospitals, terminology that is initially unknown to lay participants gradually becomes known, and thus ceases to become jargon in the exclusive sense. Patients and carers also become gradually familiarised with clinic procedures and how these are organised, and use this knowledge to inform their encounters with clinic personnel. Professionals in these settings, as here, orient to this, and the use of technical terms thus becomes a means by which patients or carers can display their knowledge. It would be interesting to discover whether consultations between doctors and long term patients exhibit similar features in terms of this displayed knowledge or expertise, and if so, how this is constituted within the interaction.

The extent to which this diminished interactional asymmetry may be accounted for by differential professional status (ie pharmacists as opposed to clinicians) is also worth further consideration. It has been suggested earlier that asymmetrical interaction is in part a result of the contingencies of the doctor/patient encounter, arising as a way of handling the interactional difficulties the encounter presents. In the sense of Bloor and Horobin's (1975) "double-bind" situation, however, long term patients on return clinic visits have not used their own judgement as to when it is appropriate to seek medical advice, although they are still expected to defer to the

doctor's judgement when undergoing treatment. Long term patients' encounters with pharmacists differ further, in that the pharmacist is in a sense the facilitator of the doctor's judgement regarding medication; whilst it is the patient's condition under review, it is not in any substantial sense the pharmacist who reviews it. Since pharmacists (in hospitals at least) are not required to diagnose illnesses, but instead provide drug therapy for patients who have already received an assessment of their condition, the "double-bind" situation as described by Bloor and Horobin (1975) as existing in doctor/patient consultations is largely redundant here. The input of the pharmacist is largely concerned with assisting the patient in carrying out the doctor's medication instructions; any 'review' occurs in relation to reported difficulties in so doing. What remains, however, is the asymmetry of task distribution seen in medical encounters, although here it is related to dispensing rather than diagnosis. It is asymmetry in this task related sense that is most apparent in these oncology clinic encounters; the suggested interactional dominance of the pharmacist in the initial phase of the extract above is strongly related to dispensing contingencies. Thus, since the pharmacist has a particular task to accomplish (handing over the medications) and the patient or carer has visited the pharmacist primarily to receive this medication, the pharmacist's directing or 'dominating' the encounter is perhaps the easiest method to ensure that this is brought about swiftly and successfully for both parties. Whilst the physical component of this task, the dispensing, is clearly in the domain of the pharmacist alone, the interactional component of advising or informing, drawing as it does on potentially mutual knowledge, is less sharply defined. Asymmetries of knowledge in this setting are both less evident, and much more fluid, reflecting the shared body of experience and competence with chemotherapy medication that exists

between the pharmacist and the long term oncology patient.

This differential professional status is certainly something to which pharmacists orient in the course of their work. Changes to an expected course of therapy, for example, or apparent irregularities, are likely to be justified by the pharmacist in terms of doctors' decisions, as in the extract below.

### Transcript 1: sc/op/be (basic transcript)

- 13 Ph: Right() so it's been increased to 75% [ () and he's coming back next week  
for
- 14 M: [ Mmmhmm
- 15 Ph: vincristine isn't [he?
- 16 M: [Yeah
- 17 Ph: I spoke to Dr (name) about this and he said that instead of () you doing  
18 another blood count next week()
- 19 Ph: he's just gonna write up two weeks this time and just give you the  
20 vincristine () and then he can go home again.
- 21 M: OK that's fine thanks=
- 22 Ph: =that that saves you some time doesn't it?()
- 23 M: Yeah
- 24 Ph: so he's got his normal full 60mg() his 30 mercaptopurine and his  
25 methotrexate and his pred that day()
- 26 Ph: and then his prednisolone for 5 days ()
- 27 Ph: and then you go back to the normal so you've actually got 2 weeks=
- 28 M: =Right
- 29 Ph: and if you have any problems then Dr (name)'ll send you back down and  
30 we'll always do you another one [if anything's changed()
- 31 M: [ OK right

Here, the pharmacist's utterance in line 17 "I spoke to Dr (name) about this and he said that..." serves to invoke authority for the change of procedure; it also gives some indication of the negotiation of boundaries which is constantly occurring in the clinic between the number of medical professionals involved in the care of oncology

patients. This division of responsibility is echoed in line 29 ("and if you have any problems then Dr (name)'ll send you back down... "), reinforcing the suggestion that the pharmacist here is responding to the doctor's instructions, and that the doctor in turn will take responsibility for any problems which occur as the result of this change.

It is not only pharmacists' interactions with patients that display this sensitivity; the delicacy of the relationship between pharmacist and doctor is also apparent in those encounters where both are present. Under the old clinic arrangements, where the two were geographically remote, most interaction between doctor and pharmacist took place over the telephone. Under the new arrangements, however, the proximity of the consulting rooms means that most queries or difficulties are dealt with on a face to face basis. In the extract below, the doctor's reason for entering the pharmacist's room is unclear, but the pharmacist takes the opportunity to raise a question about dosages (which, for chemotherapy, are calculated on the basis of body surface area rather than age).

**Transcript 39:- kj/nc/op (basic transcript)**

- 14 Ph: So it's 100% for 2 weeks then is it?  
15 M: Yeah  
16 Ph: Does that sound like what you were expecting?  
17 M: yeah  
18 ((Doctor enters room))  
19 Ph: ((To Dr)) I'm gonna give Dr ( ) (name) and the other ones the old surface  
20 area ( )  
21 Ph: [Is that fine by you?  
22 Dr: [Yeah (.) If it's only changed by 0.01 I think ( ) I wouldn't change it  
again=

- 23 Ph: =Yeah ( ) so ( ) probably won't have changed much  
 24 Dr: Have you got (name)'s there I'll do that while I'm here ((takes drug card))  
 25 Ph: Oh yeah ( ) Oh Yeah (.) (name)'s you've done a vincristine for next week  
 26 ( ) but(.) it's increased (.) from 0.8 to 1 ( ) shall I ( ) shall I order it at the  
 new one?  
 27 Dr: I've done it actually (..unclear as leaves room)  
 28 Ph: Oh ( ) Oh ( ) Right  
 29 Dr: ((returning)) It doesn't make any difference ( ) once it's that high ( )  
 30 Sorry to step in. ((Doctor leaves))  
 31 Ph: ((Handing medication to mother)) That's everything in there ( ) There you  
 go

Prior to this point in the consultation, the mother of the patient has informed the pharmacist that the doctor has just calculated a new surface area for her daughter. The pharmacist, however, has already dispensed a course of medication based on the old surface area, and the initial query addressed to the doctor (in lines 19-21) relates to this. Interestingly, the pharmacist's statement of intent ("I'm gonna give...") receives no immediate response, and it is not until he begins to follow it with the tag "Is that fine by you" that the doctor responds. There follows a discussion (lines 22-23) of the minimal implications of a small change in surface area for dosage purposes, and the doctor then asks (line 24) for a particular patient's drug card. As becomes apparent, the pharmacist has already noticed an oversight on this card, but the manner in which he points this out to the doctor is exceptionally hesitant (lines 25-26), and ends with a suggestion that he will correct the doctor's mistake. The response from the doctor occurs in two parts:- "I've done it actually" (line 27) produces a rather conciliatory response from the pharmacist in line 28, but this is then elaborated further to suggest that he hasn't actually "done it" ("it" being ordering the new dosage), since the recalculation of surface area made no difference to the dose.

This exchange is in many ways fairly characteristic of the difficulties that can arise

in the doctor/pharmacist relationship, since one of the main functions of the pharmacist is to act as a second check to the doctor's prescribing, picking up on any possible problems or errors prior to dispensing the medication. This function necessarily results in frequent discussion between the two professionals in which pharmacists are required to raise the possibility that an error has been made, which (as here) can be a delicate process. (As an aside, it is interesting to note that doctors frequently answer phone calls they know to be from pharmacy with the opener "What have I done?!").

Returning to this specific consultation, the doctor's final utterance in line 30, "Sorry to step in", indicates once again the boundaries which exist in the clinic setting, although as a general rule (and perhaps as a matter of status) pharmacists generally appear to orient to these to a greater degree than doctors. In the extract below, two of the clinic doctors enter the pharmacist's room to look for a patient they wish to examine; when they find him they proceed to use the pharmacist's room to carry out the examination.

### **Transcript 31:- sg/nc/op (basic transcript)**

- 81 Ph: Did we used to give you the whole tablets and make you halve them  
82 yourself ( ) yeah  
83 ((Two doctors enter room))  
84 Dr 1:Hi (.) Sorry Hi (.) Where-  
85 -Where's your rascal gone to?  
86 M:He's run off in there  
87 Dr 1: Can I go and get him?  
88 M: Yeah ( ) Yeah (.) Drag him in ((laughs))  
89 Dr 2: You don't mind if we use your room as a consulting room do you  
90 (pharmacist's name)?  
91 Dr 1: What are you doing here?



92 Ph: (Name)'s gone off to ( ) holiday  
 93 Dr 1: Get o:nnn  
 94 Ph: Yeah (.) Didn't you know she was [on holiday  
 95 Dr 2: [Yeah (.) she's gone to Syria (.) ((To  
 96 patient)) So what's the problem here?  
 97 C: Spots  
 98 Dr 2: Yeah ( ) That tape recorder's going (.) Don't say anything((laughs))( )  
 99 Not that you would anyway  
 100 C: ((laughs))  
 101 M: There's a rash on his body ( ) and it come on his hands ( )  
 102 Dr 2: Does it come and go?  
 103 M: Yeah  
 104 Dr 2: Does it come when he's hot?  
 105 M: It does ( ) but it don't ((laughs))  
 106 Dr 2: Ohh ( ) that's ( ) sorted that one out [then  
 107 M: [Well like when he's hot it-  
 108 - it's like a bit more  
 109 Dr 2: Yeah ( ) More obviously red  
 110 M: But it's not heat rash cos it don't go away when he's cold ((laughs))  
 111 Dr 2: But they don't bother him?  
 112 M: No ( ) No (.) He has a few on his neck and he scratches them but on his  
 113 belly and his hands nothing  
 114 Dr 1: ((to Dr2)) That's what (...unclear)  
 115 Dr 2: We're not ruining your tape recording are we?  
 116 R: No (.) No  
 117 Dr 2: Sssh (.) Impartial observer (.) No intrusion into the conversation  
 118 Dr 1: (To boy) You're brilliant aren't you  
 119 Dr 2: Well I must admit it does look heat rash-ish to me ( ) I really wouldn't  
 120 be ( ) I don't think it's going to trouble you  
 121 Dr 1: ((to Dr 2)) (..unclear) Carry on with the E45 ( ) Yeah I suspected that  
 122 would has it-  
 123 -has that helped  
 124 M: Not really ((laughs))  
 125 Dr 2: No that's probably not going to stop it if it's heat rash(.) I'm sure it's  
 126 something like that  
 127 M: Right  
 128 Dr 2: Yeah ( ) He's had this before hasn't he?  
 129 M: Yeah  
 130 Dr 2: What happened to it?  
 131 M: It went away  
 132 Dr 2: There you go  
 133 ((All laugh))  
 134 Dr 1: Well ( ) Second opinion (.) Worth having ( ) See you (.) Thanks  
 135 Ph: Right ( ) Mercaptopurine big ones and methotrexate ( ) That one has got  
 136 one of the ( ) labels where you fill in spaces ( ) you don't need that do you?  
 137 ( ) So that's big methotrexates ( ) that's it  
 138 M: Yeah  
 139 Ph: There you go ( ) I've given you ( ) your Septrin have I?

140 M: Yeah  
141 M: Have you got the Septrin?  
142 ( )  
143 M: Yeah  
144 Ph: Yeah (.) and you've got the prednisolone  
145 M: Yeah  
146 Ph: That's your lot ( ) OK ( ) See you in a month's time  
147 M: Yeah ( ) Bye  
148 Ph: OK Bye

Here, when the second doctor does ask the pharmacist if he minds the use of his room as a consulting room (lines 89-90), it is not framed as a question to which a negative answer is expected ("You don't mind...") and the first doctor begins speaking immediately after this utterance, so that no reply is received. After a brief exchange of pleasantries with the pharmacist (lines 91-95), the doctors then proceed to extract a history from the mother, and to examine the patient. Interestingly, although no explicit apology is made to the pharmacist for the interruption of his routine, at line 115 the second doctor asks the *researcher* if their presence is a problem, and on receiving a negative answer makes a joke about this. It is also interesting to note that although this examination takes place directly in front of the pharmacist, he is at no point asked for, and nor does he try to offer his opinion. Throughout this time he observes but takes no part at all in the conversation, and when the doctors leave (at line 134) he simply carries on from the point at which he was interrupted (making no reference to the rash or its treatment) and proceeds to dispense the rest of the patient's medication.

These two consultations where both doctors and pharmacists are present raise significant issues with regard to the negotiation of boundaries, authority and status, and suggest that they are all factors which both parties orient to, albeit in different

senses. Since these issues of deferral and negotiation are clearly available in the talk, it is reasonable to presume that they are also available to the patients and carers attending the clinic. It seems highly likely, then, that at least some of the differences between doctor/patient interaction as reported in the literature, and pharmacist/patient interaction as described here, may be attributed to differential professional status.

An interesting way in which this issue of differential professional status manifests itself in the data is in the discussion of patients' prognoses, as opposed to their treatment regime. Clearly, there are two factors at issue in these repeat clinic visits: firstly the patient's continuing chemotherapy treatment; and secondly the wider issue of their condition, their progress and their general well-being. The researcher's own experience as a member of the oncology clinic staff would suggest that whilst both of these are considered appropriate topics for doctors, patients and their carers to bring into discussion, consideration of the latter is rarely raised by pharmacists. While pharmacists discuss particular treatments, changes to dosage regimes etc, they appear to be reluctant to be implicated in any talk regarding diagnosis or prognosis of a particular patient. Perakyla (1991), in his ethnographic work on a leukaemia ward, describes "A recurrent conversational activity, whereby the medical identities of the patient and the staff are explicated in terms of the hopefulness of the situation" (Perakyla, 1991, p407). The term he gives to this activity is "hope work", of which there are three variants: in curative medicine hope work is defined as "getting better", in palliative medicine, "feeling better", and in work to dismantle hope, "past recovery". Amongst his data there are examples of doctors using such phrases as "when you get better", and such phrases are not limited to patients who are, in

medical terms, expected to recover. Accounting for this, he states that "If the patients concerned are willing to continue their work within the medical frame, then it is necessary to continually reinforce that social reality and its plausibility. This is achieved by hope work: specifying the patient as "getting better" and the doctor as being "in control of the situation" (Perakyla, 1991, p418).

Paradoxically, pharmacists do not appear to make these kind of statements in the context of the clinic. The only similar example to be found within this body of data is a pharmacist who tells a patient she is "looking better" and subsequently asks if she is "feeling better"; a question which may be related as much to a recent course of intravenous chemotherapy as to the patient's actual condition or disease state<sup>13</sup>. Where patients or carers raise these issues themselves, the responses of pharmacists, although enthusiastic to reports of progress, refrain from making any professional judgement about these.

This 'avoidance of implication' is evident in the consultation which has already been examined in some detail in this chapter, the end portion of which is reproduced below.

**Transcript 13:-lc/op/be (simplified transcript)**

- 47 Ph: You only increase your mercaptopurine (0.5) OK?  
48 M: Right(.) yeah  
49 (0.4 )  
50 As I say it's the first time she's got=  
51 Ph: =Is it the first time she's gone up that high(.) Oh right

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<sup>13</sup>"Looking better" may, in fact, be perhaps better characterised as a lay assessment rather than a medical one, since it does not focus on the objective condition of the patient.

52 that must be a good sign=  
 53 M: =(I don't need) the uhhm (.) dropper for Septrin she it must be about (.)  
 54 Uhhh three months now (I think)  
 55 Ph: Oh ri:ight  
 56 M: She's having uhh (.) pentamidine(.)  
 57 Ph: instead of Septrin 'cos she didn't respond very [well to it  
 58. M: [Well no we was just=  
 59 M: =forever going (.) right down o[ff treatment altogether and going=  
 60 Ph: [right  
 M: =[back to 50 again  
 61 Ph: [right  
 62 M: and definitely (.) well this certainly does seem to be working  
 63 M: [better  
 64 Ph:[seems to be working (.) excellent (unclear...)  
 65 Ph: Well that's a good sign anyway isn't it?  
 66 M: Mmmhmm  
 67 Ph: OK well I'll see you next week then

The point at which this extract begins is where the mother of the patient has recognized that the dose of one drug has remained the same whilst all the others have changed, and has asked the pharmacist about this. Accounting for her question, the mother begins to state (in line 50), that this is the first time her child has been able to receive full strength chemotherapy. The utterance that the pharmacist produces in response to this is not a categorical one, but a qualified assessment: "That must be a good sign", rather than "That's a good sign", which serves to locate any competence to judge this information elsewhere. In this way, whilst responding enthusiastically to this news, the pharmacist avoids passing her own judgement on the issue. The same kind of non-implicative response can be seen following the mother's assessment of the new therapy (pentamidine) which has been prescribed. The mother ends her turn by stating "Well this certainly does seem to be working better", and the pharmacist's response is a partial repeat of this statement followed by the description

"excellent". What the pharmacist is apparently stating is "excellent" then, is that the new therapy *seems* to be working better. No elaboration is offered on the mother's assessment, and no categorical statements are made. The following utterance, "Well that's a good sign anyway isn't it" has a similar non-implicative nature; again, the 'good sign' is apparently that the new therapy "seems to be working better", and the "anyway" serves to suggest that this good sign is despite the general situation.

Parenthetically, the hesitance with which pharmacists respond to these kind of patient or carer appraisals of their conditions (and the fact that they very rarely raise these issues themselves) may also shed some light on the kind of "How are you" opening strategies described previously, and the fact that there are either no responses at all or non-committal "OK thanks" type responses received to these. If patients and carers are aware that pharmacists do not usually raise the topic of their general well-being and coping, then it is unsurprising that they may hesitate to answer questions which are possibly directed at this very issue.

In terms of the reasons why pharmacists decline this type of interaction, it seems there are several likely factors. One of these may be knowledge, since they are not party to the same degree of knowledge regarding disease processes as doctors. However, they do attend patient case conferences in which these factors are discussed; equally, it is possible to tell a good deal about the progression of someone's illness from the drugs and dosages which have been prescribed. Thus it

is not exclusively that they are not in a position to make at least some comment through lack of knowledge, but rather that they consciously decline to. In terms of the division of labour within the paediatric oncology clinic, and indeed in terms of relations between the two professions in a hospital setting in general, matters of the patient's actual condition seem to be seen as falling into the domain of doctors<sup>14</sup>. In addition, it seems that pharmacists orient to this to a greater extent than do patients, since patients and carers do raise these matters with pharmacists.

It seems highly likely then, that at least some of the differences between doctor/patient interaction as reported in the literature, and pharmacist/patient interaction as described here, may be attributed to differential professional status as it is perceived by doctors, patients and carers, and pharmacists. However, it would also seem that the knowledge and competence displayed by the patients and carers in the oncology clinic is a fundamental factor in establishing the interactional basis for these encounters. This in turn has an influential effect on the nature of the asymmetries which are to be found here.

