Community pharmacy as a performance: a participant observer's account of a day in the life of a locum

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Objective — To understand, from a dramaturgical viewpoint, the performance of "community pharmacy."
Method — Participant observation supported by focus groups and semi-structured interviews; the study adopted a grounded theory approach.
Setting — Fieldwork was conducted within 21 community pharmacies in East Anglia, England.
Key findings — Pharmacists identify with their setting and stage props. On the stage of community pharmacy, the pharmacist crucially converts the drug into medicine, during a complex and well-rehearsed performance. There are sometimes distractions, which make the performance sub-optimal. Other insights included what counts as error, how to manage stress, and the fact that the trust on which professional practice rests is at stake when expressive performance fails.
Conclusion — It is possible to conduct ethnography of community pharmacy and this is among the first such studies of British community pharmacy. Were the pharmacist to leave the stage and its props (the drugs), only to advise patients on medicines, the performance of community pharmacy, as we know it, might disappear.

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THIS paper investigates the value of representing the practice of community pharmacy in Britain as if practice were a drama, a performance that communicates on several levels. Most would agree that, say, a family gathering or a religious ritual, does so. However, community pharmacists, like all workers in modern Western culture, tend to experience their daily round on one level only, as routine work that produces something for a purpose, as instrumental not expressive. If there are other levels, they are probably hidden, because they are taken for granted by those who perform the job.

It seems to follow that only one who was able to do the job instrumentally, but at the same time reflect on the expressive performance that is implicit, would be able to understand it fully. Among social anthropologists and sociologists, the dialogic method of investigation that is required for this is called "fieldwork" or "ethnography" and the investigator who uses it is referred to as a "participant observer."

One of the authors, Malcolm Brown, is a pharmacist. While studying as a sociologist for a PhD that Paul Bellaby supervised, Brown spent just over a year doing fieldwork as a participant observer of community pharmacy. His past experience was in industry and hospital pharmacy; he was made redundant from the latter. A year or so into his preparatory work for the PhD, he took work as a locum in community pharmacy. He was a novice in that area and a year's exposure to it, with associated reflection, was enough to learn a hidden socio-cultural code* without "going native"† and no longer being able to observe that code. After that period, he started to feel "at home": a warning sign of "going native"; moreover, novel insights seldom emerged.

Central to the present paper is an ethnography, entitled "A day in the life of a locum," that is drawn from a composite of his field notes. They were analysed both theme by theme and by identifying and sorting keywords, using the computer program, Ethnograph.‡

Literature on the sociology of pharmacy is scarce and has concentrated on the externals of community pharmacy as a profession that is also a trade, rather than what is involved in the ex-

* There are many other such codes which study by other ethnographers may discover

† Occasional industrial consultancy, that was very different, contributed to delaying "going native"

‡Ethnograph was used to facilitate labelling themes in primary textual data, including field notes. All occasions when a particular theme was perceived were extracted; texts where two or more themes occurred could also be selected and counted. Such selections could be printed and reflected upon holistically

pressive performance of the role of community pharmacist. Dingwall and Wilson[1] begin a paper with a similar observation to this. They describe as central that the pharmacist transforms one pharmacological entity into another. Instead of following up the insight, they move on to the professional/client relation, including pharmacists' knowledge of patients, the kind of advice that pharmacists give and the type of interventions they make. Fieldwork in the US informed their paper which may not have a straightforward relationship with the situation in the UK. The Manchester studies of pharmacy practice[2-9] tend to focus on interactions between professional and client in the delivery of service. However, Harding and Taylor focus on how the drug is transformed into the medicine, and see the transformation as symbolic as well as physical.[10] The physical processing of drugs is today more commonly performed in industry than by community pharmacists, but the community pharmacist retains the symbolic function of selecting and labelling the appropriate doses of the right drug, so transforming it into a medicine for the individual case. Interestingly, Hassell *et al*[8] demonstrate that even pharmacists' advice to clients is symbolic transformation of the drug, for it is almost wholly focused on medicines and their uses.

To grasp the expressive performance by which drugs may be symbolically transformed into medicines, we shall draw on the work of the sociologist Goffman.[11] Goffman uses drama as a metaphor for face-to-face interaction. "Actors" not only "perform" instrumental "roles," they also present expressive "fronts," which give the impression to their "audience" that they are committed to the part they play, that the role is for real. Fronts are two-sided. First, they are appropriate to the setting in which they are performed (to the "script"). This is most readily visible in everyday life when the roles are institutionalised, that is, of strategic significance and well established. Thus the expressive fronts of being a parent or a child differ quite systematically in many ways, as indeed do those of doctor and patient and pharmacist and client. Secondly, however, fronts must be managed by the actor to give the appropriate impression to others. Performances can be good or bad. It may also be the case that good performers are insincere in their commitment, though the metaphor of the drama does not require that they be insincere. Institutionalised roles in organisational settings, such as hospitals and pharmacies, do require a "team" performance. Pharmacists experience this as "being professional." For their part, clients expect a team performance, and, if the individual deviates from it, even in matters of dress and manners which are merely expressive, not instrumental to the role, trust in the professional can be damaged.

To press the drama metaphor further, Goffman suggests that actors typically depend on what the theatre calls "props" to sustain their performances. On the stage, these are items of scenery, furnishing and dress. In the community pharmacy, some of the equivalents are the sales counter with its display of goods, the half-hidden enclosure in which dispensing is performed and, of course, the drugs themselves.* Again, Goffman suggests, there are typically "front-stage" and "back-stage" areas in any setting for a performance. Front-stage is where the performance takes place before an audience. Back-stage is where the props are set aside and the roles and their fronts are cast off. In a sense, actors, when back-stage, can be themselves, but the distinction is more relative than absolute, for even the dressing room, retreat from the stage, and the staff-room, haven from the classroom or the hospital ward, have their proprieties. The metaphor of the drama is rich in implications. It has to be remembered that it is a way of looking at face-to-face interaction, and not the only possible one.

