Producing community pharmacy: complex performances in a hybrid space

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Abstract

Community pharmacies are recognisably hybrid health and retail spaces that are increasingly expanding beyond medicine-dispensing into new arenas of healthcare. However, there is limited understanding of the community pharmacy as a complex hybrid and socially-produced space. This thesis explores the community pharmacy as a hybrid, everyday and performative space using ethnographically-inspired methods to uncover the routines, performances and experiences within and across four pharmacies. Data was collected from two Life pharmacies and two Unichem community pharmacies using non-participant observation, mapping, photography, and interviews. Findings are presented in three parts, focussing on the landscape of the community pharmacy, staff practices, and customer performances in turn.

The first findings chapter reveals that Life and Unichem pharmacies have distinctly different looks, ambience and feel that immediately identify them. However, all pharmacies had seven identifiably-distinct spaces: the dispensary, Over-the-Counter (OTC) medicines, Complementary and Alternative Medicines (CAM), the counter, the consulting room, beauty, and gifts. These spaces varied in size but were located in similar positions within each pharmacy, and each space was subject to its own boundaries and power differentials. The dispensary is the most powerful space, followed by OTC and CAM spaces, because of the symbolic power of medicine and health. The boundaries around the CAM space were blurred and precarious, illustrating how CAM is on the boundaries of orthodox medicine, but is important to the expanding arena of health in the pharmacy. The counter area is subject to competing powers vying for visual and commercial dominance in the pharmacy. The beauty and gifts spaces had gendered boundaries and although beauty spaces attempted to medicalise skin care, beauty was primarily seen as a retail necessity as well as a community service. The community pharmacy is more than a hybrid

space, it is a site of multiple practices across and within seven distinct spaces. Exploring the physical and symbolic boundaries around and within these spaces illustrated how the community pharmacy meaning is comprised of movement and intersections across and within space. Exploring the spaces also revealed power differentials and competing stakeholders within the community pharmacy. Power played out within and across orthodox medicine, CAM, and beauty in aesthetics, symbols and physical aspects of the pharmacy such as marketing, product placement and staff hierarchies illustrating the complexity of the community pharmacy space.

The second findings chapter explores professionalism, boundary work and interactions of community pharmacy staff in both the dispensary and the shop floor. Boundaries around the dispensary are demarcated and exclusionary. Technicians are limited to working in the dispensary with clearly-defined work boundaries. In contrast, the pharmacist works within the dispensary and on the shop floor and the different spaces require different performances but are both tied to the pharmacist's professional identity. Pharmacy culture, expectations, the pharmacy brand, individual preferences and interests also influence professionalism and role boundaries of the pharmacist. For the pharmacist intern boundaries move and change as the performance moves from the dispensary to the shop floor. Retail staff play an important role in the social production of pharmacy. They have a range of performances from gatekeeping, sentry duty, and guiding customers in medicine, health, and beauty consultations. These staff use expertise developed with experience and on-the-job training to claim a conditional expert status, particularly in the medicines spaces such as OTC and CAM. The power of medicine functions to marginalise beauty staff keeping them on the boundaries of the pharmacy physically and symbolically. The analysis further revealed that emotional labour was required by all staff to create a sense of community in the pharmacy. Different spaces and different products required different emotional labour, with marked differences between health and beauty interactions. The boundary work and emotional labour of all staff reflects and reinforces

the dominant medical, professional and gender hierarchies that are operative, highlighting the interwoven nature of space and staff practices in the community pharmacy.

The final findings chapter explores the range of customer experiences within the community pharmacy. Customers' performances were driven by consumption of health and non-health purposes but also by the nature of the pharmacy space itself. There were distinct differences between health and non-health practices. Health consumption involved the use of boundary objects, such as the prescription, and rituals to seek health advice, products and service such as displaying symptoms and storytelling. Filling a prescription revealed interesting differences across its three distinct phases (handing in, waiting and collecting). Handing in the prescription was consistent across pharmacies and customers, whereas waiting practices were gendered. Collecting the prescription was more complicated, and differed from pharmacy to pharmacy, leading to customer uncertainty. Non-health consumption was gendered due to the products on offer, and this was sustained by the feminine aesthetic of the beauty and gift spaces. Overall, customers were found to be active consumers who embrace the hybrid functions of the pharmacy, assimilating, modifying and rejecting health and non-health products, information and advice.

The closing chapter offers a discussion, drawing on performativity, to consider how staff and customers interact with space, people and products to create the social production of pharmacy. Customers use the community pharmacy as a hybrid site of health and retail, using strategies and tactics to incorporate, modify and reject dominant health and beauty ideologies and discourses. Pharmacy staff are more constrained by spatial and role boundaries in both health and non-health spaces, but use emotional labour and patient-centred practices to create a relational and community space. Overall, this research highlights that the community pharmacy is a dynamic, relational and complex space.

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Chapter One

Why study the pharmacy?

The pharmacy is a well-known and internationally recognisable healthcare space primarily associated with dispensing medicines. However, being a well-recognised space does not necessarily make the pharmacy a well-understood space. There has been little research on the pharmacy as a space of interest, which is surprising as it is arguably a classic example of a hybrid space (commercial shop and healthcare space) with multiple purposes beyond medicines. The community pharmacy is a unique space to research because it is the only retail space that can sell and dispense prescription medicines as well as offer such a range of goods and services. Where else can you fill a prescription, get your passport picture taken, buy a toiletry bag, pick up a gift, a greeting card and replace your lipstick? In addition, community pharmacies may have services such as passport pictures, beauty services such as leg waxing or facials, offer dry cleaning services or sell Lotto tickets (Figure 1). The pharmacy may also offer health related services such as; warfarin monitoring, vaccination, or smoking cessation programmes (Pharmaceutical Society of New Zealand, 2017). Specially trained pharmacists can also dispense the emergency contraceptive pill or treatment for urinary tract infections or erectile dysfunction and offer medicines management services.

Figure 1: Services available in community pharmacies

Within New Zealand, there are two main pharmacy settings: the community and the hospital. There are two types of pharmacies in New Zealand hospitals. Firstly, the inpatient pharmacies service the wards and provide clinical pharmacy services. All medicines services administered within the hospital are provided free of charge as part of the patients inpatient service (Ministry of Health, 2017). Confusion arises as hospitals also have a community pharmacy in their foyers. These pharmacies can dispense walk-in prescriptions, fill prescriptions for discharged patients, and offer some general sale medicines in addition to selling practical items for a hospital stay and some gift type products (frame 2, Figure 2). There are also community pharmacies located near hospitals, 24-hour Urgent Care facilities, medical complexes, or doctor's offices that would have higher dispensing volumes than other community pharmacies. These pharmacies will still charge patients a co-payment and offer a combination of services (frame 1, Figure 2). There are also independent community pharmacies and branded community pharmacies. Branded community pharmacies refers to either Life or Unichem pharmacies and these pharmacies have some degree of control from Green Cross Health although are usually owned by pharmacists. Independent pharmacies have no affiliation to Green Cross Health. All these different community pharmacies offer the service of dispensing but look different, offer various services and products and even the hours open vary.

Figure 2: (L-R) Unichem, Auckland hospital pharmacy, Unichem

The range of goods and services on offer depends on the owner and/or manager, the pharmacy brand, and the location of the pharmacy (urban, rural, mall, suburban, airport or supermarket) (Figure 2). Figure 2 illustrates a Unichem situated next to a medical centre, the shop floor of an Auckland hospital pharmacy and an image from another Unichem pharmacy in a small suburban shopping mall. This last Unichem has a physiotherapist office, accessed by walking through to the pharmacy and offers dry cleaning services. These few examples immediately illustrate that community pharmacies are not standardised. It is important for research to consider that each pharmacy is therefore a unique situational and contextual space. Research exploring pharmacies often ignores this and assumes that because the specific services of pharmacies are the same, customers and staff will use the pharmacy consistently. While there has been research in England and USA looking at the different types including franchise and independent pharmacies (see Bush, Langley, & Wilson, 2009; Emmett, Paul, Chandra, & Barrett, 2006) this has not been done in New Zealand. This research will focus on four branded pharmacies (Life or Unichem) in Auckland, New Zealand.

It is an interesting time in New Zealand pharmacy history to be investigating pharmacies. In particular, the new Pharmacy Services Agreement (PSA) introduced in 2012 in New

Zealand and the Long Term Pharmacy Services Protocol (LTC) have major implications for community pharmacies in terms of government funding with more and more clinical services being part funded (Napier, Norris & Braund, 2018). There has been a push internationally to better use the pharmacist's professional expertise; yet, it has only been within the last few years that funding models have kept up with this vision (Napier et al., 2018). If community pharmacies do not embrace the new model of funding in New Zealand and rely on traditional prescription rebates for their profit, the pharmacy could be in financial trouble. The alternative for these community pharmacies is to increase the non-regulated medicines aspect of the pharmacy such as alternative and natural medicines, over-the-counter medicines, or retail products such as gifts or cosmetics. This then potentially changes the function and meaning of the pharmacy. The other element that makes this an interesting time to research pharmacies is the growing competition between New Zealand and Australia with the trans-Tasman discount pharmacy 'Chemist Warehouse' opening a branch in Auckland in late 2017. This led to a Unichem Maxx opening in Botany, Auckland, with marketing such as "crazy low prices" to ensure the discount market share is not missed (Zoio, 2017).

In summary, this research will explore the community pharmacy as a hybrid space to uncover the landscape of the pharmacy and everyday practices of staff and customers. As Whyte, Van der Geest and Hardon (2002) suggest, it is important to study pharmacies as a "strategic vantage point from which to consider healthcare systems, precisely because they do not quite fit" (p. 91–92). This research is important because there has been no research that has focused on branded pharmacies exclusively in New Zealand, minimal research that has looked at pharmacies beyond their medicines functions and limited research that has considered the pharmacy space. The remainder of this chapter will outline key theoretical ideas and discuss their relevance to this research.

Space and Place

The purpose of this section is to argue why it is important to conceptualise, theorise and research the community pharmacy as an everyday space, but one that is complex and intersectional. The community pharmacy is largely a taken-for-granted and well-known healthcare space where many of the daily practices are routine, ordinary, and not well understood. It is crucial to explore the pharmacy space and uncover the ordinariness to examine the meaning and significance of the community pharmacy for medicines and healthcare. It is also important to understand how the retail side of the pharmacy is contributing to healthcare experiences for customers and explore how staff work in a hybrid space. The retail side of pharmacy is positioned, in most literature, as nothing more than a profit venture, a problem for the pharmacist, or it is overlooked. This then ignores the range of experiences open to the customer and minimalizes the role of the retail staff. In addition, by investigating the minutiae and the ordinariness of the community pharmacy I can consider the underpinning logic, power, and politics of how people are using and consuming the community pharmacy (Buchanan, 2000). Lefebvre (1971) would argue that everyday life is a dual aspect of consumption and ambiguity or the intersection of affluence, society of want, squandering, and asceticism. De Certeau (1984) was also interested in the everyday but in contrast to Lefebvre he focused more on how everyday people resisted power through their use of spaces. Exploring the pharmacy as a complex, hybrid, everyday space allows me to uncover the complex socially constructed pharmacy performance, uncover the power differentials, and consider the storied and interactional nature of space.

Daylight (2008) says we "must pay attention to the production of space, for its meaning, its functions, and its operations, are socially and politically dependent" (p. 17). It is therefore important to understand the context in which the community pharmacy operates as this will influence how and in what ways the pharmacy is used. Chapter 2 describes the context of community pharmacies within New Zealand's healthcare system.

For the time being, it is important to remember that current community pharmacy practice in New Zealand has historical, cultural, economic, political and social influences. For these reasons, this thesis works from the assumption that pharmacies are socially constructed spaces, within which meanings are created through complex relationships, negotiations and interactions between physical place, material objects (products) and people (staff and customers). Ethnographically inspired methodology will allow me to explore the community pharmacy under this assumption.

There have been on-going debates across and within disciplines such as geography, anthropology and sociology over definitions and theoretical concepts behind the terms 'space' and 'place'. Literally, space can mean a realm in which all material objects are located and all events occur, or it can specifically mean the space occupied by a body, or spaces that are out of this world or exist in cultural worlds such as outer space or on-line spaces (Cresswell, 2004; Merrifield, 1993). De Certeau (1984, p. 118) says, "Space is a practiced place" and is composed of intersections of movements within the space. Lefebvre (1991) also argues that space does not exist in itself but rather it is produced by people and is fundamentally social. Lefebvre notes that in order to conceptualise space and knowledge together you have to understand them as three dimensions: spatial practice (perceived space), representations of space (conceptualised and ideological space) and spaces of representation (directly lived space). To capture the production of space, Lefebvre conceptualised a 'spatial triad' in order to understand this production. This triad connects physical space, mental space and social space while implicating the importance of everyday life, power and the dialectal nature of consumption and practice. In other words, space is a socially represented production between physical, mental and social elements.

In contrast, place is usually associated with a specific setting: location, locale and sense of place. Cresswell (2004, p. 7) suggests location is a physical location, locale is the "material

setting for social relations" and sense of place is the emotional and subjective attachment of people to place. De Certeau (1984) would argue that "place is the order which elements are distributed in relationships, no two things can be in the same place at the same time" (p. 117). A place is also more than a defined area; it is moments of encounter(s) that are not fixed in time or space (Amin & Thrift, 2002). Places are intersection points, tying individuals together, and thereby, "places can be seen as processes rather than motionless 'things'" (Massey, 1994, p. 154). Places can also have significance for individuals, that is, a 'sense of place' (Tuan, 1977). This sense of place defines both the subjective and the emotional attachment individuals assign to a certain place (Agnew, 2011). Place is then connected to physical, material and emotional or the "understood reality" (Dourish, 2006, p. 299). The main distinctions between space and place are related to epistemological and ontological concerns so the debates around these terms will continue.

What is important for this research is the relationship between space and place. Löw (2016) argues that spaces should be understood as a "relational arrangement of social goods (material goods) and living beings (people) at places" (p. 188) because space is about performance and social production. One could even argue that a socially produced space plays the same role as place (Cresswell, 2004). De Certeau (1984) described place making as how people "arrange everyday life through using, manipulating and making do with available spaces, resources and opportunities" (1984: xviii–xx). This immediately shows that place and space are linked because without the spaces there are no ways of creating place meaning. De Certeau also discussed "how stories can transform places into spaces and vice versa" (p. 118) demonstrating again how intrinsically connected these two concepts are. Building on the storied nature of space is the idea that there is a complex relationship between spatiality and practice and the way people create meaning for spaces or as Merrifield describes "space and place are different aspects of a unity" (1993, p. 527). Spatiality is a dimension of social relations and social experience. It does not ignore

materiality but assumes people's interactions with the world connect with their social practices (Bærenholdt & Simonsen, 2004).

It is valuable to discuss the different approaches to space and place in order to understand the complexities of exploring the community pharmacy as a socially produced space. I believe it is useful for this research to use multiple viewpoints and disciplines in order to capture how the community pharmacy space is relational, interactional, situated, contextual, and subject to micro and macro power strategies. Therefore, I use de Certeau's notions of space to consider how people use power strategies in the pharmacy space. I use Lefebvre's spatial triad to explore the relationships between people, space and products. I also assume that there is no space without place or vice versa, and space and place are relational and intertwined producing a multiplicity of possible meanings (Cresswell, 2004; Löw, 2016; Massey, 1994). This will allow me to explore the production and meaning of the community pharmacy as an everyday space. I explore both healthcare and retail spaces in subsequent sections.

Healthcare and space

The relationship between space, place and health has a long history, particularly in the discipline of geography. The traditional focus of early health geography research was on the supply of services and their relationship to health patterns, outcomes and distribution (Andrews & Evans, 2008). This discipline has moved beyond this to broader health issues that have contributed to health policy, service planning and provision, in large part due to Kearns, Barnett and Newman (2003), who called for research that focused on the significance of places as cultural and social phenomena. In fact, Kearns et al. (2003) argued that health should not be considered without looking at the places of healthcare. By exploring healthcare spaces, you can expose socially and politically located health performances, health inequalities, and meanings and representations linked to healthcare and health (Andrews, Chen & Myers, 2014). Rapport, Doel and Jerzembek, (2009) have

described healthcare environments as "the media in and through which social relations are produced, reproduced, contested and transformed" (p. 532). It is also important to remember that increasingly healthcare is provided in the community in places where people live, work and shop (Poland, Lehoux, Holmes, & Andrews, 2005), so research has moved beyond the hospital and medicine centre to how health is being enacted in other places. For example, Hodgetts et al. (2011) and Dew et al. (2014) considered medicine use in the home and Lehoux, Daudelin, Poland, Andrews, and Holmes (2007) looked at mobile dialysis units. While sites of healthcare are extending into the community, what has not changed is the importance of considering the dialectic relationships between the subjective experiences of place (or socially produced space) with the objective location when considering how health and social care is manifested (Cummins, Curtis, Diez-Roux & Macintyre, 2007).

Much of the research on health and place considers what constitutes a healthy place, a healing place, or a therapeutic space. More specifically, how environments (social, physical and symbolic) contribute to well-being, physical and mental health (Gesler, 1992). This has informed healthcare design and design of other healthy places and worker wellbeing. For example, Curtis, Gesler, Fabian, Francis, and Priebe, (2007) used the lens of therapeutic landscapes and sought staff views on a new mental health inpatient unit on whether the space was beneficial or detrimental to well-being. Health geography has also considered caringscapes as a way to expand therapeutic spaces (Bowlby, 2012). Landscapes of care (Milligan & Wiles, 2010), care of the body (Atkinson, Lawson & Wiles, 2011), geography and ethics (including care and consumption) (Popke, 2006) are a few concepts that have been developed to capture health beyond recovery. The pharmacy represents a different type of healthcare space, mixing commercial retail elements with health products and advice (Banks, Shaw & Weiss, 2007). While there is the potential for the pharmacy space to be a therapeutic, caring and restorative place, there is a lot more going on in the pharmacy space than recovery and treating ill health. The retail aspect of

the community pharmacy, staff work practices and the pharmacy space itself may negate the caring and therapeutic nature of the pharmacy (Thompson & Bidwell, 2015). I therefore argue that a focus on both therapeutic and caring landscapes is not sufficient to explore and account for community pharmacy spaces.

Pharmacies are not homogenous either within New Zealand or between countries. Community pharmacies in New Zealand do not look the same or offer the same services beyond the core function of dispensing. There are independently owned pharmacies and pharmacies branded as Life or Unichem. The location of the community pharmacy will also influence how it used. For example, rural, hospital or inner city pharmacies will have varying dispensing rates, different relationships with their customers and different products for sale. Interestingly, more nuanced explorations of different sorts of community pharmacies are the exception. Rogers, Hassell, Noyce and Harris (1998) are one of the exceptions in that they examined advice giving in three types of community pharmacies in the United Kingdom. These authors looked at three different sorts of pharmacies (inner city, small town and rural pharmacies) and considered how the physical space influenced pharmacy use. Rogers and colleagues (1998) described the inner city pharmacy as a fortress as customer/staff interaction took place across a physical barrier (a hatch situated in a bulletproof window) between the customer and staff. Interactions were limited to raised voices and impersonal conversations. Despite this, this particular pharmacy had the highest number of prescriptions dispensed in their study. The small town pharmacy in their study belonged to the same multiple group as the inner city pharmacy but Rogers and colleagues (1998) called this pharmacy an emporium due to the high sales of non-health related products. This emporium pharmacy was located in a busy shopping centre but in a high deprivation area and customers were mostly concerned with cost. Lastly, Rogers et al. (1998) called the rural pharmacy a "haven in a heartless world" (p. 371). The rural setting blurred both physical and work boundaries. Interactions between staff and customers were longer, more personal and

customers were even invited into the dispensary. The dispensing rate was one fifth that of the inner city pharmacy but customers were more likely to discuss their health problems with the pharmacist. Rogers and colleagues concluded that locality influences pharmacy services, space and functions for staff and customers. Rogers and colleagues (1998) found the pharmacy setting reinforces inequalities rather than addressing them when giving advice. This study also illustrates how important it is to consider the physical aspects of the pharmacy space in addition to the social relations as both influence how customers use and interact with the pharmacy and the pharmacy staff. While this research is one of the few that has looked at differences across pharmacies, this research was conducted only in the UK and it compares pharmacies in quite different locations. This research adds to this literature by considering pharmacies under the same marketing umbrella (or brand) in the same city. This will highlight any similarities or differences in meaning making and look beyond the medicines function in community pharmacies.

Other research on pharmacy spaces has focused on particular spaces within the pharmacy and the effectiveness of these spaces for health promotion or patient counselling (Brown, Portlock, Rutter & Nazar et al., 2014; Brown et al., 2016: Saramunee et al., 2015; Scahill, Fowler, Hattingh, Kelly, & Wheeler, 2015). For example, Anderson (2000) suggests that window space is effective for health promotion campaigns. There have also been numerous studies looking at privacy issues in pharmacies as many health consultations take place at the counter (Anderson, Blenkinsopp & Armstrong, 2004; Hattingh, Emmerton, Cheong tin & Green, 2016). Most of these studies have found that there are issues with the pharmacy space constraining these interactions and consequently, the staff use different strategies from changing sensitive product packaging, moving the customers to quieter areas in the pharmacy, and lowering voices to deal with some of these issues (Hattingh et al., 2016). However, the level of privacy required by the customers varied depending on the service and Hattingh et al. (2016) identified that customers developed strategies to deal with privacy issues as well such as coming into the pharmacy at quieter

times. This again shows how the space itself works with the people in the pharmacy to create meaning and potentially how there will be different sub-spaces in the pharmacy. There has been little research that has considered the distinctive spaces within the community pharmacy, how the different staff members and customers use these spaces and for what purposes.

Rapport, Doel and Jerzembek (2009) conducted one of the few studies that researched the pharmacy as a multidimensional and socially constructed space. Rapport and colleagues (2009) researched the UK community pharmacy space concerning the professionalism of the pharmacist. Rapport and colleagues (2009) identified three key spaces in the pharmacy – dispensary, sales area, and consulting room. They were particularly interested in the pharmacist's views on the spaces' controllability, how adequate the spaces were, the selling ethos, and how objects moved between these spaces. Rapport and colleagues (2009) found a clear relationship between the space and the sense of professionalism for the pharmacists. They found the dispensary was linked to pharmacists' professional identity but the sales area compromised their professionalism so pharmacists avoided leaving the dispensary. The pharmacists also valued a well-run space where they could perform their role, resenting time on the shop floor. While this research is particularly relevant for this research, Rapport et al. (2009) did not explore the relationship of the space to any of the other staff in the pharmacy or the customers. In addition, the professional role of the pharmacist is being extended to many more clinical tasks outside the dispensary since this research was done.

The only other research that has explored the pharmacy space is from Thompson and Bidwell (2015) who explored the spatial and social context of community pharmacies as a space of care from the perspective of the pharmacists and customers. Thompson and Bidwell (2015) found that the community pharmacy, as a space of care, is threatened by temporal factors such as customers do not have to make a time to see a pharmacist and

want their prescriptions dispensed as fast as possible. There are also privacy issues when the customer has to show body parts on the shop floor leading to embarrassment. Privacy issues led to emotional problems for the customers, but also for the pharmacists as the pharmacists had to navigate a conflicted space. Thompson and Bidwell (2015) highlight how the pharmacy space contributes to both the temporal and emotional nature of customer interactions. These two studies are the rare exceptions of research that considers the pharmacy as a socially produced space. Both studies do illustrate the strong and important relationship between staff and space in the community pharmacy. This relationship is particularly complex in a community pharmacy as it is both shop and healthcare space and the staff include both medical professionals and retail staff. However, both studies did not consider the role of the retail staff or products other than medicines and this research will address that gap.

It is important to remember that when even traditional healthcare spaces, such as hospitals, are being reinvented as spaces of consumption that commercial interests play an integral part in the design, running and management of all healthcare delivery spaces (Kearns & Barnett, 2000; Kearns et al., 2003). The other elements of health provision that are important are technology (Andrews & Evans, 2008; Cohen et al, 2010) and a continued focus on patient-centred care. These elements, alongside a dominant political and economic neoliberal ideology, has changed the clinical concepts that underlie healthcare provision (Hibbert et al., 2002). Andrews and Evans (2008) suggest these sorts of structural, technological, financial and conceptual changes in healthcare have far-reaching consequences for workers at both macro and micro levels. I suggest that these ideas are important to consider for community pharmacies because of the impact not only on the workers and the pharmacy space but also on how the customers may use pharmacies.

In summary, there is no shortage of research on healthcare spaces, particularly from the viewpoint of therapeutic landscapes. There has also been research using de Certeau and

Lefebvre's ideas and theoretical underpinnings applied to the home, higher education, cities, and retail and health sites (Dew et al., 2014; Peterson & Minnery, 2013; Soukup, 2013). However, this lens has not been applied to the community pharmacy space in New Zealand. Sites of healthcare face particular issues in practice and research and community pharmacies face additional challenges because they deliver healthcare in a retail environment. This research will explore the community pharmacy space as a complex social and interactional production using a flexible ethnographic inspired methodology. This framework allows me to conceptualise the pharmacy at a broad level but also consider the specific taken-for-granted factors that may be working on the space and producing meaning.

Power

This section will discuss how power is influential within the community pharmacy space. It is impossible to analyse space, including the community pharmacy, without consideration of power for a number of reasons (Anderson, 2010). Firstly, space can be where the discursive relations of power are actually transformed into relations of power (Daylight, 2008). Dourish (2006) suggests that when space is produced it is influenced by access and legitimacy, or frames of power, because space itself can be a means of control and domination. Therefore, power is enacted on, within and in relationship with the space. Secondly, power can also be "expressed and sustained in the reproduction of culture" (Cresswell, 2004, p. 124) or as the ability to influence others (Anderson, 2010). De Certeau would argue that culture is a "fluid and mobile set of practices constituted by the way we do things" (1984, as cited in, Sheringham, 2006, p. 218). Greenhalgh and Wessely (2004) suggest culture consists of what people say they do, what people are observed to do, and their underlying belief systems. Greenhalgh and Wessely (2004) were interested in power in health and consumption. They suggest when consumers are information rich that shifts the power from the medical professional to the consumer. This is important in health seeking behaviours and illustrates the complexity of exploring power in health

interactions where consumers have different health literacies, cultures, and expectations for different interactions such as doctor/patient, nurse/patient or pharmacist/consumer. Thirdly, by investigating the relationship between space and production one can then explore notions of power and control at macro and micro levels, as wider forces influence everyday actions (Lefebvre, 1971). Power is therefore important in analysing spaces because power affects individuals and their underlying beliefs while individuals are being constrained by powerful structures, systems and ideologies. This research assumes that the community pharmacy is a healthcare space so will be subject to structural, ideological and symbolic powers related to medicine including staff hierarchies. I also assume that the pharmacy is a cultural landscape where power will influence everyday interactions between space, people and materiality.

The structure of healthcare inherently reinforces power imbalances and these power differentials are evident in the healthcare space itself and in the individual and social practices surrounding healthcare sites. Poland et al. (2005) would argue all healthcare settings are fundamentally imbalanced and suggest that power can be reduced to three dimensions: control of material resources, control of human resources, and control of ideas. These three dimensions are embedded in, and contingent on, space and time. The power differences within community pharmacies can be explicit, for example, access to services (Guagliardo, Huber, Quint & Teach, 2007; Horsfield, Kelly, Clark, & Sheridan, 2014), healthcare agendas that target specific groups, and strategies that aim to increase adherence to medicine regimes (Waring, Latif, Boyd, Barber & Elliott, 2016). Power, in the form of social control, is evident in healthcare spaces through governance of such things as smoking laws, immunisation, and alcohol taxes (Poland et al., 2005). Certain groups are disadvantaged in healthcare by location, ethnicity, and socio-economic status and health outcomes (Cummins, et al., 2007; Stremersch, Landsman, Recanati, & Venkataraman, 2013). Other power imbalances are not as obvious, such as gender bias in care of the ill or care of the family (McKie, Gregory & Bowlby, 2004).

It is important to highlight the obvious and hidden power structures that influence how and why people are using and working in community pharmacies. This is particularly important for research in pharmacies as community pharmacists are advertised as the 'most accessible' of health professionals. However, accessibility in a community pharmacy is more complex than having access to a pharmacist for free advice. Pharmacy location, distance to a pharmacy, resources to pay for medicines, gender, age and other demographic factors influence access to healthcare and pharmacies. Researching the pharmacy as a complex space provides the potential to uncover physical, symbolic, and social power structures and discover what accessibility means in practice in the community pharmacy.

Within medical spaces power can be related to the overall design of the space (clinical aesthetics and barriers to accessing professional staff) to less blatant elements such as positioning of counters and chairs in waiting rooms (Arneill & Devlin, 2002) or how computers are used in a medical encounter (Crampton, Reis & Shachak, 2016). Waltz (2017) would go even further and suggest that gendered power dynamics are evident in medical waiting rooms because women are assumed to have more time to wait and will be attending doctor's appointments for themselves and others as carers. The waiting room also reflects the bureaucratic structures of health settings that ensure efficiency and profit. The physical setting of the clinical doctor/patient encounter has a significant influence on patients, mainly because the consulting room is the professional's space (Erdem, & Harrison-Walker, 2006; Gabe, Olumide & Bury, 2004). The professional space has an agenda that is professionally driven and there are immense power imbalances in terms of knowledge and expertise (Greenhalgh & Wessely, 2004). These studies illustrate how physical and functional aspects of the community pharmacy space may influence how people are using the space and both reinforce and uncover power imbalances and resistance.

The community pharmacy is a site housing medicines and medical professionals. This research is interested in uncovering how the epistemological dominance of medicine and science is expressed in the community pharmacy. Medicine has the capacity to guide and influence the public with concepts of medical and health neoliberalism (Kearns et al., 2003). Foucault viewed medicine as an institution of social control and proposed that medicine is one of the ways in which "populations come to be disciplined" (Ryan, Bissell, & Traulsen, 2004, p. 44). The 'clinical gaze' is a term developed by Foucault (2003) in "The birth of the clinic" to describe the focus of medical practice on the human body. Ryan describes the clinical gaze as the "process through which specific social objects, namely disease categories, come into existence'' (Ryan et al., 2004, p. 45). Foucault (2003) argued that clinical gaze was covertly a moral judgement. Within a medical encounter, a person exposes himself or herself to a medical gaze so that the physician can determine the illness. Under this clinical gaze, patients are compared to normal population ideals, which led to the concepts of normalisation and 'surveillance of the normal' or well bodies (Armstrong, 1995, 2012). This in turn led to patients being encouraged to take control of their own bodies, to survey their own health behaviours in order to limit risky behaviours. Foucault suggests that an individual may resist medical power and is far from being passive or docile. Individuals will create their own alternatives that are either a conscious or a subconscious choice (Ryan et al., 2004; Straughan, 2010). Within the community pharmacy, it is not clear how and if the clinical gaze will come to bear and this research will explore how the medical gaze of the medicines and the pharmacist profession acts on the rest of the pharmacy.

Foucault identified governmentality or the political power that operates via the state and other institutions (Dew et al., 2014). The purpose of governmentality was to bring about desirable behaviours. The state controls medicines, and the pharmacy profession, and the aim of this control is safety, policing, surveillance and ensuring adherence. Similarly, power operates upon and within the individual. Individuals will use medications based on

their own "system of knowledge and truth" (Ryan et al. 2004, p. 46) but states will also try and impose health upon individuals through health promotion and health surveillance. Health promotion services are offered in community pharmacies and nationwide health campaigns are visible in the pharmacy, such as men's health week. Foucault's theories are applicable in many health-related fields such as medical practice, doctor-patient interaction, surveillance medicine, and public health. There are however some criticisms of his work. Some of these criticisms are at his apparent lack of concern with inherent gender imbalances, failing to outline his methodologies, or defining the mechanisms of power struggles (Ryan et al., 2004). None-the-less, governmentality and the clinical gaze are clearly applicable in the community pharmacy setting. This research will explore how power works on, with and against the community pharmacy using Foucault's ideas of the clinic and state control. I believe there will be competing powers in the community pharmacy that may lead to tensions and this next section will explore who these powers may be.

It was important for me to consider the pharmacy as an everyday healthcare space within the context of a wider social and cultural situation and explore both the micro and macro power structures. Therefore, it is important to consider how to analyse the community pharmacy space and to consider how power will inform this research. I will focus on everyday practices within the community pharmacy space and use de Certeau (1984) who argues that we should distinguish between "strategic" and "tactical" spatial practices. Simply put, strategic practices are the "practices of design", or largescale notions of power and control through spatial domination. Conversely, tactical practices are the "practices of use" or acts of the weak (Dourish, 2006, p. 37). De Certeau was particularly interested in consumption of everyday (walking, reading) as a production and within this philosophy consumers are not passive but rather use tactics or subversive acts (ruses and poaching) to manipulate what and how they are consuming (Sheringham, 2006). Tactics seems to imply an absence of power however, de Certeau would say that consumers appropriate

resources within the constraints of the existing order and use them in ways to suit themselves.