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<sup>14</sup> It is interesting to note that one of the strategies with which trainee pharmacists are taught to respond to patient's queries of a "What are these tablets for?" nature is "Why did you see the doctor?" or alternatively, "What did the doctor say?", in order to prevent any potential undermining of the doctor's actions.

## **CONCLUSIONS**



Over recent years crucial changes have taken place in the profession of pharmacy. The increased utilization of ready-prepared drugs has led to a decline in the need for the traditional skills of formulation, while computerization has resulted in a situation where much of the routine dispensing work can be undertaken by less qualified personnel. The decline of the traditional aspects of pharmacy has been matched by the emergence of a greater advisory role, where the pharmacist has been promoted as an accessible and approachable source of health care information.

The realisation within the pharmaceutical profession that its members were increasingly called on to give advice, to "counsel" patients on the use of their medication, and to disseminate health education messages has largely been responsible for the development of the concept of 'pharmacy practice'. Pharmacy practice has been described as an all-embracing term which encompasses the wide range of activities involved in the provision of pharmacy service delivery (Harding, Nettleton and Taylor, 1990). What these activities have in common, however, is that they are all largely talk based. An increased availability of proprietary medicines in the UK has meant that pharmacists have a greater opportunity (and a growing necessity) to see themselves as primary health care professionals interacting with the public (Mays, 1994). This 'extended role' has in turn had a far reaching influence on the nature of 'Pharmacy Practice Research' (PPR) over the last 15-20 years. Thus a considerable body of this research has been broadly based around the area of pharmacist/patient communication.

However, as the detailed review of PPR presented earlier in this thesis has attempted

to illustrate, although much of this research is *broadly* concerned with communication, there are few studies with a specific focus on the actual process of pharmacist/client interaction, or "patient counselling", as a topic in itself. Much of the published work is actually concerned with *attitudes* to counselling, and attempts to explore whether there are particular characteristics of pharmacists or clients which influence the amount of counselling that occurs. Another recurrent theme of this body of research has been patient counselling as a function of drug therapy, so that the counselling process is assessed on the basis of, for example, how many stepwise tasks associated with the use of an asthma inhaler that the patient can correctly perform after the counselling has taken place. Those few studies that have attempted to focus exclusively on the communication process have employed a fairly simple, quantitative social psychology framework. This quantitative approach to the study of communication, as can be seen in studies by Morrow et al (1993), Smith (1992b) and Wilson et al (1989), depends on developing a categorization system, and then coding and counting occurrences of a particular category type. Thus, in Morrow et al's study, in order to consider the questioning skills dimension of behaviour by community pharmacists, questions are divided by "types" and "functions", and the results discuss such variables as "Number of questions asked by the pharmacist per minute". As a result of this process of breaking down communication into discrete components, any practical suggestions arising from such research are limited to lists of specific, isolated features of 'good communication practice'. These guidelines ignore the dynamic, two way nature of the interaction and the reactive nature of advice giving.

In the light of the limitations of this previous research, the aim of this study has been to apply established sociological methods to the study of pharmacist/client interaction in a hospital pharmacy setting. By using a Conversation Analytic approach, an attempt has been made to examine the nature of face-to-face interaction between (in this setting) pharmacists, patients and their carers. The tendency of previous PPR approaches to gloss or idealize the specifics of what they depict has, as discussed, resulted in a loss of the finer features of the event under investigation. Thus, the distinctiveness of CA in its commitment to the use of naturally occurring interaction, and an avoidance of idealized theoretical and empirical treatments of the data, would suggest that the approach has strong advantages in the study of such a variable and imprecise activity as advice giving, in that the details of the interaction are maintained. In general terms then, this study has intended to begin the process of defining and analysing the communicative competencies required of pharmacists in this setting. In addition, the existence of a wide body of CA literature on institutional talk in general, and more specifically, advice giving by health care professionals, has provided a fundamental basis for this analysis.

In terms of the encounters recorded in this setting and presented here as a whole, many of the features described in the wider literature on institutional talk can be identified. Institutional interaction is sometimes described as involving a reduction and specialisation of the available set of mundane conversational options. This reduction and specialisation of conversational options appears to result in the localised production of a broad framework of interactional events that are more or less adhered to in the course of, for example, doctor patient interactions, or the process of plea

bargaining in legal settings. The same kind of recurrent, broad framework can be found in the pharmacist/patient/carer interactions presented here.

It should be noted, however, that such a sequential organisation is not limited to institutional interaction alone; Jefferson (1988), in considering the sequential organisation of 'trouble-telling' in ordinary conversation, describes a series of recurrent, positioned elements as comprising a "candidate" troubles telling sequence. If, then, particular aspects of mundane conversation can be seen to involve a reduction and specialisation of the available set of conversational options, the question arises as to how the structure of institutional talk differs from this. Zimmerman, in his study of the interactional organisation of calls for emergency assistance (1992), suggests that, as far as a practitioner is concerned, the intended effect of a standard ordering of work tasks in an institutional setting is to make the handling of the task as routine as possible. In this way, practitioners routinely use not only particular interactional strategies, but particular conversational machinery. It is this 'task of work' (in an occupational sense) orientation which is missing from ordinary or mundane conversation. Clearly, however, there is in these oncology clinic encounters a task to be accomplished for the pharmacist, which is to dispense the patient's prescribed drug therapy and to enable them to understand and utilise this accurately, effectively and with minimum discomfort.

Building on the idea that talk oriented to institutional settings usually involves repetitive occurrences, Zimmerman goes on to describe (noting a "constrained range of variation") a prototype sequence for such interactions, based on the emergency

assistance call (Zimmerman, 1992, p459). However, as can be seen from the data presented here, this sequence does not entirely describe the pharmacist/patient/carer encounter in this setting. There are of course some important differences across the two sets of data which perhaps go some way to explaining these variations. Firstly, these clinic encounters are not essentially anonymous, since patients and their carers attend the clinic regularly and frequently, often over a period of several years. These circumstances mean that the 'identification' element of an institutional sequence proposed by Zimmerman is largely absent in this setting, although it may instead be formulated as a 'recognition' of the patient or carer by the pharmacist. Likewise, what Zimmerman describes as the 'reason for the call' in his setting, ie the request for emergency assistance, is absent here, since in the oncology clinic encounters both parties to the encounter know why they are there. Thus, whilst the overall structure of the pharmacist/patient/carer encounter described here bears a considerable resemblance to the structure explicated by Zimmerman, it is not totally described by it. In addition, these oncology clinic encounters appear to share some features in common with the loose structure proposed by Jefferson for 'troubles-telling' in mundane conversation. It is suggested here that these differences from Zimmerman's data, and similarities with Jefferson's, may largely be explained by the existence of what is broadly termed advice giving as a feature of the oncology clinic interactions.

This is not to suggest that there are no similarities between the pharmacist/patient/carer encounter and the institutional encounters described by Zimmerman. On the contrary, there are common features between the two sets of

data. In both cases clients have contacted a professional in order to receive a particular service, and in both settings there are some activities which come between the initial contact and the delivery of this service (emergency assistance in the case of Zimmerman's data, and prescribed medication in the oncology clinic). However, the differences are significant, in that clients do not directly make a *request* for pharmacy services; instead, by making themselves available to the pharmacist, they indirectly create the relevance for receiving these services, providing a shared purpose and a point of departure. In addition, the activities that come between this establishment of relevance and the actual service delivery are different. In Zimmerman's data, the interrogative series is a means to an end, the end being the prompt despatching of the appropriate emergency service. In the pharmacy data, however, the interactional task of advice giving is a constituent component of the end goal, along with the physical provision of medication.

Advice giving is a particular kind of interactional activity which, whilst it may be contained in some institutional interactions such as HIV counselling, is equally likely to occur in mundane conversation. (It does not, however, generally occur in telephone calls for emergency assistance, where pressures of time would be likely to deem it inappropriate). In a sense advice giving as an activity is similar to troubles telling, since, just as the former requires the receiving party to align as an advice recipient in order for the activity to proceed, so does the latter require a properly aligned 'troubles recipient' in order for a trouble to be satisfactorily explicated. What is perhaps different here from Jefferson's data is that the roles of 'teller' and 'recipient' in the pharmacist/client encounter are to an extent institutionally defined; as has been

described, the 'task' of the pharmacist in this setting is to ensure that the patient or carer is in a position to utilise their therapy as prescribed, and with the minimum discomfort. As a result of this advice giving component of the interaction, the overall structure which has been explicated here for these encounters, and is reproduced overleaf, exhibits a combination of features from both Zimmerman's and Jefferson's templates.

**Zimmerman (1992)**  
**Emergency assistance calls**

Pre-beginning  
 Opening/Identification/  
 Acknowledgement  
 Request  
 Interrogative series  
 Response  
 Closing

**Jefferson (1988)**  
**Troubles-Telling**

Approach  
 Arrival  
 Delivery  
 Work-up  
 Close-implicature  
 Exit

**Pharmacist/Client Encounter**

Opening/Identification/Recognition/Acknowledgement  
 Greeting/How are you?  
 Approach to advice giving  
 Arrival at advice giving  
 Acceptance/Rejection of Intention  
 (Rearrival)  
 Delivery of advice/information  
 Response to advice/information  
 Close Implicature  
 (Questions/ Reclose implicature)  
 Exit

The differences or diversions from Zimmerman's structure appear to occur largely around the issue of advice giving, and the ways in which these issues of approach to advice giving, arrival at advice giving etc are negotiated exhibit considerable similarities to the manner in which 'troubles telling' and 'troubles receiving' are negotiated in a mundane conversation. Thus, not only is 'advice giving' apparently responsible for the deviations from Zimmerman's proposed structure, it is also responsible for the irregularities in the proposed structure of the pharmacist/client encounter presented here. Not all of the segments described in the explication of the overall structure are present in every encounter, and in some encounters they are subject to disorder. As in troubles telling, it appears to be misalignments that are largely responsible for creating interactional difficulties, since for the process to move beyond an 'arrival' at advice giving requires the co-participant (in this case the patient or carer) to align as an advice recipient. As a result, a much looser overall structure is suggested for these encounters than for Zimmerman's emergency assistance calls; the fact that these irregularities occur most noticeably around the area of advice-giving highlights the interactional delicacy of this activity.

Evidently, the issue of alignment is also crucial to an orderly progression of events in Zimmerman's emergency assistance call data; it is suggested, however, that to align as an 'answerer' is potentially less problematic than to align as an 'advice recipient'. It is in this sense that the similarities to Jefferson's data are noted, since it can also require a great deal of interactional work in order to achieve a co-participant's alignment with a 'troubles telling'. This 'problem of alignment' is of course true of other mundane conversational activities, for example story telling;



Jefferson's work is used as a point of reference to emphasise the interactional delicacy which may be common to both her data and the pharmacist/client encounter.

This interactional delicacy is perhaps most evident in the clinic encounters at the **initiation**, or approach to and arrival at the section of the encounter concerned with advice giving. As has been suggested, advice giving is an activity which denotes an expert-novice relationship, and hence the setting up of an advice giving sequence in a setting where the 'advice recipient' may already have a great deal of knowledge regarding their condition and its treatment can be interactionally problematic. A range of strategies have been identified in the data which appear to constitute the existence of this client competence to a greater or lesser degree. These strategies are set out overleaf:

### **Provisional Typology of Methods of Arrival at Advice Giving**

- 1) Patient/carer initiated
- 2) "Business transaction" (where no advice is forthcoming)
- 3) "Unilateral"
- 4) Statement of intention to give advice
- 5) Statement that no advice will be given
- 6) Questioning
  - a) "Do you want me to explain?"
  - b) General questioning/ "How are things?"
  - c) "Is it what you're expecting?"
- 7) Collaborative

In actual fact, not all these strategies directly topicalise advice giving as an appropriate activity or lead into the process of advice giving itself. The "basic business transaction", for example, consists of a handing over of the medication with no attendant explanation regarding dosages etc. Likewise, the 'statement that no

advice will be given' only topicalises or projects advice in the sense that it makes relevant to the recipient that no advice will be given unless it is specifically requested. Requests by patients or carers for advice are almost absent from the data, occurring only once in the entire body of data in terms of **initiating** an advising or informing sequence, and only sporadically in terms of specific clarifications in response to a pharmacist initiated sequence. The remaining strategies, as has been discussed, actually project advice to greater or lesser degrees; with the 'unilateral' approach, the entry into advice giving forms part of the advice giving sequence itself. The production of dosage details in this type of strategy thus occurs regardless of any topicalisation or establishment of relevance for the forthcoming advice. In this sense the initial segment of advice is 'projected' and 'delivered' simultaneously. Statements of intention to give advice by pharmacists also appear to project advice quite strongly, since the kind of "I'll go through it all with you" type statements found here seem to serve to provide the interactional space for a (sometimes prolonged) advising sequence to occur.

Summarising the questioning-as-approach-to advice strategies, these appear to vary in the extent that they topicalise the relevance of an advice giving sequence. Thus "Do you want me to explain?" type questions depend on an affirmative answer from the client in order for advice giving to proceed; however, as is evident in the data, such questions may be further elaborated with a reason why the pharmacist feels it necessary to specifically offer advice on this occasion. Such an explanation of non-routine circumstances (eg the lack of blister packs) projects the relevance of a subsequent advising sequence very strongly. In some ways similar is the "Is it what

you were expecting?" type approach, which once again depends on the patient or carer's statement (in this case that it was not what they were expecting) in order for the relevance of any further dosage detail related sequence to be relevant. Perhaps most problematic in terms of setting up these consultations as encounters in which advice may be given by the pharmacist is the 'general questioning' type strategy; although "How's the medication going?" may topicalise the medication as an issue to be talked about in the encounter, it does not explicitly make relevant the production of advice unless the patient or carer gives a very specific response. When these questions become even broader, such as "How are things?", the patient or carer may be unclear as to whether it is the actual medication that is being topicalised, or whether it is more general issues of progress and well being. In this sense the relevance of an advice giving sequence is projected very weakly indeed.

The final strategy identified, the 'collaborative' strategy, addresses the actual practices that patients or carers use to manage their therapy, as opposed to the dosage instructions that will theoretically enable them to do this. Through this process, the patient or carer is encouraged to take an active part in the advice giving, so that a course of action is apparently negotiated by both parties rather than imposed by one upon the other. In this case then, advice is topicalised by the bringing into discussion of particular administrative practices or dosage related issues, and the advice which ensues is contained in this discussion format.

The second major issue around these 'entries' into advice giving is one already raised briefly in this discussion, client knowledge and competence. The strategies discussed

here orient to this competence to varying degrees, some more explicitly than others. Thus the 'basic business transaction' and 'statement that no advice will be given' type arrivals both appear to be based on a common presumption of client competence, where the implication is that no advice is offered because none is expected to be needed. In contrast, the 'unilateral' strategy makes little apparent allowance for competence, although it may be delivered using terminology which both implies and requires that the client has some prior knowledge of clinic procedures. Within this unilateral approach, varying degrees of a 'softened' orientation to competence may be found, for example the relation of current instructions to prior ones. Likewise, statements of intention may be softened where the pharmacist provides a reason for why he or she will "go through it all with you". Such kinds of unqualified statements are potentially the most antagonistic to client competence, since, as has been noted, to propose "going through it all" with someone may be heard as presupposing that they know nothing.

Questioning strategies, particularly where they too are qualified, may display a more explicit orientation to competence, since an utterance of the type "Do you want me to just explain?" allows for the fact that the patient or carer may not find this necessary. Further, when the reason for this proffered explanation is provided (as in "It's X's first time having blisters, do you want me to just explain?"), the fact is provided for that whilst on other occasions a client may be perfectly competent in the administration of prescribed medication, this is a special case and is outside, and therefore unaffacting, that competence.

General questions as an entry into advice giving are more difficult to consider in this context, since as they do not explicitly topicalise advice or a perceived need for advice, they similarly do not explicitly constitute issues of knowledge or competence. (Although there is a sense in which a question such as "How's the medication going?" may be interpreted as constituting the recipient as someone who is competent to give an assessment of this). The final questioning strategy identified, however, the "Is it what you were expecting?" type question, is perhaps the most explicit of all the strategies described in its orientation to patient or carer competence.

By use of this strategy the patient or carer is clearly identified as someone who has an expectation of their chemotherapy regime, tying in as this does to an ongoing relationship with the pharmacist and an established knowledge base. In this way, this type of questioning displays sensitivity to parental competence and serves to reduce any explicit gap of knowledge between the pharmacist and the patient or carer. However, as with all cases where a certain degree of knowledge is presumed, a possible difficulty may be that the recipient is required to have a prior expectation in order to know whether a situation differs from it.

In many ways, the sense in which the final strategy identified, the collaborative strategy, serves to constitute patient or carer knowledge has been raised above in relation to the way advice is topicalised and projected by use of this approach. Since the patient or carer is drawn in to the advice giving process and incorporated in the formulation of any future courses of action, this future course of action is apparently achieved collaboratively by both parties using their joint or shared knowledge of drug

dosage and administration. Thus, although competence is not explicitly invoked, as in the "Is that what you were expecting?" type questions, or assumed, as in the "basic business transaction", it is established in the encounter without ever directly (or confrontationally) becoming an issue for examination.

It should, of course, be stressed again that these categorisations are not necessarily considered as being employed by members of the interaction themselves, but are instead intended merely as a means of distinguishing the different ways in which advice giving is brought about in this setting, and of highlighting the members' orientations to differing approaches to advice. The consideration of these processes, however, underlines the delicate and potentially problematic nature of the 'entry into advice giving' in these consultations. Even where patient or carer knowledge is demonstrably oriented to, the ways in which this is topicalised or elicited can in themselves be problematic. In a practical sense, the perceived differences between these formats which have been summarised here appear to be most important in terms of the responses that are received from clients, and the implications of these.

It has been noted that "patient counselling" is an ill-defined activity, which occurring as it does across different settings (retail pharmacy shop, hospital ward, hospital clinic etc) involves a variety of different tasks and goals. Some of these are broad and long term goals, such as advice on diet or lifestyle; others, particularly those based around dosage and administration of a particular medicine, are both more short-term and more specific. It can be seen from the data presented here that what "patient counselling" in this setting routinely appears to consist of is the fairly specific task

of giving patients or carers the dosage details of their medication, as this medication is handed over. In some consultations this is broadened to discuss methods of administration or possible side effects, for example, and in others there appears to be a lack of even the most basic information regarding the medication. Once again, the fact that these are long term patients would seem to be a fundamental factor for the way in which these sequences develop. If advice giving in itself can be said to be a problematic activity, then attempting to give advice to someone who already has a great deal of knowledge about their situation has the potential to be even more problematic or delicate.

In addition, the fact that this is a paediatric clinic adds an extra moral dimension; there is a parental **obligation** to look after a child, and it is suggested here that this obligation is heightened in the case of a sick (or in some cases dying) child. Alongside this parental obligation is an attendant desire to illustrate that it is an obligation which is being properly fulfilled. Thus, there is a potential source of conflict, since to align interactionally as an advice recipient may serve to negate or downgrade a carer's existing body of knowledge and it turn make it more difficult for the carer to demonstrate their competence in fulfilling their obligations of care. However, there is a potential "double bind" situation here, in that it has been suggested, in societal terms, that the advice of health professionals is not something which should be challenged, because to make such a challenge calls doubt on our civil status as 'good parents' in the sense of people who are aware of and acknowledge their warrant to advise. In this way, a carer's desire to *display* that they are 'a good

parent' (in the sense of managing their child's chemotherapy regime) may run contrary to the expectation that they will listen to the advice which is given by health professionals, regardless of whether this contains items that they already know.