No previous research has reported on the dramaturgical performance of the community pharmacist. Something like the fieldwork on which this paper is based was advocated by Dingwall and Wilson.[1] We believe this fieldwork to be unique in Britain.

Method

Brown practised as a locum at 21 pharmacies. They were both dispensing and non-dispensing and included independents, branches of multiple pharmacies and supermarkets. They were situated in areas ranging from prosperous to deprived, and workloads ranged from high to low. He sometimes worked as sole pharmacist and sometimes with others. Initial fieldwork lasted for 67 weeks during 1994-6 in East Anglia.

Participant observation varies in the degree and centrality of the researcher's participation in the setting that is observed. However small and marginal the participation, there must always be an element of reflexivity on the part of the researcher. The participant observer has to be sufficiently distant from his or her performance to be able to scrutinise the impression it makes on the audience and the intentions behind his or her actions. Subjectivity clearly has its perils, but is necessary, for, without it, what seems routine may not be interpreted as performance. However "scientific" it may seem, non-participant observation — such as looking in through a two-way mirror on actors who are unaware of being observed — leaves the meaning of actions locked in the actor's heads. Brown's role as par-

*Another view is that the actors may be objects or props, as, for instance, they are with respect to the movement of religious relics (see Appadurai; The social life of things: Commodities in cultural perspective. Cambridge: Cambridge University Press; 1988)

ticipant observer was at the opposite extreme to non-participant observation, for he largely observed his own practice. He was central to the stage, not marginal. He was a participant more or less throughout his observations. This immersion in the role that was being observed makes it particularly important that Brown should be able to distance himself. Being a novice in community pharmacy and moving from job to job throughout the period of participant observation were the keys to maintaining his reflexivity. He ceased to research the situation when nothing new seemed to be happening.

Brown was a covert observer,[12] as was Holdaway in part of his study within the police force.[13] There is a view that covert research is unethical. Our defence is that the identities of healers, clients and other individuals were kept strictly confidential for Brown stripped his notes of anything that could identify the individuals involved (other than himself). Another consideration is whether the research might damage pharmacists or patients. The pharmacist we asked to assess the method felt that, so long as findings were disseminated and pharmacists had the opportunity to debate them, the research would do pharmacy no harm.[14] As for patients, Brown did not interfere with, or delay, normal treatment while making observations of the socio-cultural process in which it was embedded.

Recording had to be covert. Anything perceived as important was noted; each note was, using the term of the phenomenological sociologist Schütz, an "Act of Attention."[15] Apart from telegraphic jottings, on paper scraps, to aid memory, Brown's notes were made wholly after the event. Had he revealed his research objectives to those with whom, and for whom, he worked, the normal pattern that he wished to observe would have been changed radically.

The course of the fieldwork and analysis of data was that advocated by Glaser and Strauss for building "grounded theory."[16] We seek theory, because we are not under the illusion that we can describe things as they are. On the contrary, we are explicitly committed to Goffman's metaphor of face-to-face interaction as drama. Its use in the specific setting of community pharmacy generates a provisional, that is, "in theory," account of how and why that practice is conducted as it is. To build theory is of course a different phase of the scientific endeavour than to test theory. Testing theory presupposes that much is known already and that it has been theorised systematically. Gaps remain, but the theory allows us to deduce hypotheses that might fill the gaps. The hypotheses in turn lend themselves to testing against valid and reliable observations. Building theory is an inductive rather than a hypothetico-deductive process. It is suited to the situation that we encountered before the fieldwork, where knowledge was thin and anecdotal and the issue that was central for us, the performance of transforming the (harmful) drug into (therapeutic) medicine, was untheorised. By "building grounded theory," Glaser and Strauss suggest a dialogue between observations and theorising. It is neither a matter of accumulating "facts" and then seeking a generalisation that covers them, nor a matter of armchair theorising in the abstract, but a process of analytic induction, to the theory from the facts, and from the theory to the facts.

The end product is ethnography. It follows as "A day in the life of a locum," and has involved writing about, as well as studying, a living culture. Often that writing is for another audience than the people who are studied. In this case, we are writing for the same people that we studied. Ethnography as writing has a number of genres, several of which are reflected in what follows. One is the classical, naturalist idiom. It reports how others perform, even while the observer shares the action with them. It reports that "the natives do this." The account offered here also conforms to the confessional idiom, showing how the constraints of being a member of this society (for instance, relating professionally to clients) affect the participant observer's performance and reporting that "the natives made me do this." Finally it contains much in the impressionist idiom, that is, it reports what emerged at the time of observation and invites the reader to put his or her own construction on it: "this occurs; you interpret it."[17] We have acknowledged, and indeed justified, the subjectivity involved in both making and interpreting observations. Clearly that has its perils. What reason have we to think that one participant observer's account will be similar to that of another? Indeed, what reason have we to think that a participant observer's account is better than any other?

We tried to counter the perils in subjectivity by asking expert, "native" informants to comment on the first draft of the ethnography, then redrafting it. Two focus groups were undertaken, both based on district branch meetings of the Royal Pharmaceutical Society, some distance from where Brown was known. They included a total of 29 pharmacists. Here the researcher gave an overview of the fieldwork findings and sought comments about their validity and reliability. There were also short, non-recorded telephone interviews with any focus group members who volunteered to talk more. Finally, a 7,000-word summary of the interim results was circulated to a panel of eight pharmacists. After an independent assessment of the method (by a pharmacist not on the panel), each member of the panel was interviewed in-depth and audio-recorded, with a semi-structured, but free ranging, brief. The panel had been purposefully selected from categories that were most likely to disagree with specific aspects of the researcher's account.