In conclusion, power is particularly important in the community pharmacy because there are strong external regulations and organisations controlling pharmacy practice and the pharmacy space. There is also the wider power of medicine (disciplinary and clinical gaze) and medical professions that will influence how health is constructed and practiced in the community pharmacy. In addition, I anticipate that there will be micro power displays, representations, and resistance to power by the space, the staff and the people. While there has been research into power within community pharmacies this research tends to focus on either consumers of medicine (Ballantyne, 2016), pharmacists as gatekeepers to medicines (Chiarello, 2013) or wider structural, political, and societal powers of medicines including drug companies (Edgar, 2013; Gabe et al., 2012). This research will consider the ways customers and staff move through the pharmacy, how they use the space and all pharmacy products (not just medicines). By analysing both strategic and tactical practices the everyday, or micro practices of power, can be uncovered (Buchanan, 2000). In order to uncover power in the taken-for-granted pharmacy space it is important for me to contemplate a methodology that will allow me to observe the multiplicity of practices in the community pharmacy.

I also wanted to keep the wider context in the forefront of my data collection and analysis. Part of this construction is considering what macro power structures are influencing the pharmacy as there are many different powers pushing and pulling on the community pharmacy. Countervailing powers framework arose as a potential way of understanding how the major actors in healthcare settings interact and influence each other (Light, 2010). Light (2010) suggests this framework allows the key stakeholders roles to be explored historically while considering tensions, levels of control, interests and alliances between and within the actors and then investigate how this shapes current healthcare.

This of course has value in healthcare situations and settings where increasingly market forces, the medical industry, professionals, and expert-patients seemingly battle it out for profit, rights, and jurisdictional control of resources and good healthcare (Light, 2010). Countervailing powers as a framework within the pharmaceutical industry considers the pressures different actors exert on medicines (Busfield, 2017; Gabe et al., 2012; Light, 2010). Busfield (2017) suggests that all these actors work together to create a demand for medicines and in the process fuel disease mongering. In addition, Gabe and colleagues (2012) suggest the media and customers are countervailing powers due to the media's potential to sway opinions and because of the customer's ability to influence drug purchasing. The power given to the medicines and the actors behind the medicines – pharmaceutical companies, doctors, pharmacy industry, and government – will seemingly compete in interesting ways within the community pharmacy and this is worthy of exploration.

The other reason countervailing powers framework is important for community pharmacies is the increasing number of branded or franchise pharmacies, or what Bush, et al. (2009) call corporate pharmacies. Bush and colleagues (2009) report in the United Kingdom many independent pharmacies have been taken over by pharmacy chains. The reason for this is that independently owned pharmacies are finding it increasingly difficult to run a business in competition with corporate pharmacies. However, this is not necessarily the case in New Zealand, as pharmacies have to be majority owned by pharmacists and pharmacists cannot own more than five pharmacies. Bush et al. (2009) suggest profits become the driving force of pharmacies leading to "rationalisation of products and services" in the name of efficiency, control, predictability and calculability (p. 307). Chain pharmacies had more services and seemed to attract the bulk of NHS funding. The implications for this study are that I am using branded pharmacies with either a degree of controlling interest by Green Cross Health or a relationship with Green Cross Health that shapes their function and practices. There has been little critical research

investigating the role that Green Cross Health is playing with healthcare delivery in community pharmacies in New Zealand and how strong a countervailing power Green Cross Health is or what other countervailing powers may be at play in the community pharmacy. In summary, many stakeholders influence the community pharmacy practices from the government, the pharmacy profession, PHARMAC, doctors and the pharmaceutical industry. While there is a dominance of medical knowledge and power, I suggest there are other stakeholders that may have influence on how the pharmacy space is produced and how power differentials play out in the pharmacy.

Medicalisation and Pharmaceuticalisation

"For every ill there is a pill – and more and more often for every new pill, there is a new disease" (Blech, 2003, p. 3).

The previous section underlined the role power plays in the community pharmacy and that the community pharmacy is complicated as there are numerous stakeholders with varying degrees of power over the community pharmacy. There is no doubt as to the importance of medicines to the pharmacy space, the pharmacy professional and in treatment and prevention of ill health suggesting the stakeholders with the most power within community pharmacies will be linked to medicines. There are increasing numbers of medicines sold and prescriptions dispensed. For example, in New Zealand 26.3 million prescriptions were funded in 1980, 33.9 million in 2007/2008 and over 50 million in 2016 (Ballantyne, Norris, Parachuru, & Thomson, 2018; PHARMAC, 2016). While these figures reflect the growing cost of healthcare and medicines expenditure they also reflect the reliance on medicines in achieving health. At face value, this strongly suggests that the biomedical model of health is still dominant and powerful, however, this may be too simplistic an explanation when analysing community pharmacy spaces. Other processes may be important and two that I will explore briefly below are medicalisation and pharmaceuticalisation. The other important factor in healthcare and community pharmacies is the role of media, specifically direct-to-consumer-advertising (DTCA). DTCA

refers to marketing of prescription medicines, however, I will also reflect on marketing of other medicines in the pharmacy setting.

Medicalisation is the process by which medicine extends its boundaries into the social world and through which non-medical problems such as hyperactivity or sexual dysfunction are constructed and treated as disorders or illnesses (Conrad, 2007). There has been an increased number of new drugs being developed to treat supposedly new conditions or disease mongering (Moynihan, Heath, & Henry, 2002). There has been extensive literature documenting the impact medicalisation has had on health paradigms, healthcare and dominant ideologies (Bushfield, 2017; Williams, Coveney, & Gabe, 2017). There is no doubt that medicalisation has led to the creation of new diseases and healthcare now individualises social problems (Ballantyne et al., 2018; Maturo, 2012). Bell and Figert (2012) suggest that medicalisation has risen alongside rises in health promotion and the link of science to social life. However, medicalisation also involves positive factors such as the implementation and transfer of new technologies and the development of lifesaving drugs.

Moynihan et al., (2002) maintain there are five forms of inventing diseases and use specific examples of drug companies marketing to illustrate these processes. Firstly, normal life processes are reconstructed as medical problems such as hair loss. Secondly, personal and social problems are sold as medical problems such as social anxiety. Thirdly, risks and risk factors are sold as diseases (e.g. osteoporosis). Fourthly, prevalence estimates are used to suggest epidemics (e.g. erectile dysfunction). Lastly, slight symptoms are marketed as indicators of a serious illness to specific medical groups (e.g., irritable bowel syndrome was targeted in a marketing campaign to establish a need for a new drug). The other impact of medicalisation is that the doctor then defines your sick role through labelling and by controlling the medicines leading to medically driven expert control (Abraham, 2010; Busfield, 2017). The implications for community pharmacies are

that the expertise of the pharmacist is important to consider and that these wider health ideologies will be influencing how the pharmacy is used.

A seemingly direct impact of medicalisation is increased drug sales to treat diseases, or pharmaceuticalisation. Abraham (2010) defines pharmaceuticalisation as "the process by which social, behavioural or bodily conditions are treated or deemed to be in need of treatment/intervention, with pharmaceuticals by doctors, patients or both" (p. 290). Some examples include treatment of mood with anxiolytics, treatment of behaviour such as ADHD with Ritalin, treatment of erectile dysfunction with Viagra or even treatment of heart disease risk factors such as cholesterol lowering meds like statins (Abraham, 2010). Williams, Martin and Gabe (2011) define pharmaceuticalisation as "the translation or transformation of human conditions, capabilities and capacities into opportunities for pharmaceutical intervention" (p. 711). Both these definitions highlight the power of the pharmaceutical industry in healthcare as the suppliers of pharmaceuticals. In addition, while connected and related, pharmaceuticalisation is a separate phenomenon to medicalisation. For example, there have been instances where governments supported drug industry interests by decreasing barriers to new medicines and where medicine-users become active agents in pushing the industry to access to medicines (Ballantyne et al., 2018). These examples show how pharmaceuticalisation can occur alongside or separately from medicalisation. Interestingly, within the community pharmacy, the concept of pharmaceuticalisation and medicalisation are largely assumed and there is little critique of these processes within the pharmacy environment in New Zealand. This is likely because PHARMAC controls what prescription medicines are funded. Consequently, PHARMAC then affecting the pricing structure of medicines in the pharmacy. None-the-less the power of the pharmaceutical industry in constructing dominant illness and health ideologies is important to consider in the community pharmacy.

The other aspect where pharmaceuticalisation and medicalisation are important in the community pharmacy is in marketing. DTCA is the promotion of brand specific prescription medications direct to the consumer and delivered via mass media or personal communications (Babar, Siraj, & Curley, 2017; Eagle, Chamberlain, & Zou, 2002). There is no doubt that DTCA plays a large part in imparting information to consumers. In the United States, it is estimated that pharmaceutical companies have increased their promotion expenditure of prescription drugs threefold from 1997 to 2010, and this is reflected in corresponding sales growth (Delbaere, 2013). There are contentious ethical issues surrounding DTCA, particularly of prescription medications and the uncertainty over the implications may be reflected in the small number of countries that permit DTCA – currently only the USA and New Zealand (Babar et al. 2017; Delbaere, 2013). The pharmaceutical industry has consistently argued that DTCA is about education of consumers and empowering consumers (Arnold & Oakley, 2013; Babar et al. 2017). Conversely, DTCA has been criticised for a number of reasons. It is seen as being responsible for undermining doctor-patient relationships, providing poor-quality, inadequate information on pharmaceuticals, promoting overmedication, increasing medicalisation, altering the balance of the prevailing powers in favour of the pharmaceutical industry, increasing healthcare spending by increasing medicines costs, hindering sale of generic or non-pharmacological alternatives and manipulating consumers (Arnold & Oakley, 2013; Babar, et al., 2011). There is no doubt that the community pharmacy is a hyper-visible mediated space, reflecting both DTCA and brand focused marketing. The role that online and social media marketing play on the pharmacy is not explored in this research but will increasingly play an important part of how pharmacies are used (Egilman & Druar, 2012). Media, and the companies who produce this media, will play a part in how the pharmacy space is used and will be an important force in community pharmacies.

The practice of medicine and consuming medicine is changing. Since the 1990's, a number of once-fatal diseases are now on-going, chronic disorders. The foray of medicine into lifestyle medicine (surveying for and treating risk factors) and holistic health has influenced the number of medicines people may take as well as the definition of health and even what medicine is (Bushfield, 2017; Lenz, 2012). The integration of natural and complementary medicines into biomedical settings such as medical practices and pharmacies and into individuals' health routines suggests that more and more domains are being pharmaceuticalised (Ballantyne et al., 2018; Brijnath & Antoniades, 2016). The healthy body is then continually at risk and consequently needs constant surveillance and self-monitoring. This becomes even more important for people with chronic and serious illness and individuals increasingly look outside orthodox medicines to help manage and personalise their conditions (Tordoff, Chang & Norris, 2012). Individuals now may take multiple pills each day to alleviate acute symptoms and to manage chronic conditions or symptoms. Surprisingly, the role of the community pharmacy in creating, maintaining or resisting pharmaceuticalisation or medicalisation processes is taken-for-granted. This may be because pharmacies are at the end of the medicines chain, and doctors have the power of prescribing or because medicines are not consumed in the pharmacy. However, there is no doubt that pharmaceuticalisation and medicalisation influence community pharmacies marketing, medicine availability, how illness is treated, and through dominant health ideologies that promote wellness, lifestyle and natural health messages.

In conclusion, medicalisation and pharmaceuticalisation in the context of this research is about understanding the role of these broader influences on the community pharmacy. What regulatory aspects influence how the pharmacy is run, or on what the staff do, or on the cost to the consumer? What is the influence of DTCA or other media and marketing on the community pharmacy space? What is the impact of pharmaceuticalisation within the natural and complementary medicines arena? Accordingly, this research does not aim to define pharmaceuticalisation or medicalisation but rather will explore the complex

relationships between pharmaceuticals and all aspects of the community pharmacy exploring how this influences customers' behaviours and the professionalism of the community pharmacy space.

Professionalism

In exploring the community pharmacy space, it is important to consider the role of the pharmacist, as they are the medicines expert. There is no doubt that pharmacists are health professionals because to be a pharmacist requires extensive training and expert knowledge, and within healthcare professionalism largely comes from medical knowledge and training. A profession has jurisdictions or social and cultural mapping and medical professions typically have clear and strong boundaries (Abbott, 1995). Malin (2000) describes professionalism as a "set of workplace practices where boundaries have been redefined in response to socio-economic and cultural pressures" (p. 1). Immediately it becomes clear that professionalism implies a status and hierarchy, workplace boundaries, control and prestige (Abbot, 1995; Duckett. 2013). Within the community pharmacy the implications are clear, there will be a staff hierarchy based around the pharmacist's professional status.

In the community pharmacy, pharmacists may lay claim to professional status but this status is rather precarious for a number of reasons. Firstly, no other health professional works in such a strongly retail environment. Community pharmacists are unique health professionals because of their role with medicines and their workspace – both clinic and shop. Some would argue this puts the pharmacy profession on the medical margins (Hibbert, Bissell & Ward, 2002). Secondly, pharmacists have referred to as passive dispensers of pills as the doctor or primary prescriber retains the control and power of the medicine marginalising the pharmacists' professionalism (Harrison, Scahill, & Sheridan, 2012). Thirdly, other research has shown that consumers do not see the professional value in the act of filling a prescription (Brown, 2012) as doctors were "in charge of their

medicines" (Bissell, Blenkinsopp, Short & Mason, 2008, p. 363). Gidman, Ward and McGregor (2012) in a study of public trust in community pharmacists and GP's in Scotland found GP's still had more trust from the public than pharmacists did, predominantly because customers do not develop the same relationship with the pharmacists as with their doctor. This may be because the pharmacist in many community pharmacies remains unseen as the retail or counter assistant takes the prescription and asks the requisite questions of the patient or because the customer does not recognise the expertise of the pharmacist.

In an attempt to use pharmacists' skills more and change consumer perceptions there has been major push across most Westernised countries to reprofessionalise the pharmacist (Bush et al., 2009). There is no lack of research on pharmacists' professionalism, predominantly on how to enhance it and how to change perceptions of the pharmacist role in healthcare (with consumers and other health professionals) (Bradley, Ashcroft, & Crossley, 2018; Brown, 2012; Mossialos et al., 2015). There are two main streams of research on how to better use the pharmacist's skills. Firstly, through changing the medicines jurisdictions (through limited prescribing, conducting medicines reviews, and medication management) and secondly by increasing health promotion and health screening services in the community pharmacy (Harrison et al., 2012). Some of the extended roles include health screening (e.g. sexual health, Estcourt et al., 2017; alcohol screening, Derges et al., 2017), extended patient counselling and adherence support (e.g. mental health medication management and intervention, Hattingh, Kelly, Fowler & Wheeler, 2017), and disease management (e.g. hypertension, Bajorek & Krass, 2017).

Pharmacist's accessibility and the pharmacy space lend themselves well for the marketing and promotion aspects of 'promoting' good health. In New Zealand pharmacies, self-care fact sheets are readily available to provide advice on minor ailments and there are numerous products available to help consumers lose weight, stop smoking or monitor

general health. Research has found that pharmacies can effectively deliver interventions for high-risk conditions such as coronary heart disease, diabetes, hypertension, smoking cessation and alcoholism but the results vary from condition to condition, pharmacy to pharmacy and on the measures used (Blalock, Roberts, Lauffenburger, Thompson, & O'Connor, 2012; Blenkinsopp, Anderson, & Armstrong, 2003; Brown, Portlock & Rutter, 2012). Blalock et al. (2012) reviewed the literature from community pharmacies in the United States on the effectiveness of pharmacist-delivered patient care services. Of 21 articles, 37.3% demonstrated statistically significant and beneficial intervention effects with the strongest support for hypertension and the lowest for lipid control. While this is promising, the implications are that over 60% were not significantly delivering beneficial programmes. Brown et al. (2012) also found that there was good evidence of success for pharmacy delivered services targeting cardiovascular disease, diabetes, hypertension, asthma and smoking cessation but found more research is needed looking at the effectiveness of weight management, substance abuse, sexual health and chronic obstructive pulmonary disease. In contrast, Morrison et al. (2013) in Scotland and Um, Armour, Krass, Gill, & Chaar (2013) in Australia demonstrated community pharmacies can be effective in weight loss management programmes. Health promotion within community pharmacies is also extending to alcohol management. Horsfield, Sheridan and Anderson (2011) showed that there is potential for community pharmacies to provide screening and brief intervention for alcohol consumption in both the UK and New Zealand but there is limited evidence looking at how this would work in practice.

The views of the value of these programmes also vary depending on the perspective (customers, pharmacists or owner) and highlight the issues facing expanding the professionalism of pharmacists. Both consumers and pharmacists report that public health services should remain secondary to medicine related roles such as dispensing in the pharmacy (Eades, Ferguson, & O'Carroll, 2011; Saramunee et al., 2015). Consumers did not expect to receive public health advice at a pharmacy and pharmacists felt there were

barriers to the role of health advisor because of remuneration, time, workloads and physical space issues (Bissell et al., 2008; Eades, et al., 2011; Krska & Morecroft, 2010). While this is not a complete review of health promotion in community pharmacies it is clear there is potential for the community pharmacy to be an effective space for the delivery of some programmes but there are certain caveats. Firstly, many of the reviews on health promotion services compared pharmacies from around the world and that is problematic because training, pharmacy spaces, and pharmacy regulation varies from country to country. Secondly, the measures of success remain inconsistent across studies and the reliance on biomedical measures is concerning. Assessment should include well-being and quality of life. Thirdly, the willingness of both the customer and the pharmacy staff is important. It is important to consider how to deliver the necessary training, and what facilities and time are needed to deliver these programmes. The financial incentives for the pharmacy and the financial implications for the customer also need further discussion. Also by increasing the marketing, promotion and campaigning within health spaces, particularly pharmacies, there is the risk of over-commercialising the space and increasing scepticism over services offered. This is a more of a problem in community pharmacies, compared to medical centres, as pharmacies are already highly marketed retail spaces.

In order for pharmacists to be able to expand their skills and professionalism, they need to have a workspace that allows them to do this. Rapport, Doel and Jerzembel (2009) explored the interaction of the pharmacy space and the professionalism of the pharmacists and identified the dispensary was the most important space for the pharmacists. The dispensary was important to the pharmacist's sense of self, identity and professionalism. Rapport and colleagues (2009) were one of the first research teams to study the consulting room in community pharmacies. The consulting room has been a relatively new development in community pharmacies and is supposed to add a private place to a public shop to conduct medicines reviews and provide advice to consumers for

the pharmacists. In Rapport et al.'s study the consulting rooms were cramped and had multiple uses (including storage) which had the effect of decreasing the effectiveness and the professionalism of the space. Lastly, Rapport and colleagues (2009) found the pharmacists avoided the sales area seeing this area as problematic and not tied to their sense of professionalism. Rapport and colleagues (2009) highlighted how professionalism and space are intrinsically linked in the community pharmacy, but their study focused only on pharmacists, not the other staff.

This research will build on Rapport and colleagues (2009) study and explore how the community pharmacy space in New Zealand influences the pharmacists' professionalism while they work in the dispensary and in other spaces in the community pharmacy. I believe that Rapport's findings may hold true for some pharmacists but the attitude that customers take time away from the core function of dispensing is changing. Many of the new services require the pharmacists to leave the dispensary and it is by interacting with customers that their sense of professional identity will change. Moreover, since Rapport's study in 2009, many pharmacies now have a much more professional looking and dedicated consulting room. This research will therefore explore and develop understandings of any physical and spatial boundaries to expanding the pharmacist's role within the community pharmacy. I will also observe how customers are using the space and the pharmacists, and seek customer views on expanding clinical services for pharmacists. This is important to understand and draw attention to the physical, structural and affective boundaries for staff and customers in the community pharmacy.

Boundary work

This section will address the boundaries and barriers within and to community pharmacies. It is important to understand boundaries and boundary work as they can reveal hierarchies or territories, barriers to service, and the nature of social reality (Peterson, Tanner & Munsie, 2015). It is important to remember that boundaries are

relational, contextual and dynamic and that there may be physical, symbolic, temporal and emotional factors influencing, maintaining or eroding boundaries (Owens, 2015). One way to conceptualise the work people do around boundaries is through boundary work. Gieryn (1983) devised the term boundary work to describe the "discursive practices by which scientists attempt to attribute selected qualities to scientists, scientific methods, and scientific claims" (p. 792). Boundary work in this instance was originally applied to medical and scientific professionals so they could claim professional status. Considerable work goes into constructing and maintaining boundaries within medical environments and Abbott (1998) was particularly interested in boundaries and their relationship to medical professions. Abbott (1998) argued that professions were subject to jurisdictional boundaries, reflected in boundaries of control, zones of work and in a system of relations. This in turn leads to jurisdictional conflicts and barriers related to control. The concept of boundaries is useful when examining professions and looking at how they can be distinguished from one another (Lamont & Molnar, 2002). This of course is particularly relevant in medical professions and healthcare settings such as hospitals where there are many occupations working within the same space. Thus, the main processes by which practitioners negotiate work roles and status hierarchies in health spaces can be defined as 'boundary work' (Apesoa-Varano, 2013). Where there are boundaries there is work done to either maintain or resist these boundaries. Within team environments, particularly where there is an evident hierarchy such as in hospitals, individuals will engage in boundary-defining acts of exclusion in order to construct and maintain distinctions between themselves and others (Barrett, Oborn, Orlikowski, & Yates, 2012). The relevance for pharmacists working in hospital environments is clear and there has been research exploring the specific types of boundary work that these pharmacists use (Barrett et al., 2012: Eaton & Webb, 1979). However, there has been little exploration of boundary work in community pharmacy settings, and none considering all the staff working within the community pharmacy space.

One of the main functions of boundaries is to help create order by classifying individuals and groups by providing clear demarcations between objects, people and space (Shuval, Gross, Ashkenazi & Schachter, 2012). This can lead to a sense of security and comfort as whatever is in the space is contained (Cain, 2011; Lamont & Molnar, 2002). For example, Rapport et al. (2009) suggests that community pharmacists' boundary work is clearly tied to space, as the pharmacists' in their study did not want to leave the dispensary, as this was their professional space and where the objects of their profession were located (Rapport et al., 2009). As such, in the community pharmacy pharmacists will engage in boundary work that maximises their medicinal and clinical work and minimises their retailing role (Barrett et al., 2012; Mossialos et al., 2015). Within the walls of the community pharmacy, the pharmacists are the most powerful medical professionals; boundary work predominantly reinforces their professional status. However, within wider healthcare systems, pharmacists are potentially seen as being on the margins of healthcare because they are on the end of the medicines chain (Hatah, Braund, Duffull, & Tordoff. 2012) which suggests their scientific knowledge is less legitimate than a GP for example (Gidman, Ward & McGregor, 2012; Rubio-Valera et al., 2012). Therefore, it is important to note that boundary work is context specific and complicated in the community pharmacy.

Epstein (1992) suggested that because boundaries were about human relations, they could exclude or admit people, but that there would be rules that enable the boundaries to be crossed. One way that the boundary between science and non-science can be crossed is with a boundary object. Star and Griesemer (1989) defined the boundary object as "an object that lives in multiple social worlds and which has different identities in each" (p. 409). The boundary object can also be simultaneously universal and transferable but also adaptable for specific situations. In the pharmacy, the prescription acts as a powerful boundary object. The prescription has the potential to act as a form of social control, indicate legitimacy of the patient's sick role, act as evidence the pharmacist is doing their job, symbolise the power of the drug industry and technology in medicine and can indicate

the termination of an interaction between pharmacist and patient (Cooper, 2011). Cooper explored whether an electronic prescription can act as a boundary object and found that the actual physicality of a piece of paper acting as the prescription had more legitimacy as a symbol and boundary object than an electronic prescription. Therefore, boundary work and boundaries are important concepts when theorising relationships between power, supply, finances, autonomy of the patient, and surveillance (both of government and pharmacist) in the pharmacy setting.

There is very little research on the boundary work of the other staff in the community pharmacy. This is most likely because of the boundaries around science and medicines that are pervasive and ordinary in the pharmacy. Gieryn (1983) argues that it is important to explore everyday spaces because this is where the world of science is performed and scientific power displayed. However, the boundaries around medicines are largely taken-for-granted in the community pharmacy because the pharmacy acts as the interface between science and non-science (or clinic and shop) for the customer. There are interesting areas in the pharmacy that sell natural medicines that have less scientific credibility. The boundaries around Complementary and Alternative Medicines (CAM) have received some attention in the pharmacy setting (Simmons-Yon, Roth, Vu, Kavalieratos, Weinberger, & Rao, 2012; Ung, Harnett & Hu, 2017). Most of the barriers identified were related to medical uncertainty over effectiveness and lack of training for pharmacists. This highlights how important spatial research is for uncovering assumptions, and taken-for-granted aspects of the community pharmacy.

Therefore, I contend that it is impossible to consider spatial research in community pharmacies (or any space) without considering boundaries and boundary work for three main reasons. Firstly, because of the professional status of the pharmacist and the dispensary there will be jurisdictional boundaries around the pharmacy profession and the dispensary space and it is important to understand what this does to the practice of

community pharmacy. Secondly, due to the nature of space and place there are physical boundaries set up in terms of the community pharmacies building, layout and location that work to include or exclude others. Lastly, space and place is also about the symbolic, mental and social space and boundaries can help contain, control or change the practices. In order to understand the role of community pharmacies one must consider the real, imagined, cultural, social and physical boundaries in community pharmacies as well as consider how these boundaries are being maintained and resisted on a daily basis in the community pharmacy space. These considerations have informed my research methodology in a number of essential ways from helping me frame my research questions, focus my data collection, valuing mapping for data collection, and informing data analysis by highlighting physical and symbolic barriers and borders in the community pharmacy data.

Health ideologies

I have argued that this research will explore the community pharmacy as a socially produced space. I have made a case to uncover the ordinariness of the community pharmacy practices and performances in order to explore taken-for-granted boundaries and power strategies and capture the relationships between people, products and space. It is therefore important to understand the context in which this takes place. For consumers of health there are dominant ideologies shaping health policies and individual practices. Previous sections have highlighted the influence of these factors on the pharmacy space and the pharmacy profession. However, I have not dealt with healthcare as a form of consumption and this next section will address this.

Many would argue that modern healthcare in Western countries is a commodity or product and as such is treated as a commercial industry (Klein, 2010). This suggests the power in healthcare lies with the market or companies with money to promote their products. It also highlights the role media play in promoting health and health products

and leading consumer behaviour (Poe, 2012). On the other hand, health, or rather access to healthcare, is also seen as an individual's basic right, alongside food and housing, and this constructs health as an institution and something that the wider community including governments and the state should be responsible for (Abraham, 2010). The caveat is that the state is trying to manage the health costs of an aging population with more chronic conditions and seemingly, the main way of doing this is to make good health a moral imperative through health promotion, surveillance and governance (Ballantyne, Mirza, Austin, Boon & Fisher, 2011).

There is a strong moral and political environment created by neoliberalism (Cohen, Grote, Pietraszek & Laflamme, 2010). Current health ideologies are framed within neoliberalism, encouraging individuals to be personally responsible for their own health and subjecting unhealthy individuals to blame and health interventions (Klein, 2010). Within this framework, being overweight, and behaving in other risky health ways (such as smoking, not exercising, drinking to excess, and so on) subject the person to judgement. This also makes individual lifestyles worthy of surveillance, measurement (using predominantly medical measures such as weight, blood pressure) and targeted interventions (Gillespie, 2011) and can lead to an internalised sense of governing of self (Ballantyne, 2016). The other implication of the political environment of neoliberalism is the reliance of medicines in healthcare or as Ballantyne (2016) refers to as "medicines proliferation" (p. 1). Within a neoliberal political environment on individualised driven healthcare, pharmaceuticals play an increasingly important role in healthcare. This adds another form of surveillance and policing of individuals taking medicines. As such, community pharmacies, as the depot of these medicines, need further investigation as monitors and controllers of medicines. It is also important to understand how consumers use and resist this control and surveillance.

'Healthism' was a term coined by Crawford (1980) to reflect the modern consumer of health, particularly of the middle-class who have the resources to become information rich

and then do something with this information. Characteristics associated with healthism are high expectations of health professionals, high health literacy, distrust of science and doctors, and favouring 'alternative' lifestyle choices. Greenhalgh and Wessely (2004) suggest that healthism developed in response to widespread commercialisation of health, medicalisation of daily life into areas such as mood, food, leisure, and stress, and increased individual reflexivity and self-awareness. Healthism can increase health anxiety and demand for tests for consumers and challenge medical professionals (Ballantyne, 2016). The other issue with healthism is that not all consumers of health will display these characteristics or have the resources to enact healthism. Certainly, in the pharmacy consumers can source health information about medicines (both natural and orthodox), health promotion activities, monitor their health in a limited manner such as taking their blood pressure and the stage set by the pharmacy is highly commercial.

The other important consideration for the social context of health is the availability of health information via the internet, marketing, and health promotion. Health and medical matters are some of the most popular media items illustrating the strong role media plays in the consumption of health. My research is being conducted in a highly commercial and mediated space and how customers interact and use this aspect of the pharmacy is important to consider. While some media are critical of healthcare systems and structures, the majority reinforce dominant medical ideals and encourage competition and more marketing (Cohen et al., 2010). Certainly, as the medicalisation and pharmaceuticalisation section of this chapter discussed there are strong market forces on medicines and health and healthism highlights how social and contextual health consumption is within a predominantly neoliberal society. Schrecker (2016) argues that whenever neoliberal policies have been implemented around health; economic insecurity and inequality have increased. This then leads to an increased probability of adverse health outcomes because a broad range of social issues are being individualised. Health and poverty are then seen as

individual issues, the result of poor individual choices rather than societal issues and subjects individuals to blame and moral judgements.

Health concepts and constructs can influence the structure of healthcare systems, social power relations, what constitutes an illness and for what conditions you will receive subsidised care (De Maio, 2010; Gabriel & Lang, 2006). However, for consumers of health lay understandings, and performances, of health vary in accordance with individual beliefs, history, culture and available resources (Ballantyne, et al., 2011; Bissell, Ward & Noyce, 2001). Lay beliefs influence all aspects of health consuming from how individuals use medicines, deal with minor ailments, interact with the health system, seek new information, or in effect consume health (Ballantyne et al., 2011; Bissell et al., 2001, Cohen, McCubbin, Collin & Pérodeau, 2001). There has been little change to the idea that health consumerism "emphasises the good life for all, through the individual pursuit of objects to satisfy individual wants" (Eyles, 1987, p. 94, as cited in Kearns & Barnett, 1997). Consumers practice health in a social context that encourages the assumption that the 'correct' consumption of a set of behaviours and purchasing of the right goods and services can ensure good health and prevent ill health (De Maio, 2010). This positions certain groups of people as being more at risk, reinforces dominant health ideologies (such as biomedical paradigms), inequalities (gender, ethnic and economic inequalities), and assumes a rational health consumer, all while emphasising individual responsibility for health. Consumers therefore have to negotiate a complex health system, strong moral and political health discourses, and face unequal access to healthcare. Increasingly research is focusing on the strategies people use to consume in ways unique to their situation. The next section discusses this.

Consumption

The community pharmacy sits within a wider society of health and non-health consumption. In order to understand the pharmacy as a socially produced space it is

important to consider both health and retail consumer practices and theories. Within Western countries, consumer culture is a way of life (McDonald, Gough, Wearing, Deville, 2017). Consumption or consumerism can encompass the production or ways of using things, shopping behaviour, the thought and planning behind purchasing, or on-line experiences (Iqani, 2013). Consumer behaviour research has highlighted that consuming is culturally, socially and politically located (Cochoy, 2008). De Certeau (1984) defined consumption as the "ways of using the products imposed by a dominant economic order" (p. xiii). De Certeau's definition highlights the interactional and social role of the consumer but also the role of power. Researching retail practices can therefore illustrate the wider social and cultural experiences of the consumer while exposing smaller resistances (Woodward, Emmison & Smith, 2000). Healy, Beverland, Oppewal and Sands (2007) suggest the nature of the retail experience should be explored through static and dynamic factors. Static factors include the physical elements of the store and the functional aspects of the product. Dynamic factors relate primarily to the interaction between customer, staff and store. Customer's experiences are shaped by aesthetics, symbolism, personal characteristics and beliefs, store and product brands, and emotions (Healy et al., 2007). The retail or non-health experiences of customers in the pharmacy has received very little attention. This research will explore the customer's health and non-health consumption experiences under the assumption that consumption is a social production (de Certeau, 1984). I will study the complex interactions between the customer, staff and space by considering static and dynamic factors of the experience.

Other consumer research has considered identity, patterns of consumption across gender, ethnicities, and the role of mass media on consumption (Bowlby, 1985; Gabriel & Lang, 2006; Woodward et al., 2000). Fuentes and Hagberg (2013) highlighted how the type of product will influence how it is sold, bought, and consumed (Fuentes & Hagberg, 2013). For example, outdoor products elicit ideas of nature, being active and outdoors. Sporting goods often prompt ideas of performing and being athletic, and daily provisioning such as

grocery shopping is connected to the ideals of family and often is a gendered activity (Fuentes & Hagberg, 2013). This is important within the community pharmacy as medicines are not the only products for sale in the pharmacy.