This paradox may play a major role in explaining the fact that in the entire corpus of data collected here, there is only one instance of a mother-initiated approach to the commencement of an advice sequence. Even this sequence, analytically, however, may be better described as a request for information. As Heritage and Lindstrom (forthcoming) note, considering their health visiting data, a request for advice constitutes an admission of uncertainty about an appropriate course of action, and may further imply that its producer lacks knowledge concerning the issue at hand or is unable to cope with a problem without external assistance. A request for information, however, may be viewed differently, in the sense that "If you can supply me with this factual detail, then I will be in a position to undertake this activity unproblematically, and using my own knowledge". Thus a request for clarification of a chemotherapy regime does not imply general uncertainty, but the lack of knowledge of a specific detail, which, once provided, will enable the carer to continue with the administration of her child's medication. Nevertheless, allowing for the removal of this 'moral' dimension from the equation, the issue of 'being seen to lack knowledge' in itself appears to be important in this setting.

The delicacy of this situation becomes clearly apparent in the receipts of pharmacist's advising or informing utterances by patients or carers in the oncology clinic. Characterising these receipt utterances as a whole, they are largely minimal, and in



some cases are evidently intended as an attempt to truncate particular segments of the pharmacist's talk, or at least to interactionally downgrade their apparent 'usefulness'. As a result, these responses are often unhelpful in allowing us (or the pharmacist) to establish the actual degree of knowledge or understanding which a patient or carer actually and demonstrably possesses, as opposed to claims to possess. This situation is perhaps most apparent in the sequences where pharmacists deliver information in a 'unilateral' fashion, without any prior attempt to establish whether this information is needed or desired by the patient or carer. The minimal response tokens received in these kind of sequences are perhaps then, a result of two factors: firstly that a minimal response is all that is interactionally required from the patient or carer for these kinds of sequences to proceed; and secondly, since this may well be 'old' information which is being imparted, an attempt to downplay or minimise their acknowledged usefulness. It has been suggested here that this kind of delivery has considerable similarities with the instructional sequences described by Goldberg (1975); where the two sets of data differ most obviously is in terms of recipient response. In particular, Goldberg suggests two things which do not appear to apply entirely to this data: firstly that, although there are limited resources a recipient can use to demonstrate rather than assert understanding in this kind of sequence, there are devices such as 'transformations' (eg 'one fourth' for 'a quarter') which will achieve this, and which can be located in her recorded talk. Secondly, in order for an instructing sequence to proceed, there is an interactional requirement for one instruction component to be acknowledged by the recipient before the next can be issued; Goldberg illustrates how such acknowledgements are interactionally sought by the instructing party. Considering the former issue first, in this oncology clinic data

these kind of 'transformations' are largely absent from what might be described as instructional sequences in the interactions, although there is one example of a patient producing a 'resummary' in response to the conclusion of the sequence. In the vast majority of cases, acknowledgements of instructional utterances consist of minimal acknowledgement tokens such as "Mmm", "Yeah" and "Right". This in turn relates to the second of the issues raised by Goldberg, since in some cases there is no acknowledgement forthcoming at all. Additionally, where this lack of response occurs, it is not necessarily followed by any pursuit of acknowledgement on the part of the pharmacist, who may continue with the next instructional segment regardless.

Considering that the end goal of the pharmacist in these encounters is presumed to be to ensure that the patient or carer is in a position to comply with their prescribed therapy safely and effectively, such interactional sequences do not reveal a great deal about the achievement of this goal. Thus, although interactionally they may appear to proceed smoothly, in this (limited) sense they may be considered unsatisfactory. It may also be supposed that this 'unsatisfactory' characterisation is likely to extend to the patient or carer's viewpoint, as the irritated tone which has been remarked upon in some of these transcripts suggests. The major problem with this approach then, is suggested to be that, whilst it may attend to competency in some respects, it is not specifically tailored to individual competencies. In this way, although the extent of an instructional sequence may be made negotiable, the initial instructions are not. Thus the pharmacist runs the risk of at best providing information which is redundant, and which at worst may be regarded as an attack on the patient or carer's competence

in the continued administration of their chemotherapy regime.

As has been noted, other methods of approaching the advice giving sequence which are used by the pharmacists in this setting do not necessarily preclude the subsequent production of a 'unilateral' delivery. In particular, 'statements of intention' to give advice and questions of the 'Do you want me to just explain' type appear to act at least partly to 'set the stage' or provide the interactional space for this kind of sequence, with the same resulting problems. In fact, of all the 'arrival devices' discussed, it is only the 'collaborative' strategy that in any real sense routinely produces extended responses from patients or carers, and thus explicitly brings out the issue of demonstrated knowledge. However, this strategy is also potentially the most difficult for the pharmacist to bring about successfully, in the sense that the avoidance of any direct questioning of competence means that it may be misinterpreted by the carer. Nevertheless, it is precisely the indirect nature of this approach which leads to its description as the most 'successful' of all those strategies identified here, in terms of both achieving the end goal of the pharmacist, and overcoming the attendant difficulties of patient or carer knowledgeability or competence by topicalising an interactional demonstration of this.

Attempting to evaluate these findings in the context of the wider CA literature, there is a body of work to draw on which has considered the activities of advising and informing in broadly medical settings, and in some cases attempted to draw distinctions between the two. As can be seen from the consultations presented here, "patient counselling" in this setting is largely an activity that consists of making

statements to clients about what should be done or how one should act in the future. As such, it is possible that it may be set up in a normative, non-normative or directive fashion. Likewise, it may be produced and treated as advice or information without this distinction being problematic in the interaction. However, in terms of the wider literature, there are some significant observations to make. In particular, Silverman, Bor, Miller et al's (1992) suggestion that non-specific, non-personalised talk is likely to be produced and treated as information, and that in contrast advice is personal and specific, is problematic in this data.

Silverman further suggests that the difference between the two 'formats' is that, in an 'Information delivery format', patients are only interactionally required to give response tokens or unmarked acknowledgements. In the oncology clinic, pharmacists tend to set up all their consultations as non-normative, or even directive. What are prevalent, however, are utterances containing personalisation and specification. However, even with near identical interactional set ups in terms of patient specific, non-normative packaging of details, these utterances are received in a variety of ways. Whilst (almost exclusively) pharmacist's utterances are not framed in terms of choices or opinions about alternative courses of action, but rather the stating of one definitive strategy, a variety of responses may be found. These range from minimal response tokens which merely assert understanding, through to clear demonstrations of this understanding. Interactionally, these differences are important not only in terms of demonstrated patient understanding, but also in relation to whether a minimal response may be heard as accountably disattending the character of a previous utterance.

Judging by the data presented here, it does not appear that these interpretations are treated as problematic, since, as has been noted, all of the responses (including the most minimal) are generally treated as adequate by the pharmacist. To an extent, what Silverman's distinction seems to hinge on is that advice giving requires strong interactional uptake to persist over several turns. What has been attempted here is to adopt a descriptive approach, which avoids imposing *a priori* definitions of advice and information, and instead tries to explicate the practices used by the participants themselves. Although this draws on other concepts of advice and information (particularly Heritage and Sefi's (1992) concept of the normative dimension of advice giving), it has tried to consider advice, information and instruction as members' or participants', rather than observers' distinctions. A lack of interactional uptake suggests, for Silverman, that an utterance has been treated as information. In terms of this approach, however, minimal uptake does not imply that an utterance has not been heard as advice, merely that it has been interactionally minimized, rejected or dismissed by the client. The difficulty in this situation, as in other professional/client encounters, is that only some of these responses will actually indicate that the client has taken on board (and is in a position, if they so wish, to act upon) what has been said.

Concluding for the moment the discussion of advising or informing as an activity carried out by pharmacists in this setting, and turning to consider other aspects of the encounter, there are other areas in which the existing CA literature (and particularly the literature on institutional talk) appears to shed light on the interactions which occur. The way that exits from advice giving and closings are managed in this setting

displays a clear orientation to the fact that these are conversations-in-a-series, and thus the use of 'next time' is an available resource which may be used to indicate that 'this time' is over. Issues of knowledge and competence are also pertinent here. Since there may be a lack of a clearly defined end point to the consultations (both in terms of time and in terms of 'agenda'), it generally falls to the pharmacist (as the party ostensibly 'in control' of the interaction) to topicalise bringing the encounter to a close. However, there are instances in the data of consultations where a movement out of advice and into closing is topicalised by a patient or carer. In order for the client to bring this about, the assumption must be that they have the competence to know when the 'advice giving' is over. As suggested, there may be several factors in play here, including the availability of non-verbal cues. However, whether the competence described is competence in the sense of knowing that all the required medications have been handed over and described, or knowing that if all the visible medications have been handed over that this is in itself closing implicative, it still appears to be a significant factor in establishing these endpoints.

These issues of knowledge and competence which pervade the data link in to the final theme for analysis which has been presented here, which is the issue of asymmetry. There is a large body of institutional talk literature which considers asymmetry as a feature of the doctor/patient interaction, and describes how this asymmetry is interactively achieved by both participants to the setting. In part, it is suggested that these patterns develop as a way of handling the interactional difficulties that the doctor/patient encounter creates, and the tasks that it entails. However, the majority of this literature is based on episodic, rather than long term sequences, and

conversation analysts in general have not tended to focus on long term interactional sequences. It has been suggested here that encounters with long term patients contain significant differences, and that these differences centre around the issue of knowledgeability. In addition, the 'ownership' of a chronic illness is in many senses greater, since the patient has a wealth of personal experience on which to draw when making statements with regard to management or treatment. The fact that these are paediatric clinic encounters adds a further dimension, in that it is generally the *carer* rather than the patient who is in receipt of the advice, resulting in a triangular situation where the carer is in an authoritative position in relation to the patient. Furthermore, since this data involves pharmacist/patient, rather than doctor/patient consultations, interesting questions of status and expertise are raised in the sense that, within the medical hierarchy, pharmacists are not generally seen as having the same status as doctors. A final factor is that, since the existence of specialised or 'dedicated' clinic pharmacists in the hospital setting is a relatively new development, there may be some additional uncertainty with regard to their status.

There are also important differences to note between these encounters and other non-physician health professional/client encounters; the example that has been used is that Health Visitors may need to establish with their clients 'what their visits are about'. In this setting, however, the patients or carers have a clear idea of why they are there, and will already have had regular contact with a pharmacist during their initial inpatient therapy following diagnosis. All of these factors have implications for the interactions which occur, and may go some way towards explaining some of the

apparent differences between these encounters and the health professional/patient encounter as reported in the literature.

Issues of competence appear to be significant here not only in terms of whether this competence is oriented to, but also **who** is perceived to possess this competence. Strong's (1979) assertion that the medical audience has "tacitly validated mother's authority" (Strong, 1979, p61) is apparently evident here also, since the rare fathers who attend the clinic as occasional sole representatives of their child are not treated as 'ideal' representatives. Instead, the expertise of the mother may be invoked (by both parties), so that where competence is claimed by the father or assumed by the pharmacist, this reference is made on behalf of another party. Although representatives other than a mother may be treated by the clinic staff as competent parties, this orientation appears to be something which is achieved over a period of time and evaluation.

The use of jargon (in this case medical, technical terms) in the consultations is one means by which competence and knowledge are explicitly invoked. Throughout this data, patients and/or carers commonly use technical terms, and pharmacists appear to treat this knowledge as something which the patient has access to. This is one of the significant ways in which the 'knowledge based asymmetry' which is commonly described in institutional settings appears to be somewhat eroded in this data. Additionally, although features of knowledge based asymmetry are sometimes evident, the ability of the patient or carer to relate 'new' information imparted by the pharmacist to the knowledge that they have already built up has a minimising effect.



This body of knowledge which the patient is party to in turn can have an effect on the degree of interactional dominance which is commonly exhibited by the professional party in lay/professional encounters. Patients' or carers' descriptions of their conditions or treatment in this setting are frequently couched in the same terms as those used by pharmacists, and they are not hesitant to draw their own conclusions or to make their own assessments as to how a particular drug is working, or how the use of a particular drug should be tailored to their circumstances.

However, returning more explicitly to the relation of this data to the published doctor/patient literature, the notion of "interactional submission" (Ten Have, 1991) would still seem to have some relevance. In the case of doctor/patient encounters, such submission has been accounted for in terms of the task distribution that exists, particularly in terms of diagnosis. Likewise, in these clinic encounters, there is a particular task to be carried out (dispensing a patient's medication) which may necessitate the establishment of certain facts by the pharmacist. Despite their (often apparent) knowledge, patients or carers seem prepared to accept this 'control' of sections of the encounter by the pharmacist, and it is therefore asymmetry in this task related sense that is most apparent in these oncology clinic encounters. Asymmetries of knowledge are both less evident, and more fluid, and it is suggested that this observation reflects the shared body of knowledge and competence with chemotherapy medication which exists between the pharmacist and the long term oncology patient.

Turning to consider issues of professional status, the ways in which pharmacists orient to this are evident in the data. Thus, as has been described, pharmacists invoke

the authority of doctors in terms of describing changes to therapy or procedures (or indeed, in terms of dealing with anticipated problems). Further, the ways in which pharmacists treat patients' discussions of their prognoses, or general well being, as opposed to their treatments, appears to demonstrate an orientation to status and/or boundaries. While pharmacists discuss particular treatments, changes to dosage regimes etc, they appear reluctant to be implicated in any talk regarding the diagnosis or prognosis of a particular patient, even where this issue is initially raised by the patient or carer. Although this may in part be knowledge related, it would seem that this is not the only factor involved. In terms of the division of labour of the clinic, it would appear that matters of the patient's actual condition seem to be seen as fully within the domain of doctors' rather than pharmacists' expertise. In addition, it would appear that pharmacists orient to this to a greater degree than do patients, since patients and carers do raise these matters with pharmacists. It seems likely then, that at least some of the differences between doctor/patient interaction as reported in the literature, and pharmacist/patient interaction as described here, may be attributed to differential professional status as it is perceived by doctors, patients and carers, and pharmacists. However, the fact that these are long term patients with a serious chronic illness is a fundamental factor, and the influence that this exerts on the interactions can be seen throughout the data. The knowledge and competence that these patients and/or their carers come to possess over their period of hospitalisation and attendance at the clinic is perhaps the most significant of all the factors described in establishing the interactional basis for these encounters. Evidently, this in turn has an influential effect on the kinds of asymmetries which are described here.

This discussion began by suggesting that the practical relevance of some previous research into pharmacist/patient communication has been limited, largely by virtue of its methodology, to providing lists of specific, isolated features of 'good communication practice'. In conclusion here then, some brief consideration will be given to the possible practical applications of a Conversation Analytic based study such as this. Despite the emergence of the 'advisory role', communication with patients or clients is not an area which has received much attention in the strongly natural science based undergraduate pharmacy curriculum in the UK. In recognition of this, the Royal Pharmaceutical Society of Great Britain has introduced a mandatory requirement for a social and behavioural science component to be taught in Schools of Pharmacy. Part of this component is described as "the study of those interpersonal processes and factors which affect the behaviour of pharmacists during social interaction" (RPSGB, 1991). Commendable though this development is, it creates a training problem in that it is difficult to consider interpersonal interaction in isolation from its setting, and many undergraduates have no experience of working in a pharmacy. For some pharmacists-to-be, their first experience of dealing with clients comes in the pre-registration year spent in employment, where formal training is at the discretion of the employer.

There is perhaps then, a contradiction between the expectations of the modern pharmacist's role as an advisor, and the training with which they are equipped for this. In order to translate interactional skills into training, there is an initial need to see how good advice giving practice within pharmacy can be identified and disseminated. This study has been intended largely as an *examination* of face-to-face

interaction between pharmacists and clients in a specific setting, in order to shed some light on the actual interactional process of "patient counselling". In so doing, however, it has attempted to consider the apparent association between the way in which an advice giving sequence is set up in the course of an interaction and the response which is elicited. It seems reasonable to suggest, in the light of this, that this line of work ultimately offers an opportunity to develop interactional skills training for professionals which will help them both to design more effective advice giving sequences and to monitor patient response, so that they can find out at the time whether people have actually received and understood what they have been told. Focusing on clients' responses is one such method of establishing whether advice has been understood or even acknowledged. Given the variety of situations in which a pharmacist may find him or herself, CA cannot attempt to provide a blueprint for communication in the way that social psychology attempts to do with its instructions on touch, gaze etc. However, advice giving is a reactive process, and what CA methods can do is to make pharmacists aware of the range of different interactional strategies that are open to them. Those that they currently employ are likely to be adequate on some occasions, but there are others which may be preferable in different circumstances, or at different points within the same occasion. The process of viewing the interaction as a naturally occurring whole, fundamental as it is to CA, could be used to encourage pharmacists to think about the dynamics of advice giving, and to aim towards designing each individual encounter in an appropriate and effective manner. Reflecting the time and resources available, the study presented here has concentrated on a small set of data collected from one particular site; nevertheless it is hoped that this has underlined the importance of face-to-face

interaction as a fundamental component of the advisory role. Further work would enable a more close definition of the communicative competencies required of pharmacists, an exploration of the ways in which these may influence patient outcomes, and a provision of resources for training in interaction skills.

**APPENDIX: Glossary of Medical Terms**  
**Patient Information Leaflet**  
**Simplified Transcripts**

## GLOSSARY OF MEDICAL TERMS

**ALL:** Acute Lymphoblastic Leukaemia. A form of leukaemia most common in the first five years of life, and rare after the age of 25. Accounting for 85% of all childhood leukaemia, the survival rate may be as high as 60%.

**Allopurinol:** Drug used to control breakdown products of cells during chemotherapy treatment.

**Corsodyl:** Antiseptic mouthwash used to prevent oral bacterial infections.

**Co-trimoxazole:** Antibiotic used as prophylaxis against infection in UKALL XI patients.

**Gentamicin:** Broad-spectrum antibiotic used for the treatment of 'blind' (ie unknown) serious infections, usually in conjunction with another antibiotic.

**Lactulose:** Liquid laxative preparation.

**Magnesium glycerophosphate:** A source of magnesium which can be given orally.

**Mercaptopurine:** Cytotoxic drug used as maintenance therapy for acute leukaemia.

**Methotrexate:** Cytotoxic drug used as maintenance therapy for acute leukaemia.

**Morphine:** Opiate analgesia used for control of severe pain.

**Neuroblastoma:** A malignant tumour originating in any site in the autonomic nervous system. Spontaneous remission may occur.

**Non-Hodgkin's lymphoma:** A tumour of lymphoid tissue distinct from Hodgkin's disease.

**Ondansetron:** Drug used for the treatment of nausea and vomiting induced by chemotherapy.

**Orbital rhabdomyosarcoma:** A malignant tumour involving the muscles of the eye.

**Osteosarcoma:** The most common and most malignant tumour of bone, occurring predominantly in children and young adults.