We conclude from this form of external validation that the account is not idiosyncratic, and

that it may help its readers who are community pharmacists to see aspects of their work that would otherwise remain hidden beneath the routine and familiar.

Like other ethnographies, this has been rewritten several times. Reflective journal notes were made throughout the analysis and writing, not just during the fieldwork. Presentations, including evaluation of biases, filters and other problems, were made at seminars for feedback. Brown re-entered the field for six weeks in 2001 in order to observe any recent changes in community pharmacy practice. Sound ethnography should be understandable to the "natives" (in this case, community pharmacists). Publishing this paper in this professional journal and inviting comment is thus part of the continuing research process.

Results and discussion

When a keyword count was done with Ethnograph on the field-notes, 96 per cent of the observations involving the community pharmacist occurred when medicines were present. The crucial issue is whether activity involving the medicine was wholly instrumental and physical, or communicated meanings from pharmacist to patient that of themselves helped transform an otherwise unsafe drug of general properties into a safe medicine with therapeutic benefits to the individual patient. If the latter, then, like any other ritual, it would be a dramatic performance during which actors did work to change or maintain the perception of their audience. It would be appropriate to seek variation between performance front-stage, the pharmacist's actions and exchanges with the team off-stage, and, so to speak, dressing beforehand and undressing afterwards that would occur back-stage. To deliver their performance, pharmacists would use their minds and bodies, the setting in which they acted and situated interactions with others, such as their team and the patients.[18] This is analogous to Goffman's account of the world within mental hospitals where staff and patients have to continuously act (do work) in order to fabricate the identities expected of each of them.[19]

The self

Dress and demeanour play an important part in the performance of community pharmacy. The performance is preceded by dressing back-stage.

Typically, male pharmacists select a formal, well-ironed shirt. Today, our locum pharmacist notices a stray thread against his shirt; he uses scissors to snip off that thread. He always winds his tie into an imposing double Windsor knot and adjusts the tie to precisely the most fashionable length. He removes trousers from a trouser press; he scrutinises creases. Are they sufficiently sharp? Could he get away without polishing his shoes? Probably not: they are muddy around the heel. He applies black parade gloss polish, wipes with a moist cloth until the shine starts, then buffs with a soft brush to a mirror finish. He checks the jacket lapels. Are they crumpled and do they require ironing?

In 1994, the written dress code for the multiple now called Moss Pharmacy stated that, for locum pharmacists, white coats were preferred, although not obligatory. For males, jeans, corduroys and all similar casual trousers were unacceptable. Jumpers worn with white coats or jackets had to be V-neck. Earrings were not permitted. For females, trousers were not allowed, except on religious grounds, when a white coat had to be worn. Excessive jewellery must not be worn. Our pharmacist's wife, also a pharmacist, generally wears a dark skirt, blouse and jacket. She also always applies make up for work: "I don't feel dressed without it," she says.

The pharmacist whose restrained, respectable livery is compromised at work will undertake an emergency repair. Once our pharmacist spilled Mucaine, a white suspension, over his dark suit. He immediately mopped the stain with a dishcloth and wiped with a towel, but a white patch remained. He avoided patient contact until the stain had faded. He dried the patch before a roaring, gas fire, but a white stain kept reappearing; only after 3pm was it acceptable. That stain was so stigmatising that he sent the suit for dry-cleaning the next day.

Pharmacists' livery has always changed with fashion. Nowadays, females occasionally wear formal, smart trousers, for example, while the ASDA/Wal-Mart superstore chain fosters informality, expecting males not to wear jackets.

"It's the first time I've been paid to take my clothes off," our pharmacist notes, wryly.

Meticulous attention to clothing contributes to constructing the pharmacist's specific, respectable, trustworthy front, just as accountants seldom wear brown suits,[20] while traditional butchers retain red, striped aprons and vicars, dog collars. The pharmacist's costume is rehearsed in the pre-registration year. An extreme example is that a pre-registration student who presents with a sweatshirt with logo, considered undignified by his tutor, will receive prompt counselling that such a garment is inappropriate.

In 1997, the Royal Pharmaceutical Society authorised pharmacists to purchase badges, about 5cm in diameter, with the Society's name, crest and the restricted title "pharmacist." The pharmacist had bought one such and worn it occasionally — until another pharmacist said "Oh. That's what they're like. Looks like a taxi driver's badge." Our pharmacist has never worn it since.

So pharmacists dress for their British stage performance in the formal, dignified garments, without specialised insignia, commonplace amongst Western managers and politicians. It contrasts

with permanently back-stage staff, such as shelf-fillers, who are present when the public is not. Back-stage clothing includes scuffed trainers and baggy, jogging trousers. A more telling contrast is front-stage, between pharmacists and drug addicts, in so far as addicts are more likely to have facial tattoos, body piercing, many rings and casual attire.[21] Were only clowns' outfits available (let alone no clothing) pharmacists' dignified front would be a much more difficult performance.

In the car park, find the locum pharmacist's car — a BMW. Proprietor pharmacists, especially, tend to drive prestigious cars. Such status symbols, tainted little by the place, in Goffman's words,[19] are examples of conspicuous consumption. Such portable props generally suggest high material income and class position: such a dignified person of substance can be trusted[22] with converting drugs into medicines.

The setting

We now move further from the pharmacist's body, on to the setting: the stage and the props.

Props Now, the pharmacist is entering a permanent building, in order to produce medicines, unlike the drug pusher who produces drugs in the proverbial street. The pharmacist carries the tools of his profession. As a locum working in a different pharmacy most days, he carries his registration certificate: a stage prop advertising his personal skills and knowledge and specifying his unique number. A pharmacist's certificate in Great Britain includes the title "pharmaceutical chemist" and an image of a retort and receiver, symbolising pure chemicals. Chemicals (drugs) remain pivotal in the pharmacists' world as empirical starting ingredients that physical and social processing convert into medicines. The frame of his certificate is new; it had become so battered that he has just paid for reframing.