What Miller (2005), Cochoy (2008) and others have argued for is more of a focus on ordinary shopping because exploring the routine and ordinary objects and tasks involved in shopping can uncover new meanings. Miller (1998) suggests that ordinary consumption is about social relationships and love. In an ethnographic study of supermarkets, Cochoy showed how the mundane objects such as supermarket trolleys, price tags and shelves had an impact on the shopping and consumption practices of the shoppers. The interaction between space, people and artefacts created meaning for the customers (Cochoy, 2008). In addition, de Certeau (1984) would argue that studying the everyday has the potential to expose tactics of power and resistance. This is important in the community pharmacy for both health and non-health consumption as there are strong dominant health and beauty ideologies within a highly mediated retail environment. My research will investigate all types of consumption within a community pharmacy including how the consumers use the entire community pharmacy. In particular, I will consider the intersections between customers, pharmacy services and products, and staff. This should uncover the strategies used by the customers to personalise the pharmacy experience and highlight any resistances to the marketing and dominant forces.

Community pharmacies are spaces of consumption imbued with power differentials (de Certeau, 1984; Lefebvre, 1991). Consumers in community pharmacies have some power and may influence the product choice, advocate for certain prescription medications or alternative medications to be stocked, thereby directly influencing the community pharmacy. However, the pharmacy staff also attempt to change customer behaviour through medicalising, selling and informing customers. Hibbert et al. (2002) suggest the role of the pharmacist is to transform an object (drug) into a social object (medicine) but

this process is complicated by consumer choice and lay expert knowledge. In a commercial transaction, such as the sale of medicines to treat minor ailments, customer expertise creates a boundary to the pharmacist who is attempting to transform objects. This changes when the product is a prescription medicine because the power lies more strongly with the pharmacist (Hibbert et al., 2002). Thus, there is a complexity to exploring customer's experiences in the pharmacy because of the range of products.

Pettinger (2004) found that retail sales assistants in pharmacies also play an important role in consumers' behaviour and suggests retail staff work to increase the desirability of the products and transform sales transactions into health conversations. This raises an interesting paradox in pharmacies based on the role of the customer in the pharmacy and their purpose in the pharmacy. If the customers are treated as 'retail' consumers then the assumption is that the customer is always right and can purchase what they want and they have all the power but the power of the customer decreases in interactions involving controlled medicines. When the customer seeks medicines particularly with general sale medicines where the customer needs guidance, the pharmacy staff have a difficult role in guiding the customer. Van Eikenhorst et al., (2017) found the 'right consumption' of medicines or of other products included issues of risk management, such as dosage, interactions, or potential abuse. Van Eikenhorst et al., (2017) also found that if a customer came in with a request for a specific type of medicine this was potentially problematic because of the possibility for misuse. In this instance, having high medicines and health literacy was seen as both a problem and a positive depending on the customer. This example also shows the interactional nature of consuming in the pharmacy for the products or services consumed.

For customers the consumption experience can also be a personal occurrence with emotional significance (Arnould & Thompson, 2005; Miller, 1998). Other research on shopping experiences has highlighted that shopping is a visual, embodied and meaningful

experience (Gorman, 2017; Iqani, 2011, 2013). Of course, not all consumption is pleasurable and can be a chore such as food shopping. There are many contradictions of consumption, which Goss (2006) summarises as emotion versus logic. For example, when logic over cost and functionality battles with excitement over purchases. The other complicating factor is that consumers are exposed to images, media, marketing and sales constantly in the age of technology so consuming is a visual and hyper mediated experience (Elias, Gill, & Scharff, 2017). This has led to some retail sites aiming for a spectacular experience (e.g., Nike Town - Penaloza, 1998; Mall of America – Goss, 1999). There is no doubt that retail displays and spaces are part of a hyper visible physical and virtual world and Witz, Warhurst and Nickson (2003) suggests organisations use aesthetics as symbols to affect how people feel, add value and to differentiate themselves. Arnold, Kozinets, & Handelman (2001) found Walmart advertising aimed for the idealised version of hometown America. This study did not explore if customers agreed with this symbolic representation but rather point to the role of media in creating brand experiences. There are also gendered differences in how customers shop and engage with spaces. Borges, Babin & Spielmason (2013) showed that women favour hedonic or pleasurable retail atmospheres compared to men who prefer utilitarian atmospheres. In addition, Borges and colleagues (2013) found that women would spend more money in a store with an enjoyable and pleasant feel.

Other factors such as workers' appearance also influence the shopping experience (Foster & Resnick, 2013). Foster and Resnick (2013) showed that matching the age and gender (and to a lesser degree race and ethnicity) of customer-facing staff changed the evaluations of customers in retail encounters. In particular, interactions that involved staff and customers with matching characteristic lead to the customers being happier with the experience because they perceived the communication was better and the staff more trust-worthy. Foster and Resnick (2013) do discuss that this finding is complicated and conditional as the research was conducted using primarily feminine products. Interactions

for more high involvement products also changed the values expected with technical skills being valued over appearance in these instances.

Retail spaces are perhaps the archetypal site of visual consumption where the display of commodities, the atmosphere and store aesthetic are as much part of the consumption experience as actual material purchases (Iqani, 2013). While there has been research in the community pharmacy that has identified that store atmosphere influences customer satisfaction, there is minimal research that has explored the complete visual, sensory and embodied consumption experience in community pharmacies. The next section discusses the consumer research from pharmacies.

Consumer behaviour in community pharmacies

There is extensive research that considers individual consumer behaviours within pharmacies and unsurprisingly the dominant focus of this is on medicines use. These studies highlight that individuals will use the pharmacy differently depending on gender, age, ethnicity, health need, and type of medicine sought (Buurma et al., 2008; Chan & Tran, 2016; Kohli & Buller, 2014; Merks, Kaźmierczak, Olszewska, Koltowska-Häggström, 2014). For example, females of reproductive age are dispensed more medications for a wide range of medications including antibiotics, antihistamines, antidepressants, and diuretics (Anthony et al., 2008). Consumer interaction with the physical elements of the pharmacy has also been explored. Pharmacy location, opening hours, convenience, services on offer, loyalty programmes and store environment have all been shown to influence customers perceived value, trust in the staff, and satisfaction with service (Kevrekidis, Minarikova, Markos, Malovecka & Minarik, 2018; Rabbanee, Burford, & Ramaseshan, 2014).

The main research in consumer behaviour in community pharmacies is typically focused on the purchasing behaviour with regards to different types of medicines such as CAM (Braun et al., 2010; Dodds, Bulmer & Murphy, 2014), Over-the-Counter OTC (Chan & Tran, 2016; Kevrekidis et al., 2016; Kohli & Buller, 2014) and pharmacy-only and pharmacist

only medicines. The research on pharmacy-only or pharmacist-only medications focuses on safety and if pharmacy staff are fulfilling professional and legal requirements (Gauld, Emmerton, Kelly, & Buetow, 2012). Some studies have used mystery shopper scenarios, usually to explore how the staff sell controlled medications and if the advice they give is appropriate (Collins et al., 2017). Hibbert et al. (2002), in discussions with customers about OTC use, found the customer focused on the benefits of medicines, not the risks – if the product was on the shelf on the shop floor, it was perceived to be safe for consumption. Lastly, research focusing on customers' understandings of medicines, including generic substitutions, pricing, labelling and branding, advertising, and safety, reveals that there is confusion around generic substitutions, that customers have varying degrees of brand loyalty to a medicine, and that packaging and labelling influences customers purchasing habits (Babar et al., 2011; Kohli & Buller, 2013). Figueiras, Cortes, Marcelino, & Weinman (2010) found that the seriousness of the label determined how lay people perceived the effectiveness of the medication. These studies highlight how the different classes of medicines influence both staff and customer behaviours. Van Eikenhourst, Salema and Anderson (2016) in a systematic review of the supply of medicines found customers valued staff performance and professional knowledge the highest. Professional knowledge included communication skills, interpersonal skills, practical skills and medical knowledge.

There is an increasing amount of research on what customer's value when using a community pharmacy (Castaldo, Grosso, Mallarini, & Rindone, 2016). Wood and colleagues (2015) used focus groups with older adults to explore what they value when using the community pharmacy. For older adults, pharmacy location, extra services such as home delivery, consistent supply of medicines and relationship and trust in the staff were the most important. Guhl, Blankart and Stargardt (2018) administered surveys about perceived customer value in pharmacies, to random people on the streets of Hamburg, Germany. Guhl and colleagues found customers valued personal interaction, physical

aspects of the pharmacy, reliability of the pharmacist and the pharmacy, store policy, professional consultation, availability and accessibility, product quality, fairness of price, satisfaction and loyalty. Interestingly the most significant elements of value were in interactions with staff and included waiting time, honesty, politeness, and time spent with the customer. This was valued over cost, store policy and medicines for sale. These two examples illustrated that it is not one simple characteristic that is important in understanding community pharmacy use as customer value depends on individual, physical and affective factors.

Gavilan, Avello and Abril (2014) completed one of the studies that has considered retail, health and medicines use by customers in community pharmacies. Gavilan et al., (2014) identified that community pharmacies are being used for a complete experience rather than just medicines. Both functional and affective elements were important to customers satisfaction, number of products bought and number of visits. Functional factors included the physical space (location, layout, displays, marketing, staffing), and products including availability, type and cost. Store environment, atmosphere and communication were also important for customers to develop loyalty to a pharmacy. Affective elements that lead to changes in consumer behaviour included emotions such as trust, satisfaction and value, relationships with staff and the space, and aesthetics of the staff and space. Interestingly, experiences that were more pleasurable led to a "shopping cycle" (p. 9) which was seen as a positive sign that the pharmacy was embracing health and wellness and offering a complete experience. There are limitations of this research because the study was done in Spain so cannot be generalised to New Zealand. In addition, data was collected via a self-reported questionnaire meaning customers were not observed or interviewed. Gavilan and colleagues (2014) were also interested in how pharmacies can increase sales through shopper marketing rather than understanding how and if health and non-health experiences differ. While it is positive to see research highlighting the complete pharmacy experience, there are still gaps in this area.

The other problem is the differences in how loyalty, value and satisfaction are measured. Loyalty and customers' behaviours can change depending on the product or customer. It is of note that the prevailing method of researching consumer behaviour in many pharmacy consumer studies is survey research. There is little research that explores the in-depth experiences of the customers and very little the full range of experiences in a pharmacy. Kairuz, Bellamy, Lord, Ostini, and Emmerton, (2013) did a study using interview to see what customers value but they only talked to the pharmacy staff and not the actual customers. In addition, most of this research has been conducted overseas and not in New Zealand. There is a clear need to understand how New Zealand consumers are using community pharmacies.

In New Zealand, there are specific population differences in health outcomes, health usage and medication use, particularly for Māori (Norris, 2002). Norris (2002) found that there was regional variation in pharmacy services across New Zealand, particularly in areas that had potentially higher health needs. In particular, there was a tendency to provide less counselling in areas with higher socio economic deprivation and more Māori, which was concerning. In contrast, Green, Brown, Burgess, Chong, & Pewhairangi (2012) investigated the interactions between pharmacy staff and customers with a focus on Māori. Green and colleagues (2012) did not find a significant difference in consultation time for Māori but did find that men and Māori and Pacific people were more likely to use the pharmacy as a 'prescription depot' and less likely to buy over-the-counter medications. Norris, Horsburgh, Sides, Ram and Fraser (2014) also identified that there is poorer geographical access to pharmacies in rural areas and that the total number of pharmacies in New Zealand has not increased from 1995-2010. This suggests fewer community pharmacies are servicing more people as the population of New Zealand continues to rise.

While this research is not specifically investigating rural pharmacies or Māori, it is important to consider the context in which community pharmacies in New Zealand

operate and acknowledge there are people that may be more vulnerable than others. Moreover, it is important to identify barriers to community pharmacy access that ethnographically inspired methods may uncover that statistical analysis would not. In addition, this research is only considering branded pharmacies and there is no research to date that has used this group of pharmacies in New Zealand.

I finish this section by summing up the main elements I consider important to understand consumption in the community pharmacy. There are common elements to most retail and consumption research that apply to the community pharmacy. Firstly, shopping and consuming is an individualised experience that may or may not be enjoyable. Secondly, the environment in which it takes place is important and this may include online spaces. Thirdly, the interaction with staff will be important. Fourthly, the consumer is being controlled and manipulated via marketing, atmosphere, and work practices, and the customer knows and resists this. Lastly, the product being consumed is important. This is what makes the community pharmacy so interesting and worth investigating; the mix of health and shopping experiences on offer, the range of services and products, and the different atmospheres in each pharmacy.

The community pharmacy is a complex hybrid space with intertwined networks of practice, expertise and advice, and pharmacy customers are not passive users in the pharmacy nor are they passive in relation to dominant neoliberal health or beauty ideologies (Dew et al., 2014). Customers actively and tactically engage with and resist many established rules and ideals in community pharmacies and it is by attending to these, as de Certeau (1984) would argue, that I can analyse the micro-subversive power tactics. For de Certeau consumption is active and productive. This research therefore explores the active processes of production of medication, beauty, and other practices. There has also been very limited research on the community pharmacy staff other than pharmacists and limited research on customer's experiences with products other than

medicines. To explore the complexity of the community pharmacy I used ethnographic methodologies that incorporated non-participant observation, interviews with staff and customers, visual and aesthetic data, and embodied reflections and field notes.

In conclusion, a strong moral and political neoliberal health ideology that emphasises individual responsibility shapes customers health experiences in the community pharmacy. However, this sits alongside an equally strong market economy driving both health and non-health consumption. The community pharmacy is a unique space for consumers where both functional and affective elements influence consumption experiences. This research will explore the complete range of experiences for customers in the community pharmacy focusing on the interaction of the customers with the space, people and products.

Summary

There has been extensive research on pharmacists and customers of pharmacies but very limited research using the pharmacy site or space as the primary focus. In addition, there has been limited research on pharmacy staff other than pharmacists. This research will use social constructionism as the underlying epistemology with key theoretical ideas from spatial theory, consumerism, and professionalism alongside the use of multiple qualitative methods. Burr (2015) suggests there is no one definition of social constructionism but rather a set of assumptions that underpin the concept. The first assumption is that social constructionists take a "critical stance towards taken-for granted knowledge" (p. 2) and challenge the idea that one can objectively define and measure behaviour. The next assumption that underpins social constructionism is that it is important to consider historic and cultural contexts as social and economic conditions will influence dominant ways of knowledge production. Thirdly, within social constructionism knowledge is sustained by social process or through interactions with each other. This then suggests that language will be important in understanding the world. Lastly, Burr contends that

within social constructionism knowledge and social action are intertwined so it important to consider power. In summary, Burr (2015) suggests people are the products of social processes and that there is no one objective truth but rather multiple realities situated within contexts.

This will allow a unique and in-depth exploration of community pharmacies in urban New Zealand. There is a complexity when investigating spaces as they are socially produced, relational and full of potential meanings. People and objects bring meaning to the space and this research aims to see how people and objects change the space, how the space changes them, does it exclude them in any way or include them, what does this mean for the people and objects when they are in the space and when they leave the space. The community pharmacy is particularly complex as it is a healthcare space (with dominant health ideologies) and a retail space (with consumer culture) all playing a part in creating pharmacy meanings. This research will explore the community pharmacy as a socially produced hybrid space with a particular focus on the intersections of customers, staff and space practices and performances.

Chapter Two

Pharmacies in New Zealand

It is important to understand the context in which this research was undertaken and how community pharmacies fit into New Zealand's health system as each country has different regulations for the pharmacy profession, the pharmacy space and the different types of medicines. This chapter will begin with a brief look at historical New Zealand pharmacies as this has influenced existing New Zealand pharmacies. The chapter will then describe how community pharmacies work within the New Zealand health system. I discuss the many pharmacy regulations to understand the regulatory, political and structural constraints on the community pharmacies. Lastly, I outline the aims of the research and the structure of the thesis.

Historical New Zealand pharmacies

In pioneer communities, the pharmacist was a leader in the community and it was a mark of success when a chemist opened a shop in town (Frost, 2010). Frost (2010) describes how the local pharmacist historically was the first point of call for all those seeking medical advice and the doctor (usually situated in an office in the back of the shop) would get referrals from the pharmacist. This changed in 1938 with the introduction of the Social Security Act in New Zealand. Under this Act, the New Zealand Government paid for subsidised or free medicines prescribed by a doctor and made visits to the doctor more affordable. This resulted in a dramatic shift away from the pharmacist being the first point of call for medical advice and made the pharmacist dependent on the doctors rather than the other way around (Frost, 2010).

One of the initial questions that inspired this research was "why do pharmacies sell things other than medicines?". Chemists in New Zealand have always stored and sold non-medical consumables (Perepelkin & Findlay, 2009). An advertisement from 1876 for a community pharmacy in New Zealand advertised drugs, chemicals, homeopathic medicines, stationery, prayer books, musical instruments, tobacco, and mineral water (Frost, 2010). Early pharmacists or druggists also stocked infant foods, optical goods, toiletry products and veterinary preparations (Zam, 2012) and as early as the 1920's pharmacies did photographic processing (Frost, 2010). The distance from the wider world and limited shops in early New Zealand meant that pharmacies were traditionally like general stores and quite similar in design across New Zealand. There were also limited options available for shop owners in terms of shop-fittings, medicine ingredients and other stock because everything was usually shipped from England (Frost, 2010).

Early pharmacists made all their drugs on their premises and this influenced the name of early pharmacies - Chemists (Frost, 2010). This was in-line with the Galen principle where recipes for drugs and formulas were secret and guarded. The change from the Galen principle to proprietary medicine meant that many of the drugs were manufactured off-site (Frost, 2010). Formulas became the property of drug companies rather than individual pharmacists. This had enormous implications for these early pharmacists in terms of what they sold and how the pharmacy had to operate to make a living. In sum, New Zealand pharmacies have a long history of being a combination of general store and healthcare site due to location, policy, and commercial need. All these factors are also important when considering current community pharmacies.

New Zealand's healthcare system

Healthcare in New Zealand is a mixture of public and private care; however, the predominant model is one of government-funded healthcare (Ministry of Health, 2017). Healthcare is delivered through publicly funded payers and contracted services via a

public hospital system and privately owned medical and pharmacy practices. The physicians in primary care are affiliated with Primary Health Organizations (PHO) and consumers are strongly encouraged to register with a PHO (Ministry of Health, 2014). District Health Boards (DHB's) provide population health services and manage secondary and tertiary care services. DHB's also contract with the PHO's and other primary care providers so that consumers registered with PHO's pay a partially subsided fee-for-service (Harrison et al., 2012). Community pharmacies and pharmacists are part of this complex integrated healthcare system. Until recently community pharmacies contracted directly with the DHB's based on a fee-for-service model (Harrison et al., 2012) but the model has moved to a combination fee-for-service and patient-centred funding to capture the additional services pharmacists now offer beyond dispensing (Central Technical Advisory Service, 2017). Thus, pharmacists in New Zealand claim government subsidies for dispensing subsidised medicines and then additional fees for other clinical services.

The community pharmacy in New Zealand

There are approximately 900 licenced pharmacies in New Zealand (Pharmacy Council of New Zealand, 2016). In 2017, there were 3718 registered pharmacists, 65% were women and 46% were 35 years or younger (Pharmacy Council, 2017). Of these pharmacists, 73% work within community settings, 12.6% in hospital settings and the rest in a variety of settings (Pharmacy Council, 2017). In New Zealand, under current legislation, a pharmacist must own at least 51% and no one person can own more than five community pharmacies (Ministry of Health, 2010). Some pharmacies are managed and owned by the same person, some community pharmacies have absent owners with managers (typically pharmacists) and some of the branded pharmacies have 100% ownership by Green Cross Health (with business managers in place to run the pharmacy and a dispensary manager who is a pharmacist). The pharmacist manager is responsible to the owner for all aspects of the business from human resources, financial performance, planning and enforcement of current pharmacy policies, procedures and legislation (Al-Arifi, 2013). Owners take on

the financial risk and Al-Arifi (2013) would argue that owners want to play an important role in the community. Green Cross Health has some control over all the pharmacies under their brand.

There are two different types of community pharmacies in New Zealand: independent and branded community pharmacies. Branded pharmacies prior to 2014 were marketed under the following names: Life, Amcal, Care, Radius, and Unichem, under the company Pharmacy Brands. Pharmacy Brands was a retail pharmacy group whose aim was providing "merchandising, marketing, operational support and professional services to independent pharmacies operating under their brand" (Pharmacy Brands, 2012). There was a spectrum across these five brands that reflected the level of health related services and dispensing business. At one end of the spectrum was Life Pharmacy, which tended to have cosmetic stands and perfume for sale in the front of the store (Pharmacy Brands, 2012). In comparison, at the other end of the spectrum was Care Pharmacies whose focus was on providing healthcare advice and marketed itself as a "healthcare coach" (Pharmacy Brands, 2012). Pharmacy Brands was renamed Green Cross Health in April of 2014 and over the course of 2014-2015 the five brands were collapsed into two – Life and Unichem – and the look of these pharmacies changed across New Zealand (Figure 3 - the images used in Figure 3 are of pharmacies I did not use in this research). The reasons given for re-branding by the CEO of Green Cross Health were to create a better support structure for the pharmacies and because having the five brands was considered unnecessary "as they were not that different" (Dunn, 2016). The four specific pharmacies I used in this research were two Life and two Unichem pharmacies located on the North Shore of Auckland, New Zealand.

Figure 3: Rebranding of Unichem and Life pharmacies from 2014 to 2017

Currently, Green Cross Health supports a network of around 354 pharmacies (63 Life and 291 Unichem), 40 medical centres and provides community-nursing services throughout New Zealand (Green Cross Health, 2017). The pharmacy ownership regulations apply to Green Cross Health, so they have up to 49% holding in most of their pharmacies. Over 50 million prescriptions for medicines are dispensed each year in New Zealand (Pharmacy Council, 2017) and Green Cross indicated in their 2017 annual report that they dispensed 31.2 million items (Green Cross Health, 2017). In summary, Green Cross has an operating interest in over a third of current licenced pharmacies, and reports delivering approximately 61% of all dispensed items, however they own 100% of only three trading pharmacies (Green Cross Health, 2017).

There are clear demarcations in terms of how Life and Unichem pharmacies look, feel, and market themselves and in where they make the bulk of their profit, including dispensing. Green Cross Health (Dunn, 2016) reported a 60-40 dispensing/retail split for Unichem and the reverse for Life (i.e. 40-60) but of course, this was an average across all branded pharmacies in New Zealand. Since re-branding, Green Cross Health has made subtle

changes in their marketing from 2014 to 2017, although the pharmacy logos have remained the same. The marketing strategies show the differentiation between Life and Unichem (Table 1). The slogans in Table 1 were taken directly from Green Cross Health annual reports in 2014 and 2017. While the distinctions between the brands remain clear (Life – health and beauty, Unichem – health and family), Life pharmacies are marketed more as prestige pharmacies (indulgence, luxury) and Unichem have retained the family aspect with health clearly being emphasised. I therefore argue that there still is a spectrum of branded community pharmacies, just a more distinct spectrum with two defining points. It is also clear that Green Cross Health is a driving force in pharmacies in New Zealand.

Table 1: Green Cross Health, Life, and Unichem pharmacies marketing (2014 and 2017)

Logo	2014	2017
GREEN CROSS HEALTH	We are passionately committed to owning the health and wellness conversation with our communities. We believe in complete well-being, looking good and feeling great.	We believe easy access to good healthcare is a right of everyone in New Zealand. You'll always find the professional care and advice you need at your local pharmacy. We're here to help with all your health, wellness and beauty needs. Come on in.
life Pharmacy	Life Pharmacies are shopping destinations for people who want to look and feel great. "Life Pharmacy – Beauty and Healthcare for Life"	At Life Pharmacy, you'll find a full range of health, wellness and beauty products to keep you looking good and feeling great. Our Life Pharmacy stores also offer a touch of indulgence, with prestige beauty products and the convenience of health and beauty services in store
Unichem	Unichem provides advice, care, service and products to your family.	With a presence in New Zealand communities since the early 1980's, Unichem is your local health professional. Unichem offers care + advice, products and services which you, and your family, can trust for all your health and wellness needs.

Regulations

The pharmacy profession is subject to multiple regulations making it one of the most tightly controlled industries. There are regulations around dispensing, prescribing, advertising, the pharmacy premises, licensing and pharmacy ownership, medicines storage, packaging and labelling, who can sell what medicines, consumer guarantees, ethics, and privacy information (Ram & Chesney, 2011). I will briefly cover the regulations for staff and for medicines.

Professional practice regulations

Pharmacists are regulated during their training and once they are practicing, regardless of where they work; in a hospital, community or other setting. The entry-level qualification for a pharmacist in New Zealand is a 4-year Bachelor's degree with an emphasis on applied therapeutics and patient-centred care (Harrison et al., 2012). Upon graduating, pharmacists have to complete an intern year. The purpose of this year is practice-based training and successful completion of a competence-based assessment. The intern must pass successfully before they are eligible for registration as a pharmacist. Once registered, all pharmacists must undertake audited continuing professional development to retain their annual practising certificate (Pharmacy Council, 2007).

There are a large number of organisations that promote, support and monitor pharmacists and pharmacies. The Pharmaceutical Society of New Zealand manages the on-going support and training of pharmacists in New Zealand. The society describes their role as "professional support, advocacy and professional development" (Pharmaceutical Society, 2017). The Pharmacy Council of New Zealand is a regulatory agency whose role is to protect the public by making sure that pharmacists are fit to practice and competent (Pharmacy Council, 2017). The Pharmacy Guild of New Zealand is a membership organisation, which provides professional and financial services and support to community pharmacy proprietors (Pharmacy Guild, 2017). Whilst pharmacist prescribing

has been a reality in the UK for a number of years, New Zealand has only recently responded to increasing demands of health services by increasing the scope of pharmacists to be able to prescribe. The first prescribing course began in 2012, by both the University of Auckland and University of Otago pharmacy schools. These pharmacists are now able to prescribe within a collaborative team environment but not in retail pharmacies. As of August 2016, there were 18 prescriber pharmacists (Ministry of Health, 2017).

Pharmacy technicians handle medications and work in the dispensary. Technicians are trained at one of four training institutes within New Zealand (Pharmaceutical Society, 2017). The technicians and pharmacist interns frequently compile the bulk of prescriptions; however, the pharmacist checks their work. In 2016, the Ministry of Health approved a new role for technicians – Pharmacy Accuracy Checking Technicians. The main role of the checking technician is to do the final accuracy check; checking labelling and whether the correct medicine matches the prescription, but the clinical check remains with the pharmacist (Napier et al., 2018). The aim of this move is to free the pharmacists to spend more time out of the dispensary with customers, performing clinical services such as medicines reviews (Pharmaceutical Society, 2017).

Community pharmacies also have retail staff members (also known as sales assistants, pharmacy assistants or medicine counter assistants) that staff the retail or shop end of the pharmacy. While they have no formal training requirements, many of these people have extensive on-the-job training in specialised areas such as beauty, natural and complementary medicines, or over-the-counter medicines. Quite often, the customer will only interact with a retail staff member and may never see a pharmacist in the shop depending on the management of the pharmacy.

Medicines

Medications have a range of different classifications in New Zealand. They are either: prescription-only, restricted (i.e. pharmacist-only), pharmacy-only, or available for general sale. Some prescription-only medicines have further restrictions on supply and are known as Controlled Drugs (Ram & Chesney, 2011; Ministry of Health, 2014). Controlled drugs contain ingredients scheduled as 'Controlled Drugs' under the MisUse of Drugs Act 1975 (Ministry of Health, 2017). Certain medications, classed as general sale medicines, are available in supermarkets, petrol stations, and so on. Any medication that is available without a prescription is an OTC medication. These types of medications are readily available, generally considered safe, and there are usually generic brands so consumers have a choice of what they buy. Medicines classification depends on medicines ingredients, pack size, dose form, and labelling (Medsafe, 2017). Pharmacy-only medicines require the customer to interact with pharmacy staff in order to purchase them. Pharmacist-only medicines require the person to consult with the pharmacists and personal information is recorded. There has been an increasing amount of medicines being re-classified from one category to another in New Zealand which has implications for pharmacies and the public (Gauld, Kelly, Emmerton & Buetow, 2015). For example, prescription oral contraceptives have recently been reclassified so now women prescribed with oral contraceptives in the last three years can access repeats directly from the pharmacy (Gauld, 2018; Pharmaceutical Society, 2017).

In New Zealand, the cost of the subsided prescription medication to the consumer is $5 but it is free for children under 13 years (Ministry of Health, 2017). Obtaining prescriptions requires a doctor's visit which has a higher cost again (anywhere from $20-$100 depending on whether the person is registered with the medical practice) and again children 13 and under are free. After 20 prescriptions, for a patient and/or family, the patient will receive a Pharmaceutical Subsidy card, which means all subsidised prescriptions are free until February of the following year. If the medicines are not

subsidised then there may be an additional cost to the consumer regardless of whether the medicine is prescribed or not (Ministry of Health, 2014). There are also community services cards for low-income users and high user health cards for patients who use the health system regularly for a specific health purpose. These cards decrease health services costs, such as GP visits (Ministry of Health, 2017).

In New Zealand, Medsafe is the regulatory authority for approving new pharmaceuticals and generic medicines (Ministry of Health, 2017). Medsafe is also the regulatory agency responsible for classifying medicines (i.e. deciding which should be prescription only, pharmacist only etc.), and overseeing pharmacovigilance activities in New Zealand (Medsafe, 2015). Medicine importers and manufacturers have a statutory obligation (under section 41 of the Medicines Act 1981) to report untoward effects of medicines to the Director-General of Health. While, Medsafe is the authority that ensures the safety of medicines, Medsafe relies on doctors, pharmacists, pharmacies and the public to report side effects and problems with medicines (Ministry of Health, 2017).

In contrast to this, Medicines Control is a regulatory team within the Ministry of Health (formerly situated in Medsafe) that oversees the local distribution chain of medicines and controlled drugs within New Zealand. The Director-General of Health has delegated certain legislated powers and functions to Medicines Control. The medicines control team issues licences and authorities, undertakes drug abuse containment activities and monitors compliance with legislation - in particular, the Medicines Act 1981, Medicines Regulations 1984, the Misuse of Drugs Act 1975 and the Misuse of Drugs Regulations 1977 (Ministry of Health, 2014).

PHARMAC, the Pharmaceutical Management Agency, is the government agency that determines what medicines will be publicly funded. PHARMAC also oversees the DHB's spending on vaccines, cancer, community, and other medicines (PHARMAC, 2017). PHARMAC also makes decisions on some medical devices, hospital medicines, and

haemophilia treatments (PHARMAC, 2017). PHARMAC's primary role is managing the Pharmaceutical Schedule within a fixed combined pharmaceutical budget (PHARMAC, 2016). The pharmaceutical schedule outlines funding decisions and funded or subsidised medicines. PHARMAC negotiate the budget each year and decides, in consultation with other funders, what medicines to include in the Schedule and under what rules. PHARMAC is not a national medicines buyer, it does not actually purchase medicines, nor does it stock or distribute them (with rare exceptions). These functions are undertaken by other organisations.

The Ministry of Health produces the Community Pharmacy Services Agreement (CPSA), which outlines the service objectives for pharmacy-specific services (Central Technical Advisory Service, 2017). The CPSA includes: (a) the Pharmaceutical Schedule; (b) the Pharmaceutical Transactions Data Specification; (c) the Procedures Manual; and (d) the LTC Pharmacy Services Protocol (Ministry of Health, 2014). A new CPSA came into effect in July 2012 but this agreement is due to expire in 2018 and it is currently being renegotiated. The current agreement is between individual community pharmacies and their relevant DHB with the overall goal of national consistency (Central Technical Advisory Service, 2017). The pharmacy's specific services include dispensing, provision of advice and counselling, maintaining service user records, reporting (significant findings and abuse), and administration. The community pharmacy also must comply with service objectives around supplying bulk orders, NRT (Nicotine Replacement Therapy) and assessment, and other aspects of LTC pharmacy service. A community pharmacy must supply the specific services and LTC services but may choose which additional services they will provide (Central Technical Advisory Service, 2017). Additional specific pharmacy services are subject to their own regulations (also found in the CPSA) which must be complied with and include services such as methadone or special food services.

The LTC Service was designed so pharmacists could assist patients on long-term regimes and those with poor medication adherence to better self-manage (Central Technical Advisory Service, 2017). Pharmacists assess eligibility, register those who meet the criteria and work with the patient and prescriber to improve both clinical and financial outcomes. The LTC pharmacy services agreement is included within the CPSA and pharmacies now must include LTC services in order to receive a CPSA contract (Smith, Scahill, Harrison, Carroll, & Medlicott, 2018). The LTC also has its own services protocol and these protocols cover assessment, eligibility criteria, approvals process, essential LTC services, handovers, periodic assessment, and exit criteria and procedures (Central Technical Advisory Service, 2017). The LTC services protocol was rolled out in April 2013.