**Pentamidine:** drug used as an alternative to co-trimoxazole (see above) for patients with a history of adverse reactions to, or who have not responded to, co-trimoxazole.

**Prednisolone:** Steroid drug with a marked anti-tumour effect in ALL, Hodgkin's disease and non-Hodgkin's lymphoma.

**Septrin:** Proprietary name for co-trimoxazole (see above)

**UKALL XI:** Multi drug treatment regime used for childhood ALL.

**Vincristine:** Drug used to treat acute leukaemia.



## **PATIENT COUNSELLING AND ADVICE FROM PHARMACISTS**

### **A RESEARCH PROJECT**

The paediatric oncology department of the QMC is taking part in a study of the counselling and advice services provided by pharmacists. This is being carried out by Alison Pilnick, a pharmacist at the University of Nottingham, under the supervision of Professor Robert Dingwall. Dr Walker and Dr Hewitt have agreed to their patients being asked to participate in this study. They are trying to help pharmacists improve the service they offer by looking at the ways in which pharmacists, patients and their parents, and other family members talk to each other. This will make it possible for pharmacists to identify the most effective ways in which they can give people advice. It will also help them to learn how to deal with any difficult moments that may arise in this process.

This research involves us making tape recordings of consultations for analysis by Professor Dingwall and Alison Pilnick. The only people who will listen to these tapes will be members of the research team, and nothing will be made public in any way that might allow people to recognise patients or anyone else in their families. We are very grateful to those families who feel able to share these experiences so that we can learn the best ways of helping others in the future.

If you have any questions about the research, you can contact Alison Pilnick at the School of Social Studies, University of Nottingham, NG7 2RD Tel (0115) 9515237

## TRANSCRIPTION SYMBOLS

<p>[ Ph: Monday Wednesday [Friday M: [Friday</p>		<p>Left brackets indicate the point at which a current speaker's talk is overlapped by another's talk.</p>
<p>= Ph: Alright= M: =okay</p>		<p>Equal signs indicate a continuous flow from prior talk.</p>
<p>(0.3) Yes(0.5)Yeah</p>		<p>Numbers in parentheses indicate elapsed time in silence in tenths of a second.</p>
<p>(.) And then(.)when you come back</p>		<p>A dot in parentheses indicates a micropause of less than 0.1 seconds.</p>
<p><u>Septrin</u> And the <u>Septrin</u></p>		<p>Underlining indicates some form of stress through pitch of talk.</p>
<p>SEPTRIN And the SEPTRIN</p>		<p>Capitals indicate loud sounds relative to the surrounding talk.</p>
<p>.hhh So if (0.2).hhh</p>		<p>A row of h's prefixed by a dot indicates an inbreath; without a dot, an outbreath. The length of rows of h's indicates the length of this breath.</p>
<p>? Okay?</p>		<p>A question mark indicates questioning intonation.</p>
<p>: Oh::h</p>		<p>A colon indicates prolongation of the immediately prior sound. The length of the row of colons indicates the length of the prolongation.</p>
<p>( ) And so ( )</p>		<p>Empty parentheses indicate the transcribers inability to hear what was said.</p>
<p>(that's) And (thats) how it goes</p>		<p>Words in parentheses indicate quiet sounds relative to the surrounding talk.</p>
<p>(( )) Okay? ((puts in bag))</p>		<p>Double parentheses indicate author's descriptions rather than transcriptions.</p>

**Transcript 1: sc/op/be**

- 1.Ph: Prescription for (name).() Is he still not back, (name)? Right ((laughs)).  
Here we are. Hello (name) are you alright?
- 2.P: Yes.
- 3.Ph: ((To mother)) Can I just check with you ( name)'s last prescription we did for  
him was it [one or two() Right()
- 4.M: [yeah you did two weeks
- 5.Ph: Have you still got those with you o:::r()
- 6.M: They're at home
- 7.Ph: Right. You shouldn't use those now 'cos they've changed his dose of vincristine  
to 75% so we've done you a new lot for this one () [I'll go through all these  
with you
- 8.M: [Right
- 9.Ph: Right() so it's been increased to 75% [ () and he's coming back next week for
- 10.M: [ Mmmhmm
- 11.Ph: vincristine isn't [he?
- 12.M: [Yeah
- 13.Ph: I spoke to Dr (name) about this and he said that instead of () you doing  
another blood count next week()
- 14.Ph: he's just gonna write up two weeks this time and just give you the vincristine  
()
- 15.Ph: and then he can go home again.
- 16.M: OK that's fine thanks=
- 17.Ph: =that that saves you some time doesn't it?()
- 18.M: Yeah
- 19.Ph: so he's got his normal full 60mg() his 30 mercaptopurine and his methotrexate  
and his pred that day()
- 20.Ph: and then his prednisolone for 5 days ()
- 21.Ph: and then you go back to the normal so you've actually got 2 weeks=
- 22.M: =Right
- 23.Ph: and if you have any problems then Dr (name)'ll send you back down and we'll  
always do you another one [if anything's changed()
- 24.M: [ OK right
- 25.Ph: so as I say the other ones() you can either throw them away or bring them  
back next time you come()
- 26.Ph: Right so that's one week((laughs)) that's two ((hands over medication))
- 27.Ph: and that's your 7.5ml twice a day Mondays Wednesdays Fridays you've got  
enough for 2 weeks there.
- 28.M: Yeah can you put in a syringe?
- 29.Ph: Yeah course I can ((puts in bag))
- 30.M: (he....)
- 31.Ph: Pardon? () Yeah ((laughs)) Do you want a couple? ((fetches syringes))
- 32.Ph: OK then () two water pistols. ((puts in bag)). Right then see you [bye
- 33.M: [bye
- Present: Mother, Child aged 4 years**  
**Start of treatment 11/92**  
**(ALL)**

**Transcript 2 :-kj/op/be**

- 1.Ph: Prescription for (Name)() Hiya () It's (name)'s first time having blisters isn't it?
2. M: Yes=
- 3.Ph: = Do you want me to just explain it () [this is a really simple one for her
- 4.M: [Yes if you would
5. Ph: ((to child)) Do you want to come and have a listen?()
- 6.Ph: Right() what we do is date each day that you have them and what time OK()
- 7.Ph: you're just having the mercap  
-mercaptopurine at the moment aren't you so you've
- 8.Ph: just got one tablet in each one.
- 9.M: Right
- 10.Ph: As you get to have more tablets() when she gets into the next stage of the chemotherapy what we do is
- 11.Ph: we put all the tablets for the morning or all the tablets for the evening in a
- 12.Ph: specific one() [with the day and date on just to make it easier
- 13.M : [I see
- 14.Ph: and I'll just show you how they peel off actually () it's alright that one's not
- 15.Ph: needed()They should tear () but it's easier probably if you just peel it all back()
- 16.Ph: and the tablet's popped in there [so you can actually see there's a morning
- 17.M: [oh right great
- 18.Ph: lunchtime and evening dose OK?()
- 19.M: So she's just got every morning [tomorrow morning
- 20.Ph: [ Yes if she takes those either just be-  
we:ll it's best
- 21.Ph: just before breakfast with mercaptopurine() and then when's (name) when are you coming back in again?
- 22.M:[Monday
- 23.P:[monday
- 24.Ph: Right() I didn't know if she was coming Monday or Tuesday with it being a Bank Holiday so you'll have an extra tablet()
- 25.Ph: if you just give it back to the ward that'll be fine
- 26.M: Right
27. Ph: Can I take those() put them in a little bag so you know what you've got
28. M: Thank you very much

**Present: Mother and child aged 13 years.  
Start of treatment 3/93  
(ALL)**

### Transcript 3:- d/op/be

1. Ph: Hiya() prescription for (name)()
- 2.Ph: Right, I'm sorry about this but we've run out of blisters  
[because our supply's stuck ((laughs))
- 3.M [oh() that's alright
- 4.Ph: Right so I'll just go through them with you(.)he's coming back next week isn't  
he?
- 5.M: Yeah
- 6.Ph: Right() so he's got some mercaptopurine in a bottle ()
- 7.M: [Right
- 8.Ph:[It's just one half tablet to be given each morning() you've already had the  
halves
- 9.Ph: in the blisters so [that's to start tomorrow
- 10.M: [right()right
- 11.Ph: and then his methotrexate's 3 to be give on Wednesday 23/6()
- 12.M: OK
- 13.Ph: and they've reduced his Septrin dose a little bit [he's gone down to 5ml
- 14.M: [yes?
- 15.Ph: so just 5ml Mondays Wednesdays Fridays()
- 16.M: OK that's great() I've got a syringe
- 17.Ph: You've got a syringe right? I've got a habit of going backwards and forwards
- 18.Ph: [so I thought I'd bring them with me() There you go ((hands over medication))
- 19.M: [I know
- 20.Ph: You got by quick today
21. M: I know() for a change((laughs))
- 22.Ph: It's nice isn't it? Right then
- 23.M: Thank you

**Present : Mother , child aged 3 years**

**Start of treatment unknown (transferral)**

**(ALL)**

#### Transcript 4 :-sc/op/be

- 1.Ph: (name)?()[Hi
- 2.M: [hello
- 3.Ph: Well firstly we've got to apologise for the bottles but there's been
- 4.Ph: a delay with the [blisters()
- 5.M: [oh
- 6.Ph: [so that's why we've
- 7.M: [Yeah so long as it tells you what's()
- 8.Ph: Yes we've put everything on for you()just let me go through it for(.) with you
- 9.Ph: Right () the mercaptopurine
- 10.M: Yeah
- 11.Ph: 50mg() they've already been halved ()
- 12.M: oh yeah
13. Ph: so you're just giving one each morning starting tomorrow()
14. M: Right
- 15.Ph: OK?() and they're 10mg so you're giving 4 each morning()
- 16.M: yeah
- 17.Ph: starting tomorrow() so that'll make up the total dose that he needs
- 18.M: Right
- 19.Ph: OK() the methotrexate() you're only giving on Wednesdays() and of the  
2.5mg you're giving three
- 20.P: Are they the Wednesday tablets?
- 21.Ph: that's right() they're just Wednesdays
- 22.P: I wondered why I got them for [like that
- 23.M: [ Just on a Wednesday then
- 24.Ph: That's right
- 25.M: Right
- 26.Ph: and they've got the dates on there for you [23rd and the 30th
- 27.M: [right() right
- 28.Ph: uhhh and the () 1 of the 10mgs to make up the total dose() [And the
- 29.M: [Yeah
- 30.Ph: Septrin() you're giving twice a day on Mondays Wednesdays and  
[Fridays() starting this Friday OK?
- 31.M: [Fridays right () can you just mark that with a 1()
- 32.M: just put a mark on it with a 1 and we'll know to give him one of them()
- 33.M: Four of them is it? =
- 34.Ph: =yeah
- 35.M: I'll put on there () one of those() four of them
- 36.Ph: No there's 3 of those
- 37.M: 3() put a 3 then
- 38.Ph It says three there as well if you forget but I'll put it in numbers as well
39. Ph: 4() and that's 1() and and they have been halved in the bottle()
- 40.Ph: and one of those()
- 41.M: And one of these() but that's =
- 42.Ph: Yeah() do you understand?
- 43.M: yeah() I understand that one() Yeah yeah that's it

- 44.Ph: OK and when are you actually due to come back?  
45.M: Uhhh() the 30th  
46.Ph: In two weeks' time () yeah that's right  
47. P: Am I having these ones of a night time?  
48.M: [No() these all start tomorrow don't they  
49.Ph:[No() You're having them on Wednesdays your mam will know when to give them to you  
50. P: I know but it's Wednesday today () am I having [them?  
51. M: [no  
52.Ph: [no you're not having  
53.Ph: them today you're starting next week() OK () I'll put them in a bag for you

**Present:- Mother, Child aged 4 years 6 months**  
**Start of treatment 11/92**  
**(ALL)**

**Transcript 5:- eg/op/be**

- 1.Ph:(Name)?
- 2.M: hello
- 3.Ph: Right OK() (Theres) There's your mercaptopurine()
- 4.M: yeah
- 5.Ph: and they've already been halved for you so you're taking j-just one
- 6.Ph: to be given each morning()
- 7.M: Right
- 8.Ph: and two of those to make the full 45mg [so
- 9.M : [Right so she has
- 10.M: one of them and two of them each morning()
- 11.Ph: That's right()[and the methotrexate just on Wednesdays
- 12.M: [Mmmhmm
- 13.M: Yeah
- 14.Ph: OK
- 15.M: So that's one() that's one big'un and one little 'un?
- 16.Ph: That's right() one of each
- 17.M: That's great() Thanks a lot

**Present :- Mother and child aged 6 years  
Start of treatment 10/91  
(ALL)**



**Transcript 6:- ar/op/be**

- 1.Ph: Prescription for (name)? () I've got some Septrin for him here=
- 2.M: =Yeah
- 3.Ph: and you're to give him 7.5ml () on Mondays Wednesdays and [Fridays
- 4.M: [Right
- 5.Ph: and you're starting this Friday ok?() and again we've got some sunblock
- 6.Ph: for him as well()
- 7.M: Right
- 8.Ph: When are you due to come back?
- 9.M: Next Wednesday
- 10.Ph: Next Wednesday() that's fine () There you go ((puts medication in bag))
- 11.Ph: Thank you very much
- 12.M: 'Bye

**Present:- Mother and child aged 7 years**  
**Start of treatment 2/93**  
**(ALL)**

**Transcript 7:- dc/op/be**

1.Ph: (name)? () ok [I'll go through it all with you

2.M: [Yes

3.M: It's alright(.) I know it already

4.Ph: Oh() yeah() I apologise for the bottles but we've had a bit of a delay with the

5.Ph: blisters so we've had to put them in [bottles for today

6.M : [oh right

7.Ph: OK?

8.M: yeah()

9.Ph: But all the labels have been ()have sort of got all the instructions on()

10.M: yeah

11.Ph: But I'll just go through it () the methotrexate() is those two ((indicates))

12.Ph: and you're giving two of the 10mg on Wednesday()

13.Ph:[the 23rd and the 30th and you're giving one of those()

14.M: [Yeah() and the same with that?

15.M: Yeah

16.Ph: on the Wednesday () the mercaptopurine() right() you've got 3 strengths

17.Ph: to make up the total dose that you need

18.M:(mmmhmm)

19.Ph: and you're giving one of the 50mg uhhh starting tomorrow morning()

20.M: Yeah

21.Ph: and you're giving one of those tablets they've already been halved [so you

22.M: [yeah

23.Ph: only have to give him one half in the morning()

24.M: mmmm

25.Ph: and three of the 10mg() the lower strength

26.M: Yeah

27.Ph: OK()

28.Ph: The Septrin you're giving one twice a day on Mondays Wednesdays and Fridays

29.Ph: and starting on this Friday()

30.M: yeah

31.Ph: and the prednisolone () it's a 4 day course () uhhhm you have to take 9 tablets a

32.Ph: day so if you give it like() morning midday and evening to give him sort of 9 a

33.Ph: tablets a day and it's just the 4 days' worth of those()

34.M: Yeah

35.Ph: and he's starting those tomorrow()

36.M: That's it()

37.Ph: OK() is everything() so when are you due to come back?

38.M: uhhh 28th

39.Ph: Yeah ((puts medication in bag)) There you go then thank you very much()

40.Ph: Bye

41.M: Bye

**Present: Mother, boy aged 10 years**  
**Start of treatment 7/91**  
**(ALL)**

**Transcript 8:- uk/op/be**

- 1.Ph: I apologise for the bottles we actually-  
there's been a delay with the blisters
- 2.Ph: so() all the directions are on there OK?
- 3.M: yeah
- 4.Ph: I'll go through it with you() the mercaptopurine()
- 5.M: yeah
- 6.Ph: you're giving two to be given each morning starting tomorrow OK?()
- 7.Ph: There's 2 strengths of prednisolone () and you're giving 3() in the morning
- 8.Ph: and 2 at midday and in the evening()
- 9.M: Yeah
- 10.Ph: It's on the bottle() and it starts on the 17th which is uhh=
- 11.M: =yeah
- 12.Ph: tomorrow OK?() and it's a 4 day course and the same with the 2.5mg you're
- 13.Ph: giving one each morning for 4 days() I'll just repeat that the tablets
- 14.Ph: are to be swa-  
swallowed whole() OK()
- 15.Ph: The Septrin (.) you're giving 3 on Mondays Wednesdays and Fridays you're
- 16.Ph: giving 3 twice a day()
- 17.M: Mmmm
- 18.Ph: Ok() the methotrexate 2 to be given on the 23/6 which is a Wednesday()
- 19.M: What else() uhhh oh that's it() Yeah that's it yeah()
- 20.Ph: When are you actually due to come back?
- 21.M: A week on Monday() the 28th
- 22.Ph: Yeah that's right() that's brilliant((puts medication in bag)) OK thanks very  
much
- 23.M: Thanks() Bye
- 24.Ph: Bye

**Present:- Mother, child aged 7 years**  
**Start of treatment 2/93**  
**(ALL)**

**Transcript 9:- dt/op/be**

- 1.Ph: (name)? () (name)? () No? ()  
2.F: [Hi  
3.Ph:[Right(.) uhhh sorry about the bottles [but there's been a bit of a delay  
4.F: [It's OK  
5.Ph: with the blisters so we've had to put them in bottles()  
6.F: Right  
7.Ph: Has he actually had any prednisolone today?()  
8.F: no() he's supposed to be having it all tonight()  
9.Ph: Right that's brilliant yeah we've got some here for him but we weren't sure  
10.Ph: we thought we'd better check()  
11.F: Yeah  
12.Ph: so that's 6 of those to be given today()  
13.F: Yeah=  
14.Ph: =right uhh he's got another [4  
15.F: [sorry when was this uhhh (6 to be given)  
16.F: when does he have his next() oh(.) that's just today's in there is it?  
17.Ph: That's just today's()  
18.F: Right () Just throws you without these [packs doesn't it?  
20.Ph: [yeah() And then there's another  
21.Ph: 4 days here()  
22.F: Yeah  
23.Ph: and that's gonna be starting tomorrow  
24.F: Yeah  
25.Ph: and if he has 2 like in the morning midday and evening [to split it up for him  
ok?  
26.F: [ Right  
27.Ph: and the co-trimoxazole() he's having 3 uhhh in the morning-  
twice a day sorry  
28.Ph: on [Mondays Wednesdays and Fridays starting this Friday(.) OK?  
29.F: [Mondays Wednesdays and Fridays () Right then  
30.F: Fine() Thank you()  
31.Ph: When's he actually due to come back?  
32.F: Next week  
33.Ph: That's fine ((puts medication in bag)) There you go thank you very much  
34.F: Bye

**Present:- Father, child aged 5 years**  
**Start of treatment 5/92**  
**(ALL)**

**Transcript 10:- jm/op/be**

1.Ph: Sorry to keep you waiting () but uhhh Dr (name) had to be contacted()

2.M: Yeah

3.Ph: and it WAS 75% but we thought we'd better check()

4.M: Yeah

5.Ph: These are the bottles that you looked at()

6.M: Right

7.Ph: there's been a delay with the blisters so we have to apologise () so we've had

8.Ph: to put them in bottles()

9.M: Yeah (.) right

10.Ph: but each bottle's been labelled up so() with the dose and everything on () ok?