Some of his pockets bulge slightly. They contain a magnifying glass, to help read faint prescriptions, and a ballpoint pen; a pencil that can be rubbed out is seldom used. That ballpoint is purple. It has a rubber skirt, which creases, intriguingly, when the button exposing or retracting the nib is pushed, an unusual curving clip and proclaims, "Pravastatin Sodium Lipostat." Its value is as a status symbol, because it cannot be bought; drug company representatives give it away. They generally keep their bigger status symbols, such as Losec table lamps, for doctors. The pharmacist, unusually, also has a small light, bought from a garden centre, which he occasionally uses for ophthalmic inspection.

Front-stage Today he is working within a superstore. It comprises a vast, open space containing numerous commodities for self-selection. General Sale List medicines, such as ibuprofen, are just one of them; they can be paid for at any checkout. The superstore geography itself suggests customers are sufficiently expert to require no help in choosing alcohol, blades, solvents — or medicines; checkout operators, however, occasionally refuse a sale.

The pharmacy appears in view. It is brilliantly lit, not with the oxyacetylene-heated, incandescent "limelight" of earlier theatres, but with fluorescent and noble gas/halogen spot and floodlights. It stands out, framed by darker borders, like a proscenium arch.

He enters, and looks for somewhere prominent to display his certificate. "They generally put it over there," says an assistant.

Looking out towards the superstore aisles, stage scenery includes the usual pharmacy green cross about two feet square and a cutout of a bunch of bananas, dangling down. That display is swaying gently, is six-foot by four-foot and proclaims "29p a pound." Such non-pharmaceutical props are not limited to superstores. The independent pharmacy where he worked the other day was an Aladdin's cave; it offered painting by numbers books, cuddly monkeys, rhinoceroses and toucans, sewing accessories, teapots and oven cleaner.

Today, the pharmacy front has clean rows of brightly coloured merchandise, all gaps filled, brought forward into immaculately ordered, straight lines.

"You cannot sell air," one pharmacist manager had said. Our locum stoops and picks some litter from the floor.

Off-stage At the interface between the public area and the dispensary is a raised step. From the dispensary, there is a good view of the sales area below. However, the public cannot easily see into the dispensary. Yesterday's pharmacy had no step, but shelves screened part of the dispensary; in every dispensary, some part is hidden from the public, so retaining a little mystery.

A yellow fabric strip saying "staff only" guards the dispensary back. Various pharmacy symbols are prominently displayed: a large mortar and pestle, and an antique, porcelain inhaler; stylised symbols of carboys adorn the scenic backcloth. He pockets his Controlled Drug key, and scans the little row of textbooks, including the latest Martindale. On top of the rubbish in the bin is the old British National Formulary (BNF). A quarter of its covers have disintegrated: he suspects that it will be a busy day. The brand-new BNF is on the bench. He notices that there is new guidance on malaria prophylaxis for travellers; yesterday he heard an official of his Royal Pharmaceutical Society, on the radio, defending a pharmacist's advice.

The dispensary inner sanctum contains equipment, especially the computer system, which Goffman[19] calls "heavy plant." The computer uses familiar software, thank goodness. There is

the labeller and a full roll of labels, an automatic endorser, a leaflet printer and an e-mail modem. Whenever a medicine is dispensed, the computer reorders that medicine automatically, warns of interactions with the patient's other medicines (already in its "perfect" memory) and prints out extra, warning labels. Sometimes, computers failed and could not be restarted despite support from a telephone help line, pounding of keyboards with fists and language which, although colourful, was quiet enough not to be overheard by patients. Then, labels and extra warnings had to be handwritten and interactions checked in books. It took so long, yet had been the norm at the start of his career. Now he feels that machines seem to have chased away his old skills.

Soon, the pharmacist is working in a steady rhythm, the labeller churns out labels and the pharmacist and the machines seem to spawn together, as one. Within that public stage, all is light, hygiene and efficiency as drugs are converted into medicines.

Back-stage Such an immaculate show requires a dumping ground: the hidden back-stage. There, unwashed cups in the sink, last summer's sunglasses, the biohazard container, the torso advertising Gaviscon with a heart with flashing red light (had the battery not been flat) gather dust. In some pharmacies, concrete crumbles and roofs leak.

Situated interactions

Within those settings, the pharmacist, the team, patients and customers interact. First, performance front-stage will be considered, and then the action off-stage and back-stage.

Front-stage Pharmacists use mannered, respectable speech, which matches their formal attire.

Professional speech — "All your tablets are there, Mrs Smith," says the pharmacist. He uses the patient's title and surname instead of the familiar, first name, so retaining some clinical distance. The pharmacist attempts to say something, no matter how small, to each patient, to add value to the medicine.

Pharmacists use argot as a common emblem.[23] Some is shared with medical practitioners; mutual argot includes clinical terms.

"Yes, your ankle is a swollen," says the pharmacist, but he cannot help adding, "You've got some oedema there."

The most voluminous vocabulary of argot contains thousands of drug and medicine names, over which pharmacists possess complete mastery. Names change with innovation, obsolescence and fashion.

Mrs Brundle asks if she can take "ibuprofen" with "paracetamol", pronouncing the "i" in ibuprofen as in "ink". The pharmacist tells her she can, pronouncing the "i" in ibuprofen as "I".

"Oh, is that how you say it. . . . Ibuprofen," she repeats.

Accomplishing expertise — Expertise is not altogether a given. It has to be accomplished on stage, and the performance is both enabled and, occasionally, impeded, by other members of the team and the audience.