Within New Zealand, in 2007, some of the DHB's began funding Medicines Use Reviews. Community pharmacists deliver this service and aim to increase patients' understanding of their medicines and to address adherence issues (Pharmaceutical Society, 2017). Hatah, Tordoff, Duffull, & Braund (2014) describe Medicines Use Review as being "free to patients who are at high risk of medication misadventure such as those with chronic disease or patients who use five or more medications" (p. 186). Pharmacists must be accredited to conduct these services and the pharmacy is funded for up to four consultations per patient per year. This type of Medicines Use Review is not a clinical review and is intended to increase adherence to a drug regime rather than determine if the regime is clinically appropriate. More clinical medication reviews – Medicines Therapy Assessments also require accreditation but are less common in community pharmacy settings in New Zealand. Medicines Therapy Assessments are similar to Clinical Medication Reviews in the UK or Home Medicines Reviews in Australia (McDonald, Cheraghi-Sohi, Sanders, & Ashcroft, 2010). Other accredited courses on offer for pharmacists include emergency contraceptive pills, Trimethoprim (antibiotic primarily used for bladder infections), and Community Pharmacy Anti-coagulation Management Service (Pharmaceutical Society, 2017).

The recent introduction of a set of national standards, LTC protocols and patient-centred medicines management within New Zealand makes this an interesting time to explore community pharmacies. The system wide approach New Zealand has taken with the new Community Pharmacy Services Agreement has seen a major shift to a patient-centred model of reimbursement arguably one of the biggest reforms in pharmacy for over 70 years (Smith et al., 2018). These changes are also being reflected in future policies and health strategies from DHBs for an integrated pharmacist service that will support New Zealand's Health Strategy and the Pharmacy Action Plan (Central Technical Advisory Service, 2017). It is extremely positive to see pharmacists' skills being recognised and valued for all their medication expertise rather than just dispensing. However, in a recent review of New Zealand community pharmacies, Smith and colleagues (2018) identified there are on-going barriers to delivery of these expanded skills including staff availability and costs. Interestingly, in this review the two highest ranked tasks by the pharmacies were for non-funded services including education and advice giving on prescription and OTC medicines. Thus, while it is promising that there are now prescribing pharmacists and that pharmacists can get remuneration for services other than dispensing, there continues to be obstacles to implementing the CPSA in practice. What this means for the pharmacy space, all the pharmacy staff, and the consumer will be more evident as time goes on and these services become more commonplace.

Summary and research aims

The overall aim of this research is to explore the community pharmacy as a complex hybrid space. The community pharmacy works within a complex health system and is highly regulated, however, the pharmacy is also situated as a retail space. In order to explore the community pharmacy as a socially constructed space, it is important to consider the physical and material elements of the pharmacy space (including aesthetics), the social interactions between people and place and the symbolic meanings of the community pharmacy. This requires a flexible methodology so I plan to use ethnography,

specifically non-participant observation, mapping, taking images, and interviews. I will primarily focus on four branded community pharmacies – two Life and two Unichem – as there are distinct differences in how these two brands of pharmacy spaces are utilised and marketed in New Zealand.

There are a series of objectives to address the overall aim. The community pharmacy is a complex hybrid space with multiple purposes and the research objectives reflect this complexity. The first objective is to understand pharmacies and to explore the differences and similarities between the four branded pharmacies in look, practice, and performance. The second objective of this research is to examine the pharmacy as a complex space with different sub-spaces within the pharmacy. I anticipate that all spaces from dispensary through to beauty spaces contribute to the social production of pharmacy. Meaning will be created by and with the space and the people who use the space. The third objective is to investigate the role of all the staff in the pharmacy, focusing particularly on professionalism and boundaries. The fourth objective is to explore the role of the customer on and within the community pharmacy. The last objective is to consider the interaction of the pharmacy space, objects, and people (both staff and customers) in order to understand the production and range of performances of the branded community pharmacy.

In summary, this research is important as there has been minimal research that has used spatial theories in the study of the community pharmacy. It is important to understand the community pharmacy as a hybrid space and what this means for customers, staff and healthcare delivery in New Zealand. This research is also important to understand the complexity of the social production of pharmacy as previous research has predominantly focused on pharmacists and medicines, meaning the non-medicines spaces and the staff who are not pharmacists have not been researched extensively. This research explores how all the staff and all the products and services on offer in the community pharmacy

contribute to the meaning of pharmacy. The complexity of the range of performances available to customers is also not well understood. It is important to understand the complex interactions between space and customers use, as community pharmacies and customer needs are not homogenous. There has not been any research looking at branded pharmacies in New Zealand and it is important to understand the role that Green Cross Health has with the pharmacies under their umbrella. This research will have practical implications for customers, pharmacies, the pharmacy profession, and potentially medicine regulatory organisations (Ministry of Health, DHB's, Pharmacy Society and so on).

Structure of the thesis

Chapter 1 provided the theoretical framework for this research and provided an overview of the research that framed the thesis. I started the chapter focusing on space and place, arguing it is important to research the community pharmacy as a socially produced space. I then discussed the issues for healthcare spaces and moved onto the few studies that have explored the community pharmacy space. It was also important to consider that the pharmacy staff use boundary work and experience power differentials. The social context of the community pharmacy means it was also important to explore professionalism and the theories of medicalisation, pharmaceuticalisation, and healthism. The community pharmacy is also a retail space so I lastly discussed theories and research on health and non-health consumption, with a focus on current research on consumer behaviour in community pharmacies. In particular, I emphasised the interconnections between space, people, and products in the pharmacy and the importance of exploring the community pharmacy as a socially produced space.

Chapter 2 outlined the social, cultural, political and historical contexts of the community pharmacy in New Zealand. I described the highly regulated environment in which the pharmacy operates including professional practice, medicine and other government

regulations. This has direct implications for all aspects of the pharmacy space, the staff who work there and the customers who use the pharmacy. I then outlined the research aims.

Chapter 3 outlines the methodology, including the data collection process and data analysis. Specifically, I describe my four specific community pharmacy sites, discuss the three stages of data collection, outline the analysis and then explain how the analysis informed the structure of the findings chapters.

Chapter 4 focuses on the different spaces in the pharmacy exploring the boundaries into and around the spaces with specific relation to power differentials. Spatial analysis also allowed me to consider the material, physical and social elements of the pharmacy space. The chapter discusses each of the distinct seven spaces in the pharmacy, the boundaries around these spaces, and how power plays out within and across these spaces. The chapter also highlights how Life and Unichem pharmacies are similar and different in look, feel and purpose.

Chapter 5 explores staff practices and performances within the different spaces within the community pharmacy. I explore the professionalism of the pharmacists in the different spaces they work in, the products they handle and the boundary work they do to maintain their professional identity. I also study the boundary work and role jurisdictions of the retail staff as these staff have an important role in delivering health and other services in the community pharmacy. Lastly, I explore how the staff create an environment of community and patient centred care in a retail environment through emotional labour.

Chapter 6 explores the customers' role within the pharmacy, their understandings of what pharmacy is, and how they use the different community pharmacies and the different spaces in the community pharmacy. I explore the different performances open to the customers within the community pharmacy, from medicine use to cosmetic purchases, and

investigate how the customer interactively contributes to the overall production of community pharmacy. I then argue that customers use hybridising strategies and tactics to resist, modify or incorporate health and non-health products and advice when consuming in the community pharmacy.

Chapter 7 links the pharmacy space, the staff and the customer's practices and performances together to discuss the overall social production of the community pharmacy. I argue it is useful to consider the social production of the community pharmacy as a performance and use dramaturgy to discuss the different performances, practices and scripts of the community pharmacy. This chapter will also outline the methodological strengths of this research and directions for future research.

Chapter Three

Methodology

This chapter will begin with an outline and justification of the methodology for this research. I then outline the three stages of the research process including a description of the four specific pharmacies used for data collection. I finally move onto the discussion of the data analysis and outline the findings chapters.

Ethnography, visual representation and aesthetics

In order to explore the ordinariness and complexity of the community pharmacy space the method for this research had to be flexible, use multiple data points and be socially situated. The pharmacy is a recognisable space and the primary function of medicines dispensing is familiar to customers. Even some other services such as passport pictures and getting medicines for minor ailments are accepted and valued within the community pharmacy. However, there are many elements about the pharmacy that are either not well understood, either because they are routinized and familiar or because research has not focused on this aspect before (such as the beauty spaces in pharmacies). Therefore, the method had to allow me to uncover the strange, put a new light on the familiar and allow me to actually understand and be in the pharmacy space. Ethnography is uniquely suited to exploring the micro practices (observable everyday life) and wider cultural structures and systems in which the micro practices take place (Soukup, 2013). The other strength of ethnography is its ability to uncover issues, cultures and processes over time and within context (O'Reilly, 2012). There is a long history of using ethnography in social science research and more specifically in health services research (Mays & Pope, 1995; Russell et al., 2012). For health spaces, Hughes (2013) argues that ethnography is particularly good at revealing routines, investigating micro and macro behaviours and shedding light on

service delivery in practice. Ethnographic methods have been used in many different health care settings including community pharmacies (Banks, et al., 2007; Brown & Bellaby, 2002; Cramer, Shaw, Wye & Weiss, 201; Duckett, 2013, Farrell, Ward, Dore, Russell, Geneau, & Evans, 2012). These studies have shown how ethnographic methods are useful for providing a rich understanding "of the processes of collective 'sense making' by which knowledge and practices are negotiated, constructed and internalized in daily professional life for a wide variety of concerns" (Russell et al., 2012, p. 456). In addition, Healy et al. (2007) argue that ethnography is also well suited to exploring retail spaces because this method allows the researcher to observe the everyday, dynamic and complex behaviours of consumers. Thus, ethnography is the most suitable methodology to explore the complexity of the community pharmacy and the social production of pharmacy as both a retail and healthcare space.

Ethnography is also well suited to explore the community pharmacy as an everyday space. Harper (2017) would argue that place (and space) is integral to even the idea of ethnography. Firstly, the physical elements of the space were explored and these included location, aesthetics, architecture, design, location of walls, shelving, products, who worked in the space and where. This meant I included mapping, photos, and diagrams as part of my data collection. Secondly, space includes people (both staff and customers) so it was important to understand how the people used the spaces and interacted with each other and the space and used the objects in the space. Thirdly, space has symbolic meanings within a cultural landscape. Therefore the method for this research considered semiotics and symbolism so I collected marketing material, noted common and unusual symbols and considered the objects in the space. Lastly, space is filled with meaning and emotion related to power and the wider context in which the space sits and ethnography is an excellent way of exploring instances of power within context. Thus, ethnographic methods render rich understandings of people and social processes by considering how behaviours, beliefs, and actions are made meaningful in local settings (Hammersley & Atkinson, 2007).

This is important when interpreting complex spaces like the community pharmacy as the space, the people and objects within the space are shaped by the culture and society in which the pharmacy is located.

The other complicating factor for this research is the community pharmacy is a hybrid space so it was also important to have a methodology that would allow me to explore what the hybridity represented to the community pharmacy. Hybridity adds to the range of experiences that may occur in the pharmacy, therefore, I wanted a methodology that would allow me to study the experiences of the staff and the customers within the pharmacy. Ethnography is uniquely suited to understanding hybridity in everyday spaces where the boundaries are blurred, moveable and permeable and may change over time (Soukup, 2013). The methodology allowed me to explore the pharmacy as a mix of cultures, ideologies, practices and performances (Healy et al., 2007). In addition, it was important for this research to be multidisciplinary and look beyond psychology because the pharmacy is a hybrid space. I therefore explored health geography literature and consumer culture while looking into the disciplines of sociology, psychology and anthropology. Latour (1993, p. 2) argues that culture and nature are "churned up" in everyday life which, disrupts pure categories and creates unruly hybrids. Seemingly, the community pharmacy is an unruly hybrid as the retail aspects of the pharmacy disrupt the pharmacy as a healthcare space. However, this is only part of the story and ethnography allowed me to look beyond the obvious hybrid assumptions and well-known aspects of the pharmacy to the other experiences within and across the different pharmacies.

I approached this research from a critical interdisciplinary perspective. In this framework, it is extremely important to consider the relationship of power to and within the community pharmacy space and my role in the research. While some might argue that all ethnography is critical as it considers the world in context, I wanted to focus on power differentials in the community pharmacy in order to expose health and other inequalities

(Dourish, 2006). Denzin (2006) argues ethnography is not an "innocent practice" but rather political, pedagogical and performative (p. 422). Health and health spaces can be inherently unequal and even retail spaces are comprised of boundaries and power differentials (Iqani, 2013). It was important to consider power and boundaries as the community pharmacy is touted as being the most accessible of healthcare spaces and customers do not need to make an appointment to see a healthcare professional. However, I believed that there might be taken-for-granted boundaries that affect accessibility so it was also crucial to explore gender and other potential sources of inequality (ethnicity, age etc.) in the community pharmacy. The other power challenges were to see how dominant health ideologies played out in the community pharmacy, particularly neoliberalism. Ethnography allows the exploration of power in everyday interactions between people, space, and material objects within the wider social context.

The concept of Baudelaire's figure of the flâneur also influenced my research experience for two reasons. Firstly, Baudelaire's flâneur was a person who walked through Paris's arcades and streets during the industrial revolution both participating and observing and it is through this wandering that the visual culture of public spaces is uncovered (Balducci, 2017; Soukup, 2013). The understanding comes from a constant shifting between being mindful of the minute practices and wider more abstract conceptualisations of how the city came to be (Soukup, 2013). The wandering spectator explores the ordinary cityscape through visual and embodied experiences leading to both insider and detached perceptions (Balducci, 2017). Wandering is a way to learn about something and this experience produces a type of finding that is unique. I obtained a large part of my data from wandering around pharmacies, malls, and suburban streets, some of this wandering was with purpose and some wandering was for other purposes that meant I came across pharmacies. Ethnography allows a flexibility to explore the physical aspects of a space within context but also explore the unseen aesthetic, symbolic, sensory and embodied aspects of participant observation or as Soukup refers to the "mobilized gaze" (2013, p.

228). Secondly, my role in the research as both researcher, observer and consumer was an important part of the research process and like the flâneur, this required a constant and lived reflexivity (Soukup, 2013). Iqani (2013) argues that being both observer and consumer (participant) is important for researching retail spaces in order to uncover the ordinariness, routines and the most "authentic" of events (p. 342). In any one visit, I could be observing (looking, walking, noticing, writing in my field notebook), start shopping, have a conversation with a retail staff member and go back to observing. I also used shopping trips that happened to include a pharmacy to inform this research. I typically kept a notebook in my handbag for random visits to pharmacies. I never wrote notes while I was in the unplanned site. I would leave these pharmacies, find somewhere quiet and quickly write descriptions, impressions, thoughts, and consider how these observations were the same or different to my specific pharmacies. In this way, my research status moved from outsider to insider and back again. This movement and mobilised gaze influenced my mood, what I noted during observations, and informed my analysis as I moved in and out of the data. Lastly, the flâneur paradigm meant I could explore how the community pharmacy represented and produced gender in a public space, where arguably certain spheres in the pharmacy are created for women.

To capture the experience of being in the pharmacy I both created images and made note of images. I took photos, drew maps and diagrams, collected brochures and other promotional material. I noted what images were in window displays or doors, what marketing material was most visible and what was hidden away. This interplay of taking images, making images and making note of the image presented to the public in the pharmacy allowed me to look at the co-creation of the pharmacy between people and place. In addition, the images informed and guided the research process rather than just sitting alongside my field notes and interview transcripts. Ethnography involves more than words and Pink (2007) describes how images are interwoven into "personal identities, narratives, lifestyles, cultures and societies, as well as with definitions of

history, space and truth" (p. 21). It is very difficult to separate the visual aspects of consumption from the experience and this was true in the community pharmacy. To consider only the spoken or written word would have ignored a large part of the social production of the community pharmacy. In other words, images and visual representations were fundamental for this research allowing me to explore the visual representation of pharmacy.

As well as being visual, spaces are also embodied, emotional and sensory (Hammersley & Atkinson, 2007). Ethnography is not just a visual journey but rather an embodied experience including all senses (Pink, 2007). My overall goal with this methodology was to allow all data to influence the findings and not have a methods hierarchy where one form of data was more important than another (Pink, 2007). Focusing on aesthetics for me in this research took me to touching and smelling products, purposively listening for sounds and paying attention to the feelings invoked by the experience. By focusing on what I could hear beyond voices and conversations (such as radios, noise from outside the shop space), and what I could smell and touch allowed the observations to be richer and also uncovered ideas that I would not have found had I just used interviews (Gorman, 2017). For example, smell highlighted how gendered the pharmacy space is. In one particular observation, I entered the gift section of Unichem 1 and was overwhelmed by a strong floral scent, as there were multiple infuser sets open as testers. This highlighted to me how the visual impact of this area are feminine but also how the rest of the senses contribute to the feminisation of this area. The representations, meanings and production of the community pharmacy would be incomplete without considering all my senses. I also paid attention to my emotions and the mood of the people within the pharmacy. I was careful to make note of how I was feeling during observations and after interviews with staff and customers. I also paid attention to my mood in the different spaces within the pharmacy and to the overall atmosphere of the pharmacy. I made subjective judgements based on

my experiences and my observations of other people's mood as well. Laughter, smiling, anger and annoyance were usually clear to me.

The community pharmacy is a public space and the symbolic and aesthetic elements of consumption in public places can be explored by observing non-verbal behaviour (Iqani, 2013). Iqani (2013) would argue that shoppers' experiences can be texts in their own right and observing is the starting point of "painting a picture of some of the recurring practices" as there is meaning inherent in everyday activity (p. 343). For this research, this is an important point as I deliberately moved away from conversations during observations. This was partly for ethical reasons – the customers were being covertly observed in a public health space. Another reason was that the overall aim of the research was to explore relationships between space, people and products to see how the pharmacy operates rather than investigate the discourses in these conversations. Spaces of consumption are often designed in ways to either encourage interaction with people or place or discourage loitering (Bowlby, 1985). By observing how the staff and customers interacted with each other, the pharmacy and products in the pharmacy meant I could explore the relationship between space and people. In addition, observing the actions of consumers acknowledges the symbolic value and meaning associated with these interactions and relationships (Iqani, 2013; Goffman, 1959). Thus for this research ethnography allowed for a critical lens in exploring 'taken-for-granted' assumptions and exploring unthought-of operations while considering the social context in which those practices were taking place.

Ethical issues

Ethical approval was gained from Massey University, Northern Ethics committee. There are ethical issues with any research but particularly with ethnographic studies that involve covert observation. In this study, customers were unaware that I was in the pharmacy observing. The solution proposed by the ethics committee was that I put a sign

up in the pharmacy stating that there was research taking place (Appendix D). I put this sign on the window of the pharmacies consistently in the first few observation sessions but then I stopped using the sign. Because the sign was small, most customers did not seem to notice the sign or pay attention to anything on the window. This is an example of procedural ethical issue identified by an institutional committee that in practice was not an issue. Guillemin and Gillam (2004, p. 277) suggest that what constitutes "ethics in practice" can differ from procedural ethics particularly for qualitative research. Guillemin and Gillam do not discount the need or value for fundamental guiding principles but rather suggest procedural ethics do not inform all aspects of the research. They propose reflexivity be expanded to ethics so that research can respond to "ethically important moments" (p. 276) sensibly, ethically and with sensitivity. For this research, it was never my intention to overhear any consultations between staff and customers and I would deliberately move away from conversations. I did not have access to any patient information, including prescription details, at any time. I did inadvertently overhear parts of conversations and in these cases I would make a mental note to change how I was moving through the space and I would not make any note of what I had overheard.

Informed consent for pharmacy staff was an important issue. I met with the owner and/or manager in all cases before any observations began, to explain the research and to gain permission to access the pharmacy (Appendices A and B include all the information and consent forms and Appendix C has the invitation to participate). All staff members of the pharmacy were given information sheets explaining the project, informing them I would be observing and outlining the purpose of the research. The staff members were not informed of which days I would be there, as after the first observations session I would show up at varying times and days of the week. All participants (pharmacy staff and customers) who were formally interviewed were given information sheets for this activity and signed consent forms. Interviews were audio-recorded and then transcribed by myself. Transcripts and audio-recordings were kept secure at all times. All identities were

kept anonymous by assigning pseudonyms or initials to the participants in the transcripts and in other dissemination material. All photos I took of pharmacies were shown to the manager, who signed consent forms for the use of the images. No photographs I took had either customers or staff members in them.

I addressed the potential for harm in four main ways. Firstly, by seeking access to the community pharmacy site and getting consent from all pharmacy staff. This ensured the staff all knew why I was in the pharmacy, that the information they told me was confidential and that I would not report anything said to me back to management. Secondly, it was also important that the pharmacies themselves could not be identified in any publications or other dissemination of findings so no pictures were taken with people in them or with specific identifying features such as the name of the pharmacy. I do acknowledge that community pharmacies are public spaces and images may be recognised so consent was sought for the use of the images from each of the pharmacy managers. Thirdly, all participants (both staff and customers) were informed of their rights verbally and via the information sheet. I also obtained written consent before each interview. All staff and customers data was anonymised in all data dissemination, no health information was recorded and all participants were treated with respect and courtesy. Lastly, I did not anticipate any potential harm to myself but I was collecting data in a public space, so I informed my family where I was, reported to the pharmacy manager at each observation session, and kept my cell phone on me at all times.

Reflexivity

The other aspect that is important to acknowledge is my role in the research. Ethnography creates and represents knowledge based on the researcher's own experiences and learning the culture of the site the research is taking place, in this case the community pharmacy (Hammersley, 2018). There is no separating the researcher from the research and Jeolmack and Khan (2018) suggests that researchers should accept and

value the outsider status as this transgression can uncover new data, influence the analysis, and cast light on the hidden. I was an outsider in terms of traditional ethnography (I am not a pharmacist and I did not work on the shop floor with the other retail staff) but I was also an insider as a consumer. I could anonymously go into any pharmacy and shop or 'just look' and these observations influenced the research alongside the planned observation sessions and interviews. However, it is important to explore my reflexivity and subjectivity and explain how it influenced the research process.

The identity of the researcher is important with ethnographic research as personal attributes such as gender, ethnicity, class and race may lead to power differentials (Pink, 2007). My position as a white, 40 something, female, mother, and researcher is important to note. The position afforded to me by this identity was dominant in my mind throughout the entire research process. For example, I was careful in how I dressed. I tried to look more like a woman who might be in a shop during working hours, rather than a student or businessperson. I was also conscious of the power afforded to me as a researcher and that lurking around pharmacies could be unsettling for the pharmacy staff. Being a woman in a retail space was a comfortable one when I was a shopper but then also an uncertain one when I was observing and carrying a notebook as I stood out. Gibbs (2008) suggests that fear, worry and loneliness are common issues when gathering data in ethnography. The experience of being an observer was emotional and did cause me some anxiety. Gaining access to the pharmacies, developing rapport with the staff and the constant reflexivity was particularly challenging. Being constantly reflexive is inherently part of ethnographic process; however, for me this was an internal dialogue of a number of issues during data collection. I reminded myself about specific technical aspects of data collection (such as notes to observe something in particular), to pay attention when my attention wandered, to be alert to the epiphanies and the mundane, and to talk to staff and be sociable. There was a sense of being uncomfortable and this was related to the feelings I bought into the experience. The space itself contributed to my feelings, as there was the potential to

overhear distressing information given it is a healthcare site. Another reason was that I was in a shopping space but not there to shop. Lastly, being uncomfortable was invoked by a sense that I did not belong, that I was disrupting the natural flow of the work and that my presence was changing the interactions and therefore the data. I am sure most of this related to my novice ethnographer status but also reflects the reflexivity required in this type of research.

> *I am supposed to start data collection this week. Feeling nervous about getting in there, the reactions of the staff to me standing in the corner. Am I a fly on the wall – only annoying when I move otherwise unnoticed, or will I change how people act? I am excited about finding out what is going on in pharmacies – how are they working? Who will do what? Are the pharmacies going to be very different or will there only be slight differences? I hope this enthusiasm lasts. Maybe this observation stage will make my interviews better – allow a better understanding of what is going on [reflective journal, 17.03.13].*

This comment is from a journal entry I made before I did my first observation session at Unichem 1. My emotions were high and I was particularly nervous before this first observation session. Within each observation session, I was constantly aware of my place and role within the pharmacy, of what I saw or what I thought I missed, what was said and not-said in informal conversations, and how I might be influencing the data collection. Did the staff change what they were doing, were they feeling self-conscious, uncertain, wondering what I was doing and what was going to happen with the data? The staff did seem uncomfortable at times knowing I was observing them and would repeatedly ask 'why I was back again'. This required constant reassurance of the research brief and that I was not reporting work behaviour back to management. I would reassure them that I was interested in how they were using the pharmacy and whom they interacted with, and really getting a good understanding of what happens in a community pharmacy. On reflection, when I consider whether the staff changed their behaviour while I was observing, the answer is yes, to some degree. The implications of this are that they may

have tried to seem busier, more helpful, or happier in their work. However, arguably pharmacy staff and staff in any retail space are on show every time they are in pharmacy (not including back spaces) and as such are used to being observed in their work. In addition, at very busy times there was not enough time for staff to worry about what I was doing. I believe the staff got used to me observing, although my research topic remained a bit of a mystery.

I did develop strong relationships with key staff which Gibbs (2008) suggests is important in ethnography. These informants showed me hidden things (stock management systems, back rooms, sales figures etc.), invited me to special events, and seemed invested in assisting with my research. These informants ranged from the retail manager, to retail staff, to a pharmacist and a business manager. The one time I felt very uncomfortable was when I was asked to help in the pharmacy by a staff member. She asked me to watch a customer to ensure she did not shop-lift. The customer was labelled as 'difficult' by the retail manager, which I found troubling. I also wondered what I was going to do if I saw something problematic such as shoplifting. I did anticipate my status as a researcher in the field would swing between observer, shopper, formal interviewer, informal discussant, friend and colleague. At the time of being asked to help watch the potential shoplifter I was almost flattered as it indicated my research status had swung to colleague. Madden (2010) suggests that these swings between emic and etic status (insider versus outsider) should be balanced and reflected on within ethnography methodology. In practice, I was only asked to help one time. I did develop key relationships with certain staff in the pharmacies, particularly with the retail staff, where I moved from 'strange, unknown researcher' to 'known but still strange'. There was always some distance between the staff, and me even after months of seeing me regularly in the pharmacy. This highlighted for me the divide and power discrepancies that existed between me and the people I observed.

The staff knew I was in the pharmacy observing but the customers did not. Therefore, I was very conscious of the customers noticing me observing and writing in my field notebooks. I was mistaken for a staff member by customers several times and asked questions, usually about the locations of products. At those times, I happened to be wearing black and the uniforms of the retail staff members were black. I was also carrying a notebook indicating I might be 'working'. One customer asked the pharmacy manager why I was taking notes but I did not notice and the manager bought it to my attention later on. This made me feel uncomfortable and led to more furtive behaviour on my behalf for the next few weeks. There were other times when I felt like an interloper or an imposter in the pharmacy, usually when I felt like I had been spotted. Positioning oneself within communal areas in the pharmacy was particularly problematic as finding places in the pharmacy to observe interactions but not overhear them was difficult. In the bigger pharmacies it was also difficult to see all the different spaces from one vantage point due to high shelving. Observing and making notes at the same time involved me balancing my notebook on counters, shelves or on my arm while I wrote. I would alternate roaming, watching, writing all while trying to look like I was not doing any of those things. This involved a constant awareness of where I was in relation to staff and customers.

The shop side of the pharmacy was a more comfortable space for me to observe. The staff knew me, talked to me, asked me about my family, and I would do the same with them. In contrast, the dispensary remained a space that was 'off-limits'. Even though I had access to the whole pharmacy interrupting or conversing with dispensary staff while they were in the dispensary felt wrong for a number of reasons. Firstly, I was concerned about staff making mistakes with the medications because they were worried about me watching them. Secondly, I felt that I would see personal health information if I was directly in the dispensary. Thirdly, because customers were waiting for scripts I felt that slowing the dispensing process would be against the 'rules' the manager and I had discussed prior to data collection (predominantly to minimise disruption to the pharmacy). Overall, I felt I

had legitimate rights to the retail space but limited rights to the dispensary. The power of the medical space of the dispensary compared to the retail spaces was forceful and prominent throughout the research process.

While there were four main pharmacies (referred to as my four specific community pharmacies) used in the data collection, other pharmacy experiences informed the data. Community pharmacy images became clearer and more 'noticed' during the entire research process. I became aware of every pharmacy I passed, every advertisement for a pharmacy, or a pharmacy product. I made note of medication or herbal remedy advertisements both on the street, in print, on television and on the internet. I stopped and looked at community pharmacy window displays, signage and spatial layouts of all pharmacies that I came across. Instead of filling prescriptions at the same pharmacy, I took to using different pharmacies from a number of sites across urban Auckland. I also was highly reflective of what constituted 'data'. At times, this meant that I went into the pharmacy 'looking' for something, focusing on a particular element of my research. At other times I let the images, thoughts, observations, conversations, marketing material, spatial locations, signage lead me. The reflection also continued after I had left the pharmacy when I reviewed my field notes. I was continually surprised to find that in every observation period, I felt that I learnt more and that I noticed things that were different to last time. Reflexivity was integral to all stages of the research process and inspired the analysis in particular. It was a delicate balance between looking for these themes and allowing the data to lead me.

Research Process

Ethnography can be flexible in definition and can encapsulate full immersion into a 'field' through to non-participant observation (Pink, 2007). This research therefore uses an ethnography-inspired methodology, informed by the basic assumption that the researcher can gain a rich understanding of culture (what it is and how it works) by studying situated

social practices, rituals, behaviours and beliefs in comparable settings (Pink, 2007). I used four specific pharmacies for most of my data collection (two Life and two Unichem pharmacies). I begin with a brief description of these four specific pharmacies and illustrate the scope of the data collected. I then discuss the research process, which consisted of three main phases; stage one, (non-participant observation) two (staff interviews), and three (customer interviews) so I outline each of these phases.

The pharmacies

The two Life and two Unichem pharmacies were located on the North Shore of Auckland. At the start of the research process, there were five branded pharmacies in New Zealand and these were described to me as being on a spectrum based on their focus on health or retail (see Chapter Two). This impacted on the two Unichem pharmacies who changed branding during the research process but at the time of data collection were either connected to Pharmacy Brands (Green Cross's precursor) or had been rebranded into the Green Cross company. All four pharmacies are currently under the Green Cross Health umbrella and are summarised in Table 2 (size is an arbitrary label based on my experiences with pharmacies). The services offered are those listed on their websites at the time of data collection and are in addition to regular dispensing services. The four pharmacies were selected on their different locations, their size, their brand and their proximity to medical centres. Four pharmacies were considered an appropriate number based on the number of hours observing, the number of interviews with staff and interviews with customers and the size and complexity of the pharmacies (see table 3 for scope of data collection). I assumed that the demographics of the customers would differ depending on the area where the pharmacies were located so while all the pharmacies were on the North Shore of Auckland, I had pharmacies from four different suburbs. The aim was to keep the group homogenous by using branded pharmacies but also allow for comparisons of the Life and Unichem pharmacies. In addition, I was interested in the pharmacies that had a level of control and regulation by Green Cross Health so if I had

added independent pharmacies the research would have changed considerably. Table 2 shows the specific services of each of the pharmacies in the order I collected data. I started with Unichem 1, then Life 1, followed by Life 2 and then Unichem 2. All four pharmacies had general sale and controlled medicines for sale, CAM spaces, some type of beauty space and all sold some gifts.

Table 2: Summary of the community pharmacies

Brand of pharmacy	**Location, size and opening hours**	**Staffing**	**Services offered**
Unichem 1 (was a Care pharmacy at time of data collection)	Medium sized. Suburban location in small outdoor mall. One entrance No medical centre or pharmacy within walking distance. Open 6 days	Absent owner, Pharmacist/manager, 2 other pharmacists, 2 technicians and 3 retail staff (window dresser), 1 delivery person and cleaner	Clozapine dispensing Long-term conditions service Methadone dispensing Smoking cessation service Blister packs Emergency contraceptive pill Incontinence products Needle exchange service Specialised wound care WINZ and other reports Sildenafil dispensing for erectile dysfunction
Life 1 Pharmacy	Large pharmacy. Located within a large Mall - outside and internal mall entrance. Nearest medical centre 5 minute drive but there is a pharmacy next to this medical centre. One other independent pharmacy in the mall. Open 7 days	Absent owner, business manager, 2-3 pharmacists, 7-8 retail staff, 6-8 beauty consultations, stock handler and other staff (window dressers, cleaners etc.).	Ear Piercing Men's Health Week Coeliac Testing Blood Pressure Testing Zinc Testing Compliance Packing Passport Photos Vaccination Weight Management Treatment for Urinary Tract Infections Emergency Contraceptive Pill Skincare Cosmetics Fragrance
Life 2 Pharmacy	Large pharmacy located in suburban high street, street access only, 5 minute walk to the nearest medical centre. 3 other pharmacies within walking distance. Open 7 days	Owner/pharmacist, 2 pharmacists, 1 technician, stock handler/payroll, 6-8 retail staff including 1 dedicated beauty staff member. Other beauty staff come for peak days.	Ear Piercing Men's Health Week Coeliac Testing Blood Pressure Testing Bone Density Scanning Bowel Health Screening Zinc Testing Equipment hire Compliance Packing Medicine Management Smoking Cessation Passport Photos Vaccination Weight Management

Brand of pharmacy	Location, size and opening hours	Staffing	Services offered
Unichem 2 (formally an independent pharmacy)	Large pharmacy. Located within a building with other medical services (medical centre, Labtests, radiology etc.) near a large commercial area and close to a residential area. Open 7 days	Pharmacist/manager, 3 other pharmacists, 3 technicians, 7 retail staff to cover the 7 day opening period, no dedicated beauty staff.	Treatment for Urinary Tract Infections Emergency Contraceptive Pill Blood pressure testing Cholesterol testing Coeliac testing Long-term conditions service Smoking cessation service Blister packs Emergency contraceptive pill Trimethoprim dispensing WINZ and other reports Equipment hire Needle exchange service Passport photos Vaccinations

The two brands of pharmacies used in this study (Life and Unichem) are quite distinct. Life are marketed as prestige pharmacies selling luxury items and Unichem more as the family community pharmacy. As such, these two brands of pharmacy have clear differences. Firstly, Life pharmacies normally have about one third of their floor space devoted to beauty houses and products and a smaller dispensary. The Unichem pharmacies have less space devoted to beauty products and larger spaces devoted to medicines. Of the pharmacies selected for this study, Unichem 2 was located next to a medical centre. Unichem 2 has a very high prescription turnover; it also offers plenty of wellness products and other medicines but very few beauty products. Unichem 2 reported to me that 80% of transactions involved dispensing prescriptions. This is in comparison to Unichem 1 and Life 2 where the prescription rates were closer to 40%. The Life pharmacy in the mall reported about 15% prescription rate to me. Unichem 1 had the widest range of goods for sale including food, music, clothing and home decorations. The key differences between Life and Unichem are highlighted in the hierarchies of space devoted to medicines. Life pharmacies have more lifestyle products such as CAM, beauty and skincare, whereas Unichem tend to have more medicine products, larger dispensaries and more OTC medicines.