11.M: OK

12.Ph: I'll go through it all with you as well [so you know

13.M: [yeah

14.Ph: Right() the mercaptopurine() there's two strengths to make up() the total

15.Ph: strength that's needed()

16.M: Right

17.Ph: and uhhh the 50mg have already been halved so you only have to give her one

18.Ph: half each morning()

19.M: Yeah()

20.Ph: starting tomorrow and 3 of the 10mg to be given each morning

21.Ph:[starting tomorrow

22.M: [ yeah right

23.Ph: OK? () The methotrexate again there's 2 strengths to make up the total() dose

24.Ph: she needs and that needs-

one needs to be given on Wednesday()

25.M: Yeah()

26.Ph: with 2 of the 2.5 needs to be given [on Wednesday ()

27.M: [Yeah

27.Ph: and the Septrin you're giving one twice a day on Mondays Wednesdays and

28.Ph: Fridays [starting this Friday

29.M: [Right() OK () I've got that

30.Ph: OK() When are you actually due to come back?

31.M: Next Wednesday

32.Ph: That's brilliant() Thanks() Bye

33. M: Thanks() Bye

**Present:- Mother, child aged 9 years**

**Start of treatment 10/91**

**(ALL)**

**Transcript 11:- sg/op/be**

- 1.Ph: Prescription for (name)? () No? ()  
2.Ph: Right() (name)'s not had maintenance therapy before has he?()  
3.M: No  
4.Ph: Right () I'll explain it all() First of all(.) whenever we do the blister cards()  
5.Ph: we always get them done at the back 'cos they () get done in preference then  
6.Ph: [so you don't hang around for so long()  
7.M: [Right  
8.Ph: Right he's got to have() his mercaptopurine() (find the tablets for you) he has  
9.Ph: 45mg a day () so you need to give this each morning() it's one half a tablet  
()  
10.Ph: we've already halved the tablets for you there=  
11.M: =Mmmhmm  
12.Ph: of that and two of the small one-  
-small round ones  
13.Ph: each morning () starting tomorrow morning()  
14.M: Mmmm  
15.Ph: Right() He's also got his methotrexate which he's been having weekly()  
16.Ph: that's one to be given each Wednesday on the -  
-on Wednesday the 30th and  
17.Ph: Wednesday the 7th() and he'll need one of the 2.5s as well to be given  
18.Ph: at the same time()  
19.M: Right  
20.Ph: Well we've given him liquid for his Septrin I didn't know if (name) preferred  
21.Ph: tablets or liquid normally()  
22.M: Uhh well I do-  
- have to dissolve everything=  
23.Ph: =you have to dissolve everything anyway [Right  
24.M: [laughs  
25.M: with the tablets()  
26.Ph: Right with his Septrin then it's 7.5ml() marked on the syringe on there  
27.Ph: you've used one [of those before haven't you to be given twice a day  
28.M: [yes  
29.Ph: Mondays wednesdays and Fridays() that's two weeks [so  
30.M: [Mmm  
31.M: do I start that today()  
32.Ph: Uhhm start it () if you give him a dose tonight if you want and then Friday()  
33.Ph: and then carry on Monday Wednesday Friday like that()  
34.M: [Mmm  
35.Ph: [OK?  
36.M: OK.  
37.Ph: You are coming back in two weeks aren't you(.) That's right (laughs)

(Pharmacist puts medicines in bag)

38.C: Can I put these in?

39.Ph: Yeah(.) course you can(.) Thank you()

40.Ph: There you go then (indistinct) [see you

41.M: [Bye

**Present: Mother, child aged 4 years**

**Start of treatment 3/93**

**ALL**



## Transcript 12:-gg/op/be

- Ph: Right (.) first of all I'm sorry but we haven't got any blisters (0.6) they're all stuck somewhere between here and America  
(.)
- C: (looking at mouthwash) I wanted the green one  
(0.5)
- Ph: You want the green one do you not like the (0.5) red one?  
(.)
- C: Mmmm  
(0.6)
- Ph: Right (.) I'll have a word with the technician and we'll get that changed for you th[en
- C: [ow long will it (.) will that be?  
(0.5)
- Ph: Be about two or three minutes=  
C: =Alright I'll have t[hat then
- Ph: [Just let me check we've got some up here just hold on a minute (goes to check)  
(2.2)
- C: (into tape recorder) Hello  
(1.5)
- T: You want the gree::n one (0.1) right  
(0.9)
- Ph: Won't be long (1.5) (C bangs on tape recorder) oy (laughs) (1.2) Right (0.5)  
Uh:hm (.) do you want me to explain your tablets cos they're not [in blisters to you
- C: [No:olknowwhat  
to do  
(0.5)
- Ph: You know what to do with them all (1.2) Right so you've got all those for your mercaptopurine (1.1) [Two of them
- C: [What do I do take (0.5) two of them and what d' ya call it one of them each?  
(0.6)
- Ph: Hold on (.) you take two of the 10mg each morn[ing (0.2)=  
C: [Yeah
- Ph: =that's two of the little ones[ (0.5) two of the 50mg=  
C: [yeah
- Ph: =(0.7) 't's two of those (.) and one of the half tablets it's already halved (1.5) o[kay?
- C: [Yeah yeah=yeah=ye'
- Ph: so that makes you a total of 145mg  
(0.2)
- C: Oh (0.4) Why didn't you just say that  
(1.0)
- Ph. Pardon?

Transcript 12:- gg/op/be

C: Why didn't you just say that I would have remembered that

Ph: OK Right (.) Well (1.0) and you've got your methotrex[ate

C: [Yeah  
= y[eah

Ph: [That's [Wednesday mornings (0.6) Yeah (1.1) your=

C: [Three of them Yeah

Ph: =prednisolone (.) that's not to be taken until the 7th of July (0.9) yeah because you're having another injection then aren't you (0.6) and there's twelve in there for you (0.9) and your co-trimoxazole same as usual (0.4) twice a day

[Mondays Wednesdays Friday (0.7) okay? (0.9) we=

C: [Mondays Wednesdays Fridays

Ph: =should have blisters for next time you come (1.5) Can I just get round to that lot

(9.2) (Puts in bag)

C: Who wanted to tape this anyway?  
(0.9)

Ph: She's doing a (0.5) a Phd (uhhh ) (0.5) to become a doctor (0.3) and she wants to know all about the role of the pharmacist (0.9) I can give you a leaflet about it if you want one (0.7) Want on[e?

C: [No (.) I don't like student doctors to be honest wi'  
ya=

Ph: =Oh she's not a student doctor she's a pharmacist she's a qualified pharmacist

C: Oh right [yeah

Ph: [and then she's doing something else (0.7) Do you want to take a seat and I'll give you your Corsodyl when it's ready it won't be long

**Present: Patient aged 16 years (C), Pharmacist (Ph), Pharmacy Technician (T)**

**Start of treatment: 10/91**

**ALL**

### Transcript 13:-lc/op/be

- 1.Ph: Prescription for (name)? () (Name)? Anyone else down there(.) No?  
2.Ph: (to other non-clinic patient) Are you being seen to by the way? (Response unclear)  
3.Ph: Prescription for (name)? (sneezes) I'm a bit sniffly(.)  
4.Ph: I've [just had a burst of the sneezes  
5.M: [It's alright (laughs)  
6.Ph: Now first of all I've got to apologize we haven't got any blisters  
7.Ph: at the moment()  
8.M: That's alright  
9.Ph: They're somewhere between here and America()  
10.M: Oh right!  
11.Ph: I'd love to know where [ (laughs) hopefully they'll be in for  
12.M: [ (laughs)  
13.Ph: next time you come back=  
14.M: =Right  
15.Ph: (name)'s coming back in a week that's [right isn't it  
16.M: [Yeah (.) Yeah (...)  
17.Ph: Yeah and she's had her vincristine hasn't she()  
18.M: yes  
19.Ph: today(.) so she's got her prednisolone to go with her vincristine (.)  
20.M: Yeah  
21.Ph: It's just 25mg tablets(.) one to be taken each morning and [night  
22.M: [night yeah  
23.Ph: Right that's just for 4 days() and (.) she's got her mercaptopurine here(.)  
24.Ph: 2 of the 50mgs each morning starting tomorrow()  
25.M: Yeah  
26.Ph: and one of the halved() [they've already been halved for you  
27.M: [Oh right yeah oh right yeah good yeah  
28.M: two and a [half  
29.Ph: [so that makes your 125  
30.M: Right  
31.Ph: Uhh () What's next oh the methotrexate(.) two to be taken on Wednesday  
32.Ph: the 30/6 the 10s () and two of the 2.5s=  
33.M: =Right so that doesn't go up then it's only the()  
34.Ph: No (.) once you get to 100% your methotrexate doesn't increase()  
35.M: Right  
36.Ph: You only increase your mercaptopurine OK?  
37.M: Right(.) yeah() As I say it's the first time she's got=  
38.Ph: =Is it the first time she's gone up that high(.) Oh right  
39.Ph: that must be a good sign=  
40.M: =can I have the dropper for Septrin (unclear...)  
41.Ph: Oh right  
42.M: She's having pentamidine(.)  
43.Ph: instead of Septrin 'cos she didn't respond very [well to it  
44.M: [Well no we was just

45.M: forever going right down off treatment altogether and going [back to 50 again  
46.Ph: [right  
47.M: and apparently (.) well this certainly does seem to be working  
48.M: [better  
49.Ph:[seems to be working excellent (unclear...)  
50.Ph: Well that's a good sign anyway isn't it?  
51.M: That's right  
52.Ph: OK well I'll see you next week then (.) OK [Bye bye  
53.M: [OK  
54.M: Thank you

**Present: Mother, child aged 13 years**  
**Start of treatment: 1/92**  
**ALL**

**Transcript 14:- ps/E38/ta**

- 1.Ph: So(.) are you having any problems with [the morphine?  
2.M: [the morphine () Oh no (.)  
3.M: no he () tends to (.) you know () The other it takes too() I-  
-you know(.)  
4.M: if he's in a lot of pain he can't do his physio work()  
5.Ph: Right() [OK  
6.M: [But you know(.) it seems to control it(.) at least he gets you know  
7.M: sleep at night [which you don't very often get()  
8.Ph: [he gets (.) yeah ((laughs))  
9.Ph: it means [you get a decent night's sleep as well ((laughs))  
10.M: [he hasn't got to ( ) yeah (.) yeah(.) Yes  
11.Ph: And he's not having much breakthrough at all is he? () I mean he's not  
12.Ph: having much of the liquid at all?()  
13.M: No [ no no (.) That's right (.) it's just morphine  
14.Ph: [He's alright with what he's on then( ) Right  
15.Ph: The other thing is (.) is he OK?() he's alright with tablets and everything isn't  
he?  
16.M: Yeah (.) yeah  
17.Ph: And his lactulose (.) is he going to the loo alright?()  
18.M: [yes  
19.Ph:[Because morphine can cause a bit of constipation sometimes()  
20.M: Yeah well they did give us some medicine for that which he takes()  
21.M: but I've cut it down to once a day because he does [go easily  
22.Ph: [Yeah he's  
23.Ph: alright with [that?  
24.M: [so yeah(.) I didn't want to cause him to have you know()  
25.M: [diarrhoea or anything () yeah  
26.Ph:[To go to the loo all day  
27.M: so yeah(.) he just has it once a day  
28.Ph: And when are you going home?  
29.M: Uhhhm I'm not sure() I think they're trying to get us home for the weekend.  
30.Ph: Right.((Exchange of patient's address follows in order to dispense Rx))  
31.Ph: That's great(.) thanks very much  
32.M: Thank you

**Present:Mother, child aged 10 years**  
**Start of treatment 1/93**  
**Osteosarcoma**

**Transcript 15:- jm/E38/ta**

- 1.Ph: The magnesium glycerophosphate(.) the nurse was saying that you're giving  
2.Ph: them now is that right?()  
3.M: Yes  
4.Ph: Right(.) are you alright with them (.) just half a tablet?()  
5.M: Yeah(.) I just dissolve it and put it down the nasal tube  
6.Ph: That's OK then ( ) Is she going to be on them for much longer?()  
7.Ph: She's not is she?  
8.M: No idea(.) no one's said to me()  
9.Ph: Mmmm (.) it's just that somebody's written "two more days"() I don't know  
10.Ph: what that's about ( )  
11.Ph: (to child) Hello (.) you're looking a bit fed up.  
12.M: She's got a tantrum() she keeps putting that (unclear...) (((laughs))  
13.Ph: (((laughs))  
14.Ph: Do you know if she's having her chemo today?  
15.M: Hopefully  
16.Ph: Hopefully they are giving it today() [right ( )  
17.M: [yeah  
18.Ph: The ondansetron (.) do you give it as a liquid or? ()  
19.M: They usually put it through a line  
20.Ph: Oh right(.) (That's OK then)  
  
(Both laugh at child who has put bedpan on head)  
  
21.Ph: Right that's it then (.) Bye  
22.M: Thanks() Bye

**Present: Mother, child aged 2 years**  
**Start of treatment 3/93**  
**Neuroblastoma**

## Transcript 16:- lsm/E38/ta

- 1.Ph: You know his tablets (.) are they going into his line now or is he taking them?()
- 2.M: No he's taking them in (.) in a drink
- 3.Ph: In a drink (.) he's alright with it in a mixture?()
- 4.Ph: [He's OK with that?
- 5.M: [Yeah
- 6.Ph: And you know the steroid tablets (.) does he have the [pink ones or the ( )
- 7.M: [ Oh hang on no that's
- 8.M: what he has in the medicine (indicates bottle). What's the other one for?
- 9.Ph: That's his allopurinol(.) that's ( ) when the tissues break down they can cause
- 10.Ph: [problems()
- 11.M: [Yeah(.) whatever the ( ) I'm not sure about that one ((indicates drug card))
- 12.M: but that one definitely he does have.
- 13.Ph: Right(.) that's OK() He's taking the allopurinol [in his drink
- 14.M: [In his drink
- 15.Ph: That's fine(.) fine()
- 16.Ph: So when you go home [do you prefer them as a soluble [or a mix? ( )
- 17.M: [Yes [Yes
- 18.Ph: We tend to try and make it easier for you with the ones we [give( )
- 19.M: [Yeah
- 20.Ph: And has anyone spoken to you about the nystatin for him or not?()
- 21.M: That's the mouth stuff [is it?
- 22.Ph: [Yeah (.) it's just really to try and get him to
- 23.Ph: keep it in his mouth as long as he can( ) just like to rinse it round as well
- 24.Ph: and then swallow()
- 25.M: Oh the mouthwash yeah yeah (.) oh yeah he's doing that
- 26.Ph: Oh well there's two (.) there's the Corsodyl which is the big bottle()
- 27.M: That's what he's got
- 28.Ph: He's supposed to spit that one out()
- 29.M: Yeah
- 30.Ph: And then there's nystatin (.) he's supposed to hold that in his mouth
- 31.Ph: and swallow() the yellowy one (.) I don't think they've actually given
- 32.Ph: him that one yet but I'm sure (name) will explain it all to you when it comes()
- 33.M: Yeah(.) When's that going to be starting?
- 34.Ph: It looks as though he's written it up yesterday ((indicates card))
- 35.Ph: so it should start sometime today ( ) It's better to use them both together()
- 36.M: ((Laughs)) It's alright if he knows he can spit it straight out but if
- 37.M: he knows he's got to hold it in there might be a few problems
- 38.Ph: ((Laughs)) Well if you can do that after mealtimes then it works more effectively
- 39.M: So basically we do that one first (.) and then that one?
- 40.Ph: That's right( ) I'll just check the doses now ( ) OK thanks

**Present: Mother, grandmother, child aged 7 years (asleep)**  
**Start of treatment 6/93**  
**Non-Hodgkins Lymphoma**



**Transcript 17:- kj/E38/ta**

- 1.C: ((On way out of room)) My Mum's not here at the moment()  
2.Ph: No it's OK (.) I shan't be here long anyway [((laughs))  
3.C: [((laughs))  
4.Ph: Let's see( ) Have you been alright with your tablets (name)?  
5.C: Yes  
6.Ph: And you haven't had any more mouthwash recently (.) have you? ( )  
7.C: No  
8.Ph: So your teeth haven't gone another strange colour?()  
9.C: No  
10.Ph: That's alright then ( ) And you've not been feeling sick or anything  
11.Ph: [have you that's been alright then  
12.C: [No  
13.Ph: Right (.) good() You're looking better than last time I saw you actually ( )  
14.C: Yeah  
15.Ph: Are you feeling better?()  
16.C: Yes  
17.Ph: Good (.) Let's find the card ((looks at card)) I don't know if I've got much to ask you  
18.Ph: about these ( ) Are you going home soon?( )  
19.C: Uhhh I should be going home on Saturday.  
20.Ph: Saturday(.) right ( ) So you'll need your tablets to take home on Saturday [won't you  
21.C: [Yeah  
22.Ph: That's OK then (.) right(). I can let you run away now (.) Bye

**Present: Patient aged 13 years**

**Start of treatment 3/93**

**ALL**

**Transcript 18:- m/E38/ta**

- 1.Ph: You know when you have your tablets (.) your sickness tablets(.) Wha-
- 2.Ph: -do you have them at home at all or not?()
- 3.C: Uhhh [Yeah [Yellow ones
- 4.F: [He has some don't [you ( ) half(.) half
- 5.Ph: You have half a one?(.) Are you alright with those (.) you can take them
- 6.Ph: alright (.) you've got no problems? ( )
- 7.F: He prefers the tablets to the (uhhh fluid) Don't you? ( )
8. C: Yeah
- 9.Ph: Sorry (.) say that again
- 10.F: he prefers the TABLET FORM [instead of the fluid stuff
- 11.Ph: [Oh right that makes a change(.) most people
- 12.Ph: prefer the liquid ones()
- 13.F: Well he says it tastes horrible
- 14.Ph: Ahhhh Well I'm afraid we haven't got a way of making it taste nice yet
- 15.Ph: but we're trying() And do you know when you're going home (name) (.)
- 16.Ph: how much longer you'll be in for?
- 17.C: [I think it's ( )
- 18.F: [Probably tomorrow
- 19.C: Or today
- 20.Ph: Probably tomorrow(.) Today [or tomorrow(.) Right
- 21.F: [It won't be today it'll be tomorrow I think  
(indicates drip))
- 22.Ph: Are you still running the drip through ( ) Yeah ( ) OK then (.) you're alright
- 23.Ph: with everything else aren't you? ( ) There's no problems? ( )
- 24.C: [No
- 25.F: [No
- 26.Ph:[Thank you

**Present: Father, child aged 10 years**  
**Start of treatment 4/93**  
**Non-Hodgkins Lymphoma**



**Transcript 20:- It/E38/ta**

- 1.Ph: I'm just gonna check over the chart just to make sure [all the medications are OK ( )
- 2.M: [Yeah (.) OK
- 3.Ph: Have you met (name) the other pharmacist?
- 4.M: Pardon?
- 5.Ph: Have you met (name) [the other pharmacist (.) Right OK
- 6.M: [No no
- 7.Ph: I'm not the usual pharmacist for the ward I'm just here covering
- 8.Ph: for her [today ( )
- 9.M: [Right
- 10.Ph: Do you know about the medication that (.) he's going to be having?
- 11.M: Yes she=
- 12.Ph: =You do
- 13.M: (name) told us [about
- 14.Ph: [Yeah fairly strong sort of [ anti sickness tablets
- 15.M: [Yeah
- 16.Ph: just in case (..unclear...)
- 17.M: ((to child)) Yeah please (.) thank you ( ) No let go of the gun( ) (...)
- 18.C: (...unclear)
- 19.Ph: OK that's fine
- 20.M: Alright?
- 21.Ph: Yeah (.) Bye

**Present: Mother, child aged 5 years**  
**Start of treatment 3/93**  
**Orbital rhabdomyosarcoma**

**Transcript 21:- sg/E38/ta**

((Intravenous drip alarm is bleeping throughout))

1.Ph: How are things then? ( )

2.M: OK

3.C: OK

4.M: ((to child)) Come here ( )

5.Ph: Have you had the blister packs from us yet? ( )

6.C:[ ( ...unclear)

7.M:[ I don't know uhhhh

8.Ph: The blister packs that we provide you haven't had them yet? ( )

9.Ph: Well sometime in the future you'll start to get all your tablets ( ) in (.)