Mr Brundle wants to know which of his tablets are for arthritis and which for the tummy. The pharmacist shows the labels for Arthrotec and Zantac; "arthritis" and "stomach," respectively, have been added and their backgrounds highlighted with a fluorescent, yellow marker. He knows those things so well that there is no need to look them up; however, some things he would not trust to memory, such as whether a counter-prescribed medicine interacted with warfarin.

"I think it's OK, but I'll just double check," he says, retiring to check whether it had a symbol, signifying a potential hazard, in the BNF. He tries to keep his knowledge[24] up to date, undertaking the 30 hours of continuing education required every year, by distance learning courses and district branch meetings of his professional society. The latest had been on terminal care. Not many of his colleagues had attended such a sombre meeting; after a long day's work they had other priorities. The best-attended presentations were by medical practitioners.

A woman, about 30 years old, asks him for a large pack of ibuprofen. "You're not an asthmatic?" he asks. "Spare me the lecture. I am a doctor," she replies. He stops talking, hands over the tablets and change, politely, with a smile.

Sometimes he uses humour. A couple with colds require a menthol and eucalyptus inhalation and he sells one bottle. "You can use the same bowl and towel over both your heads, if you like," he says. They start to chuckle, then double up in pain. His interactions are affable as are those of other retailers such as fishmongers.

A woman presents, asking for the "morning after pill". He first checks the pharmacy has Levonelle in stock and that the packet actually contains two tablets. He does not want to spend 10 minutes asking questions and giving advice only to find that this pharmacy has no stock. He takes his checklist and walks with her to a more secluded area of the pharmacy. She follows as if an iron bar drawn by a magnet.

"You realise that it's £19.99," he starts. She nods. "I'm going to have to ask you some questions to make sure it's right for you. Some are of a personal nature," he continues.

He is absolutely certain that he could supply

the medicine because he has just handled the packet and checked that it was full. He feels content, at home, licensed to ask intimate questions, comfortable with different personalities and situations because he has met so many before. Books could not provide that sort of knowledge. It is a blend of information and judgment that is acquired by experience. Jamous and Peloille call it "indeterminate" knowledge.[25]

Managing patients en masse — By the time he had sold a pack of Levonelle, a long queue had formed and some patients were scowling. Suddenly the whole store is heaving with customers. The pharmacist puts his head down, dispensing and checking as fast as he can. He feels patients' eyes boring into him.

"Why is he taking so long?" asks one woman. "It's only tablets."

"Won't be long," says an assistant, soothingly.

Now he is working flat out. He bustles like a bee. He rations his time, cutting corners. He pares a little time off checking here, gives a more telegraphic answer there, shakes and squeezes tablets within a carton instead of opening it and counting them — yet still the queue grows.

The tannoy interrupts, a great, mechanical heckler, the antithesis of the actors' supporting orchestra.

"Fresh Galia melons, half price!"

"Sorry, there are four people waiting to see you now," says an assistant.

Coping with stress — The pharmacist is feeling stressed now. Pharmacists, like other managers, are taught to cope with stress.[26] The following account, of an extremely busy period, illustrates, for clarity, a rare situation where coping only just occurs.

He is in the middle of deciphering a marginally legible prescription, which, because of the dose, is probably the hypoglycaemic Glipizide, conscious that, if he gets it wrong, a non-diabetic could receive it, with untoward, personal consequences. Professional conscience forbids.

In the midst of this, he answers the insistent telephone: "To save a long and expensive journey, have you still that special offer of aftershave?"

He is completely thrown. He is working to the limits of his competence, when he is interrupted by trivia. Such "dirty work" snatches his identity, as Fine suggests.[27] Non-pharmaceutical interruptions result in loss of concentration and risk patient safety.

"This is the pharmacy," he says, irritably, his customer service gloss slipping, wishing he still worked in hospitals where patients were patient.

"Yes, I was put through to you."

He wonders whether the new pharmacists, registering with master's degrees, will put up with such trivia. He hopes they will not.

The tannoy proclaims: "Attention customers. The latest lucky customer registration number is A37. Would the lucky customer go to the reception desk to claim their mystery gift."

Now, a grumpy looking man wants advice on which anti-malarial is needed for Goa and nine prescriptions await dispensing. Like a rush in the kitchen, paradise has become hell.[27]

He feels near to the limit of his ability to cope, filled with "baffling and unsheddable tears," a phrase he had heard in Alastair Cook's "Letter from America." His patients are at risk — but he is "forbidden" to tell them. He has to resume control. Suddenly, time seems to slow; he is conscious of being on a cusp — a "fateful moment" to cite Giddens.[28] The pharmacist's next action could change the lives of his patients — and himself. He must, as lead actor, make a scene. It will be a carefully restrained scene: he must doggedly contain tension and not "flood out", using Goffman's phrase.[29]

He stops checking and goes down to step into the queue. Our thespian says, smiling: "We're dispensing prescriptions as quickly as we can, in order, but at the moment there are 12 in the queue. Sorry for the delay."

Unlike a magistrate reading the Riot Act 1715 to assemblies of 12 or more persons, commanding them to disperse, the pharmacist does not threaten people with consequences. However, the queue calms. The demeanour of clients waiting in queues, at pharmacies, is variable, but patients do complain about queuing and pharmacists have various strategies for dealing with this.

Indeed, pharmacists tell each other, with cathartic glee, many stories of how they have heroically controlled impatient patients. These underground stories expose pharmacists as chameleons: changing between a professional who knows what is right for their patient and will impose it, to the trader with the motto "The customer is always right." Our pharmacist dare not use some of the stronger versions such as "You can have it fast or right." By these means, patients become passive, which, according to Wilding,[30] is the state that professionals prefer. Pharmacists working for one large multiple currently use a strategy which is more in tune with contemporary, consumerist expectations. They ask: "When would you like your prescription dispensed?" on presentation, and then negotiate a realistic time and write this on both parts of the "cloakroom ticket".