The scope of the data collection is summarised in table 3. This data was collected at multiple data points within three research phases. Phase one was non-participant observation, phase two was staff interviews and phase three was customer interviews. I completed each phase in order within the four specific pharmacies. I did have some crossover periods where I was collecting data in two sites at one time but the data was still collected in the same order for each pharmacy. The next section outlines the details of each phase. Table 3 also shows the other data I used to inform the analysis. This included annual reports, a pharmacy industry magazine (Pharmacy Today), and targeted emails from the Living Rewards loyalty programme sent to my personal email.

Table 3: Scope of data collection

Phase	Data collected
Non-participant observation	Between 20-25 hours of observations within each of the 4 specific pharmacies over period of 2-6 months (to cover all hours the pharmacy was open) 20 hours of other observation in other pharmacies 7 notebooks with field notes and reflective journal entries (8B4 exercise books with 100 pages each). 280 photos The four specific pharmacies websites Monthly Life and Unichem brochure and other pamphlets (50+)
Staff interviews	Manager interviewed in each pharmacy: Pharmacist manager Unichem 1 – male, Business manager Life 1 – female, Pharmacist manager, Life 2 – male, Pharmacist manager, Unichem 2 - female 1 owner (male) – Unichem 1 6 pharmacists (2 males – Unichem 1, Life 2 and 4 females – Unichem 1, Life 1, Life 2, Unichem 2) 1 technician (1 female) 12 retail staff (all female)
Customer interviews	12 customer interviews (3 from each pharmacy) 12 women ranging in age from 40 – 70 years
Other data	Personal emails from Living Rewards Annual reports from Green Cross Health (2014 – 2017) Subscribed to 'Pharmacy Today' in 2013 – monthly magazine

Phase one – Non-Participant Observation

> *Still feel a bit like a voyeur – it is not natural observing, writing notes, moving and trying not to be seen but still 'see'. I was asked if I could help by two customers. Obviously, I am not doing a good job of being unobtrusive or fading into the background. Maybe I should stop wearing black as the retail staff wear black [field notes, Unichem 1, 4.4.13]*

Gaining access to any site of ethnography is the first and one of the most difficult parts of any ethnographic work (Hughes, 2013). I sought initial permission to enter every community pharmacy before I did any observations (Appendix C has an invitation to participate). This involved a meeting with manager/owner to explain the process, giving them information sheets and seeking formal permission from the pharmacy owner. Once permission was given, the manager informed staff members and distributed information sheets (Appendix A - information sheets). I then obtained formal consent from all the staff (Appendix B - consent forms). Access continued to be an issue throughout the data collection as the observation period took place over the course of many months (see Table 4). There were two periods during data collection where my daughter was very unwell. I was not able to get into the pharmacy to observe for those two times. On returning to the pharmacy, I talked with the manager again to re-establish contact, ensure I still had access and to explain why I had been absent. The on-going issue of access is common with ethnography research and due to my extended periods of observation (ranging from six months to a year) for each pharmacy, this was particularly pertinent.

Table 4: Observation dates

Pharmacy	Observation period	Comments
Unichem 1	25 March 2013 – 26 November 2013	This pharmacy moved physical locations after I finished observations. I purposely have not visited the new location.
Life 1	23 June 2014 – 14 March 2017	Most data collection was done by 12 February 2015. I frequently am in the mall where this pharmacy is located so did two final observations in 2016 and one in 2017.
Life 2	17 March 2014 – 25 March 2015	This pharmacy situated the furthest from my house so observations were extended over a longer period
Unichem 2	2 April 2014 (one-off visit for summer work) 2 March 2015 – 30 August 2015	Did a project for a summer scholarship using independent pharmacies. At the first visit this pharmacy as independent then became a Unichem.

After receiving permission and gaining consent from all the staff, I undertook a period of non-participant observation. Data was gathered over a range of days and times with a minimum of 20 hours in each site to ensure I had covered all periods the pharmacy was

open (Table 4). I spent two to three hours on each observation. Madden (2010) describes observation as noticing things and making note of these or learning things from the "natives" point of view (p. 98). I was never going to be a pharmacist or even a retail staff member, but I could be a native consumer and shop in the pharmacies and I could learn how pharmacies work. Therefore, the point of my field notes was to move from "first impressions to insider sensitivities" (Madden, 2010, p. 102). When taking field notes I used O'Reilly's (2012) suggestions for effective note taking – write often, ensure you have sufficient detail, reflect and include feelings and emotions. Gibbs, (2008) and Reeves, Peller, Goldman, & Kitto (2013) suggest focusing on the following topics when conducting non-participant observations: space (what is in the physical space), actors involved, activities, objects, acts (what are the individuals doing), events (what type of routine or other more surprising events happen), goals (what do they want to accomplish), feelings and time. I used these topics initially to help me focus during the observation and subsequently developed an observational checklist, which was also helpful (Appendix E).

Each observation session would follow a similar routine. Before I entered I would remind myself what I was looking for, look back at past observations (if there were any), and stand outside the pharmacy to see if the exterior had changed, maybe take a photo or draw a diagram if there had been changes. Once in, I would seek out the manager to say what my plan was for the day, store my handbag and then get to work. I recorded field notes by hand in medium sized school type notebooks. Initially, I made note of how the pharmacy was presented in terms of advertising, window and other displays, how the shop and dispensary and other spaces varied, and who actually made these display changes. I noted new displays or marketing and what was the same. I noted who was working and where. Then I would focus on customers and what they were doing with staff and the pharmacy space. I would take and make images through the session. No discussions were recorded during the observations and I purposely wandered away from customer/staff interactions so I could not overhear those conversations. On leaving the site after each observation, I

also wrote reflective field notes. I reflected on what I had made note of, what I had not made note of, reflecting on my observations and made initial notes on meanings, themes, possible ideas for my next visit. I returned to these notes many times during the analysis and over the entire data collection phase. Being on high alert for possible interesting data, ensuring I was not 'obvious' to the customers, finding places to write notes without seeming to write notes, and frantically writing relevant comments in informal conversations with staff meant that three hours was the maximum time I would spend in one session.

As the sessions progressed and the observations became more mundane and the newness wore off, I had to concentrate at times to actually observe, think, reflect and feel. However, the first session typically was a bombardment of images, ideas, and information. I described what I had seen being as vivid and informative as possible. I also counted people coming in and out of the pharmacy and made notes and maps of their movements in the space. I noted what the customers purchased and which staff member they dealt with. I also drew maps of the pharmacy space, taking specific note of what was for sale and where, signage, physical and symbolic barriers, and placement of shop fittings, including display units. I made particular note of areas that changed over the time I was in the space (seasonal displays, window displays, counter displays). I drew hierarchies of the pharmacy staff and products and made note of similarities and differences across spaces and different pharmacies. I mapped where staff moved and for what purpose and mapped how the customers used the space from entry to exit. I asked to see hidden spaces and made maps of these spaces. Mapping was very useful for spatial awareness, noting who used what spaces, what the function and role of each space was, and exploring any boundaries between and within spaces. The examples of the maps I drew illustrate the complexity of the spaces (Figure 4). I also drew other maps using arrows to show staff and customer movements around the space. The maps used in the findings chapters are maps I

re-created in PowerPoint. I did this primarily as the maps I hand drew were difficult to read and messy and I wanted to have two copies of the maps.

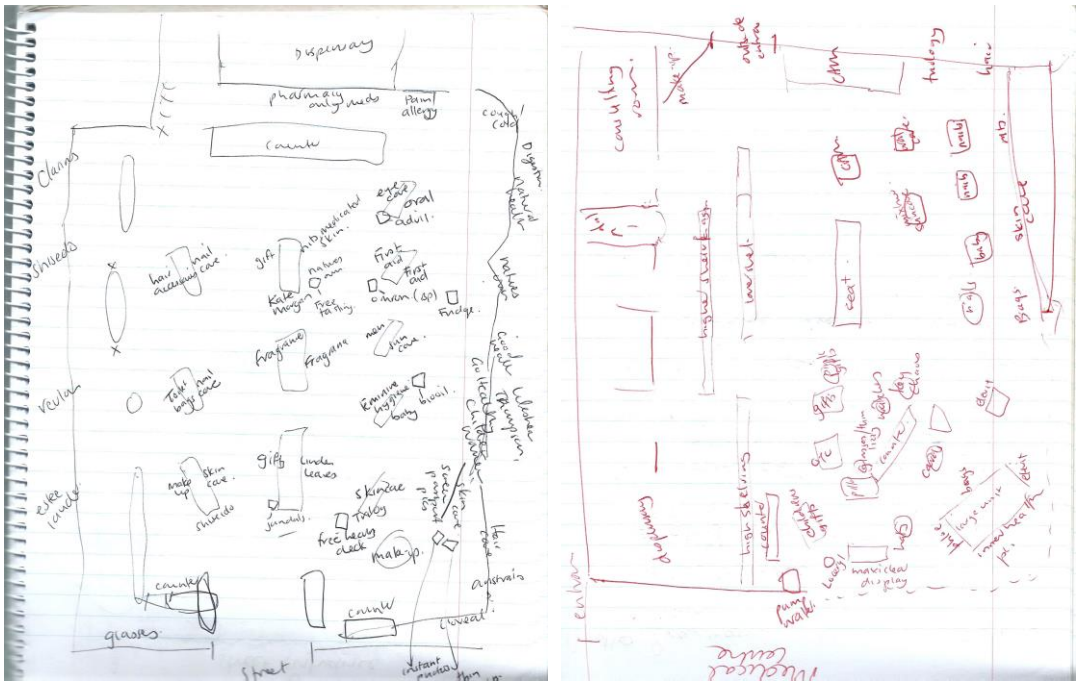


Figure 4: Examples of maps from data collection, Life 2 and Unichem 2

I took photographs of the spatial and visual layout of pharmacies and things that I thought were interesting or symbolic of the pharmacy. I also took pictures of the displays, including displays that were either external to the pharmacy (sales tables, tubs of products, window displays, children's rides, movable advertising stands and signage over the security stands) and internal displays to remind myself of what was for sale, where, how it was displayed and marketed and where it was located in the pharmacy. I initially used a digital camera but later moved to using my cell phone to take pictures. This was much less obvious as other people had cell phones in their hands within the store and I did not stand out as being different. The use of these images as data remained under the control of the pharmacy; managers looked at all photos taken and signed consent for the use of these. There was agreement that photos would not contain people, which precluded shots of the dispensary area. These photos were also invaluable for interview prompts (in customer and staff interviews). I collected copies of marketing material and brochures

that were available to customers, and noted what 'specials', sales, and pharmacy spaces were involved.

The other things of note in the observations were the aesthetics of the pharmacy and using all my senses in my experiences. I would spend time being aware of what I could smell, what I could hear, and made note of things that I could taste, try or experience. This proved to be something that required me to be purposeful. I did not usually notice the smells or sounds until I made a conscious effort to do so. I took to trying any product with the 'tester' sticker such as sampling perfumes or hand lotions. I also picked up, smelt and shook products. Paying attention to the aesthetics of the community pharmacy meant I considered how the overall look, feel and other senses contributed to the store atmosphere. I made note of marketing, extra displays, and changes to the pharmacy and I would take pictures of these changes. It was also important to note what did not change. I looked for physical, material and social differences of the staff (such as uniforms, hairstyles, shoes, or makeup) and noted customer genders, approximate ages, and ethnicities. If a group entered, I made note of who was in the group and what they did in the pharmacy. Paying attention to aesthetics allowed me to collect rich data and enhance the experience.

In addition to formal interviews with staff, I had many informal conversations with the staff. Some of these conversations would be 'mini' interviews and discussions of roles and responsibilities. Other times they turned to personal discussions of trips, family and so on. I would make notes of these conversations in my field notes after the conversation had finished. I usually developed a stronger relationship with one particular person in the pharmacy and these people would purposively show me hidden tasks and these were always unplanned during quieter periods (such as ordering product, cleaning, payroll, how dispensing works, stock takes, changing displays and so on). I also shopped and purchased

products, attended Christmas parties, and purposely got makeovers at the pharmacies. I did this to 'support' the pharmacy and the staff. All these experiences informed my data.

Phase two – Staff Interviews

I conducted tailored, semi-structured interviews with four managers, one owner, six pharmacists, one technician and 12 retail staff (table 3). Table 3 illustrates the gender of the staff interviewed and which pharmacy they worked at. Finding times to interview staff was difficult at times. In the pharmacies that were open seven days, the staff may work part-time or in weekends and have weekdays off. There were opportunities to talk during working hours on breaks, but these pharmacies were busy a lot of the time so it was hard to arrange interview times in quiet, private places. I was told more than once by the pharmacy manager that it was fine to talk with the beauty consultants at any time but that the other staff were busy and not to be disturbed (other staff were the ones dealing with medicines). There were many informal discussions with the staff during the observation phase, however these were never recorded, therefore these discussions relied on my memory and later notes of the conversation.

The formal interviews were recorded and questions were based on an interview schedule with suggested questions (Appendix F). Interviews used open-ended questions and explored the role of the staff (what they did, where they worked, and who they worked with), their understanding of the pharmacy practices and their role and relationships with customers. I explored any dilemmas and tensions as the staff discussed these. I conducted some interviews during work hours with permission of the manager and others outside working hours (before shifts began). I transcribed the interviews.

Phase three – customer interviews

Customers were recruited by the pharmacy, as I wanted loyal or returning customers. By talking with loyal customers, I felt that I could explore the reason for this loyalty, which is not something that has been done in the pharmacy setting. In addition, I assumed these

customers would be familiar with the specific pharmacy and would have enduring relationships with the pharmacy staff. Therefore, the purpose of talking with the customers was two-fold. Firstly, it was necessary to talk with customers about their experiences in pharmacies. I wanted to explore the different roles the customers may have within the pharmacy setting (patient/consumer, loyal/drop-in) and how this influenced their experience. Secondly, I anticipated these long-term customers would have strong relationships with the staff and I wanted to explore these relationships and any other factors that were contributing to their loyalty to the pharmacy.

The pharmacy retail managers invited all the customers to be interviewed with the exception of two customers who were referred to me by these invited customers. The retail manager gave their selected customers envelopes with an information sheet and letter from me. Customers then contacted me if they were happy to be interviewed. I conducted semi-structured interviews with three regular or loyal customers from each site, for a total of 12 customer interviews (Table 3). Questions focused on why they used that particular pharmacy, what they used the pharmacy for, the relationships they had with the pharmacy staff, and their history with the pharmacy (see Appendix F - interview schedule). I used photos I had taken of the specific pharmacy space as interview prompts. No specific health information was requested. The interviews were conducted at customer's homes except for one that was conducted on site at Massey University, Albany campus.

Data Analysis

> *The most difficult thing is knowing when to stop or even if there is an end point. Analysis is seemingly a never-ending process as it tied to my writing and endless thinking [reflective journal, 3.11.16]*

As with any ethnographically-focussed study the analysis was a cyclical, constant inductive process of moving from data to analysis and back again, eventually grounding the data in

theory (Hammersley & Atkinson, 2007; Madden, 2010). Data for this project consisted of field notes, reflective journals, interview transcripts, hand drawn maps, photos, brochures, magazine subscription, and the pharmacy websites (Table 3). However, data implies there are discrete data points and that analysis was a linear process. Nothing could be further from the truth as reflected in my agitated comment in my reflective journal. The analysis started from the first initial site meeting with the pharmacy manager, continued through the months of observation period and continued as long as I was writing (Pink, 2007). Writing is not an activity that is distinct from the fieldwork or analysis and Reeves et al. (2013) suggests the writing is about separating the researcher from the data so is integral to all aspects of the research process, particularly the analysis. Coles and Thomson (2016) argue that the in-between space of data collection (field notes, interviews, writing descriptions) and knowledge representation is not usually described well. This is however, what this section attempts to do – describe how I derived meaning from data. This is a messy process to explain and was continually developed and refined alongside the data collection. This means that all the steps are intertwined and difficult to differentiate but I outline the three main steps of my analysis next, based on the most elemental definition of analysis as defined by Gibbs (2008). Gibbs states that analysis is a process comprising of description, analysis and interpretation. Description refers to descriptions and recounts of the data. Analysis requires looking for linkages and relationships in the descriptions, and interpretation is the explanation and understanding beyond analysis (Gibbs, 2008). I reframe these steps as: 1) getting to know the pharmacy; 2) making sense of the pharmacy; and 3) producing community pharmacy meaning.

Getting to know the pharmacy

Corban and Strauss (2008) describe the first stage of analysis as the process of examining something in order to find out what it is and how it works and suggest this means starting with identifying properties and dimensions. As an outsider (not a pharmacist, never worked in retail and not a businessperson) I had no clear concept of how a pharmacy

worked, who did what and why, and what products are for sale in a pharmacy. This meant the first stage of analysis was fact-finding, sorting out ideas and starting to think about what all this means for the focus of my research or as Hughes (2013, p. 6) calls it "unstructured fieldwork". This initial stage was overwhelming as I learned how pharmacies worked, and continued throughout the data collection as I kept learning new information. I initially focused on physical space (what was in it, where was it located, who worked in that space and how did it look). It was here that having maps, photos and diagrams was particularly helpful. Collecting information on the design, look, layout and content of pamphlets, advertising, window displays and other promotional material was also important for my understanding of how the pharmacy worked, the aesthetics and display and how customers and staff interacted with these items. I then moved onto staff/staff interactions within the pharmacy and staff/product interactions. The purpose was to see which staff member did what and when. The next process was to explore how the customers used the pharmacy including how they moved in the pharmacy, whom they interacted with and what products they interacted with. Mapping, photos, field notes, informal conversations and interviews were useful in these processes involving people. It was beneficial in this early stage of analysis to focus on one element of the pharmacy at a time and this then later informed how I split my findings into space, staff and customers. I repeated this stage of analysis for each of the four specific pharmacies and for each informal visit into a pharmacy.

Making sense of the pharmacy

Getting to know the pharmacy was only an analytical starting point. Once I had a clear understanding of the complexities of the pharmacy space, who worked there and how they worked, and had an idea of how customers were using the pharmacy I was able to move to the next stage of analysis. I could move from fact finding to starting to make sense of a large amount of visual, linguistic, and spatial data. O'Reilly (2012) describes this as "summarising, organising and translating" (p.186). This required constant revisiting of all

the data, looking at field notes, consulting interview transcripts, and considering all the images I created looking for patterns, summarising the data, organising themes, thinking and writing. The difficulty in describing this step is the movement back and forward between the different pharmacies. For example, I would consider all the data for Unichem 1, and started summarising the data and making interpretative comments alongside the field notes and in separate word documents. I then started looking for patterns and organising themes in mind maps for Unichem 1. I then moved to Life 1 and did the same thing but started comparing and contrasting the pharmacies as well. In the meantime, I was collecting data in Life 2 and then Unichem 2 so I would go in and out of the data from these pharmacies as well. This constant going back and forward, in and out of the data and within and across the different pharmacies and types of data meant that the initial analysis was informing the data collection in the later pharmacies.

It was important for this research to keep the descriptions separate from any interpretative work. The reason was I wanted to keep the initial descriptions clear and unaltered as there were sometimes multiple meanings for one observation. I also wanted to be able to visually track my interpretative and analytical process. I did this in two ways. Firstly, I kept a reflective journal separate from my field notes and made handwritten notes, memos and thoughts in this journal, sometimes following an observation, sometimes in 'thinking' times and sometimes as I wrote. Secondly, I also transcribed my field notes onto my computer into a Word document so I then could add interpretative comments via tracked changes (Figure 5). Having the field notes in Word meant I could search on terms very quickly, see the date of the observations, and I had two copies of the notes. The reflective notes were data as well as initial analysis as I always took time to reflect on what I was noticing or what I had not thought of (usually these were feelings or aesthetic things that I would need reminding of to notice). I always took time following each observation to reflect, expand on descriptions and then make some interpretative comments in my reflective journal. I was also able to use this method with the other data

as well. For example, following the interviews, I would make reflective notes and I made interpretative comments on the interview transcripts in Word documents. For the images, I made notes about each image in the reflective journal noting time and date of the image, why I thought the image was important and why I had taken it. All these interpretations, thoughts, and reflective journals informed this stage of the analysis as much as the descriptions or images themselves. Pink (2007) describes how different mediums of data represent different elements of the fieldwork and states that "images and words contextualize each other, forming not a complete record of the research but a set of different representations and strands of it" (p. 120).

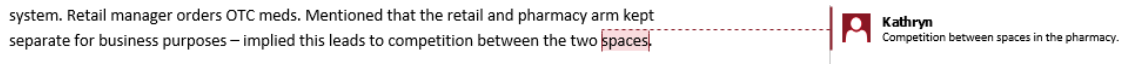


Figure 5: Example of keeping description and interpretative comments separate

The reflective journals and initial interpretative comments are analytical but also data. By this I mean, this stage of the analysis informed the findings and helped shape the thesis structure, but this stage was still only part of the analytical process. For example, at times, a pattern or theme would emerge in observations or other data. I would then see if the same theme or idea applied to all the pharmacies or if it was unique to that particular pharmacy and I would start to think about the broad theoretical idea that may apply. Part of my interpretative comments would note that I needed to explore literature and theories around that idea. Some of the ideas were noted during a-ha moments and it would be clear that what I was observing was important. However, most of the patterns and themes were uncovered after longer periods of observation and considering all the data, thinking, and writing. It is also important to note that while I hoped I noticed everything, I could not analyse everything. I made choices along this analytical journey about what to look at and how to look at it (Gibbs, 2008; Jerolmack & Khan, 2017). Coles and Thomson (2016) would argue this requires critical scrutiny, thinking, writing and then more critical scrutiny, thinking and writing. I found that being reflective and writing constantly was an important aspect of choosing what to focus on analytically. For example, many of my field

notes commented on the type of products for sale in a community pharmacy and in my initial analysis I wanted to write a chapter on the materiality and meaning of products in the pharmacy. However, it became clear over the course of many months that shifting my focus to the interaction between space, staff and customers with the products was more productive. For this research it was not the products themselves but rather, who was using them, their symbolic power and their location in the pharmacy that was important.

Producing community pharmacy meaning

The final stage of the analysis was the process of linking the analysis back to theories and wider concepts and answering 'so what' questions. For example, I found that medicines have power in the pharmacy but it was important to move beyond describing this to considering what does this mean for this research and answering the so what question. This was an ongoing practice consisting of going back and forward between theoretical concepts and empirical materials moving towards theoretically grounded findings (Coles & Thomson, 2016). Coles and Thomson argue this stage of analysis is also about overcoming assumptions, trying different interpretations to find the most appropriate and stimulating conceptualisations. This stage of the analysis led to the final decisions on the structure of the findings chapters and informed how these chapters were arranged, what theories were used and what I focused on or included in the thesis. However, it is important to emphasise again the importance of writing and thinking and constant revisiting the data. These processes were interconnected and ongoing.

The focus of this research was always on the community pharmacy as a space therefore it was clear that space would be a chapter in the thesis. It also made sense to have this as the first chapter. This sounds like a simple analytical strategy where I focused on anything to do with space. However, space, theoretically and in practice, is complex and includes many elements (physical features, marketing, aesthetics, experiences, staff, customers) so I had to make some decisions on what to focus on. The literature review strongly suggested that

boundaries and power would be important in the pharmacy space therefore the initial spatial analysis and first findings chapter focused on these two ideas with regards to the different spaces in the pharmacy.

The second findings chapter emerged from the analytical work from the space chapter. It was very evident that staff were also important to boundaries and power and were interacting with the space and products to create meaning. In addition, the pharmacist, as the controller of prescription medicines is integral to the meaning of the pharmacy so it was clear that I should devote time to the pharmacists. Reflecting on theoretical frameworks and the relevant literature suggested that professionalism and boundary work would be important for the pharmacists. There is very little research on boundary work with retail staff in pharmacies, but this framing was also useful in considering the jurisdictional and hierarchical power differentials between staff. Therefore, the chapter focus on boundary work and professionalism emerged. However, it became evident after further analysis and interpretation that all the pharmacy staff were creating a sense of community and care and that many of the tasks of the retail staff were gendered. This then led to the theory of emotional labour as a way to capture the work pharmacy staff were doing to put the community into the pharmacy. I also considered if all the pharmacy staff were using emotional labour within and across pharmacies.

The final findings chapter developed as I then felt that the customers had been ignored to this point but that they played an important role in the social production and meaning of the community pharmacy. It was important for me to look at how customers used the entire pharmacy, not just the dispensary or minor ailment areas; therefore, I had to consider both retail and health interactions and theories of healthism and consumerism. The most complicated aspect of this chapter was attempting to conceptualise what customers were doing in the pharmacy if they used the pharmacy for a non-health related purpose (for example, to buy a gift or have their passport picture taken) and to move

beyond describing what the customers did in pharmacies to answer the 'so what' question. This eventually led to the theories of hybridisation and exploring the tactics of the customers in personalising their consumption experience in the pharmacy.

In summary, this third component of the analysis was complicated and time-consuming, involving taking a multi-disciplinary theoretical approach to the analysis and being highly and continually reflexive. The analysis was primarily about looking critically across and within the data, being reflexive and writing to allow for meaning making. In many ways, the analysis only ended because this thesis has an end-point.

Chapter Four

The landscape of community pharmacy

The purpose of this chapter is to discuss the community pharmacy as a cultural landscape (Kearns & Barnett, 1997). Cultural landscape is a term that I use purposively to encompass that the community pharmacy is a shared, social space, situated in a landscape of health and commerce. While theorists can disagree on what constitutes space and place, my aim was to situate the community pharmacy as an inter-relational, contextual, practiced, and produced site where space and place co-exist (Agnew, 2011; de Certeau, 1984, Lefebvre, 1991, Löw, 2016). It is important to analyse the community pharmacy as a socially produced space in order to explore the tangible or physical elements of the pharmacy alongside the symbolic and visual aspects of space. This is particularly important for healthcare spaces since experiences of medicine and health cannot be isolated from sites of care and because there is a mutually reciprocal and reinforcing relationship between place and people (Cummins et al., 2007; Poland et al., 2005). Pharmacies are hybrid spaces of health and retail (clinic and shop) and consequently provide unique spaces for investigation, as they present a fascinating visual and symbolic example of the commodification and ideology of health consumption (Kearns et al., 2003). Using the idea of cultural landscapes and meaningful spaces will allow me to explore the community pharmacy from a socially constructed, symbolic and spatial perspective exploring both health and retail sides of the pharmacy. The community pharmacy is a socially produced space and the pharmacy production takes place within specific underlying power relations (Dourish, 2006; Kearns et al., 2003). The ethnography-inspired methodology allows me to explore the power concealed in the ordinary routines of the pharmacy while paying attention to the wider culture in which community pharmacy is produced (Soukup, 2013).

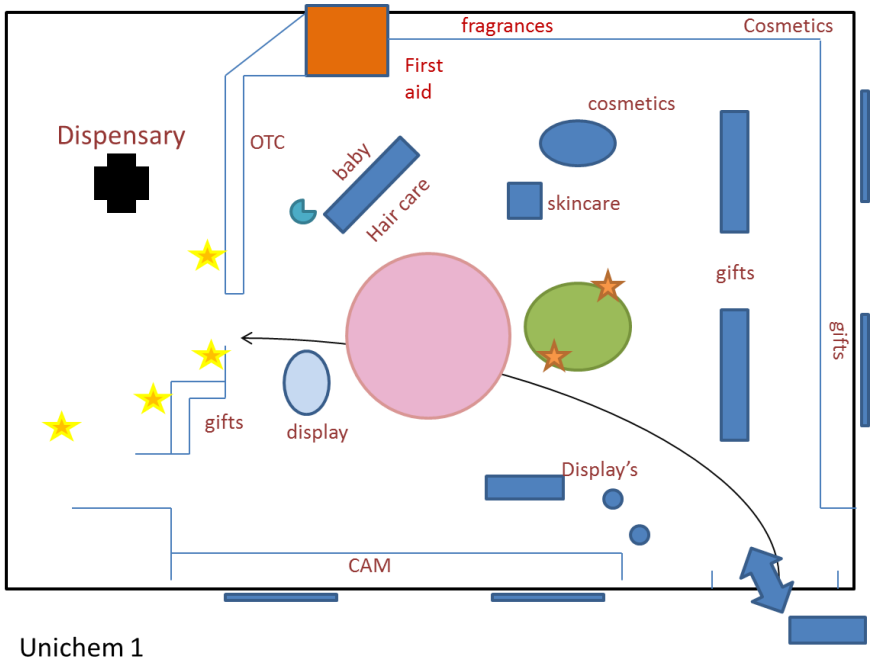
This chapter presents the findings from reading and decoding the varied spatial meanings of pharmacy beginning with a brief overview of the layouts of the four specific pharmacies, followed by an in-depth discussion of the different subspaces in the community pharmacy. I finish by discussing the community pharmacy as a complete landscape.

The four pharmacies (2 Life and 2 Unichem) used in this research were quite different in size and layout. Figure 6 shows the distinct differences across the two brands and the four specific pharmacies through floorplan maps (not drawn to scale). Life and Unichem pharmacies have different aesthetics, different branding and an ambience that mark them clearly as either a Life or a Unichem pharmacy. The brand of pharmacy also influenced the pharmacies corresponding dispensing rates, the services offered, and the number of staff employed (see table 1 in Chapter 3 for more information on each pharmacy).