10.Ph: Uhhh packs which are specially made out for each day's dosages ( ) that'll happen

11.Ph: sometime in the future (.)

12.M: Yeah

13.Ph: It makes it a lot easier for you you know (.) just to administer (.)

14.Ph: each day's drugs or (.) you know (.) you know which day you have got to give which

15.Ph: drugs (.) So we'll tell you all about that when it happens which shouldn't be too (.)

16.Ph: far in the future (.) Right ( )

17.M: ((to child- alarm is continuing to bleep) (...Unclear..) If you leave it

18.M: the nurses will come and do it( )

19.Ph: That's fine (.) [OK (.) That's fine

20.M: [Alright

**Present: Mother, child aged 6 years**

**Start of treatment: 3/93**

**(ALL)**

**Transcript 22: kj/nc/op**

- 1.Ph: Right [then  
2.M: [Back for treatment this week  
3.Ph: Oh yes(.) back from 0% to 50 ( )  
4.M: Is it all ready?  
5.Ph: Certainly is ( ) if it's just for one week(.) yes. (You'll) be back next week?  
6.M: Yes ( ) Ooh can we have some EMLA cream as well?  
7.Ph: Yeah ((puts cream in bag)) What's that for (.) is it for ( ) EMLA cream?=  
8.M : =EMLA cream yeah ( )  
9.Ph: So the Septrin's in there already ( )  
10.M : Great  
11.Ph: In there ( )  
12.M: Have you taken over from (name) then?  
13.Ph: Yes  
14.M: Oh right(.) I didn't know if you was just filling in while (.) [he was on holiday  
or  
15.Ph: [No I've had a ( )  
16.M: Do you have so long on (.) [oncology  
17.Ph: [3 months=  
18.M: = Oh right  
19.Ph: So I finish at the end of October ( ) so there'll be a new face then ( )  
  
(puts medication into bag)  
20.Ph: Right [then that's it  
21.M: [Ok then  
22.Ph: There [you go  
23.M: [Thanks very much then  
24.Ph: Thank you-  
- Oh EMLA cream  
25.M: Oh EMLA cream  
26.Ph: Do you want the uhhm=  
27.M: =patch as well ( ) Thanks then  
28.Ph: OK [Bye  
29.M: [Bye (.) Bye

**Present:- Mother, patient aged 14 years**  
**Start of treatment 23/3/93**  
**(ALL)**

**Transcript 23:- ds/nc/op**

- 1.Ph: Can I just check we've got the right chart there (.) (name)(.) s'that right?  
2.M: Say yes () [(name) that's me (.) yes  
3.C: [Yes  
4.Ph: Right ( ) ((looking at chart))  
5.M: Two weeks this week  
6.Ph: Right ( ) (well) we've only done one week (.) just to ruin it so I'll just change that  
- add another week in ( )  
7.Ph: 'cos he only had a week last week didn't [he  
8.M: [Yes yes  
9.Ph: But his counts are fine (.) so we'll just add those in ( )  
10.M: ((to child)) You're too much trouble aren't you throwing [everybody out ((laughs))  
11.Ph: [ (( laughs))  
12. C: Yeah ((laughs))  
13.M: Dr (name)'s sorted him out today though huhh () he showed you your tickle spots didn't he (name)  
14.Ph: ((laughs))

((Child tries to tickle mother))

- 15.M: No (.) I'm not ticklish there  
16.C: ohhhh ( ) Can I have a high one  
17.M: He wants a special place where I tickled him round there (must be a tickle spot)  
18.Ph: I've got a tickly spot there ((points)) ( ) It'll never go away (.) it'll always be ticklish ( )  
19.M: What have they done another 100% (.) I never even looked  
20.Ph: He's on ((looks at chart)) 100% yes cos he had one week of 100% last week ( ) another 2 ( ) and then if he -your-  
- if his count's alright (.) in 2 weeks (.)he'll have one more week of 100% and then go up to 125 ( )  
21.M: Well you're not (.) cos you've been you've been ((unclear)) with his chemo so ( )  
22.Ph: Oh right he's coming in for his injections  
23.M: Yes he's had four weeks of tablets  
24.Ph: Yeah  
25.M: ((to child)) (...) At least he hasn't got to come back next week ( ) It's ages since you had 2 weeks (name)  
26.Ph: ((laughs))  
27.M: ages and ages  
28.Ph: Right then (.) that's it ( ) oops

((Unclear exchange between child and mother:- child is asking for money for a drink))

29.Ph: Do you need any Septrin?=  
30.M: = Yes please (.) Yes  
31.Ph: 5mls? of that one((shows bottle))that's the right one isn't it ( ) [is that the aniseedy one  
32.M: [Yes  
33.C: [Yes yes  
34.Ph: Is that one nice (.) do you prefer that one (.) right  
35.M: It's the tablets he doesn't like ( )  
36.Ph: Oh right  
37.M: They're too big  
38.Ph: Yeah  
39.C: ((unclear)) blackcurrant  
40.Ph: Have they (.) I don't know what they (.) I've never tasted but it [smells nice  
41.M: [he he likes  
it yes yeah he likes the blackcurrant one  
42.Ph: Right ( ) That's it ( ) Well I won't see you in 2 weeks because I'm going on holiday but ( )  
43.M: Oh  
44.Ph: somebody will be [here  
45.M: [well have a nice time  
46.Ph: There you go (name) ( ) OK ( )  
47.M: Thank [you Right  
48.Ph: [Cheerio  
49.M: Bye  
50 C: Bye (Mom the money)

**Present:- Mother, child aged 8 years**  
**Start of first treatment 15/1/90 (Relapsed and started on new protocol)**  
**(ALL)**



**Transcript 24:- lp/nc/op**

- 1.Ph: Right ( ) you're still on 50% ( )  
2.C: Yeah  
3.Ph: so ( ) and it's just one week (.) and you'll be back next week  
4.Ph: so I'll just change that  
5.C: (OK)  
( )  
6.Ph: Right and you've got your Septrin in there as well  
7.C: OK=  
8.Ph: = That's what normally happens (.) This is quite quick to change ( )

(Patient and mother watch pharmacist redispense medication)

- 9.Ph: That's it (.) It was quite quick to change  
10.C: ((laughs))  
( )  
11.Ph: There you go then  
12.M: Thank you  
13.C: Thank you  
( )  
14.Ph: So you'll be back next week  
15.M: Yeah=  
16.C: = Yeah  
17.Ph: OK [thanks  
18.M: [Bye  
19.C: [Bye  
20.Ph: Bye

**Present: Mother, child aged 12 years**  
**Start of treatment 23/2/94**  
**(ALL)**

**Transcript 25:- sc/nc/op**

- 1.Ph: ((Taking drug card from patient)) Thanks  
( )
- 2.Ph: Great (.) I don't have to change anything
- 3.B: Yeah (.) I don't think so
- 4.Ph: No (.) the count's fine
- 5.B: Mmmhmm  
( )
- 6.Ph: And you're coming back in a week
- 7.B: Monday
- 8.Ph: Alright yeah(.) I've given you seven days anyway
- 9.B: Yeah
- 10.Ph: Because it's-  
- it it works out easier ( ) but you'll get a new lot on Monday ( )
- 11.Ph: D'you want some of the Septrin ( )
- 12.B: Yeah (.) better take some just in case
- 13.Ph: Yeah ( ) well there's that one and that's 7.5ml =
- 14.B: = Mmmhmm
- 15.Ph: twice a day on Monday Wednesday and Friday (.) is that alright (.) Do you  
want a bag (Child's name)
- 16.C: No thank you
- 17.Ph: No [OK
- 18.B: [Alright then ((laughs))
- 19.Ph: ((Laughs))
- 20.B: Bye
- 21.Ph: Bye

**Present: Patient aged 6 years, patient's elder brother**  
**Start of treatment 12/10/92**  
**(ALL)**

**Transcript 26:- ma/nc/op**

- 1.Ph: Right then ( ) Now then (.) you're coming back in 2 weeks (.) is [that right  
2.C: [Yeah ( ) yeah  
3.Ph: and you've got everything in there ((checks blister))  
((Mother enters))  
4.Ph: Hello=  
5.M: Hi(.) Hello ((to researcher))

((Researcher introduces herself and asks for permission to tape the consultation. This is given))

- 6.M: Do you want that back or [do I keep it? ((indicates study information leaflet))  
7.R: [No you can keep it  
8.M: Alright  
9.Ph: Right then (.) [Here we go (.) two weeks  
10.M: [Right ( ) yeah  
11.Ph: Septrin's in there  
12.M: Mmmhmm  
13.Ph: Alright ( ) Quite straight[f  
14.M: [Yeah but we're due back a week on Monday (.)  
15.M: lumbar puncture  
16.Ph: Right (.) I've given you 2 weeks there anyway [cos it's easier  
17.M: [That's fine  
18.Ph: for us (.) and (.) but you'll (.) have 2 days leftover (.)  
19.C: Mummy (.) mummy  
20.Ph: and I'll give you a [new lot on Monday  
21.C: [Mummy I'll get (patient's name) and (patient's name) and  
say hello  
22.M: Go and fetch 'em then ( ) OK then

((child leaves))

- 23.Ph: Is that alright?  
24.M: Yeah  
25.Ph: So I'll see you then  
( )  
26.M: OK then ( ) Right thanks  
27.Ph: Cheerio=  
28.M: =Bye  
29.Ph: Bye

**Present: Mother, child aged 9 years**  
**Start of treatment 29/1/93**  
**(ALL)**

**Transcript 27:- kb/nc/op**

- 1.Ph: so what're you back in 2 weeks for-  
- just( ) you're not coming in on a Monday
- 2.Ph: or anything like that ( )
- 3.C: Yeah for (.) my uhhh lumbar puncture=
- 4.Ph: =Right ( ) Two weeks-  
- one week on Monday that is
- 5.C: Yeah  
( )
- 6.Ph: So you'll have an extra 2 days there ( )
- 7.C: Yeah uhhh
- 8.Ph: You'll get a new lot (Monday) ((begins to put in bag))
- 9.Ph: Where've I put it? (.) Did you give it to me?
- 10.C: Yeah

((pharmacist searches for drug card))

((Nurse enters))

- 11.N: Is this the last (indistinct)
- 12.Ph: Yeah (.) certainly is ( ) OK
- 13.N: Thanks
- 14.Ph: Now ( ) Do you know if you need any Septrin (name)
- 15.C: Uhhhh=
- 16.Ph: =Do you want to take it anyway
- 17.C: Yeah I'll take [it
- 18.Ph: [Right ( ) OK ( ) Do you want it in a bag?
- 19.C: Yes please

((Pharmacist puts medication in bag))

- 20.Ph: Right then ( ) See you in 2 weeks
- 21.C: Yeah ( ) [Bye
- 22.Ph: [OK then ( ) Bye

**Present: Child aged 8 years (alone)**

**Start of treatment 3/2/93**

**(ALL)**

**Transcript 28 :- jm/nc/op**

- 1.Ph: Dose has changed hasn't it  
2.M: It has yes (.)[yeah  
3.Ph: [Down to 50%  
4.M: Yes (.) that's right  
5.Ph: And could we-  
-have we got any left of this?  
6.M: I should've brought some but-  
-I've got some bottles at home with drugs in actually (.)  
7.M:I should've brought-  
-I'll bring them in [next time  
8.Ph: [Yeah(.) bring them in  
( )  
9.M: and [you can reuse them all  
10.Ph: [go from there yeah( ) save you getting mixed up at home as well  
11.M: Well if they're in bubbles it's-  
-it's cos we've been away on holiday and we've had  
12.M: them all in bottles  
13.Ph: What (.) for while you've been away( )  
14.M: Ye[ah  
15.Ph [Yeah  
( )  
16.M: (to child) Is that a good lolly ( ) Mmmm(.) Yeah?  
( )  
17.M: You know he's just had vincristine (.) is he having prednisolone (.)as well  
18.Ph:Yeah=  
19.M: =Yeah  
20.Ph: I've uhhhh (.) there we go ((hands over)) ( ) Six each day  
21.M: That's right  
22.Ph: That right? [normal?  
23.M: [Thanks (.) Yeah ( ) Excellent ((Shows bottle to child))  
24.M: Red tabs ( ) Your favourite ( ) look (.) Shiny red tabs  
25.Ph: Do you like those better than the white ones? ( ) Mmmhmm  
26.M: He's a very good boy with his tablets (.) aren't you eh? ((to child)) What have  
you got on here?(.)Bits of white fluff(.) I think they're bits of cotton wool( )  
  
((Another patient enters room))  
  
27.Ph: Hiya (name) (.) If you just want to leave it with me uhhm (.) call back in ( )  
uhh 5 minutes or so  
( )  
28.Ph:Right ( ) just a week's worth?  
29.M: Yes (.) we're back next week  
30.Ph:Yeah  
( )  
31.Ph: OK  
32.M:(indistinct) Can I take some EMLA as well?

- 33.Ph: Oh yeah ( ) there you go (.)Right  
34.M:Excellent thank you ( ) see you next week [then  
35.Ph: [Tata  
36.M: Come on then (name)  
37.Ph: See you (name)  
38.C: See you

**Present: Mother, child aged 4 years**  
**Start of treatment 6/9/93**  
**(ALL)**

**Transcript 29 :- kj/nc/op**

1.M: So are you covering for holidays (.) this week=

2.Ph: =Yea:ah (.)I am

3.M: Oh (.) yeah

4.Ph: (name)'s gone away to somewhere exotic so ( ) old muggins here [((laughs))

5.M: [((laughs))

6.Ph: You know (.) "(Pharmacist) can do it " they all say

7.M: Yeah (.) "(Pharmacist)'s used to it"

8.Ph: Yeah "he doesn't mind" ( ) Mind you they forgot to mention that

9.Ph: I would-

-I'd still be doing my own things as well ( ) so it's ( ) a bit busy

((looks at drug card))

10.Ph: Yeah (.) Just what we expected by the looks of it ( ) 75% ( ) coming back in  
2 weeks

11.C: Yes

((Pharmacist checks blister pack))

12.M: Are they all there?

13.Ph: Yeah

14 M: Good

15.Ph: Unless any escape before I get the lid on

( )

16.Ph: Have you had a vincristine or is that next week? ( )

17.Ph: That't next [week isn't it ( ) Oh yeah (.) next time you come

18.M: [Two weeks ( ) yeah

19.C: Next time I come

((Pharmacist puts medication in bag))

20.M: Can we have some EMLA please?

21.Ph: Yeah (.) sure

((hands over cream))

22.Ph: There you go ( ) That's everything isn't [it

23.M: [Have you got any brown bags?

24.Ph: Uhhhm ( ) Yes I have ((hands over bag)) There you go

25.M: Thank you

26.Ph: See you

27.M: [Bye

28.C: [Bye

**Present: Mother, patient aged 13 years**

**Start of treatment 23/3/93**

**(ALL)**

**Transcript 30: nq/nc/op**

- 1.Ph: ((indicating tape recorder)) It's a bit official isn't it ( ) I'm not going to say anything to you really because you've had it all before haven't you?
- 2.F: No ( ) the missus usually does this
- 3.Ph: Oh right ( ) It's what we were expecting (.) 50%
- 4.F: Yeah  
( )
- 5.Ph: Do you have any oral syringes at home ( ) or do you want me to give you some ( )
- 6.Ph:[you know the
- 7.F: [Uhh yeah (.) we've got some
- 8.Ph: You've got plenty =
- 9.F: =Yeah
- 10.Ph: Ri:ight ( ) That's the (.) once a week on Thursday morning (.)
- 11.Ph: metho[trexate ( ) Yeah ( )3.75ml which is a bi:it ( ) dodgy to measure ( )
- 12.F: [trexate (.) Yeah
- 13.Ph: But do the best you can there'll be no problem ( ) and the mercaptopurine every day (.) 3mls of that one every day
- 14.F: Mmmhmm
- 15.Ph: and the Septrin (.) have you got plenty of Septrin at home or do you want some more?
- 16.F: Not sure ( ) [I'll
- 17.Ph: [Do you wanna take it anyway? ( ) Yeah? (.)You may as [well ( )
- 18.F: [Can do
- 19.Ph: Yeah ( ) Right ( ) That's all you need (.) D'you want a bag for them or are you OK like that?
- 20.F: Uhhh have you got a bag here?
- 21.Ph: Yeah
- 22.F: If you've got one I'll have one  
((Pharmacist hands over bag))
- 23.Ph: Thank you very much
- 24.F: Thanks a lot
- 25.Ph: See you

**Present: Father of patient only**  
**Start of treatment 4/94**  
**(ALL)**



**Transcript 31:- sg/nc/op**

1.Ph: I didn't know you were coming ( ) And if I did (.) I've left them in uhhh-  
-in the pharmacy ( ) If you just wanna hang on here a moment I'll be back in 2  
minutes

( )

2.M: ((to child)) He's forgotten your tablets

3.R: he's covering for somebody who's on holiday so I don't think he knows what's  
going on (.) to be honest with you

4.M: I know ((laughs))

(Child asks to go out to play with other children in clinic, and leaves)

5.M: Right (.) Come straight back to me then

6.C: Yeah

( )

7.R: Did you ever come when you used to have to go to the back hatch at the  
pharmacy

8.R: [to get your tablets done?

9.M: [Yeah ( ) It's better here now

10.R: Yeah (indistinct..)

( )

11.Ph: Here we go ( ) Right (.) it's a full month's worth isn't it?

12.M: Yeah

13.Ph: There's the (.) Septrin already done for you ( ) a:and the prednisolone? (.) just  
had a vincristine has he?

14.M: Yeah

15.Ph: There's your prednisolone ( ) you'll have to bear with me for five minutes

16.Ph:[while I uhh put [up all the bottles for you

17.M: [Yeah [Alright

18.Ph: Are you still (.) uhhh ( ) finding this OK?

19.M: Yeah fine (.) yeah

20.Ph: Did you ever ( ) used to come back every week (.) or have you always done  
this system?