Vulnerable patients resent it when a matter so crucial to them as the dispensing of their prescription is queued and treated clinically — yet it is the many other prescriptions dispensed that day that enable the team, including the pharmacist, to become expert. Paradoxically, according to Hughes,[31] it is the queue, patients' frequent

object of complaint, that also demonstrates that pharmacies have the competence that is crucial for safe dispensing, The queue advertises: "This is where safe medicines are prepared." A wise visitor arriving in a strange town looking for a good place to eat applies similar logic: the restaurant crowded with locals is preferable to the one that is empty. Another paradox is that pharmacists urge the public to use pharmacists more, yet complain when they are too busy.

Sometimes the whole pharmacy team is busy. Whenever assistants feel competent to do so, they question patients before supplying the medicine. They use the WWHAM mnemonic, such as "Who is the medicine for?", so attempting to protect their pharmacist from avoidable workload. Surgery receptionists screen patients, from their general practitioners in a similar, although generally more assertive, fashion. However, sometimes assistants know insufficient about medicine for sale and say "I think you'd better have a word with the pharmacist." In some neighbourhood pharmacies the assistants say "I'll just go and get our gentleman." Our pharmacist, after a two-way discussion, chooses the stage prop Zirtek from the Pharmacy Only medicine shelf, so making that medicine specific for that individual patient, by infusion of the pharmacist's extra knowledge. The assistant stands aside, silent, listening to the exchange, looking at the pharmacist, who, for a while, is centre-stage, as a sort of star, in Goffman's words.[11] Each tablet then contains added value: a little bit of the pharmacist. Dispensed Prescription Only Medicines are even more valuable: they also contain a little of the prescriber.

Dealing with anomaly — There now appears a woman, aged about 35 years, quite drunk. She presents a prescription for chlormethiazole capsules. An assistant whispers urgently to the pharmacist: "Quick, let's do hers first, or she'll be trouble. She has [been] before." Such fast-tracking of patients who might make a disturbance and disrupt other customers is routine in community pharmacy, unlike hospital pharmacy. There, dispensing order depends upon the time of presentation or clinical need.

In this community situation, all the patients within the pharmacy are being treated as a batch, much as pupils are treated by the teacher in a classroom,[32] according to Bentham's "felicific calculus": the best government secures the greatest happiness of the greatest number of people.[33] Civilians do not readily tolerate group control. One tactic for control is for the team to appear pleasant and courteous, even to the least pleasant clients. Witness the universal, friendly stance of shop keeping staff — such as pharmacists and assistants. "Make eye contact. Smile," urges the poster that staff must pass before entering the shop floor. One of the delicatessen staff, wearing rustic costume, offers a customer a plate. "Belly pork?" she says, with wide smile and personable demeanour.

Occasionally, despite the patient having queued, pharmacists may refuse to give individuals the medicines they request. This occurred in fully 45 per cent of Brown's field notes that involved "mingling": the intense involvement of the pharmacist with the medicine. For example, one woman, who is taking a beta-blocker, asks for a medicine containing decongestant. The pharmacist refuses: "It's not right for you. It would interfere with your blood pressure control." Another illustration is an underweight-looking woman who presents week after week requesting laxatives, according to the assistants. Suspecting that the maximum dose is being exceeded, the pharmacist refuses supply, so denying access to the medicine. Upset, she leaves. Her husband tries later. "Wasn't he aggressive," says an assistant, off-stage.

Occasionally, clients ask pharmacists to confirm that medicine is safe. For example, a man telephones, who sounds middle-aged. He is taking trimethoprim 200mg tablets daily for a urinary infection. His buttocks and thighs have become numb and swollen. Could it be the tablets?

The pharmacist scans the BNF. "Yes. It could be a rare side effect. Perhaps it would be best if you don't take any more and called out the GP (pause) today."

The pharmacist chooses his tone carefully, concerned that the patient may have toxic epidermal necrolysis or a serious infection that is resistant to trimethoprim; the pharmacist's words must ensure that the patient contacts the doctor, but be sufficiently casual not to alarm the patient unnecessarily. Here, a medicine already in the patient's possession has suddenly been converted back from a (safe) medicine into an (unsafe) drug. Though the pharmacist (within a laboratory) can also convert the medicine physically back into the drug, the change noted by the participant observer is a matter of reclassification.

Another man, about 45 years old, says, offering Ceporex capsules:

"Should they smell like this?"

The pharmacist sniffs, "They are OK. They always do."

Here, at the pharmacist's olfactory epithelium, actual drug molecules are combining with nerve cells that are an extension of his brain itself.[34] He compares perception with memory. Such instant, organoleptic opinion requires corporeal presence.

Yet another man reads in his package insert that 5 and 10mg Zestril tablets are pink while the 20mg are red.

"My 20mg are pink," he complains. "Are they the right sort? I want my blood pressure to be controlled."

The pharmacist is uncertain, and telephones Zeneca's emergency number. "They probably had not put enough iron oxide in," they say. "It did have 20 stamped on to it didn't it?"

It did. In that situation, the pharmacist sends a sample to the company and asks for, and receives, a written explanation and informs the patient of the result. The pharmacist knows how to access external, supporting expertise.[24]

Occasionally, the public acknowledges pharmacists' expertise. A doctor's error in a woman's prescription is corrected: the dose is halved. The husband telephones and says:

"Oh. Thank you for your sharp eyes."

"A pleasure. It's what we are paid for."

Now, a woman returns a medicine to our pharmacist in the superstore.

"Have you given the wrong drug because it is a penicillin, wasn't it? My boyfriend told the dentist that he was allergic to penicillin."

The pharmacist checks the prescription and finds that it is, indeed, phenoxymethylpenicillin and telephones the dentist.