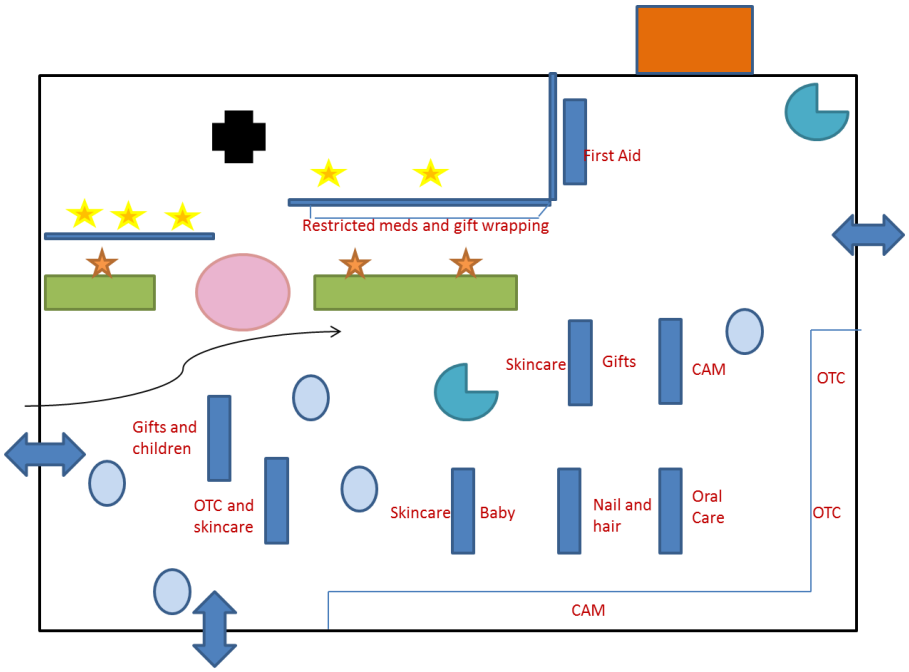
> *I am in the Life pharmacy today in the mall and what a different feel to the Unichem pharmacies. It is a bigger and brighter space with so many people working in there compared to Unichem 1. I avoid the make-up side (half the space is filled with cosmetics and fragrances) with the intention of heading to the part of the pharmacy with the medicines in it but I get distracted by the infuser sets and hand cream on sale. Time to be a consumer and shop [field notes, Life 1, 28.7.15]*

I identified that there are seven distinct spaces with the pharmacy; the dispensary, the OTC medicines space, the counter and till area, CAM space, the consulting room, the space retailing beauty, and the space that sells gifts and other non-health related products. The four specific pharmacies all have the same seven subspaces with the exception of Unichem 2, which did not have a dedicated beauty space but did have beauty products. The seven spaces within these four pharmacies vary in size and where they are located and Figure 6 illustrates the locations of the different spaces within each pharmacy. This chapter discusses these different spaces in turn, starting with the dispensary, as this is the main purpose of the pharmacy, and then deals with the other spaces in the pharmacy that involve medicines (OTC, counter and till areas, and CAM). I then discuss the consulting

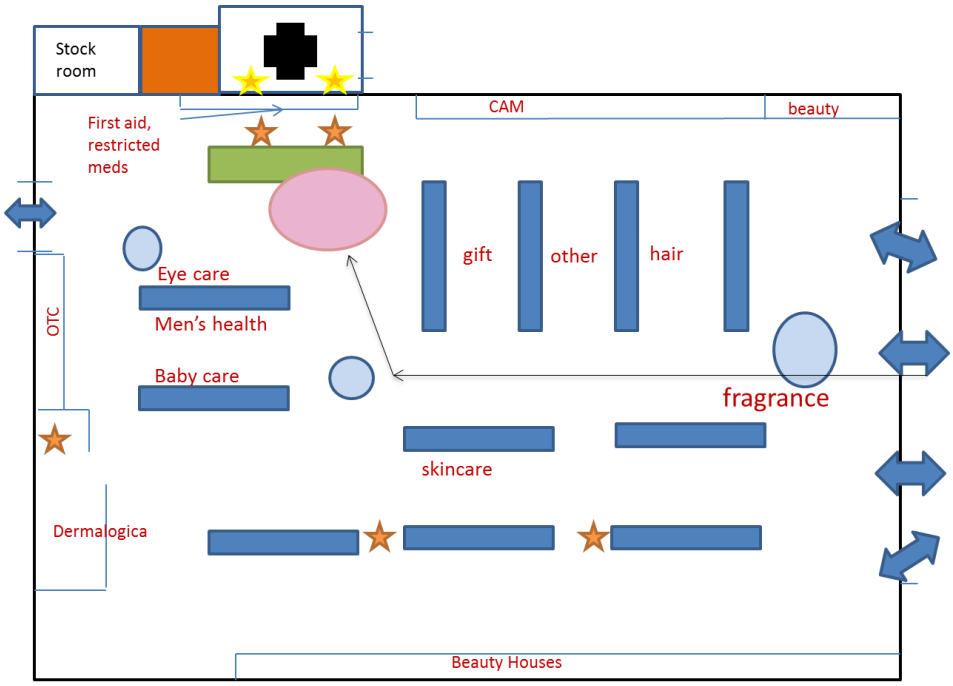
room and lastly the beauty and gift spaces. I explore the meanings of each distinct area within the community pharmacy concentrating on what is in the space (material), the design of the space (physical) and how the space works with the other spaces in the pharmacy (social).



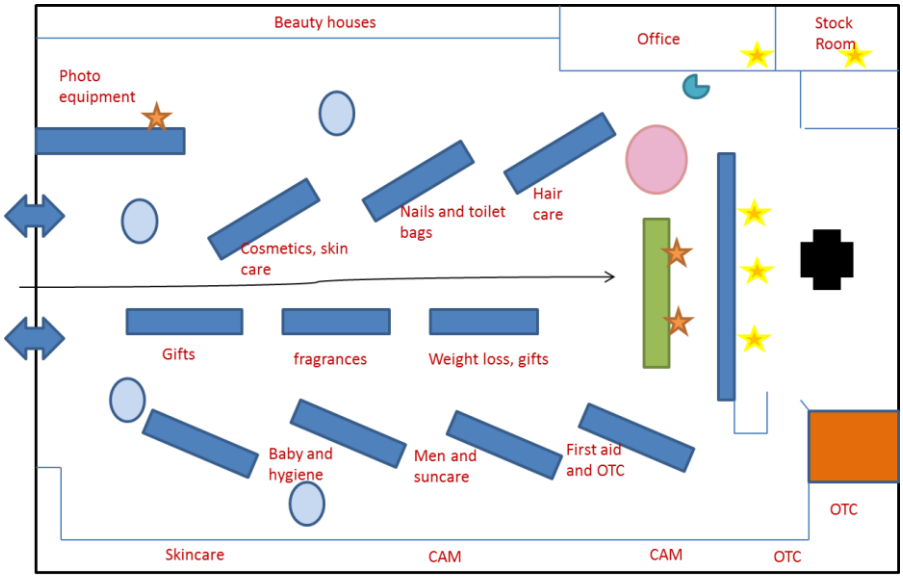
Unichem 1



Unichem 2



Life 1



Life 2

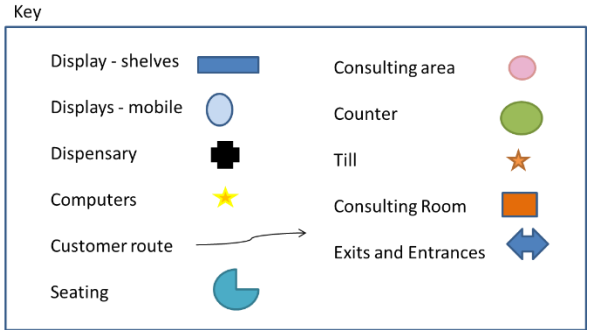


Figure 6: Floor plan of Unichem 1 and 2 and Life 1 and 2 (not drawn to scale).

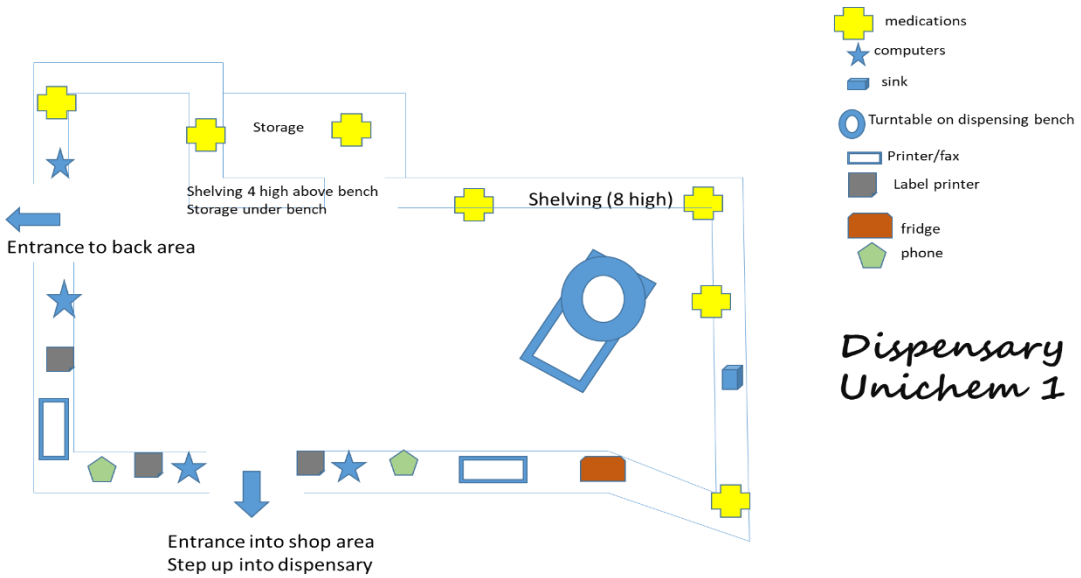
The Dispensary

> *I walk into a new Life pharmacy today so it is unfamiliar, holding my precious prescription in my hand (it takes a lot to get a prescription for antibiotics these days) and know instinctively to head to the rear of the shop. I scan for the prescriptions sign, the counter and a staff member or a pharmacist. I know it is the pharmacist as he is wearing a white coat and he is the only one in the dispensary. The female retail staff member, who is wearing a black uniform smiles at me, spots the prescription and takes it from me, passing it to the pharmacist while giving the standard comment – should be about 10 minutes [field notes, other Life pharmacy, 3.3.15].*

The dispensary is a distinct and recognisable space within all pharmacies. This is due to the look of the dispensary, where it is located and its purpose (to securely store and dispense restricted medicines). In all four specific pharmacies, the dispensary was located to the rear of the pharmacy space (Figure 6) and this is typical for most pharmacies (Emmett, et al., 2006). Even Auckland hospital pharmacies have a shop front and counter located in front of their dispensaries. The location of the dispensary in the pharmacy space means the customers have to pass through the rest of the pharmacy to move to the dispensary, a good retail technique to expose customers to the rest of the pharmacy space. It also makes sense to have the dispensary at the rear because the dispensary contains controlled medicines and medical professionals. The dispensary is restricted space; off limits to customers and separated from the rest of the pharmacy by high shelving and the counter. This is different to the rest of the spaces in the pharmacy that are freely accessible to customers.

The size, design and shape of the dispensary varied depending on the pharmacy brand (Figure 7). Unichem 2 had the largest dispensary with freestanding shelving as well as using external walls for medicines storage. The dispensary in Life 2 was located at the rear of the pharmacy but there were rooms behind and to each side of the dispensary, which was different to the other pharmacies. Unichem 2 had the most unusual shaped dispensary and had one small room with medicines directly off the main dispensary. Life 1 had the

smallest dispensary so used other walls in the back of the pharmacy for storing medicines. I also found that the layout and function of the dispensary reflected the age of the pharmacy and the limitations of the initial pharmacy design. As one pharmacist said, *"this dispensary is a bit old so doesn't function as well as some of the newer ones, its ok but... You should check out the new one in … It is like a coffee shop – drop your order at one end of the counter and collect it from the other end"* [field notes, Unichem 1, 5.5.13]. While the design of the dispensary varied, the actual process of dispensing was similar in all pharmacies. This was because the tools necessary to dispense medicines were in the dispensary space (medicines, benches, secure storage, computers and printers, sinks, fridges, phone, fax, and so on) highlighted in Figure 7. The work in the dispensary is highly controlled because of the regulations around medicines and the pharmacy profession so there is limited flexibility in how the dispensary works, what is in the dispensary and how it looks. Thus, the dispensary space is relatively formal, standardised, and highly controlled space regardless of size or brand of community pharmacy. This differs from the rest of the pharmacy spaces as they have more flexibility in display, purpose and function.



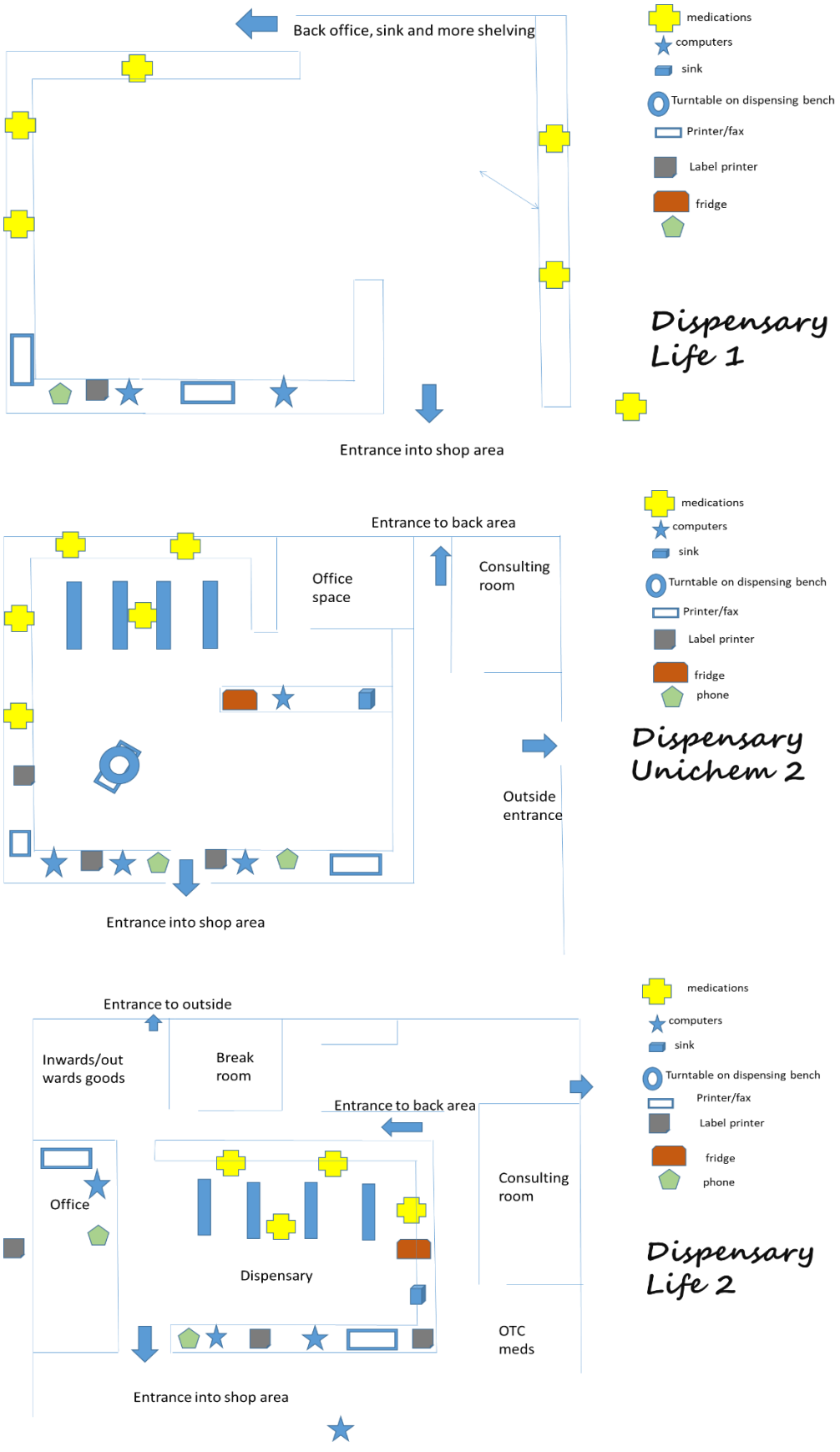


Figure 7: Dispensary maps (not drawn to scale)

The dispensary is a medical space in look, feel and purpose. Aesthetically, in all four pharmacies the medical look is established through the white or grey shop fittings, the distinctive uniform of the dispensary staff (typically white, and differentiated from the shop staff), and because the medicines on display in that space are predominantly in white packaging (Figure 8). The prescription sign is the biggest sign in the entire pharmacy space, with the exception of the pharmacy name, and was always above the dispensary. The prescription sign guides the customer into the pharmacy space, locates the dispensary, identifies the pharmacy as a place to obtain prescription medicines, and as a healthcare space. Since the Green Cross rebranding the prescription sign also now includes the Green Cross logo increasing the symbolic meaning of the dispensary as this green cross signifies pharmacies internationally (Green Cross Health, 2017). Figure 8 shows a dispensary from a newly refurbished Unichem pharmacy in New Zealand. This image is not from my specific pharmacies, as for ethical reasons I did not take photographs of pharmacy spaces that had people in them (and the dispensary always has staff in it when the pharmacy is open). The image does demonstrate the typical features of the dispensary: the large prescription sign, medicines and dispensary staff on view, and a clean and clinical aesthetic with the characteristic blue colour of Unichem pharmacies.

Figure 8: View of a Unichem pharmacy dispensary (source: Lloyd Sinton Design)

In my four specific pharmacies, the dispensary was on a higher level than the rest of the pharmacy and could only be accessed by going up one-step and through a narrow gap between counters. I even note in my field notes that "*pharmacists came down from the dispensary into the retail space*" indicating a physical drop onto the shop floor and a professional drop because the pharmacist was leaving their professional space. In addition, the dispensary always has tall display units plus a counter separating the dispensary from the rest of the pharmacy as shown in Figure 8.

> *The last area that I really look at closely today is the dispensary. I do this from the retail area – trying to peer over the tall shelving that means I cannot see into this space well at all. Even on tiptoes, I am limited to watching the staff from waist up. I want to see if there are benches, computer, storage under the benches and so on but I feel that this space is off-limits to enter, the staff all seem constantly busy and it is such an 'important' space I do not want to interrupt the work flow. The staff are on view all the time except for a small back room and a space to the left of the dispensary. The space is visible but also invisible [field notes, Unichem 1, 28.3.13].*

As I note, the higher display units and the counters act as a barrier to prevent customers entering the dispensary, make it difficult to see into the dispensary and provide extra shelving for restricted medicines that are typically stored behind the counter. These physical features highlight the separateness of the dispensary from the rest of the pharmacy and help reinforce physical boundaries around the dispensary.

There are a number of ways that the dispensary uses symbolism and visible power of medicine to be a legitimate healthcare space in a retail environment. Firstly, having the medicines visible to customers within a clinical-looking dispensary reassures the customers that the pharmacy is a healthcare site and adds medical legitimacy to the pharmacy (Rapport et al., 2009). Secondly, the white uniform of the staff working in the dispensary inspires confidence that the people working in the dispensary have medicines expertise are professionals (Foucault, 1976; Rapport et al., 2009). Thirdly, the prescription sign and dispensary tools and fittings signal knowledge and respect, and reinforce the

values of science and the pharmacy profession. Fourthly, as the dispensary is higher than the rest of the pharmacy the dispensary takes on the qualities of the panopticon, surveying and controlling the rest of the pharmacy (Foucault; Ryan et al., 2004). Lastly, the dispensary space is relatively free of advertising. While the rest of the pharmacy can feel highly mediated, the dispensary remains aloof from the marketing and commercialisation that litters the rest of the pharmacy. There are no visible advertising spaces, marketing, posters, or brochures in the dispensary. While there are no visible signs of advertising within the dispensary, as Edgar (2013) has observed, there is no doubt as to the power of the companies behind the drugs on display and the regulatory forces that allow these medicines into the dispensary. These prescription medicines are powerful symbols of medicalisation and pharmaceuticalisation because of how strongly medicines are linked to healthcare (Abraham, 2010; Dumit, 2012; Harvey, 2013). In these ways, the dispensary relies on medical symbolism and power to push a retail space into the healthcare landscape.

There are physical boundaries around the dispensary – the high counters, small entry, white uniforms, step up and different flooring. There are also other, less visible, boundaries to the dispensary. As I note after my first visit into the dispensary in Unichem 1 "*I have entered the dispensary only once, on invitation by the owner of the shop. I felt that I had been let into the inner sanctum. I was finally on the 'inside' of this aspect of the pharmacy and maybe I had been accepted*" (field notes, Unichem 1, 18.4.13). These unseen boundaries were related to the physical separateness of the dispensary, the power of the products in the dispensary and the professionalism of the staff in the dispensary, but also as an outsider the dispensary is considered off limits. Much of this power is because of the clinical gaze of medicine and professions (Abbott, 1998; Foucault, 2003). All these factors created a sense that the dispensary was a sacred and powerful space, worthy of respect and awe. The sacredness of the dispensary is reinforced by both physical and invisible but tangible boundaries. This is in stark contrast to the rest of the pharmacy spaces, which are

open and accessible; with the exception of the consulting room, but even this space is open to customers on invitation.

The most significant boundary to the dispensary is the power of the products in the dispensary. The prescription medicines are the most powerful physical objects in all pharmacies. There is a hierarchy of medicines based on people's inherent respect for prescription medicines and their power to cure, treat, and relieve pain and suffering (Benson, Cribb, & Barber, 2009). The degree of regulation around prescription medicines also suggests that prescription medicines are safe for consumption because of the rigorous testing and control before they can move into the dispensary (Edgar, 2013). Prescription medicines also have numerous regulations around dispensing, storing and working with these medicines (Ram & Chesney, 2011). This makes the dispensary the most powerful space within the pharmacy because it holds these medicines and the customer needs a boundary object (the prescription) to access the medicines (Cooper, 2011). When there is power, there can be resistance (Foucault, 2003; Ryan et al., 2004). However, the community pharmacy space embraces the power of the dispensary and the medical profession and there is no spatial or symbolic resistance to the dispensary by the community pharmacy. Whilst there may be resistance in work practices or how customers use or do not use the medicines this is not evident in the dispensary space. The dispensary uses the hegemonic understanding of the relationship of medicines to illness and the power of knowledge behind the medicines because it operates in a retail environment. The pharmacy needs the dispensary to create a clinical aesthetic, house the medicines and the pharmacy professionals and push the landscape into healthcare.

In conclusion, the dispensary is a separated and restricted space with strong boundaries created by medicine and medicines. In all brands of pharmacy, the dispensary is uniform in function and purpose although the size may vary. The dominance of medicine is pervasive and all encompassing, reflected in the aesthetics, the physical features, the

symbolism and overall purpose of the dispensary. The dispensary is a powerful, sacred space within the community pharmacy because it is essential to the symbolism and social production of the pharmacy. In essence, having the dispensary in the pharmacy makes the community pharmacy a healthcare site as opposed to a retail space.

Over-the-counter (OTC) medicines

> *I stand in the allergies section of OTC pondering different hay fever medications. I forgot to get my daughter's allergy pills on her last prescription and rather than pay for another prescription I decide to bypass this and just to buy the pills. I immediately strike a problem - in the eight shelves of allergy medicines there are no boxes there with the same name and the same colour packaging as the one she normally uses. How do I buy something with the same active ingredient? I will have to ask. I remember I did see an allergy medicine in the supermarket but only in small boxes [field notes, other Unichem, 7.9.15]*

My field notes immediately illustrate the differences in the OTC space compared to the dispensary as I have a choice: of product, if to buy the medicine at all, how I access the medicine, where I get it from, the price, the colour of the box, and access into the space. However, the OTC space still relies on the power of medicines so is always located near the dispensary and is similar in look and aesthetics across the four specific pharmacies. The products in this space are always grouped by ailment then by the brand whereas a dispensary typically stores the medicines alphabetically. Cough and cold, pain relief, digestive care, and allergies are the main headings in all the OTC areas and these signs were in high positions above the shelfing (Figure 9). Other products in these spaces are eye care, baby care, oral health, men's health, first aid and some medicated skincare. Having the products grouped via ailments makes the boundaries about what is in the OTC area, and what is not, much more rigid compared to the other retail areas in the pharmacy. The rules and regulations for the OTC products (storage, packaging, and safety) are similar, but usually not as restricted as the dispensary, because these products are still medicines. There are stricter regulations for certain OTC products which require

increased monitoring by the pharmacy staff (e.g. age of children, safe for pregnant or breastfeeding women, or potential interactions with other medicines).

Figure 9: OTC areas grouped by function (L-R, Unichem 1 and Unichem 2)

Having the OTC area next to the dispensary is important for three main reasons. It is more convenient for the pharmacist, as they have less space to travel when they leave the dispensary to give advice about OTC medicines. Secondly, grouping the medicines in adjacent spaces leads the customer into a clearly defined 'medicines' area of the pharmacy space. Thirdly, the knowledge assumptions and power behind the dispensary (and prescription medicines) can then leak into the OTC area – making the rear of the pharmacy a more medical and professional healthcare space. There is some flexibility for the pharmacy to decide what 'other' medicines can move into the OTC space such as CAM products. The products moved at the discretion of the manager (retail or dispensary) of the pharmacy.

> *There are some natural medicines in the OTC area. I wonder who decides if this product moves and how it migrates from natural to OTC area (orthodox). Sambucus for boosting immunity is in the OTC area but the flowery label and 'natural' on the box label as well as 'best-selling' seemingly undermines the product compared to something like children's pamol (pain relief) which has more medical packaging [field notes, Unichem 1, 8.10.13].*

The most visible products in the OTC area of the pharmacy are usually seasonally based products such as cold and flu products, sunscreen or allergy medications. These products

have prime retail spots and the most stock on the shelves. At times, these products came off the shelves and into temporary cardboard stands that are placed strategically closer to the counter or the front of the store (frame 1 and 2, Figure 10). The pharmacy has to purchase a certain amount of product to acquire the temporary stand so these stands are a symbol of brand competition and the power of OTC companies in the community pharmacy space. While having these products in convenient and easy-to-spot places suggests the OTC area is highlighting seasonal products to increase convenience for consumers, it also illustrates how commercial this space is. Whether this is actually helpful for the consumer is debatable – it simply markets minor ailment treatments and OTC products directly to the customer. In addition relevant health information is rarely situated next to these temporary stands. If the consumer wants this information they have to obtain it from the pharmacy staff or take a self-care sheet from the Care+Advice stand located near the dispensary (frame 3, Figure 10), or from sources outside the pharmacy (family, doctor, internet, and so on).

Figure 10: OTC display stands (Life 1 & Unichem 2) and care+advice stand (Life)

Competitions were also common for OTC medicines, particularly pain relief (Figure 11). For example, there were competitions to spend time with the All Blacks rugby team if the customer purchased Voltaren pain relief or the customer could win a diamond or $1 million by buying Maxigesic (Figure 11). I note in my reflective journal, *"I am always taken*

aback by these really big competitions as they seemed out of place in a pharmacy. Interestingly, I do not even notice the other marketing strategies (posters, brochures or moving seasonal products) for OTC as they seem to be so ingrained into my experience in a pharmacy now" [reflective journal, Unichem 2, 5.5.16]. Having an event zone in the community pharmacy was also confronting to me (frame 1, Figure 11) particularly as this was located in Unichem 2, which is next to the medical centre. The event stand would be less provoking in a Life pharmacy as Life pharmacies have more of a retail atmosphere. This suggests that the OTC area is the strongest reflection of the commodification of health and the power of the OTC companies in the pharmacy space. The atmosphere of the OTC space and having more competitions and giveaways in this area compromises the value of pharmacy. Perepelkin & Zhang (2011) found that consumers valued pharmacies that demonstrated competence and sincerity over gimmicks and sophistication. Much of the power in the OTC area lies with the manufacturers of the OTC products but also Green Cross Health, as these companies negotiate price, location and marketing with Green Cross Health. Of course, the consumer has the choice if they engage with the competition or ignore the marketing, but having this type of advertising in community pharmacies has the effect of making the pharmacy less professional.

Figure 11: Event zone and competitions in Unichem 2

> *Green Cross send an outline to the pharmacy each month with the specials and this dictates where the products will go in the store. Green Cross will have a person responsible for a "group" of medicines such as allergies, cold and flu and they are responsible for getting the deals for the pharmacies. The companies negotiate deals for space (prime eye space) [field notes, Unichem 2, 9.11.16]*

The OTC area strongly displays how medicalised and pharmaceuticalised minor ailment health care is. Abraham (2010) identified five factors as being important to pharmaceuticalisation and they are all evident in the OTC area. Firstly, biomedicalism ("drug research, development and innovation") is evident in how the OTC products are sold, marketed and displayed (Abraham, p. 606). Secondly, the OTC area also shows how medicalised many natural processes are. For example, pregnant women and infants have special sections in the OTC area highlighting that they have different medical needs to the rest of the population. Thirdly, the criticism of the pharmaceutical industry is usually about prescription medicines, however, there are powerful companies behind OTC products – in fact, sometimes they are the same company. These companies have immense power in the pharmacy and in the OTC area as they have the money to fund their drug promotion and marketing with the aim of increasing the appeal and sales of their products and brand loyalty (Edgar, 2013). Fourthly, taken-for-granted links between consumerism and health illustrate that marketing is hegemonic and expected in the OTC space. With neoliberalism and health policies driving for personal responsibility for health, the pharmacy will increasingly play a role in managing minor ailments to relieve pressure on GPs and hospitals. While many pharmacists have already starting providing (and charging for) some of the more traditional GP tasks such as flu vaccinations this does not necessarily lead to better access to healthcare. Lastly, the OTC area reflects the ideology of the regulatory state (Abraham, 2010). Throughout the Western world, more and more prescription medicines are being re-classified as OTC medicines. This supposedly makes more medicines readily available to the consumer but in reality puts healthcare costs back onto the consumer (Gauld et al., 2015; Tong, Raynor, & Aslani, 2017). The OTC space

therefore reflects the dominant factors that contribute to pharmaceuticalisation including competition and commercialisation, rather than better healthcare access for customers.

In summary, the OTC area is a clearly defined medicines space and is located near to the dispensary in all the pharmacies. In contrast to the dispensary, the OTC space is commercialised which diminishes the power of medicines and the boundaries around the OTC space. This allows some CAM products into the space and allows for mobile OTC display stands and competitions. The OTC companies are strong countervailing powers in the pharmacy and use marketing to distinguish themselves from one another in the OTC space and from other places that sell OTC medicines such as supermarkets. The OTC space thus demonstrates the medicalisation and pharmaceuticalisation of minor ailments where consumers incur many of the costs of medicines.

Complementary and Alternative Medicines (CAM)

> *Retail manager tells me supplements are one of the biggest income earners for the pharmacy but the owners when she first introduced it they were sceptical (13 years ago). She said, "They weren't sure of the witchy, witchy stuff. They are not so sceptical now" (laughs) [field notes, Unichem 2, 25.3.13].*

In all four pharmacies up to a third of the available shelving contained vitamins, supplements, remedies, and other natural products (Figure 12). The range of products in these areas varied across pharmacies but within my four specific pharmacies the CAM space was one of the largest sub-spaces (Figure 6). Even in Unichem 2, the most medical of all the pharmacies, the CAM area was still large. I also observed CAM spaces in independent pharmacies, hospital pharmacies and made note of what CAM products were for sale in supermarkets. I received many reports from pharmacy staff that the popularity of CAM increased significantly over the last few years (Retail manager - Unichem 1 and Unichem 2, retail staff - Life 1 and Life 2). These same staff indicated, as a consequence the amount of space devoted to CAM in the community pharmacy has increased. This is not surprising, as the number of people consuming CAM products has steadily been increasing

(Raaphorst & Houtman, 2016, Pharmacy Today, 2017). In my pharmacies, the CAM areas were always located near the OTC or dispensary areas and customers would have to pass through other retail spaces to progress to this space.

The CAM areas varied significantly from pharmacy to pharmacy and from brand to brand. This is in contrast to the OTC areas that were uniform in look and sold a similar range of products. The differences were evident in the different signage within the CAM area, the range of products, the grouping of products, the aesthetics, and general layout of these areas. For example, in Unichem 1, the signage over the CAM area was 'healthcare' but in other pharmacies it was labelled natural health and supplements, natural health, or sometimes even the label of the CAM company, such as Go Healthy (Figure 12). The CAM area also varied aesthetically across the two brands of pharmacy. The CAM aesthetics in Unichem were similar in look and feel to OTC areas. In comparison, in Life pharmacies the CAM areas were similar look and feel to the beauty areas. This was evident in where certain products were located. For example, in Life pharmacies, natural skin care products were located in the CAM areas but in Unichem pharmacies, these products were located in the OTC areas. Despite the different aesthetics, signage and ambience of the CAM areas across brands, both types of pharmacy predominantly stock ingestible vitamins and supplements. Having mostly pills in the CAM space creates a medicines boundary and positions the CAM space as a medicines space.

Figure 12: CAM areas (L-R, Unichem 1 and Life 2)

While the CAM area is part of the medicine area in the pharmacy, this status is rather precarious. Part of this insecurity is because the four pharmacies CAM spaces had the products arranged in brands. There are four implications of this. Firstly, this complicates how customers use the space. The customer cannot use signage to locate a specific type of product but rather has to look across brands for a specific product, for example, multivitamins or fish oils. Secondly, brand power then becomes more visible, important and powerful in the CAM space. Brands can have specific associations for consumers and companies use their branding to differentiate themselves (Perepelkin & Zhang, 2011; Saunders & Rod, 2012). In the CAM area, the product display (size and layout) reveals the power of the bigger CAM companies. The largest displays with the most product are always from the same prominent CAM companies. Thirdly, the boundaries around the CAM area were more porous than OTC or the dispensary as the products in these areas could be classed as medicines or other health products. Products such as weight loss pills or supplements, superfoods, or protein powders that lie on boundary of medicine and health sit alongside products that may help you sleep better, manage stress or recover from a hangover. Fourthly, some CAM products had the power to move to the OTC area of the pharmacy, earning a higher status as medicine. For example, certain natural cough syrups were moved from the CAM section of the store to 'cough and cold' changing their status on the medicines hierarchy but this was not consistent across the different pharmacies.

> *There was a display in front of the CAM area with all weight loss products. This included optifast, svetol 2800, reducta, quickslim, "lifestream cleanser" – detox for gut. These products are not near the other weight loss products such as meal replacements shakes or the scales. CL told me it was a sales technique rather than promoting weight loss in a pharmacy setting [field notes, Unichem 1, 25.3.13].*

Further evidence of porous boundaries was that the CAM products moved outside the designated CAM area more often than OTC products (Figure 13). Tubs of CAM products, usually on special, had clearly visible sale signs and were placed near the pharmacy

entrance or near the aisles leading to the counter area. Like the weight loss products in the quote above, I was repeatedly informed the reason for this is to "move product out of the pharmacy" [retail manager, field notes, Unichem 1, 25.3.13; field notes, Life 2, 25.10.14]. This has the effect of making the CAM products seem 'less medical' and more commercial as the CAM products are not physically in the medicines area of the pharmacy.