21.M: No when I was first in and we had the blister packs it was more [often

22.Ph: [Right ( ) and  
then you've taken over this system after that ( ) and you find it much better?

23.M: When you break the tablets in half for him it's alright

24.Ph: Pardon

25.M: Uhhh when you break the tablets in half it makes it alright ((laughs))

26.Ph: Oh right ( ) When you have to do it yourself then it's not ((laughs))

27.Ph: Yeah

( )

28.M: I've still got tablets at home from last time (.) are they still alright to use?

29.Ph: Yes (.) Yeah ( ) Uhhh ( ) What you can do is (.) bring them back with you  
each week ( )and we'll ( ) just put them into a new bottle ( ) and you'll only ever  
have one bottle of each ( ) but it's always (.) full ( ) otherwise you're gonna end up  
with like lots and lots of bits of bottles like these ((unclear...)) and we can recycle  
them ( ) keep on packing them down

- 30.M: I've got all the empty bottles at home actually
- 31.Ph: All empty bottles? ( ) Oh that's alright you can just bin them
- 32.M: Is that alright?
- 33.Ph: Just throw them away (.) We never recycle them anyway
- 34.M: It's just that I come once and they asked me for the empty bottles
- 35.Ph: Really ( ) Ohhh that's strange
- 36.M: You don't know why that was
- 37.Ph: I can't think why ( ) no ( ) throw them away and if anyone asks you for them uhhh say "(own name) says throw them away" ( ) and ask them why they want them ( )
- 38.Ph: 55 ( ) 55 + 66 ( ) is ( ) 120 (.) Does that sound right? ( ) Me maths was never the best in the world ( ) ((to researcher)) Do you agree with that ? ( ) 55 + 66
- 39.R: ((unclear))
- 40.Ph: You've got an extra one ( ) (Don't tell anybody) ( ) mercaptopurine 10mg ( )  
Approximately 120 ( ) there you go ( )
- 41.M: What dosage has he had (.) I forgot to ask them
- 42.Ph: Uhhh ( ) 7th (.) that's today ( ) 100% for the next 2 weeks
- 43.Ph: Yeah (.) Do you know-  
- Do you follow the system of how it works as to which percentage he goes to?
- 44.M: 65 mercaptopurines ( )
- 45.Ph: Uhh (.) yeah ( ) He stays on 100% for 4 weeks uhhh everything being OK (.) and he's had one week already so for the next 2 weeks he should be ( ) and for the third week-  
- fourth week he should be as well ( ) unless his count changes ( ) and the second and third weeks are the next two (.)
- 46.M: He's had 2 weeks of 100 ( )
- 47.Ph: Ohhh yeah ( ) [2 weeks already ( )
- 48.M: ((laughs))
- 49.Ph: Here's all the halves ( ) (( begins to prepare tablets)) Right there's your half mercaptopurines-  
- Do you want a bag? (.) Oh you've got a bag already
- 50.M: I've got a bag (.) yeah
- 51.Ph: Did we used to give you the whole tablets and make you halve them yourself ( ) yeah
- (Two doctors enter room))
- 52.Dr 1:Hi (.) Sorry Hi (.) Where-  
-Where's your rascal gone to?
- 53.M:He's run off in there
- 54.Dr 1: Can I go and get him?
- 55.M: Yeah ( ) Yeah (.) Drag him in ((laughs))
- 56.Dr 2: You don't mind if we use your room as a consulting room do you (pharmacist's name)?
- 57.Dr 1: What are you doing here?
58. Ph: (Name)'s gone off to ( ) holiday
- 59.Dr 1: Get o:nnn

60.Ph: Yeah (.) Didn't you know she was [on holiday  
61.Dr 2: [Yeah (.) she's gone to Syria (.) ((To patient)) So what's the problem here?  
62.C: Spots  
63.Dr 2: Yeah ( ) That tape recorder's going (.) Don't say anything ((laughs)) ( ) Not that you would anyway  
64.C: ((laughs))  
65.M: There's a rash on his body ( ) and it come on his hands ( )  
66.Dr 2: Does it come and go?  
67.M: Yeah  
68.Dr 2: Does it come when he's hot?  
69.M: It does ( ) but it don't ((laughs))  
70.Dr 2: Ohh ( ) that's ( ) sorted that one out [then  
71.M: [Well like when he's hot it-  
- it's like a bit more  
72.Dr 2: Yeah ( ) More obviously red  
73.M: But it's not heat rash cos it don't go away when he's cold ((laughs))  
74.Dr 2: But they don't bother him?  
75.M: No ( ) No (.) He has a few on his neck and he scratches them but on his belly and his hands nothing  
76.Dr 1: ((to Dr2)) That's what (...unclear)  
77.Dr 2: We're not ruining your tape recording are we?  
78.R: No (.) No  
79.Dr 2: Sssh (.) Impartial observer (.) No intrusion into the conversation  
80.Dr 1: (To boy) You're brilliant aren't you  
81.Dr 2: Well I must admit it does look heat rash-ish to me ( ) I really wouldn't be ( ) I don't think it's going to trouble you  
82. Dr 1: ((to Dr 2)) (..unclear) Carry on with the E45 ( ) Yeah I suspected that would has it-  
-has that helped  
83.M: Not really ((laughs))  
84.Dr 2: No that's probably not going to stop it if it's heat rash(.) I'm sure it's something like that  
85.M: Right  
86.Dr 2: Yeah ( ) He's had this before hasn't he?  
87.M: Yeah  
88.Dr 2: What happened to it?  
89.M: It went away  
90.Dr 2: There you go  
  
((All laugh))  
91.Dr 1: Well ( ) Second opinion (.) Worth having ( ) See you (.) Thanks  
92.Ph: Right ( ) Mercaptopurine big ones and methotrexate ( ) That one has got one of the ( ) labels where you fill in spaces ( ) you don't need that do you? ( ) So that's big methotrexates ( ) that's it  
93.M: Yeah  
94.Ph: There you go ( ) I've given you ( ) your Septrin have I?

95.M: Yeah

96.M: Have you got the Septrin?

97.M: Yeah

98.Ph: Yeah (.) and you've got the prednisolone

99.M: Yeah

100.Ph: That's your lot ( ) OK ( ) See you in a month's time

101.M: Yeah ( ) Bye

102.Ph: OK Bye

**Present: Mother, child aged 5 years**

**Start of treatment 24/3/93**

**(ALL)**

**Transcript 32:- ml/nc/op**

1.Ph:Right ( )

2.Ph:Coming back in a week's time ( ) Right ( ) have you got plenty of Septrin at home? (.) or (.) [uhhh

3.F: [We have (.) uhhh better take some more

4.Ph: There's your blister=

5.F: =Ta

( )

6.Ph: There you go (.) There's another bottle for you

7.F: Oh alright (.) thank you

8.Ph: Have fun (.) See you

**Present: Father (alone)**

**Start of treatment 8/93**

**(ALL)**

**Transcript 33:- jb/nc/op**

1.Ph: Same as usual =

2.M: =Right ( )you

3.Ph: Right ( ) There's nothing for me

4.M: Nothing

5.Ph: Yeah (.) Same as normal (.) Two weeks worth is it?

6.M: Yeah

7.Ph: Two weeks' worth ( )

8.M: I think he's gone up [to 150

9.Ph: [150% yeah =

10.M: = Yeah

11.Ph: Right (.) that's [syrups (.) All the numbers all the-

12.M: [syrups

13.Ph: -all the volumes are on the uhhh ( ) have you got ( ) some

14.Ph: oral syringes [still

15.M: [Yeah we've got loads of [them

16.Ph: [You don't need any (.) to take any more

of those ( ) that's 8.75 ( ) mercaptopurine every day ( ) and 6mls ( ) of the methotrexate

[every day

17.M: [Right

18.Ph: Don't forget to give them a shake before you use them

19.M: OK

20.Ph: No problems? (.) Oh and prednisolone

21.M: Yeah

22.Ph: He's had a vincristine hasn't he

23.M: Yeah

24.Ph: Right (.) Do you want a bag for them all?

25.M: Please

26.Ph: ((puts medication in bag)) Have you got enough Septrin?

27.M: Yeah I've got [loads

28.Ph: [You've got plenty of Septrin

29.M: Loads

30.Ph: Uhhh (.) nothing else?

31.M: No [thanks

32.Ph: [smashing

33.M: Thanks

34.Ph: OK (.) Bye

**Present:-Mother, child aged 3 years**

**Start of treatment 3/9/91**

**(ALL)**

**Transcript 34:- nq/nc/op**

1.Ph: everything goes quiet once the tape goes on

2.M: ((laughs)) Yeah ( ) I'm not gonna say [yeah ((laughs))

3.Ph: [I make sure I say all my things first ( )

((Dietician who has been using room previously enters and there is a discussion about the removal of her equipment))

4.D: Do you want me to ( )

5.Ph: If possible yeah (.) On a Wednesday afternoon we use this room for dispensing the ( ) chemotherapy =

6.D: = Oh right (.) Sorry ( ) Nobody uhhh (.) told me ((laughs)) let me just take ( ) can we just [take

7.Ph: [Yeah I'll-

-I'll leave- I'll leave it with you (.) I'm uhhh getting by as we are

8.D: Alright let me just [uhhh

9.Ph: [Can I just get to that corner ( ) I'll be out your [uhhh

10.D: [Yeah sure

11.Ph: -I'll keep right out of your way

( )

12.Ph: Right then ( ) There's the mercaptopurine ( ) Yeah (.) no problem there (.) It's all ready for you ( ) 5mls and (.) 5mls of each ( )

13.M: Yeah (.) yes that's [methotrexate is it yeah

14.Ph: [every day

15.Ph: Methotrexate just on a Thursday morning

16.M: Yeah (.) Yeah

17.Ph: Do you want a bag for them (.) [I've got one here

18.M: [Please (.) Yes please

19.Ph: How does he find the taste of them?

20.M: Uhhh (.) he doesn't mind these two (.) anything rather than the steroids (.) he hates them [so (.) Yeah (.) these are better than those

21.Ph: [Really

22.Ph: Right (.) uhhh which steroids does he have (.) does he have the (.)

23.M: Prednisolone

24.Ph: The white soluble ones ( ) [or the red ones?

25.M: [soluble ones (.) yeah

26.Ph: Does he not like those?

27.M: No

28.Ph: We can ( ) can he take any tablets (.) cos we've got some sugar coated tablets (.)

[he can't take any form of tablets?

29.M: [No he usually has all syrups you see

30.Ph: Yeah (.) [Yeah cos some people don't like the ( ) there are 2 different types

31.M: [Yeah

32.Ph: of tablets as well ( ) [and some taste horrible and some (.) are sugar coated

33.M: [Yeah

- 34.Ph: and they're nice ( ) so if you can get them down him then (.)  
35.Ph: Then [you're sorted but  
36.M: [Yeah ( ) Well it's only once a month so ( ) we get 'em down him  
37.Ph: Yeah ( ) Yeah  
38.M: Thank you [then (.) Thanks ( ) Bye  
39.Ph: [There you go then (.) See you

**Present:- Mother, child aged 5 years**  
**Start of treatment 4/94**  
**(ALL)**



**Transcript 34a:- ds/nc/op**

1.Ph: Hiya

2.Other parent ((to patient's mother)) He's doing you next (.)Yeah ( ) Don't want to push in

3.M: Yeah

4.Ph: (Name)'s

5.M: (name)'s

6.Ph: Here we go ( )

7.M: We nipped upstairs to ( ) [get his (...unclear) changed

8.Ph: [Yeah (.) I was uhh (.) I had a meeting at lunchtime and it over-

-it overran a bit so ( ) I'm late getting here( )

9.Ph: Right ( ) 100% (.)[Is that what you were expecting? (.) for ( )

10.M: [Yes

11.M:Twelve days=

12.Ph: =Twelve days (.) Very confusing ( )

13.M: A week on ( ) Monday

14.Ph:Yeah

15.M: Yes

( )

16.M: He's got very hot ears ( ) (name)

17.Ph: Has someone been talking about him?

18.M: I know [((laughs)) They're very uhh ( ) hot (...unclear)

19.Ph: [((laughs))

20.M: ((to child)) Put the videos back (name)

21.C: I'm watching them now when I get home

22.M: I know (.) Which one you gonna watch first?

( )

23.Ph: Right (.) We've miscalculated (.) We've gone to 7ml rather than 12 so we're gonna have to put some more in ( ) so you ( )if you can just bear with me

( ) ((Pharmacist recalculates doses to 100%))

24.Ph: There we go (.) up to and including Monday morning ( ) a [week on Monday

25.M: [Yeah ( )

26.M: We've got Septrin=

27.Ph: =You've got Septrin

28.M: Yes

29.Ph: That's smashing ( ) Are you in for a vincristine ( ) or is it a ( ) an intrathecal as well

30.M: Intrathe-  
-Yeah

31.M: ((To researcher indicating microphone)) He'll sing you a song if you want now [ ((laughs))

32.R: [((laughs))

33.C: [((laughs))

34.M: ( ) give us something to laugh about  
35.Ph: We send these off to Top of the Pops you know  
36.M: Yeah ((laughs)) Good job we didn't bring (patient's sister) isn't it?  
37.C: Yea:ah (.) She'd have sung  
38.R: Is that your sister?  
39.M: His sister yeah ( ) She's only five (.) She's not shy yet ( )  
40.R: Right  
41.M: she'll sing (.) to anybody  
42.Ph: There you go then  
43.M: Thank you very [much  
44.Ph: [Twelve days' worth  
45.M: Right (.) Thank you  
46.Ph: See you ( ) See you (patient)  
47.M: Bye

**Present: Mother, child aged 8 years**  
**Start of treatment 15/1/90**  
**(ALL)**

**Transcript 35:- kb/nc/op**

- 1.Ph: Right ( ) How's the medicine going?  
( )
- 2.Ph: Yeah ( ) I've got five days' worth already made up so:oo ( )
- 3.Carer: Yeah
- 4.Ph: So that's what I'll give you ( ) rather than keep you hanging round (.) and put some more in ( ) this'll do you until Monday then on Monday just come to Pharmacy and they'll do it (.) [we'll take
- 5.Ca: [Will I need a card or ( ) [go straight in and
- 6.Ph: [No ( ) prescription ( ) Yeah (uhhh)  
you'll have been up on (ward name) anyway won't you
- 7.Ca: Yeah (.) probably yeah
- 8.Ph: Uhhh ( ) They'll probably-  
- they'll have the card up there (.) they can give it to you  
to bring down so ( ) to identify yourself
- 9.Ca: Yeah ( ) yeah
- 10.Ph: Sort it out for you
- 11.Ca: Uhhh ((looking at tablets)) normal procedure?
- 12.Ph: Yeah ( ) There you go [there's 5 days
- 13.Ca: [Uhh she's on some other tablets she's on uhhh I guess  
these can be taken with them
- 14.Ph: What are [they?
- 15.Ca: [It's like amoxicillin-  
- It's like an antibiotic
- 16.Ph: Oh Yeah ( ) [There's no problem there
- 17.Ca: [So give the amoxicillin and another one
- 18.Ph: Yeah (.) Carry on with the instructions on those ( )
- 19.Ca: Yeah
- 20.Ph: and those ( ) and there's [no problem there at all
- 21.Ca: [Ok then ( ) Bye
- 22.Ph: Have you got enough Septrin just before you go?
- 23.Ca: Sorry?
- 24.Ph: Have you got enough Septrin?
- 25.Ca: Uhhh ( ) She usually has some at home doesn't she?
- 26.Ph: I can-  
- I'll give you some more [anyway
- 27.Ca: [(name) (.) (name) the mom (name) normally  
brings her like ( ) but ( ) she's [busy babysitting
- 28.Ph: [Yeah ( ) I ( ) I'll give you some more anyway
- 29.Ca: Right ( ) Uhhh hold on a minute uhh I think she might have three bottles of  
that stuffed in the [fridge I'm not sure
- 30.Ph: [Alright ( ) well ( ) it lasts for a long time so =
- 31.Ca: ((to child)) =Yeah (.) You've got some of that ain't you?
- 32.C: Yeah ( ) I've got loads
- 33.Ph: You've got loads (.) Definitely?
- 34.C: Yeah
- 35.Ca: Yeah I in fact I think uhhh Grandma's got some hasn't she

36.Ph: Well you can take it [just to be on the safe side  
37.Ca: [Yeah  
38.Ca: OK then ( ) What is she supposed to do with this stuff then?  
39.Ph:[you ()  
40.C: [You're supposed to give me it=  
41.Ca: =Oh she can take it yeah  
42.C: It's aniseed ( ) It stops you from getting infections [so there  
43.Ca: [Does it  
44.Ca: Well you better start taking some then ( ) OK ( ) Thanks  
45.Ph: See you  
46.Ca: Ta-ra

**Present: Child aged 8 years with carer**  
**Start of treatment 3/2/93**  
**(ALL)**

**Transcript 36:- sr/nc/op**

- 1.M: Have we only got one this time?  
2.Ph: Yeah ( ) Hi [(child's name)  
3.M: [They did it wrong  
4.F: Can I have another patch?  
5.Ph: Yeah sure  
6.F: Last time they couldn't get a vein (.) on that hand so they had to transfer it to  
( )  
[to where ( ) on the other hand ( ) I know ( )  
7.Ph:[Oh right  
8.Ph: There you go ( ) a spare one  
9.C: What's that for Mummy?  
10.F: Injection darling=  
11.M: =For your ( ) for your magic cream  
12.C: Have we got some Mom?  
13.M: We've got some magic cream  
14.Ph: Coming back next week then aren't you  
15.F: Yeah  
16.Ph: Just a week's worth here  
17.F: Yeah ( ) yeah  
( )  
18.Ph: ((to child who is watching him prepare blister)) You've got lovely eyes you  
know  
19.F:Come back Thursday  
( )  
20 F: It's much better now than pharmacy before ( ) I used to hate doing that  
21.Ph: Waiting outside you mean ( ) Yeah ( ) Most people have said they like it much  
better [this way  
22.F: [It's a lot quicker isn't it and nearer ( ) no point in waiting around there  
( ) hours  
23.Ph: Are you OK for Septrin ( ) or could you do [with some more  
24.F: [No ( ) we need some more (.)  
want some more  
25.M: Please  
26.Ph: No problems (.) tablets then  
27.F: Thank you  
28.Ph: Here we go=  
29.M: =What's that one  
30.Ph: This is the ( ) [aniseed one  
31.F: [aniseed  
32.M: aniseed ( ) that's the [one  
33.F: [That's the one  
34.Ph: Two and a half mls of this one yeah  
35.M: Yeah  
36.Ph:Yeah ( ) That's it  
37.M: She doesn't like the other [one does she?

38.F:

[No

39.Ph:

[Thank you (name) ((to doctor who has brought in

a drug card))

40.Ph: Yeah ( ) OK ( )

41.M: Come on then

42.Ph: See you then

43.M: Bye

**Present: Mother and father, patient aged 4 years, patient's brother.**

**Start of treatment 6/93**

**(ALL)**

**Transcript 37:- sk/nc/op**

1.Ph: Right ( ) Two weeks' worth (.) Is that what you were expecting?