"I'll go and check the notes," she says.

"Yes. Allergy was in the notes. Thank you very much indeed for being a safety net. I don't know what we would do without you people."

Dentist and pharmacist agreed that erythromycin would be an acceptable alternative; the pharmacist substitutes it and the patient ingests it: the medicine has become proper again. However, the pharmacist cannot do that alone but requires the practitioner's authority; the pharmacist annotates the prescription "pc" (prescriber contacted).

"Is that my pen?" our pharmacist asks the assistant.

"Oh yes," she says, returning it. "What a nice colour."

Those clinical errors are examples of tales which pharmacists recount, among themselves, with pleasure. Dingwall categorises them as "atrocity stories" told by lower status people in a division of labour, about higher status people.[35] The tales redress inequalities by showing that the undervalued, lower status people were necessary. From the perspective of this paper, the examples illustrate pharmacists as team members who help convert a false medicine-which-is-unsafe into a proper medicine-which-is-safe.

Sometimes, pharmacists themselves make errors. One example occurred in a pharmacy where, as expected by management, the pharmacist had worked through his lunch hour, eating his sandwich in two minutes, facing the wall, and then visited the toilet for two minutes. When he returned, 11 patients were waiting, including one particular woman, about 35 years old. He saw a problem on her face.

"I've read the package insert," she said, "and I don't feel depressed."

"Let's have a look."

He had given clomipramine, the antidepressant, instead of clomiphene, the fertility enhancer. He had got it wrong. His heart sank. He apologised, embarrassed, while a man of similar age, nearby, cocked his head, and listened with interest. Pharmacists seldom make errors, but, in Brown's experience, errors/near-misses always seemed to occur when he was busy or otherwise stressed. That opinion was presented to panel members. No panel member dissented from that view and one volunteered, "I could not agree more." However we acknowledge that other pharmacists argue vehemently that they make more mistakes when not busy and we present only one incident that could be considered mere anecdote.

Off-stage Behind the scenes, other interactions occur, including prompts that sustain the performance. They help to prevent a safe medicine becoming a harmful drug.

Prompts — The pharmacist hangs a prescription, firmly clipped with its uniquely numbered duplicate ticket, on a rail; the patient keeps the other half. The dispenser selects, from the shelf, the item that matches the order. Were the wrong item selected, it would not work or could do harm; for a person without knowledge, selection would be difficult. The dispenser counts the correct quantity, interprets directions, produces a label, with the correct patient's name and directions, and assembles it all, with its prescription, within a stage prop: a tray — a tiny territory bounded by polythene walls. The pharmacist checks the contents, aided by a "help" mnemonic:

H — how much has been dispensed
E — expiry date of original stock
L — label matches the patient's name, product name, extra warning(s) and dose — which must be safe; medicine must not interact, unacceptably, with anything else on the prescription or purchased
P — product check: medication and strength matches the stock used.

The box contents are then bagged. There is another check on medicines requiring particular care, such as anticoagulants or children's doses; the pharmacist's indeterminate knowledge or intuition may also warn about an anomaly. The bag is sealed with an extra label detailing the patient's name and address. The pharmacist calls the patient's name, matches the "cloakroom ticket," asks the address as an extra check and gives any specific advice. The other day, another pharmacist, working with our pharmacist in a very busy pharmacy, volunteered, "We are a conveyor belt," in a voice exhausted but also tinged with pride.

Accomplishing efficiency — An important component in the system is the Royal Pharmaceutical Society inspector. An impending visit by the official focuses minds; an extra visit is likely if the Society has received a complaint about the pharmacist. Uncomfortable correspondence, a hearing before the Statutory Committee, or even being struck off the Register, may result. Any sort of investigation may demand disclosure to that pharmacist's insurers — at best, considerable paperwork. The system also includes government: the state legitimates pharmacists converting drugs into medicines for patients; street drugs remain "drugs" for "drug misusers." It is from this whole system that the property of safety emerges.

The system itself has systematic components: every part within should be present. A physicist, knowing pharmacists well, observed that they made lists of everything.

"Of course we do," replied one female pharmacist. "How else would you remember everything?"

Were a pharmacist a patient, he or she would prefer medicine to be dispensed in a systematic fashion, in a rhythm, neither too fast nor too slow. However, sometimes, the dispensing performance is sub-optimal, for example, if a rush occurs.

Five other sorts of impediment are now detailed. Sometimes, especially in smaller pharmacies, only the pharmacist knows how to dispense; there is no dispenser competent to check. In that situation, the pharmacist checks, attempting to have a mental break between the dispensing stages and so hoping for "fresh eyes" to perceive anomalies. Such pharmacists must be their own pourers, peelers and snippers. In some pharmacies, dispensing space is so limited that prescription medicines and labels are congested together, increasing the opportunity for mix-ups.

Sometimes the team may not work together efficiently. For example, the technician compounds a skin ointment and presents it to a pharmacist for checking. However there is insufficient documentation of the ingredients; the pharmacist requests it, knowing that if too much active ingredient has been added it would burn the skin, but also suspecting that the question will upset the dispenser. It does.

"I've 19 years' experience," she says. However, the viscosity probably looks correct to that pharmacist's experienced eye and the prescription is handed out.

Sometimes, an individual team member may lack experience. For example, our pharmacist had to calculate quantities for an unusual morphine mixture prescription; the unfamiliar work required extra care, taking time, and a backlog of other items resulted. At 2am the next day, he woke in a cold sweat, concerned about that calculated dose. It niggled him so he could not sleep until he had repeated the calculation by two separate routes; they matched and he returned to sleep, but started the following day tired.

Finally, the pharmacist requires a physically able body to physically manipulate a medicine, to draw it so close to its prescription that they are in the same visual field. That field must then so engross the pharmacist that all else disappears.[36] Time rationing dictates that the check takes only seconds of intense, effective scrutiny. A colleague found he was dropping things and could not dispense; he had multiple sclerosis, although was at the time in remission.