Figure 13: CAM sales stands inside Life 2

In an effort to reinforce the medicines boundary, many CAM products are in medicine-like bottles and the packaging of CAM products is quite similar to OTC medicines (Figure 14). This commodification of CAM to look like medicines suggests that CAM and OTC companies are aiming for branded compliance through distinct medical packaging and marketing (Dumit, 2012). Dumit (2012) argued that drug companies want branded compliance for prescription medicines so that pharmaceuticals become integrated into everyday lives. The overall goal for the companies is for "personal product endorsements" as there is "nothing more powerful" (Dumit, 2012, p. 84). I propose that the CAM companies also want their product to become part of a daily health routine and they want brand loyalty. The other implication of commodification is that the advertising and marketing for CAM products was highly visible in all pharmacies, similar to beauty products and more visible than OTC marketing. CAM product marketing was evident in window displays (alongside beauty products) (Figure 14). The most prominent advertisements in the pharmacy were always out of the well-known CAM companies (Go

Healthy, Good Health, Nutralife, Swisse, Blackmores, Clinicians, or Thompsons) (Figure 15). The products from these CAM companies are the most visible in terms of marketing of medicines, have the largest amount of shelving in the CAM space, (Figure 14).

Figure 14: CAM space (hospital pharmacy) and external window displays (Unichem 1)

There were seven CAM companies that appeared more frequently in marketing both in the monthly brochure produced by Green Cross Health and in the actual pharmacies (Figure 15). I noted in my reflective journal "*When I go back and look at all the pictures I have taken, brochures and email advertising from the loyalty programme (living rewards) there is always a CAM product (if not more than one) from one of the big seven CAM companies. The power these companies have in buying prime advertising and prime shelf space in pharmacies is reminiscent of the big five drug companies* [Reflective journal 21.10.16]. These CAM companies play an essential role in the look, services offered, staffing practices and in how health is marketed to consumers in the community pharmacy. This raises potential issues for smaller producers of CAM products because these products end up on lower shelves and are not as visible in the pharmacy. In addition, if the government regulations around CAM change these bigger companies will have the power and influence to follow the new regulations but smaller CAM manufacturers may fold.

Figure 15: CAM advertisements in the Green Cross Brochure, December 2014.

While the popularity of CAM is undisputed, there is still some ambiguity about the role of the CAM area in the pharmacy space. The uncertainty about CAM is because of the power of medical knowledge and conflicting paradigms on which CAM and orthodox medicine are based (e.g. Shuval et al., 2012; Raaphorst & Houtman, 2016; Ung et al., 2017). There continues to be a degree of scepticism of CAM products from the medical profession and some lay people due to lack of scientific testing and proven effectiveness (Shuval et al., 2012). Any medical scepticism in the CAM spaces is overcome by the commercial value of CAM to pharmacy profit, consumer demand, and through marketing of life-long medicine use. Increasingly, health markets target healthy lifestyles, holistic health and well-being encouraging well bodies in life-long medicine use (Carter, 2015; Lenz, 2012). Well individuals regularly consume CAM products for extended periods. For example, you cannot take one 14-day course of fish oil to achieve the supposed benefits – you should take one a day for the rest of your life. Thus, the CAM space ignores any medical ambiguity and uses the power of medicines and the expanding boundaries of health to create a health space in the pharmacy.

In conclusion, CAM is a medicines space in the community pharmacy because it is situated near the other medicines spaces, it sells predominantly ingestible pills and uses medical marketing and expanding definitions of health to address any medical uncertainties based

on 'lack of evidence'. However, it has a rather precarious medicine status, as the boundaries around what is in the CAM are porous and unclear as evident in how the CAM spaces look and feel across the two brands of pharmacy. In addition, the commodification of the CAM spaces and the visibility of the marketing of the CAM products commercialises the space. The brand power of the large CAM companies is significant in the community pharmacy. The big CAM companies influence the community pharmacy aesthetics and the social production of health in the pharmacy. The CAM space is an extremely important space in the community pharmacy, well and truly entrenched into the pharmacy space in modern community pharmacies.

Counter and till area

> *Most consultations with customers are in front of the counter. The pharmacist use space by the counter, on the shop floor, to talk with a customer. The counter acts a central point in the pharmacy but the counter itself is covered in commercial items. I spot earrings for pierced ears on a stand, fancy lollies in tin, mosquito repellent bands, lip balm, and the latest pharmacy brochure on the counter. There is a large poster for Ester C (a brand of vitamin C) pinned to the counter by my knees. There is not much usable counter space for customers [field notes, Life 2, 2.2.15]*

In three of my four specific pharmacies the counter was situated directly in front of the dispensary (refer to Figure 6). This meant that, in these three pharmacies, customers handed prescriptions to a retail staff member standing behind the counter who in turn would pass it back to the dispensary staff. In Unichem 1 the counter was a circular structure in the middle of the store (Figure 16) but only four steps away from the dispensary so the customer would walk directly towards the dispensary to hand in their prescriptions. The counter area also has other purposes beyond symbolising the place to enact prescription routines. The counter pulls people into the pharmacy, symbolises the business of the pharmacy and is where most interactions in the pharmacy take place. The counter also acts as an additional barrier between customer and dispensary and for restricted medicines to be stored behind in three of the four pharmacies. In Unichem 1,

these medicines are stored in the dispensary as there is no security or space in the round counter in the middle of the shop floor. In addition, in Unichem 1, the counter does not create a barrier between the shop and the dispensary and I did observe a customer stepping into the dispensary but this never happened in the other pharmacies.

Figure 16: Counters spaces (L-R, Unichem 1and Life 2).

There were differences between Life and Unichem mainly in the number of tills and places to pay. Life 1 and Life 2 had a main counter plus other smaller counters (just room for the till) at other locations nearer the front of the store. Unichem 1 and Unichem 2 only had one counter space with multiple tills. In Life 1, Life 2 and Unichem 2, there is always at least one retail staff member situated behind the main counter. The retail staff in Unichem 1 were not able to stand behind the counter so used other spaces in close proximity to the counter to intercept customers. I marked on all my maps where most of the customer/staff interactions took place (shown on Figure 6 as a pink circle). In all pharmacies, this was near to the counter. Having most of the consultations near the counter continued to surprise me as the area around the counter is the busiest in the pharmacy so privacy is always at a minimum and the aesthetic of the counter space is not as medical as other spaces in the pharmacy. While there were health pamphlets and posters located on or near the counter there were also other non-health related products such as sweets, ear-rings, cosmetics, small gifts and other retail items (Figure 16). I found I

had to be very purposeful to notice what was on the counter. These products are almost invisible, ignored or pushed to the side to make room for the mobile EFTPOS machine [field notes, Life 2, 8.6.16]. This is precisely because they are on the counter. The counter is a symbol and symptomatic of a site of commerce in a world where consumers are constantly bombarded with visual images, marketing and advertising (Elias et al., 2017). Of course time standing by the counter to wait, meaning assigned to objects on the counter, and consumer preferences will influence if the products are noticed or purchased.

As well as being a hub of activity in the pharmacy, the counter physically is an object with strong meaning for the pharmacy. The counter reflects staff hierarchies, power differentials and influences how staff work in a number of ways. Firstly, the retail staff used the counter as barrier or a safe retreat from the customers as customers do not go behind the counter. Retail staff do not have a defined workspace, like the dispensary, but they could use the space behind the counter to differentiate themselves as pharmacy staff and retreat from the shop floor. The pharmacists did not work behind the counter unless needed (such as to dispense a pharmacist-only medicine located behind the counter) but rather used the area to the side of the counter for health consultations. This midpoint between dispensary and shop floor was a rather precarious professional workspace for the pharmacist as this space is out of the dispensary. This middling area reinforces the deficiencies of the pharmacy space in health interactions and lack of privacy for consultations at the counter remains an issue for pharmacies (Anderson et al., 2004; Hattingh et al., 2015; Kaae, Traulsen, & Nørgaard, 2012). Secondly, the till (connected to a computer on the counter) is an important object in the pharmacy as it symbolises the business side of the pharmacy and staff hierarchies. The till also reflects the pharmacy culture as some pharmacists only use the till sparingly and leave this to the retail staff reflecting role boundaries (Unichem 2, Life 1 and Life 2). The pharmacists in Unichem 1 use the till regularly to conclude a consultation with payment because the owner developed a culture where the pharmacist had to leave the dispensary in all consultations

with customers. Thus, the area behind the counter is restricted to staff, whereas the area in front and to the side of the counter is open and accessible so the counter acts as a boundary but also creates and influences other boundaries in the pharmacy.

In conclusion, the counter area is a complicated hybrid space that is very important to the social production of the community pharmacy. The counter is both an object and a space in the pharmacy and both iterations demonstrate the powerlessness of the pharmacy. The pharmacy is the only medical healthcare site expected to operate in such a commercial environment and while other medical spaces have counters and desks, none perform the same way as a pharmacy counter. All staff/customer interactions at the counter whether aimed at healing the sick, promoting good health, doing health promotion activities, or ringing the till for a lipstick reflect the constraints under which the pharmacy works and illustrate the tensions of hybridity in the pharmacy. The counter serves as an indication of hierarchical power but also influences how staff work and how customers use and experience the community pharmacy. Pharmacy counters are cluttered, aesthetically busy objects. This busyness counteracts the clinical aesthetics of the dispensary behind the counter. The counter area is where the hybridity of the pharmacy actually plays out – where the symbolism and tension of being a healthcare site in a retail environment is most evident. The counter also demonstrates the social structures related to power of medicine and commerce. Out of all the spaces in the community pharmacy, the counter space symbolises the true complexity of the community pharmacy space.

Consulting room

> *For a short while, there were two pharmacists out by OTC area answering questions and giving advice to customers. Both customers stood quite close to each other and it did not seem to bother either man that they were within hearing distance of each other. The pharmacists did not make use of the consulting room or move the customers further apart from one another. Accessibility and quickness of transaction seemed to be important factors rather than privacy [field notes, Unichem 2, 7.7.15]*

All four of my specific pharmacies had a dedicated consulting room. Figure 6 shows the locations and approximate sizes of these consulting rooms. In Unichem 1, the consulting room was clearly labelled and obvious to the customers (Figure 17) but this consulting room was the smallest. In the other three pharmacies, the consulting room was present but was essentially a hidden space. There were doors that were either not clearly labelled as a consulting room (called natural health clinic in Unichem 2 – Figure 17, frame 2) or there were no labels on the doors. In Life 1, the consulting room was next to the counter and the unlabelled door was kept closed unless in use. In Life 2, the consulting room was concealed behind a wall with OTC products on it. The lack of signage for these consulting rooms is problematic as customers are unaware they can ask for a private space which is an issue that has been identified as a problem for pharmacies (Pharmacy Today, 24.11.17). All staff had access to the consulting room, including management, pharmacists and retail staff, but I never saw pharmacy technicians using this space. The boundary around this space for staff was flexible but customers had to be invited in.

Figure 17: Consulting rooms - Unichem 1 and Unichem 2.

The consulting rooms were quite medical looking being uncluttered, white or grey predominantly and all rooms had a desk and chair (Figure 18). This finding is in contrast to Rapport et al., (2009) who found consulting rooms were cluttered spaces, with multiple purposes including storage. However, Rapport and colleagues (2009) used pharmacies in the United Kingdom and it has been almost 10 years since Rapport's research. There is

certainly a push in New Zealand pharmacy profession to have dedicated professional looking consulting rooms in pharmacies to deliver clinical services in private spaces (Central Technical Advisory Service, 2017). The consulting rooms in these four specific pharmacies had health related posters in all the rooms and no retail merchandise. Posters included Kate Morgan weight advice, natural health product posters, and immunisation schedules. Two of the consulting rooms had reclining chairs similar to these you would find in a dental office (Figure 18). The medical aesthetic was important for two reasons. Firstly, for interactions that were medical in nature the consulting room aesthetic creates a healthcare ambience, which in turn increases the pharmacist's professional status. Secondly, for other services such as ear piercing, the consulting room needs to inspire trust and confidence to reassure the customer of the expertise of the retail staff.

Figure 18: Inside the consulting room (Life 2)

I found that the consulting rooms were used for many purposes and these were not always health related, which is similar to the findings of Rapport et al. (2009). I did not observe interactions within the consulting rooms for privacy reasons but staff members reported that the rooms were used for three main reasons. Firstly, for the extended clinical services by the pharmacists. This included conducting medications reviews, advice giving for an issue that required more privacy than standing at the counter, pharmacist prescribing (for example, emergency contraceptive pill, Viagra, etc.), and looking at the customer's body by the pharmacists (rashes etc.). Secondly, the retail staff used the consulting rooms for ear-

piercing, processing passport photos and some body surveillance tasks such as measuring weight or blood pressure. Thirdly, the consulting room was used for meetings, including staff meetings and meetings with sales representatives or other visitors to the pharmacy (such as myself). Unichem 1 also had an iridology machine set up in their consulting room. There was no formal booking system for the use of the consulting room but there never seemed to be a time when more than one staff member needed the space at the same time suggesting the boundaries of use are still relatively porous and flexible. In my observations, the use of this room varied from rarely to occasionally but never constantly. I do anticipate the use of the consulting room will increase in community pharmacies, which may lead to hierarchical boundary tensions for staff.

Having consulting rooms in community pharmacies creates a private and clinical space within a retail community pharmacy. Currently the consulting rooms in Unichem are more visible than Life pharmacies. The implication is that the customer cannot visually see that the pharmacy offers privacy for some services so this negates the healthcare aspect of Life pharmacies. Another major implication of having consulting rooms is about funding of clinical services that take place in the consulting room. While, funding models in pharmacy services agreements are changing slowly it is important to note that there may not be a funding model that is suitable for all types of community pharmacy for a number of reasons. Firstly, the consulting rooms are currently used for different purposes in different pharmacies (for example, Life 1 uses the room for passport pictures, however Unichem 1 uses a blank wall near the CAM area). Secondly, the layouts and spaces are different across the pharmacies. For example, Life 1, Life 2 and Unichem 2 have back offices for meetings but Unichem 1 does not. Thirdly, the four specific pharmacies have the same core services but offer different clinical and other services. Therefore, there will be different needs for the consulting room based on the pharmacy brand, design, and services offered. Lastly, there are also issues for customers using the consulting room. The process of taking a customer from the counter space into the consulting room marks the customer as

someone 'special' or someone to be noticed. Hattingh et al. (2015) found that both Australian pharmacists and customers value consulting rooms for privacy, but that there are still workflow and workload barriers for pharmacists. In addition, some customers do not expect, or want, a private service in a community pharmacy. It is therefore important to consider that adding a consulting room to a community pharmacy can completely change the social production of pharmacy for both staff and customers. Just adding a consulting room without due consideration of how to use and integrate the consulting room into the pharmacy practices is problematic because of the boundaries around use.

In conclusion, the consulting room space is a powerful medically aesthetic space that symbolises the increased professionalism of the pharmacist (increased clinical services). However, lack of clear signage and multiple purposes negate the medical power. Whilst there was a boundary to cross to gain access to the room for the customer, these boundaries were clear and the 'rules' of encroachment standard across all the pharmacies – the customer had to be invited in. For staff the rules included the need for privacy, length of consultation, lack of any other suitable place for meetings, or health consultation/prescribing. I anticipate that the consulting room use will increase as currently the use varies from pharmacy to pharmacy. This will change the boundary work for staff accessing the consulting room as medical and clinical needs will take priority.

Beauty

> *I spend a few moments watching the fragrance manager preparing the fragrance area for Valentine's Day. She 'romanticising the space' but just the fragrance space. This involves sprinkling heart shaped glitter on the shelves and positioning certain more 'feminine' perfumes at the front of the display. She is responsible for fragrances so maybe she is not allowed to alter the other spaces [field notes, Life 1, 13.2.15].*

Beauty products play a very important financial role in many pharmacies being one of the biggest earners alongside CAM products. As with CAM, a lot of the floor area in many pharmacies is devoted to beauty products including all forms of cosmetics, skincare,

fragrances, nail products and hair care. The large beauty companies with specific spaces in pharmacies are referred to as beauty houses and they sell cosmetics and skincare products. These companies have dedicated beauty consultants that may work full or part time in the pharmacy. In the two Life pharmacies, half of the entire pharmacy space contained beauty houses as well as other beauty products. The beauty houses in Life pharmacies varied between pharmacies but were from the following companies: L'Oréal Paris, Shiseido, Elizabeth Arden, Dior, Smashbox, Revlon, Estêe Lauder, Lancôme, Clarins, or Dermalogica (Figure 19). The lighting, layout and aesthetics of the Life pharmacy beauty spaces were different to the rest of the pharmacy space creating clear boundaries around the beauty spaces. The beauty houses also have distinctive colours, product packaging, staff uniforms and displays that create boundaries and separate the houses from one another and the beauty space from the rest of the pharmacy. The main goal of the beauty space is to entice people to return to the pharmacy through brand loyalty so there is brand competition and power differentials between houses.

Figure 19: Life 1 and Life 2 beauty houses

In the two Unichem pharmacies, the beauty spaces look and work differently to the Life pharmacies. There is less space devoted to beauty products and fewer beauty houses (Figure 20). The signage above the beauty area in Unichem 1 was cosmetics (rather than the name of the beauty house) and there was one beauty house. This was because the beauty consultant specialised in Elizabeth Arden so most cosmetics and the biggest

displays were from this brand. Other brands of makeup were stocked but in limited amounts and they were not marketed as strongly. There was a fragrances area and fragrance sign in the beauty area, however all retail staff would assist customers with fragrance sales. Therefore, the boundaries around the beauty areas in Unichem 1 were less distinct than the Life pharmacies. In Unichem 2, there was no clearly defined beauty space due to very limited cosmetics and no beauty houses. I observed two tubs of nail polish by the counter, a stand of haircare in the middle of the pharmacy, one small section of non-medicated skin care cream located in the OTC area, a Thin Lizzy display (Figure 20) and a stand of lip balms on the counter.

Figure 20: Unichem 1 beauty space (frame 1 and 2) and Unichem 2 single stand (frame 3)

The beauty houses in Life pharmacies are the most visible and marketed product (Figure 21). The beauty houses provide the promotional material, which means that the window displays, the largest posters and advertising material will usually be from the beauty companies. Beauty houses used 'Gift with purchase' and targeted marketing including texts, emails and mail-outs to loyal customers (Figure 21). At an international and national level, the beauty houses work together so they rotate which house is offering specials and give-aways (interview with beauty consultant, Life 1, 5.6.15). This of course gives additional power in the beauty space to the beauty house that is having the promotion, but this is fleeting, so sales must be maximised during this time. No other product or brand uses the same marketing technique in the pharmacy.

Figure 21: Beauty marketing (L-R, Unichem 1, Life 1, & Life 2)

Commodification of beauty is not a new concept, however, the extent and power of the beauty companies in pharmacies (Life in particular) was surprising. The power of these international beauty companies on the aesthetics and feel of Life pharmacies in particular is extensive. The beauty companies negotiate space within the community pharmacy through negotiations with the pharmacy owner and Green Cross Health. Green Cross Health has more control over the beauty products in Life pharmacies, compared to Unichem pharmacies, as they produce a beauty brochure specifically for Life pharmacies. There are beauty products advertised in the monthly health brochure as well. Having such a feminine and strong beauty presence in community pharmacies works against the power of medicines spaces.

One way that Life pharmacy works to keep the beauty within a healthcare space is through medicalisation of beauty and skincare. Life 1 had a Dermalogica area (skin care located in the beauty area), marketed as a more medical approach to skincare. The sales assistant in this area wears a grey uniform that could be medical scrubs. The Dermalogica space is also white and grey predominantly making it medical in look and feel (Figure 22). Beauty spaces also contain medicated skincare products and use medical discourse in marketing discourses (treat your problem skin) and offer appearance medicine services (Botox service offered at Life 1, Figure 22). Having dedicated treatment rooms with clinical

aesthetics was another medicalising strategy of Life 1. This is common also in beauty salons who use medical symbolism and a clinical gaze to ensure that skincare is medicalised (Straughan, 2010). None-the-less the overall aesthetics of the beauty areas and marketing limit the effectiveness of any medicalising strategies in Life pharmacies.

Figure 22: Dermalogica inside Life 1 and Botox display outside Life 1

The other way that Life pharmacy extends the boundaries of the beauty spaces into the rest of the pharmacy in Life pharmacies is through their marketing. The slogan of 'looking good and feeling great' links beauty, skincare and appearance to health by suggesting good health is achieved through external display and internal health. Black (2004) found that health in beauty salons includes the 'feel good' aspects, taking time for oneself, and looking good for work or personal ideals of feminine beauty. This then positions beauty as being part of holistic health, consumption and display (Elias et al, 2017). Elias and colleagues (2017) would argue that (in the West) we all live in societies dominated by visibility with a focus on appearance. This increased spotlight has led to the notion of endless labouring in the pursuit of transforming into a better version of oneself. This includes aesthetic or outward displays but also inward feelings. Elias and colleagues (2017) suggest aesthetic entrepreneurship as a way to capture the link between beauty (affect and surveillance of self and others), politics and neoliberalism. The aesthetic entrepreneur is "autonomous, self-inventing and self- regulating" (p. 39). Using aesthetic entrepreneurship within the pharmacy illustrates how the beauty spaces work within the pharmacy. Beauty fits into the pharmacy as within neoliberal society all individuals are labouring on health,

appearance and beauty. The pharmacy is therefore just another modern, commercial site of aesthetic entrepreneurship where health and beauty are interrelated. The setting of the pharmacy is important because the more clinical the setting looks then the easier it is for beauty to be classified as a health activity (Black, 2004; Straughan, 2010). The beauty space in all community pharmacies can then use the clinical gaze of the dispensary and other medicine spaces to create a social production of pharmacy that includes aesthetic and outward display as well as inward health.

There can be no doubt that beauty spaces within all pharmacies are gendered. Beauty spaces sell gendered products, the aesthetics are feminine, and the staff are females thereby reinforcing gendered beauty ideologies. This creates barriers for the beauty spaces and for the community pharmacy users including men and women who resist dominant beauty ideologies. The other barrier created by the beauty spaces is for the beauty staff who are physically restricted to working the beauty areas, excluded from health interactions [field notes, Life 2, 24.3.15]. The aesthetics of the beauty areas also create barriers for the pharmacy, setting a retail and commercial scene for the social production of pharmacy. This can be problematic, as perceptions of store atmosphere can create or disperse boundaries (Borges et al., 2013). Life pharmacies embrace prestige markets and luxury aesthetics creating additional barriers around the beauty space. However, the expense of the high-end products negates any profit loss due to barriers that may restrict some customers from the beauty space. Unichem pharmacies use their beauty spaces for relationship building and as a service to women in their community. There was still a feminine and retail aesthetic for Unichem 1 but the luxury element is minimised. This reduces the gendered boundaries created by beauty spaces in Unichem 1, compared to Life pharmacies, but does not curtail them completely.

In conclusion, the beauty spaces clearly differentiate the two brands of pharmacy used in this research. Life pharmacies have more beauty houses, more space devoted to beauty

products and more staff working in these areas compared to Unichem pharmacies. Beauty spaces are powerful spaces because they create strong boundaries within and for the pharmacy. Within the pharmacy, beauty spaces are separate from medicines and other health products, however, skincare uses medicalising marketing strategies to suggest the boundary around beauty and health is somewhat porous. Beauty spaces also influence the entire pharmacy by creating a feminine aesthetic and reinforce dominant beauty ideals, creating a store atmosphere boundary. Beauty spaces also reflect the power given to the beauty and skincare companies within Life pharmacies in particular.

Gifts and other things

Food, music, sandals, umbrellas, greeting cards, seasonal gifts, artificial flowers, jewellery, soft toys, coffee mugs, hats, swimsuits and scarves are some of the many products I observed for sale in my four specific pharmacies. These could be gifts (to either oneself or others) or may include more practical items, such as greeting cards. Unichem 1 was the only pharmacy with a label above a gift space (Figure 23). Unichem 1 sold the most feminine type gifts such as artificial flowers, scarves, floral gardening gloves, and jewellery. However, they did have a dedicated men's gift area which was one shelf including coffee mugs, shaving products and travel kits.

Figure 23: Gift areas in Unichem 1

Life 1 and 2 had dedicated permanent gift areas but not to the same extent as Unichem 1 (Figure 24). The type of products in Life 1 and 2 included gifts for babies and children. There were stands of clothing from Miracle Bras, orthopaedic sandals, hats, and scarves sitting alongside everyday self-care items such as toothpaste, sanitary items, baby care products and cosmetics. Even Unichem 2 had a small gift section including gifts for children and baby's, candles and gift boxes of body lotions. All the pharmacies had movable display stands as well with non-health items. Having the gift spaces and movable displays contributes to the retail aesthetic and symbolically suggests the pharmacy is a retail shop rather than a healthcare space. The gift spaces also significantly contribute to gendering the pharmacy shop floor as these spaces smell, look and sell products aimed at women primarily.

Figure 24: Gifts and other areas (Unichem 1, Life 1, Life 2, and Unichem 2)

While having gift spaces creates tensions for pharmacies as a healthcare site, these tensions were resolved in a number of ways. Firstly, the pharmacists or dispensary technicians never sold gift products and remained out of these spaces. Keeping the medical professionals out of these spaces keeps the boundaries around the medicines spaces well defined. Secondly, the retail staff use the gift spaces to build customer relationships and offer convenience. In this way, the gift spaces open up boundaries between the retail staff and customers in both health and other interactions. Rogers et al., (1998) found this particularly true in rural pharmacies where there were fewer

boundaries between staff and customers. Lastly, having gift spaces allows the branded pharmacy some individuality within a brand. While Green Cross Health has removed some of the personality in the branded pharmacies, particularly Life 1, each pharmacy has its own ambience and feel. The gift spaces illustrate how the staff create their own pharmacy landscape through the aesthetics of the gift spaces (and what products are in these spaces). The gift areas reflect the artistic flair of the staff and the vision of the pharmacy owner. This creates a unique pharmacy culture and ambience for each pharmacy.

In conclusion, the gift spaces reflect the uniqueness of each pharmacy landscape but negate the power of medicines and medicine in the community pharmacy. The gift spaces also contribute to the gendering of the community pharmacy, as the gift sections are aesthetically feminine and the products mostly feminine. There is no doubt though that these spaces contribute to the commercialisation of the community pharmacy, but also expand the boundaries of what customers can experience in the pharmacy.

Conclusion: The community pharmacy landscape

Life and Unichem pharmacies have distinct looks, ambience and feel that immediately identify them as either a Life or Unichem (Figure 25). Despite the differences in look, this research has highlighted that each pharmacy has the same spaces within the pharmacy and these seven spaces all work together to co-create meaning for the pharmacy. In my pharmacies, the hybrid nature of the community pharmacy was evident in the clear split between the dispensary and the rest of the pharmacy. By analysing the boundaries around the different spaces within and across the pharmacy, I identified physical, symbolic, aesthetic and gendered boundaries and could compare the different pharmacies and the two brands.

Figure 25: Different aesthetics of Unichem 2 and Life 1.

There were clear medicines and therefore health spaces within all four specific community pharmacies. The dispensary is a separated and sacred space due to its clear physical boundaries and the symbolic boundaries invoked by prescription medicines and medicine itself. There are other less bounded medicines spaces in the community pharmacy including both OTC and CAM areas. The OTC area is a commercialised and medicalised space; similar in look, size and function in both Unichem and Life pharmacies because the boundaries around OTC medicines and minor ailment treatments are clear. This is in contrast to the CAM areas, which have different looks, signage and products across Life and Unichem pharmacies. The boundaries around CAM areas are therefore porous, mostly, related to the differing knowledge paradigms of CAM compared to orthodox medicines. CAM areas use medicalising strategies such as selling predominantly ingestible pills, medical marketing and keeping the CAM space near the other medicines spaces to position CAM as a medicine space. The other medically aesthetic space was the consulting room. However, while the four specific pharmacies did use these rooms for clinical purposes such as medication reviews all pharmacies also used the consulting room for non-health reasons such as meetings and taking passport pictures. Despite this, the boundaries around the consulting room were clear; customers had to be invited in and health purposes took priority for staff but the room was available to all staff.

Both Life and Unichem have counter areas that work for health, non-health and business transactions. The counter area in many ways is the most complex because the counter is both an object and an area. As an object, the counter creates an additional barrier to the dispensary, is a cluttered commercial object, and pulls customers into the pharmacy as it is near the dispensary. As an area, it is a hybrid space. In front of the counter, the space is freely accessible, open and symbolising the pharmacy as a business and a healthcare site. The area behind the counter is restricted to staff and controlled medicines. The area next to the counter is the primary space for health consultations, not the consulting room. All these purposes complicate the boundaries in and around the counter space and this space, out of all the spaces, symbolises the true complexity of the community pharmacy. The main difference between Life and Unichem pharmacies is the extent of beauty and gift spaces. Life have more space devoted to these areas and dedicated beauty houses and beauty consultants. These spaces create a more feminine and highly mediated space that links Life pharmacy to a more retail aesthetic. The boundaries around the beauty areas, in particular, were distinct with clear rules that marginalise beauty consultants.

Power plays out in the community pharmacy within and across each bounded space and within and across the entire pharmacy in both brands of community pharmacy. This illustrates the benefits of considering each space within the pharmacy as power was evident in physical, symbolic and aesthetics of the spaces. The strongest power across the pharmacy is the power of medicine and the dispensary uses this power to create healthcare meaning and a clinical gaze within a retail environment for the pharmacy. The other medicines spaces also use the power of medicine and medicalising strategies, reflecting the dominance of medicine in community pharmacies and in constructions of health. What complicates community pharmacy spaces is commercialisation and this is evident in all spaces. This then leads to countervailing market powers vying for dominance within and across the different spaces in the pharmacy. The dominance of medicine reigns but the power of the OTC, CAM and beauty companies play an important role in the

production of the community pharmacy. This is also in addition to Green Cross Health who have varying degrees of control in all branded pharmacies in how the pharmacy looks, what it sells, and how it operates. In conclusion, the pharmacy uses medicines and medicine power to position the community pharmacy as a healthcare space in a retail environment but the boundaries and power of the other spaces complicate the social production of community pharmacy.

In conclusion, the community pharmacy is more than a hybrid space; it is a site of multiple practices across and within seven distinct spaces. Exploring the physical and symbolic boundaries around and within these spaces illustrated how the community pharmacy meaning is comprised of movement and intersections across and within space. Exploring the spaces also revealed power differentials and competing stakeholders within the community pharmacy. Power played out within and across orthodox medicine, CAM, and beauty in aesthetics, symbols and physical aspects of the pharmacy such as marketing, product placement and staff hierarchies. The consulting room and counter spaces had multiple purposes and complex and interwoven health and non-health practices. Within the pharmacy, meaning representations were produced by these intersections between people, products and space so the next chapters explore these interactions in more depth.

Chapter Five

Pharmacy staff: Boundaries, professionalism and emotional labour

In this chapter, I move beyond the spatial reality of pharmacies and their cultural landscape to exploring how the workplace practices of the staff help create and contribute to this reality (Kearns, 2003). There are different staff groups in the pharmacy with varying levels of expertise. By considering how these occupational groups are classified, used and contribute to the production of pharmacy I explore the relationships between the staff and space (Lamont & Molnar, 2002). Within the community pharmacy, the pharmacists are the dominant professionals because of their medical training. Professions are socially powerful, particularly in health settings, with strong jurisdictional boundaries (Abbott, 1988). Pharmacists have medical and knowledge power over the other staff but research to date has not explored how other pharmacy staff resist this power and control. Boundary work is a useful concept when exploring professions, power and staff hierarchies (Conn et al., 2016; Lamont & Molnar, 2002). Physical, aesthetic and symbolic boundaries within spaces are also invaluable when researching power differentials, tensions and staff relationships within spaces (Peterson, et al., 2015). I investigate symbolic and social boundaries with a particular focus on exploring social inequalities, gender, the different occupational groups' use of the pharmacy space, resources, knowledge claims and negotiations of power (Gieryn, 1983; Conn et al.; Lamont & Molnar). There has been surprisingly little research investigating the boundary strategies between groups where one is privileged through knowledge and the other is involved in manual labour or service work (Vallas, 2001). I begin with a brief look at the different pharmacies and their staff hierarchies.

Pharmacy organisation

The organisational structure of my four specific pharmacies remained relatively standard across the pharmacies. Figure 26 illustrates the staff hierarchy (where one is the highest) and the split in responsibilities and work practices between the dispensary and shop floor. The counter and consulting room are separate in Figure 26, as they are shared spaces so the hierarchies and boundary work changes in these spaces.