2.M: Yeah=

3.Ph: =Coming back in 2 weeks' time

4.M: Yeah

((Pharmacist begins to dispense medication))

5.Ph: The thing about this is that (I never say anything anyway)

6.M: ((laughs))

7.Ph: and if I do say anything to you I lower my voice on purpose  
[so it doesn't get caught on the [microphone ( )

8.M: (((laughs))

(((laughs))

9.Ph: What've we-

-you got the crutches for (patient's name)?

10.C: Oh it's uhh Perthe's disease (.) They think it's from the steroids

11.Ph: Oh yeah ( )

12.C: So I can't (.) I can't put any weight on my left leg [now

13.Ph: [Yeah

14.Ph: Oh ( ) How long's that been going on for?

15.C: it was uhh (.) 2 week ago (.) (I think)=

16.Ph: =Yeah

17.C: (I've) got to wait for it [for

18.Ph: [So they're not gonna give you any more steroids after  
(.) each vincristine or is it ( ) [see how it comes

19.C: [Yeah (.) that's it ( )

20.C: I think they're gonna carry on

21.Ph: Carry on=

22.C: =Yeah

((Pharmacist checks drug chart))

23.Ph: Do you find these easy to open ((indicates blister pack))

24.M: Yeah

25.Ph: How do you get into them ?

26.M: (Just) peel (them off)

27.Ph: When I've ever tried to do it you get sort of (.) a sticky bit in one hand and  
( )

28.M: (((laughs))

29.Ph: [a card thing in the other (.) and the tablets are stuck to the back of the sticky  
bit ( )

30.M: I know

31.Ph: and I struggle (.)

32.M: Oh[(..unclear)

33.Ph: [There must be a knack to it

34.C: It's women I think  
35.Ph: [((laughs))  
36.M: [((laughs))  
37.Ph: They've got a skill for things like this=  
38.M: =They're much better than the bottles  
39.Ph: You-  
-you much [prefer these do you?  
40.M: [Yeah (.) Oh yeah  
41.Ph: Yeah (.) It's so much easier isn't it  
42.M: Yeah (.) you don't forget ( ) I mean you've often given them the tablets and  
then you're thinking (.) did I give it him or not (.) [you know  
43.Ph: [I know what you mean  
44.M: You just have a look and it's there (you know) [but uhhh  
45.Ph: [Yeah (.) Obvious isn't it when  
it's there  
46.M: Yeah  
47.Ph: Right so that's it (.) Do you need any more Septrin Oh no it's already in there  
isn't it ( ) Yeah it will be  
48.M: Yeah  
49.Ph: That's fine ( )  
50.M: Alright  
51.Ph: That's everything you need  
52.M: Right  
53.Ph: OK  
54.M: Thank you then  
55.Ph: See you then  
56.C: Thanks a [lot  
57.M: [Bye

**Present: Mother, patient aged 15 years**

**Start of treatment 17/2/94**

**(ALL)**



**Transcript 38:- jb/nc/op**

- 1.Ph: 50% then (.) for a week ( )  
2.M: Yeah  
3.Ph: Count's up again is it?  
4.M: No (.) it's down ( ) He was on 150 last week=  
5.Ph: =Didn't he skip last week?  
6.M: No ( ) he had ( ) they phoned us up (.) he had a count taken Monday (.) they phoned us [and we had to stop it ( ) but we don't know whether tomorrow  
7.Ph: [Oh yes (.) of course  
8.M: Whether-  
-[until tomorrow whether he can take more  
9.Ph: [Yeah ( ) if he's going ahead with it yet  
10.Ph: So we're going to give you 50% just in case=  
11.M: =Yes (.) Yes  
12.Ph: I'm with you ( ) Right (.) We've got yeah-  
-we've made the 150 up  
13.M: Oh right  
14.Ph: So we're gonna have [to change  
15.M: [remake it  
( )  
16.Ph: This could need ( ) a bit of calculating out ( ) the uhh (.) the dose  
( )  
17.Ph: Do you have plenty of oral syringes?  
18.M: Uhh (.) yes  
19.Ph: You've got [plenty ( ) yeah  
20.M: [Yeah  
21.M: We've got plenty of Septrin as well  
22.Ph: Right ( )

((Pharmacist leaves to try and borrow a calculator but none of the clinic staff have one. Researcher leaves to fetch one from Pharmacy Dept.))

- 23.M: ((to child)) (Name) ( ) (Name) ( ) Don't be such a nuisance (name) ( ) get up off the floor  
24.Ph: Yeah ( ) It's silly volumes ( ) We're changing it uhhh quite soon ( ) Whereas at the moment you get 40mg in 5ml  
25.M: Mmmhmm  
26.Ph: We're going to change it to make it 50mg in 5ml [so it's much easier to work out  
27.M: [Oh right  
28.M: Yeah  
29.Ph: I don't know why we didn't do it before  
30.M: ((laughs))  
31.Ph: Uhhhm ( ) but ( ) that's happening (.) sort of once we've organised it ( ) to be able to tell everybody that it's now happened (.) that [it's not gonna be changing again

32.M: [Yeah  
33.M: Right  
34.Ph: Unfortunately we're still at the ( ) still at the other at the moment  
( )  
35.Ph: How's he doing then?  
36.M: Alright ( ) He's still doing really well  
37.Ph: Does he take the medicines OK?  
38.M: He doesn't like the methotrexate  
39.Ph: Oh the ( ) the once a week one  
40.M: Mmmm (.) He doesn't like that very much  
41.Ph: Does it taste significantly different  
42.M: I don't know ( ) I've no [idea ( ) He doesn't like steroids ( )  
43.Ph: [He must know though  
44.M: he doesn't like [steroids either that is  
45.Ph: [Oh yeah  
46.M: but I have tried [that ( )that's horrible  
47.Ph: [That's ( ) looking at this he's OK with the one he has to take  
every day then isn't it?  
48.M: Yeah ( ) Yeah ( ) and the Septrin (.) he's alright with that as well but  
he [says ( ) that one's horrible ( ) so he just has a drink ( )  
49.Ph: [Oh yeah ( ) yeah  
50.M: [and then (.) has that  
51.Ph:[Yeah (.) you can ( ) you're OK if you mix it with uhhhm some fruit juice  
or with [milk or something ( )  
52.M: [Oh right  
53.Ph: just before=  
54.M: =yeah  
55.Ph: you give it ( ) that's OK ( )  
56.M: Mmmhmm  
57.Ph: To dilute it down ( ) mask its taste ( ) he doesn't have to ( ) [take it  
58.M: [Mmmhmm  
59.Ph: neat as such ( )  
60 M: Oh right=  
61.Ph: =as long as you dilute it and then give him it straight away [rather than leave  
62.M: [Yeah  
63.Ph: it hanging about ( ) that's OK is that  
64.M: Right ( ) He doesn't take medicines for me anyway ( ) I uhh ( ) his Dad has  
to give them to him ( ) being such a pain  
65.Ph: Yeah ((laughs)) You could be right I think  
( )  
66.Ph: Are you OK for Septrin?  
67.M: Yeah  
68.Ph: You've got [plenty  
69.M: [Plenty of that (.) Yeah (.) Thanks  
70.Ph: How long does one bottle last you?  
71.M: Uhhh I've never (.) I've never put a ( ) [I'll have to put a date on it  
72.Ph: [time to it

73.M: and see how long it lasts ( ) it lasts me a long time  
74.Ph: It (.) it seems to last you a long time (.) I always offer you and you ( )  
75.M: Yeah ( ) [Yeah ( ) I've got another bottle actually in the cupboard  
76.Ph: [always ( )  
77.Ph: Still ( )  
78.M: So ( )  
79.Ph: Alright  
80.M: How long-  
-How long do they last?  
81.Ph: They last until the expiry date on them ( )  
82.M: Oh OK (.) I never ( ) [I'll have to check it then  
83.Ph: [somewhere (.) There you go ((points at bottle))  
84.M: Oh they [last some time then  
85.Ph: [expires 1997

((Pharmacist accepts calculator from researcher. Dietician enters))

86.D: That's not your stuff is it?  
87.Ph: These two are ( ) [the rest ( ) Those two are ( ) The rest isn't  
88.D: [Oh sorry  
89.D: Oh right  
90.Ph: So it's 2.9 ( ) yeah 2.9mls of that (.) and methotrexate ( ) 4.5 (.) you can  
measure those OK can you?  
91.M: Yeah  
92.Ph: You've got syringes that'll go down to that [at home  
93.M: [Yeah  
94.Ph: Yeah (.) so it's 4.5 of the methotrexate ( ) no it's not ( )  
95.M: ((to child)) (name) ( ) (name) settle down ( )  
96.Ph: 3mls of the methotrexate  
97.M: Right  
98.Ph: and 2.9 of the [other (.) of the mercaptopurine  
99.M: [OK of the ( )  
100.M: Thank you  
101.Ph: And you're OK for Septrin  
102.M: Yes  
103.Ph: Alright ( )  
104.M: Thanks very much then=  
105.Ph: =OK then  
106.M: Bye  
107.Ph: Ta-ta

**Present: Mother, child aged 3 years**  
**Start of treatment 9/91**  
**(ALL)**

**Transcript 39:- kj/nc/op**

- 1.Ph: Let's concentrate a bit  
2.M: We've had to wait (.) new surface area  
3.Ph: Yes ( ) been increased slightly hasn't it  
4.M: Yeah  
5.Ph: Yeah ( ) it doesn't make a difference to the tablets for now ( ) but we'll (.) increase the tablets next time ( ) more than likely they won't change much at all anyway  
6.M: Right ( ) So you're not going to change them this [time  
7.Ph: [No ( ) just a tiny change (.)  
8.Ph: It's gone up from 1.53 to 1.56 (.) the change that makes in the tablets is so tiny ( ) it makes no odds ( )  
9.Ph: Just a little change but we'll ( ) we'll have it done for next time ( )  
10.Ph: So it's 100% for 2 weeks then is it?  
11.M: Yeah  
12.Ph: Does that sound like what you were expecting?  
13.M: yeah

((Doctor enters room))

- 14.Ph: ((To Dr)) I'm gonna give Dr ( ) (name) and the other ones the old surface area ( )  
15.Ph: [Is that fine by you?  
16.Dr: [Yeah (.) If it's only changed by 0.01 I think ( ) I wouldn't change it again=  
17.Ph: =Yeah ( ) so ( ) probably won't have changed much  
18.Dr: Have you got (name)'s there I'll do that while I'm here ((takes drug card))  
19.Ph: Oh yeah ( ) Oh Yeah (.) (name)'s you've done a vincristine for next week ( ) but (.) it's increased (.) from 0.8 to 1 ( ) shall I ( ) shall I order it at the new one?  
20.Dr: I've done it actually (..unclear as leaves room)  
21.Ph: Oh ( ) Oh ( ) Right  
22.Dr: ((returning)) It doesn't make any difference ( ) once it's that high ( ) Sorry to step in.  
23.Ph: ((Handing medication to mother)) That's everything in there ( ) There you go  
24.M: And the prednisolone ( ) Have you got a bag please?  
25.Ph: Yeah (.) No problem  
26.M: Right then  
27.Ph: Same as usual (.) 2 of each ( ) for the prednisolone

((puts medication in bag))

- 28.M: Come on then ( ) [Thanks then ( ) Bye  
29.Ph: [See you

**Present: Mother, patient aged 13 years**  
**Start of treatment 23/3/93**  
**(ALL)**

**Transcript 40:- kb/nc/op**

1.Ph: Right then ( ) well it's quite straightforward ( ) Two weeks (.) you're back in 2 weeks aren't you?

2.C: Yeah

3.Ph: Do you need some Septrin?

4.C: Uhhhm ( ) I think I've got enough

5.Ph: Well you're still on that low dose-

-You know you're on three point-

-I don't know whether

you know you're on 3.75ml ( )

6.C: I think [I am

7.Ph: [Which is smaller than you uusually are

8.C: Yeah

9.Ph: But next ( ) time you come we're gonna put the dose up again

10.C: [Right

11.Ph:[OK ( ) but you're still on the other dose at the moment

12.C: Yeah

13.Ph: Right ( ) That's it ( ) so I'll give you that (.) Check with your Mom whether you've got enough Septrin

14.C: Yeah I'll just go [and check

15.Ph: [and come back

((Patient goes to check with mother who has remained outside))

16.C: No thank you

17.Ph: Right that's fine (.) Do you want to take that back to (nurse) ( )

18.Ph: [Thank you (.) Bye (name)

19.C: [Bye

**Present:- Patient (aged 8 years) alone**

**Start of treatment 3/2/93**

**(ALL)**



**Transcript 42:- ml/nc/op**

- 1.Ph: Now ( ) What have you been giving him the last week?  
2.M: He's been on 50%  
3.Ph: Yes (.) you've given 23mg (.) and 6mg of the methotrexate ( ) That's right isn't it?  
4.M: Not the 6mg of methotrexate (.) No  
5.Ph: Cos what's happened is what-  
-they've ordered ( ) on the 21st we've got a order for  
75[mg  
6.M: [Well it changed-  
-he changed it all  
7.Ph: [Oh right (.) when you came down to the clinic  
8.M: [and (pharmacist) did (.) tipped all the bottles out as [well  
9.Ph: [Oh right so that's ( )  
10.Ph: So you only got the right stuff in the [end  
11.M: [Yeah  
12.Ph: So this week then (.) its 75% ( ) for ( ) one week ( )  
13.M: Yeah  
14.Ph: and then you come back [next week (.) when ( ) for ( )  
15.M: [Yeah ( ) thank you ( ) for a vincristine  
16.Ph: Right ( ) That makes sense ( ) so ( ) methotrexate is 4.5mls ( ) which ( ) I don't know where they've put the tops this time ( )  
17.M: Oh ( ) right  
18.Ph: 9mg ( ) 4.5mls ( ) [(right?)  
19.M: [OK  
20.Ph: So then the other one is the mercaptopurine ( ) and that's ( ) 35mg ( ) I'll just check that ( ) that's ( ) right ( ) 4.4 yeah ( ) right ( ) [OK ( )  
21.M: [The mercaptopurine's?  
22.Ph: 4.4mls a day and then the methotrexate's 4.5  
23.M: Right=  
24.Ph: = Next one's Thursday ( ) Uhhh Septrin [Do you need any of that?  
25.M: [No I've got plenty of that thanks  
26.Ph: Right ((puts in bag))  
27.Ph: (I'll) just check the expiry dates ( ) Yeah you'll be back before that one expires  
28.M: [Thanks very much  
29.Ph:[OK (.) Thanks a lot (.) Bye  
30.M: Bye

**Present: Mother of patient (aged 5 years)**

**Start of treatment 4/6/93**

**(ALL)**



**Transcript 43:- nq/nc/op**

1.Ph: Right ( ) now is it what we expect ( ) 100% ( ) 2 weeks ( ) Yes?

2.M: Yeah (.) Yeah

3.Ph: 4mg ( ) He's had the vincristine ( ) ((begins to prepare tablets))  
Right ( )

4.M: What are those in there?

5.Ph: What?

6.M: In there ( ) They're not his tablets are they?

7.Ph: Yea:ahhh

8.M: He has syrup

9.Ph: Never. Now why didn't somebody know that

10.M: (Pharmacist) wrote it down cos we had-  
-it happened to him

a couple [of times ( ) till he written it (.) till he wrote it down

11.Ph: [To him did it ( ) yes ( ) it says ( ) Right=

12.M: =I'm sorry (.) I didn't know what they were when you were [counting them  
( )

13.Ph: [It's alright

14.M: I've never seen that before

15.Ph: It's only that ( ) I've had somebody new doing it today (.) so that's what's  
happened (.) Right I hope we've got enough s-syrup ( ) in stock again ( ) Let  
me do the prednisolone

16.M: He has that in tablets (.) all ( )

17.Ph: Yea:ahhh (.) Yeah ( ) Hello ((to another child who enters and then leaves))  
( ) So the prednisolone is 6 (.) each day

18.M: Yes

19.Ph: (30) and you can start that tonight ( ) and then give the next dose tomorrow  
morning ( )

20.M: How many shall I give him tonight then?

21.Ph: Give him 6 tonight=

22.M: =6 tonight

23.Ph:[It's best to start straight away

24.M: [Right

25.M: Yeah

26.Ph: [and then (.) and then ( ) and ( ) but

27.M: [I usually give him two of them at first ( ) up to six

28.Ph: Yeah (.) the the drug's better given in the morning so  
[keep ( ) so then start giving in the morning

29.M: [Mmmhmm ( )

30.M: Yeah

31.Ph: Right ( ) so there's that ( ) now (.) syrups ( ) (I haven't ) got any left really  
( )

32.M: I've got a bottle of Septrin unopened

33.Ph: Right ( ) good [((laughs))

34.M: [((laughs)) Just trying to save you a bit

35.Ph: You need 100mls ( ) No ( ) We've got plenty ( ) I just need some bottles ( )

If I pop round I'll get some bottles ( ) from the dispensary

36.M: Oh right

((Researcher offers to fetch bottles and leaves))

( )

37.Ph: We should have some labels ( )

38.M: One Septrin should last enough ( ) for 2 weeks [shouldn't it ( ) one bottle

39.Ph: [Oh yeah ( )

40.Ph: What dose is it 2 (.) Is it the 2 four ( ) is-

-are you giving 5mls ?

41.M: At the moment ( ) Will the Septrin go up now though he's on 100%  
[cos he was on 75% before

42.Ph: [No ( )

43.Ph: It's all done on his uhhhm ( ) size

44.M: Yeah ( ) so he's still taking 5ml?

45.Ph: Still takes the same (.) unless ( ) he gets uhhhm ( ) his counts are low  
[for a long time (.) then they tend to reduce it

46.M: [Yeah ( ) yeah

47.Ph: down {because (.) they think it might ( ) lower (.) people's counts

48.M: [Yeah

((Pharmacist continues to search for labels))

49.M: Those aren't them are they?

50.Ph: Hmmm ( ) I'm meant to have labels to stick on to say what volume you give  
( ) but I haven't got any ( ) I don't know whether it would be

51.Ph: [easier to send you round to Pharmacy ( )

52.Dr: [Is (name) gonna be ready ( ) yet

53.Ph: and I'll get whoever's doing it to do it straight away ( ) is that a better bet?

54.M: Yeah ( ) OK then

55.Ph: Cos I can't ( ) really give it out with no ( ) uhhhm some labels on just telling  
you volume ( ) sorry about [this

56.M: [OK

57.Ph: ((phoning Pharmacy)) Hi (name) is (technician) there? ( ) Hi (technician) it's  
(pharmacist) I've got (patient's Mum) here uhhm and you've done tablets  
and he's meant to have suspension ( ) but I haven't got ( ) I was gonna do it  
here but I haven't got any labels for the suspension ( ) Can I-  
-can I send them round ( ) are you freeish

( )

All you need to do is just some labels ( ) I'll bring all the bottles round and  
everything ( ) OK ( ) Thanks ( ) Bye

58.M: Do you want us [to take

59.Ph: [I'll go round with you then ( ) and you won't have to do  
uhhm do all the explaining

60.M: Right

((Both leave))

**Present: Mother, father, child aged 5 years**  
**Start of treatment 4/92**  
**(ALL)**

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