In case a medicine supplied turns out to be unsafe, because of the pharmacist's error, each pharmacist carries professional liability indemnity insurance (or has ensured alternative compensation exists) in order to recompense the patient. The pharmacist's professional body requires such cover. That strategy means that even the pharmacist's faulty medicine, which could be termed a drug, for it had not been properly converted into medicine, causes limited or no financial loss to the patient.

Bearing that in mind, and the trimethoprim interaction, when, following the pharmacist's advice, the trimethoprim could not be used, the meaning of the terms "drug" and "medicine" may now be refined. A recognised difficulty in sociology is that the same word can have lay, precise sociological[37] and other specialist meanings.

To the pharmacist-as-natural–scientist, a drug is a starting chemical. A drug is converted (usually in industry) by formulation, such as by adding excipients, into a medicine, which is chemically stable, of suitable volume to ingest and so on. Community pharmacists usually only perform part of that transformation, such as from a large pack, through counting and labelling to a repackaged product or just labelling an original pack. To the pharmacist–as–sociologist, a drug is unsafe when it is not legitimated by the most powerful groups in society. A drug is converted by the many-levelled, social performance that this paper has suggested into a medicine that declares itself "safe" and " healing." For example, the "drug" may start as "mysterious" symbols written on the prescription paper that are transformed into the final, labelled, dispensed medicine.

Back-stage The pharmacist's performance is nearly finished for the day. He drinks strong coffee, in order to attempt to keep alert for the rush of prescriptions during the last 20 minutes, counts the pile of prescriptions, which is some quantification of the workload of converting drugs into medicines and returns the Controlled Drug key. He thanks his supporting cast, the assistant(s); they set the alarm and lower the roller blinds (stage curtain) in order to guard the stage props, especially medicines, overnight. In his car, the pharmacist relaxes, after his 12 hours of per-

formance, by unbuttoning his shirt and loosening his tie.

Conclusion

The least we can conclude is that, while still a novice in community pharmacy, someone who is technically equipped to do the job and sensitised to the socio-cultural dimension of everyday life can observe the expressive performance associated with the job while taking part in it.

Other approaches in research on pharmacy tend to come from above and outside, rather than from below and within the role. Examples are focuses on community pharmacy's duality of trade and profession or the "extended role" of the pharmacist. Even ethnographic-style studies, such as that of Dingwall and Wilson,[1] in which no participant observer had full pharmaceutical, professional responsibility, miss out what it is like actually to do the job.

The main finding is that pharmacists identify and are identified with their setting and stage props, especially the medicine. Pharmacists express the conviction, by confident acting, that their medicines are useful to patients. Patients expect such a performance. So close is the self-identification of pharmacists with the stage and props, that, in a sense, they are a part of being a pharmacist, as Weinlein noted when speaking in the US in 1943 of the dignified pharmacist, towering over shelves and medicines, "like Neptune mingling with the waves."

Other professions identify with their props. Fine[27] observes that cooks: "Identify with the food they produce and see a reflection of their qualities in the outcome."

Goffman[11] notes that groups watch carefully the minutiae of their particular performance. Pharmacists are one such group. They ensure that their members and their clothing, setting and interactions are proper, so as to be trusted by the public to convert drugs into medicines.

Wittgenstein (cited in Harding and Gantley[38]) observes that "the aspects of things that are most important for us are hidden because of their simplicity and familiarity." For generations, pharmacists have polished their stage performance using drugs and medicines as props. Without the expressive performance that the props support, community pharmacy, as we know it, might disappear. A useful comparison is the dentist who works in intimate proximity to the "very objects of dentistry's enterprise: the mouth and teeth."[39] If dentists were to focus on advice on oral hygiene, rather than operate on teeth, the performance would change crucially. Pharmacists in the UK are beginning to distance themselves from identity involving direct contact with their medicines.[40] Harding, cited in Cousins,[41] considers this a high-risk strategy.

Performances in all walks of life are prone to error. They can also be threatened by how the audience responds. "Error" might have a different meaning for the professional and the lay audience. The pharmacist's idea of error is likely to centre upon delivering the wrong medicine, whether by not following a correct prescription, failing to correct a wrong prescription or advising the wrong off-the-shelf medicine. There was a point at which Brown felt that pressure of work had hurried him into making such an instrumental error. The patient's idea of error would be the same if they knew and understood what had gone wrong, but there is typically lack of symmetry between professional and lay knowledge. Lacking knowledge, the patient is likely to perceive an error where the expressive performance of the pharmacist is flawed. There is an equivalent to what is colloquially called "losing it." Brown found himself learning how to avoid that situation.

Threats to expressive performance can come from the audience even when the performance is acceptable. They are unexpected. In Brown's field notes, one such threat, more potential than actual, was posed by a long queue that became restless. Brown had to develop techniques to cope with such threats. He stepped down among the waiting customers and found the words and presence to persuade them that they all would be seen in due course.

Symbolically transforming drugs into medicines, what counts as error and how to manage threats are three facets of the performance of the community pharmacist viewed from below and within that became known to Brown as he learned to become proficient. They are all about expressive, not instrumental, performance. They are so familiar to the practised pharmacist that he or she may have lost sight of them. They are also marginalised by a professional ideology that stresses the instrumental side of performance. For instance, transforming drugs into medicines has come to be seen as inferior to advising patients about their health. To treat error as a flaw in the front the pharmacist presents to the patient rather than in how the pharmacist dispenses seems to elevate "spin" above substance. Even handling threats seems peripheral to what pharmacy is really about. On the other hand, the trust on which professional practice rests is at stake when expressive performances fail. They have to be taken seriously.

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