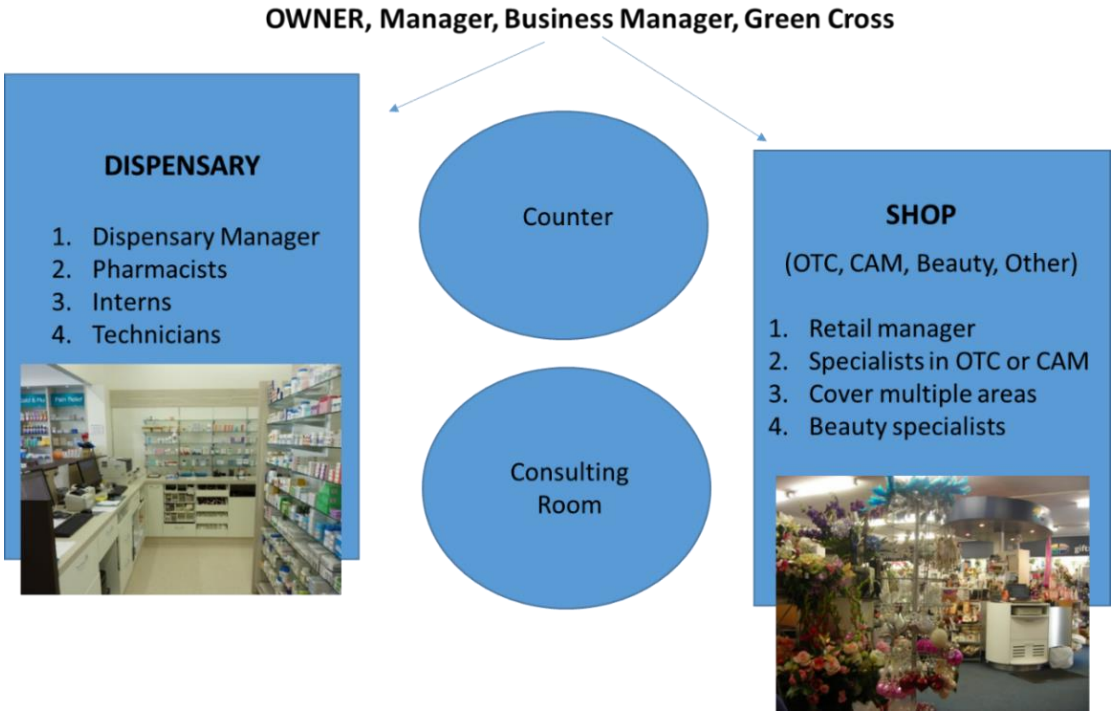


Figure 26: Typical pharmacy hierarchy within the dispensary and shop floor spaces.

While the basic function of the pharmacy staff was the same regardless of brand of pharmacy, there were differences in how the pharmacies run. For example, in Unichem 1, the owner was largely absent on a daily basis so the manager (a pharmacist) left the retail side of the pharmacy to the retail manager and concentrated on managing the dispensary. In Life 1 there was an absent pharmacist owner and the business manager (not a pharmacist) oversaw the pharmacy with a dispensary manager (pharmacist). The dispensary manager would also manage all the pharmacy staff in the weekends when the business manager was not on site. In this Life pharmacy, there were many retail staff and retail staff who worked with medicines had higher status compared to the beauty staff. In

Unichem 2, the manager was a pharmacist and there were many pharmacists and technicians as it is a more medicine-focussed pharmacy. There were fewer retail staff than Life 1 but there was a retail manager. In Life 2, the overall manager and owner was a pharmacist and a retail manager managed the shop front. I sort the findings into staff types, beginning with the dispensary staff followed by the retail staff and lastly I discuss the staff as a team working at community pharmacy production.

Dispensary

Pharmacists

> *Pharmacist stands with his back to counter, leaning on it, one leg over the other, clipboard in hand, surveying the dispensary but glancing out to the shop floor at other times. What is he doing I wonder? I ask and he tells me he is checking medicines orders and ensuring work is flowing in the dispensary. Ah, managing I think. This is in contrast to when he is dispensing – his work practices change and he moves from dispensing counter, to shop, back to counter to type the label, then to medicines storage, back to counting station and then back to counter, finally emerging with the completed prescription. This requires a chat with the customer, not always about the prescription but relationship building - he is a salesperson [field notes, Unichem 1, 30.9.13].*

From an outsider's perspective, it is harder to understand the pharmacist's role by just observing compared to the retail staff. The space that pharmacists work in remained sacred and the pharmacist's medical expertise and professionalism made them seem less accessible to me even though most of the pharmacist's work day is spent being visible to the rest of the pharmacy. The high counters mean the pharmacists and other dispensary staff are only visible from the waist up. Furthermore, the pharmacist's role is not well understood by customers or by me initially, beyond the fact that they dispense medicines. One of the pharmacists told me early on "*I would not understand the dispensing process or understand the full scope of their role*" [field notes, Unichem 1, 4.4.13]. I did discover there are commonalities in how the pharmacists move and work in the dispensaries. Each dispensary works a little differently depending on the physical layout and the culture of

the pharmacy but the basic process is the same. Figure 27 illustrates the typical movement of the dispensary staff in Unichem 1. There are exceptions to the routine because the pharmacist responsible for the Rest Home contracts will leave the dispensary to get products from the OTC or CAM area to add to the orders. The dispensary/shop boundary is crossed to access these products because they are from the health side of the pharmacy. In addition, the pharmacist manager uses the dispensary differently when he is managing compared to dispensing as illustrated by my field notes above.

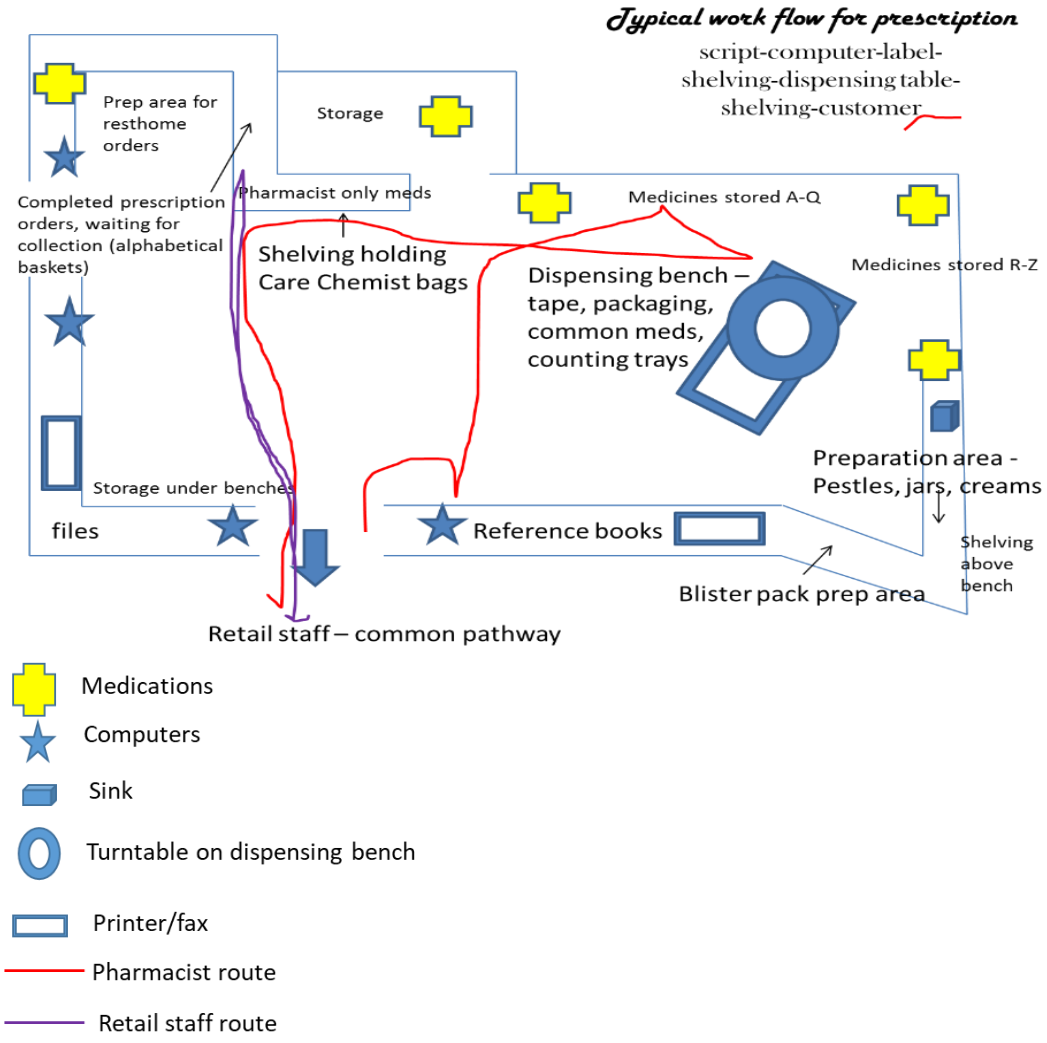


Figure 27: Typical staff movement within the dispensary (Unichem 1)

There are clear role boundaries for all the staff in the dispensary, reflected in the staff hierarchy within the dispensary. The hierarchy starts with the dispensary manager,

followed by the pharmacists who are ranked on their experience, then the intern and lastly the technicians. The hierarchy is based on medicines knowledge, duties, training, and experience or professionalism. Interestingly, the hierarchy is not immediately obvious to the public as the uniforms of dispensary staff are all white so it is not possible to tell the pharmacists from the technicians creating an impression that dispensary works as an equal team. Within the dispensary, the hierarchy is very evident in boundaries of power and control. For example, the pharmacist has to check the technicians work and only the pharmacist leaves the dispensary to consult with customers. Even something as simple as telephone use highlighted the jurisdictional boundaries as the pharmacists answered the phones and used the phones to call doctors or other companies and I did not see a technician using the telephone.

The boundaries around the pharmacist's role were clear in the dispensary. However, outside the dispensary, the boundaries, interactions and performance changed. All the pharmacists had other duties such as consultations, reviews, managerial duties, administration, and meetings. This varied depending on the pharmacist's role, experience and the pharmacy culture, but time spent outside of the dispensary had to be tied to the business of pharmacy (i.e. funding, profit). The staff in managerial positions valued these roles and used managerial duties to expand their professional status as dispensing was seen a technical and less powerful task. At times the pharmacy space also created additional barriers for the pharmacists. For example, in Unichem 1 and Life 1, the pharmacist manager did not have dedicated office space but the retail and business manager did. For these two pharmacies, the dispensary then took on multiple purposes of dispensing and business and the pharmacist managers had flexible work boundaries. For Unichem 2 and Life 2, the management staff could retreat to an office space, which had the effect of maintaining and reinforcing hierarchical boundaries.

There were distinct boundaries created by the brand of the pharmacy. Life pharmacies were seen to be less medically professional than Unichem and this changed the boundary work of the pharmacists in Life pharmacies. A pharmacist at Life 1 said she felt looked down on as a pharmacist in a Life pharmacy because of the more retail aesthetic and the smaller dispensing volume of the pharmacy. Nevertheless, when I asked her why she enjoyed working at Life she said "*professionalism and the way its run. I never have to compromise my ethics – the law is the law and there is no movement. It is black and white. The processes are good too*" [pharmacist interview, Life 1, 12.6.14]. This illustrates that the brand of the pharmacy influences the perception of professionalism but in practice, the pharmacist's professionalism is connected to the management and culture of the pharmacy. Interestingly, this was the only mention of ethics by a pharmacist. There was also limited mention of other gatekeeping duties such as deviant or problem drug use. Chiarello (2013, 2015) found that pharmacists face medical, legal, moral and fiscal issues in this role as gatekeepers to medicines. The complexities of this aspect of the pharmacists role were not the focus of this research but gatekeeping and its relationship to pharmacists identity and professionalism is worthy of further research within different brands and types of pharmacies.

The pharmacists and technicians work seamlessly in a well-known and rehearsed production to get the medicines out of the dispensary to the customers. I described the movements of the dispensary staff as performative or dance-like in my field notes, as there is a routine to these movements. I note, "*There is a rhythm to the way the staff move in the dispensary. The technician and intern work on blister pack side-by-side chatting away, tucked out of the way of other staff. The pharmacist manager and the other pharmacist work more actively exiting the dispensary to collect the prescription, and then there is a routine to the dispensing process that is becoming clearer the longer I watch, working to get the prescription done as quickly as possible*" [field notes, Unichem 1, 12.10.13]. The staff in the dispensary move together as a team and never seem to get in each other's way suggesting

the boundaries around work practices are very clear within the dispensary. This was only evident to me after observing from within the dispensary. Observing from the shop floor did not show the complexity of the staff movements or interactions with each other.

Brown and Bellaby (2002) argue there is value in seeing pharmacists' practice as a drama, because the pharmacists are on view all day and because much of their working day was a well-rehearsed performance of converting the props (drugs) into medicines. Brown and Bellaby (2002) used Goffman's metaphor of theatre to explore a locum pharmacist's experiences. Goffman (1959) uses dramaturgy and language of the theatre (front stage, back stage, characters, scenes and props) to describe how people manage their impressions as a team to present a coordinated performance. Goffman suggests team members must be loyal, disciplined, and circumspect to avoid performance disruptions or inappropriate impressions. Goffman (1959) also discusses both front- and backstage and the impact of context-dependent role playing depending if the performer is in view of the audience. There certainly is value in exploring the performances of staff in the community pharmacy for the following reasons. Firstly, the staff are on view and can escape to backstage areas. Secondly, pharmacists and the other dispensary staff work as a team in a well-rehearsed performance. Thirdly, exploring the performances can also highlight lead actors and power differentials that are role dependent. Lastly, pharmacists have to manage their professional impression whether in the dispensary or on the shop floor. Goffman (1959) would suggest that, "individuals will be concerned with maintaining the impression that they are living up to the many standards by which they and their products are judged" (p. 251). This has important implications when understanding the multiplicity of roles the pharmacist has, as not all products and services the pharmacist deals with are medicines or are carried out in the dispensary. This means I can extend the dramaturgical to the rest of the pharmacy as well.

There is no doubt that pharmacists are central to the production and meaning of pharmacy. However, while I observed the pharmacists on stage most of the day, much of the pharmacist's work seemingly happens in the background of the pharmacy like the extras in a crowd scene. Being visible but out of reach has two seemingly divergent effects. Firstly, working in the sacred and separated space helps create a mystique to the pharmacist's performance and suggests they are important. Contrastingly, the distance between the pharmacist and customer creates barriers to building relationships with customers outside the dispensary. The performance dynamics change when the pharmacist emerges from the dispensary; they become centre stage, more visible and the expert is on show. The dispensary is a well-known and seemingly comfortable performance for many pharmacists and leaving the dispensary is disruptive both for the pharmacist and for the other dispensary staff. However, in Unichem 1, the pharmacists leave the dispensary frequently and interacting with customers was routine. This requires a different performance, one that is more interactive with customers. There are also constraints to working away from the core services in the dispensary. As the pharmacists in Life 1 mentioned, "*I am the only pharmacist working at times, not for long, but it makes duties outside the dispensary difficult as patients expect their prescriptions to be filled quickly*" [interview, Life 1, 12.9.15]. The pharmacist's role is becoming more complex and the performance and stage that the pharmacist is working on is changing. More and more consultations and clinical work occur out of the dispensary. The pharmacists are still experiencing issues with these tasks such as "*it is too time consuming*" and "*I think the resistance is always there when there is change. From what I have observed the resistance may be from the lack of financial forecasts*" [pharmacist intern interview, Unichem 1, 12.8.13]. As one pharmacist manager stated "*it comes down to finances and time. It has to be good for the bottom line and how much time will it take to implement and run, and our resources*" [pharmacist interview, Unichem 1, 18.3.13].

Pharmacy culture and expectations also influence the pharmacist's performance and work boundaries. This meant there were differences between pharmacists' work practices in the different pharmacies because of the overall culture or business philosophy of the particular pharmacy. For example, in Unichem 1, the policy put in place by the owner was that the pharmacist talk with every customer filling a prescription. This is disruptive to the dispensary workflow but was important for building relationships with the customers and "*part of the job*" [pharmacist interview, Unichem 1, 15.7.13]. This was in complete contrast to the Unichem 2, a busier and larger pharmacy, with a culture and expectation of quick and efficient medicines dispensing. One of the many pharmacists would only come out on request by the retail staff. *I haven't seen the pharmacists come out in this visit. If they do, they tend to stay behind the counter or in the gap between the counters* [field notes, Unichem 2, 6.10.15]. One of the pharmacists in Unichem 2 said, "*We don't have time to do much more than dispense, there are so many prescriptions to fill*".

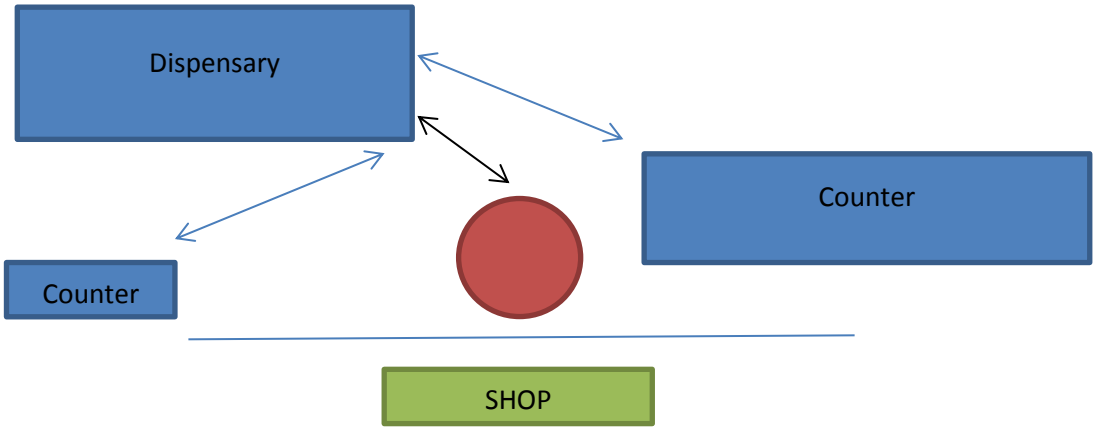


Figure 28: Typical movement of the pharmacists in Unichem 2

Figure 28 shows the common area for these consultations in Unichem 2 with the most common route indicated as a black line. The red circle indicates the area where most consultations take place, between the counters. Working in this shared space is complicated as it changes the boundary work of the pharmacist. Within the dispensary, the professional boundary is maintained through physical and symbolic power of medicine. In consultations, either in the consulting room or next to the counter, the

pharmacist has to use verbal and clinical skills to create a professional boundary. The symbolic medical white coat of the pharmacist assists with this and in the consulting room the clinical feel and aesthetics also help create a professional impression.

> *"There have been some professional changes for pharmacists but the basic job hasn't changed. There isn't much room to grow" and she personally grows by using her media and journalism skills. "I find other ways to challenge myself" [interview, Pharmacist, Life 1, 18.6.15]*

There is no doubt that pharmacists' skills have historically been under-utilised within pharmacy settings and there has been a strong push to reprofessionalise and expand the pharmacist's role (Braund et al., 2012; Thompson & Bidwell, 2015). I observed pharmacists expanding their role in all pharmacies except in Unichem 2, where the pharmacists were constrained by a high dispensing volume. The physical location and the medical aesthetic of this pharmacy, being next to a medical centre, means the pharmacists are primarily dispensers. In the other pharmacies, I did observe pharmacists doing medication reviews, talking with customers for extended periods, and utilizing the consulting rooms. I was also informed in interviews that the pharmacists were expanding their skill bases (for example attending courses in giving flu vaccinations) [interview with pharmacist, Life 1, 18.6.15]. In contrast, this same pharmacist in Life 1 downplayed aspects of the pharmacist profession saying dispensing is "fairly routine" (interview, pharmacist Life 1, 18.6.15). This pharmacist used spaces, places and roles outside of the pharmacy (but within the pharmacy profession) to extend herself and expand her professionalism. To extend herself this pharmacist currently sets exam questions and is involved in the assessment of interns. She is part of the Pharmaceutical Society and has a degree in journalism and media studies. She also mentioned that the pharmacist profession is good for women who want families due to the flexible working hours. Pharmacy is an occupation with one of the smallest gender earnings pay gaps and a high proportion of women pharmacists (Goldin & Katz, 2016). In contrast, all other pharmacists emphasised the expertise and knowledge required to work in a community pharmacy in

their interviews (pharmacist Life 2, Unichem 2, Unichem 1). They all highlighted their own professional interests such as natural medicines and women's health, business and management, and mentoring interns and used these additional interests to expand their skill base.

The other element to consider is how the community pharmacy space affects the professionalism of the pharmacist. The community pharmacy shop floor (any space other than the dispensary) is a problematic space for the pharmacists. Rapport et al. (2009) found that pharmacists avoided the shop floor as this area compromised their professionalism. This research illustrates that this explanation is too simplistic for a number of reasons. Firstly, as discussed above the performance of the pharmacist changes outside of the dispensary. Secondly, different spaces on the shop floor, including the counter, OTC, CAM and consulting room, require different boundary work. The boundaries are complicated as these spaces are shared with retail staff, they require more interactions with customers and the boundaries around the medicines are less distinct. Thirdly, pharmacists avoid some spaces, such as beauty and gifts, because these spaces have no medical connection. Other spaces such as OTC, first aid, or baby care are less difficult because of the symbolic and social boundaries of medicines so the pharmacists' expertise and status are respected.

The CAM area is an example of the tensions faced by community pharmacists. Shuval et al. (2012) suggests this is because the boundaries around the relatively secure world of truth and evidence-based medicine become blurred. Pharmacists did have different opinions on CAM, its safety, place in health care and role in the pharmacy. One pharmacist acknowledged the demand for CAM but largely framed it as 'non-medical' and an area that did not require a great deal of expertise. "*It is not as complicated as it may seem as there are only a few enzymes or ingredients that you have to be aware of. The rest is fine*" (Pharmacist, Unichem 1, 16.5.13). This is in contrast to another pharmacist from the same

pharmacy who had a strong interest in natural health. She says, "*I can usually help to bridge the gap between naturopaths and maybe doctors who aren't familiar with it. And also, you know, certain drugs deplete things and drugs interact with other things*" [pharmacist, Unichem 1, 1.6.13]. She was sought after, by customers and the retail staff, for her expertise in women's health and natural medicine – a professional niche she carved for herself to expand her professional role. However, even for this pharmacist she physically did not spend much of her working day in this space. These examples demonstrate how the pharmacists use CAM for role expansion or defining their medicines role, further illustrating the uncertainty around CAM in the pharmacy setting. Ung et al. (2017) suggests that in Australia, CAM education, training, and scope of practice of pharmacists is incomplete unless the pharmacist is personally motivated to get their own training. New Zealand currently has no formal regulation for CAM products even though Barnes and Butler (2018) found that pharmacists support the introduction of a regulatory framework. This uncertainty at a national and policy level is potentially mirrored in the differing views of the pharmacists' on CAM, as well how CAM is sold in the different pharmacies.

Many of the pharmacist's told me that a large part of their role and sense of professionalism is relationship building. I refer to this as putting the community into pharmacies. Duckett (2013) suggests to build up a successful business and trusted healthcare space the pharmacists and owners have to bridge health and commercial barriers and build relationships with customers and other health professionals. The pharmacist in Life 1 [27.7.15] said, "*I am very good at building conversations*" and tells me she has "*regular customers even though we have a relatively low dispensing rate*" because she has built a relationship with them. There was a sense of pride for all pharmacists in knowing their customers, their community and the history of the pharmacies they had worked in. Relationship building is a skill performed in both the dispensary and other spaces again highlighting the complexity of the pharmacist's performance with and within the pharmacy.

> *Pharmacist mentioned that the pharmacy is a "destination" pharmacy so it is so important to maintain and build relationships to get customers to come to the pharmacy. He said this was a personal strength of his. He also made a point of mentioning that he has morning tea with the local doctors indicating professional relationship building is important too [field notes, Unichem 1, 21.8.13].*

In conclusion, community pharmacists have a multifaceted role in the production of pharmacy. Pharmacists' professional scope is increasingly expanding beyond the dispensary and beyond the pharmacy changing the performance required of the pharmacist, the props they work with, and the people they work with. Community work, business, expanding health delivery (including health promotion) and relationship building are common activities for community pharmacists further illustrating the stage for the pharmacist is extending out of the dispensary. The organisational culture, brand and type of community pharmacy influences the performance, expectations and role boundaries as highlighted by the different stages created by Life and Unichem pharmacies. It will be increasingly important to consider the complexity of the pharmacist's roles and performances as the spaces they work in and their role boundaries expand.

Other dispensary staff

Technicians primarily work in the dispensary and perform an important role in dispensing medicines. Technician's roles have very clear but constrained boundaries because they are limited to the dispensary space and to the manual aspects of dispensing. In addition, technicians have less formal education and training than the pharmacist and all decisional authority lies with the pharmacist. Whilst there are technicians being trained to check the accuracy of prescriptions dispensed in New Zealand (e.g. Napier et al., 2018), I did not observe this in my research. The technician I did talk to said she valued the team environment and learning on the job, mentioning that each pharmacist have speciality areas and she valued learning different things of each of the pharmacists [technician interview, Unichem 1, 22.5.13]. She also discussed her role as primarily one of "*packing and dispensing*" showing her technical skills. The technicians do wear the same white

medical uniform as the pharmacists so they have more medical status than the retail staff. However, the technicians do not talk with the customers and retail staff do. Conn et al. (2015) found that expertise, patient ownership and decisional authority were important in establishing boundaries in patient-care. The technicians have very limited patient contact suggesting while they may wear a white medical uniform, the retail staff have more power in the community pharmacy than the technicians.

I was fortunate to observe, and talk with, an intern in Unichem 1, over the course of a year. His professional boundaries moved as he progressed through his year of supervised work practice. The intern attained more independence and his role changed from student/technician to one of pharmacist. As he moved from technician tasks to pharmacist tasks, he left the dispensary to talk with customers on the shop floor. As his role changed though, so did his status on the hierarchy. His enthusiasm for his role was obvious and his confidence increased over the year. In interviews he discussed what he wanted from his career, what was different from his training, and how he valued learning the 'business' of the pharmacy. *I think we are pretty naïve in the role pharmacists play in health care at university. We think quite differently [interview, intern, Unichem1, 3.10.13]*. Elvey et al. (2015) found that early career pharmacists and other key stakeholders identified competence, values and communication as the main constructs of professionalism. The intern valued these aspects of professionalism, but in addition, he valued the skills he gained in customer interactions. He was content to develop his pharmacist professionalism within the dispensary but valued expanding his physical and symbolic boundaries as the year progressed. This emphasised that it is important to consider the pharmacist's expertise and experience when considering both boundary work and professionalism.

In conclusion, the professionalism of the pharmacist is associated with the dispensary, which is not a new finding (Rapport et al., 2009; McKee, Hughes, & Hanna, 2015). This

research has highlighted that the professionalism of the pharmacist is also linked to spaces outside the dispensary and outside the pharmacy. Exploring the boundary work and professionalism of the pharmacist in the four different pharmacies illustrated pharmacy culture, the pharmacy brand, individual preferences and the actual pharmacy space all influence the pharmacist's performance. For the technicians there were jurisdictional boundaries that constrained them, excluding them from patient contact. In contrast, the intern was able to move across boundaries as they progressed through their training. This research has illustrated the complexity of boundary work of the dispensary staff and highlighted the multiplicities of performances for the pharmacist.

Shop Floor

Retail staff or shop girls?

In my four specific pharmacies, all the retail staff were female with the exception of one male pharmacy student who worked part time in Life 1 for a period of 2 months. In addition, most of the staff were aged over 30 years. Three younger women worked in the beauty houses except one trainee in Unichem 2 who worked at the counter. There are a number of reasons for women being the main workforce on the shop floor of the pharmacy. Firstly, there were practical reasons for these women to be working in pharmacies. Pharmacies are typically open for six or seven days a week requiring a part-time work force in addition to full-time. This means that women who care for others (children or others) can work part-time at certain times of their life, making this work flexible. Secondly, many of the products in pharmacies are feminine and aimed at improving feminine appearance requiring aesthetic labour (Yang, 2017). Foster and Resnick (2013) found customers were more likely to buy "high-involvement" products (such as cosmetics) from retail staff that mirrored or matched age and gender (p. 236). Borges, Babin and Spielman (2013) suggest that the selling luxury products is more effective with face-to-face contact as it lends credibility to the expensive product.

Therefore, the exclusivity of the beauty products for sale in Life beauty houses is aided by face-to-face contact by women selling to women. Thirdly, all the pharmacies offered beauty services that would require showing a 'private' or hidden part of the body (such as hairy body parts) or imperfections that may be considered embarrassing for a female customer to present to a man (Elias et al., 2017). The fourth reason is that the longer the women work in pharmacies the more experienced and knowledgeable they become so they are more likely to stay in community pharmacy retail. Most of the older women whom I observed and talked with have worked in retail, beauty and/or pharmacies for over 10 years, some a lot longer than that. For example, the Estee Lauder representative in Life 2 has spent her life in pharmacy retail – nearly 30 years (field notes, Life 2, 18.3.14). These women then build up a client base and develop personal relationships with customers. This then constrains them into beauty and/or retail service.

The retail staff in pharmacies had distinct roles and responsibilities related to specific areas of the pharmacy, and there was a hierarchy related to the area where staff worked. In all instances, the retail manager was highest on the hierarchy. Retail staff who worked in the medicines spaces (OTC and CAM) were higher up the hierarchy because of the symbolic power of medicines but also because of the expertise required to sell these products. Some retail staff members worked in multiple areas such as in Unichem 1. Regardless of where the retail staff worked, or their role, staff on the shop floor felt inferior to the dispensary staff. The retail manager reported to me "*her hours may be the longest but recognition of this is not there, they (her and the other retail staff) are the 'shop-girls*'" [field notes, Unichem 1, 10.10.13]. Other staff within the pharmacy also often referred to the women working on the shop floor as 'the girls'. For example, the woman business manager reported to me that her role was to support her girls, being on the floor with them when she can and she took pride in telling me she takes the rubbish out with 'the girls' [field notes, Life 1, 13.2.15]. This positions the retail staff not even as women but as girls implying youth, inexperience, and a lower status. In this way, the pharmacy space

impacts directly on the work practices of these retail staff and reinforces dominant gendered ideologies around shop work whilst underlining the occupational hierarchy in the pharmacy.

Having designated specialist areas (OTC, CAM, and beauty) allowed the retail staff to carve out an expertise using specialist knowledge. The diagram of the shop floor of Life 1 (Figure 29) illustrates the boundaries for the retail staff around the different spaces. The different coloured arrows show the various occupational groups, what spaces they used and the boundaries around these areas. Unlike the dispensary where the power of the space and the professionalism of the pharmacist excludes others, on the shop floor the physical and role boundaries were more porous and staff work practices were more flexible. For example, in Life 1 there was not always a dedicated staff member working in the CAM area so the staff member on counter duties would easily move into this area when needed. In contrast, the OTC retail staff member would remain in this area, moving to the counter when necessary. The boundaries for the beauty staff were more rigid and these women stayed in or near their areas predominantly. The two yellow stars near the entrance of Life 1 in Figure 29 indicate the roving retail staff who I described as **sentries.** Sentries intercept, triage and direct customers to the right area or staff member. I note, "*The sentries stand with their hands behind their back, eyes moving back and forward scanning for customers that might need guidance or those problematic customers who might try and steal something. They are ready to assist at a moment's notice* [field notes, Life 2, 12.12.14]. These staff also guard the pharmacy border, scanning the boundary of the outside of the pharmacy to determine if the customer hovering on the border of the pharmacy is problematic or can be ignored. Surveillance was important to prevent shoplifting of the expensive, small products located at the front of the store.

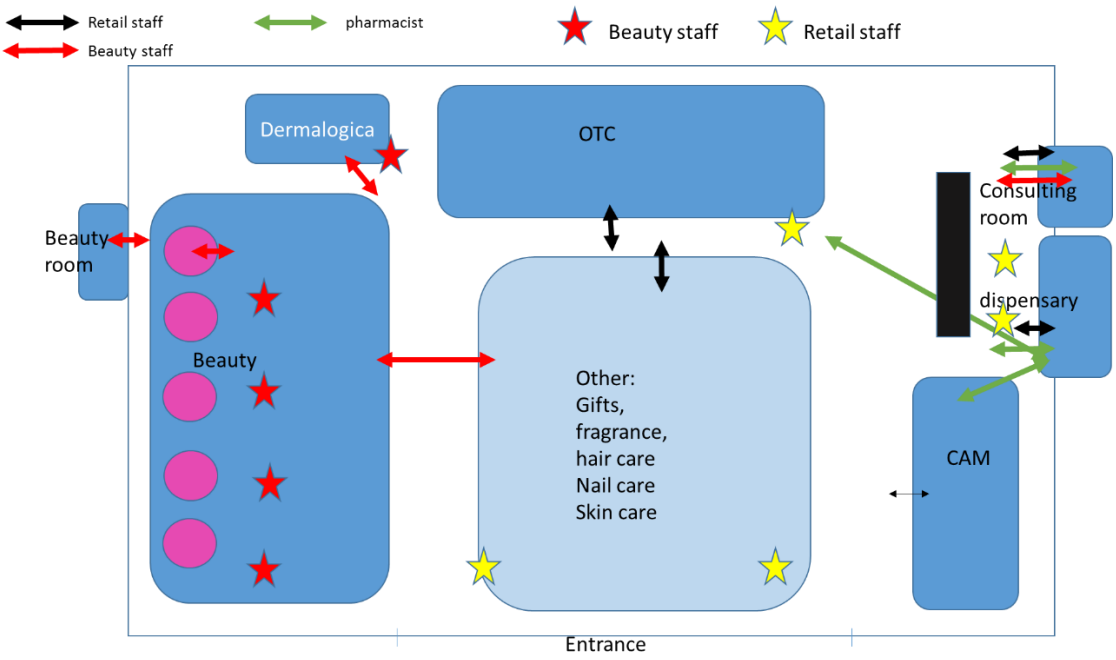


Figure 29: Boundaries in Life 1 Pharmacy

The sentries do not have defined workspaces as indicated in Figure 30. Having less defined boundaries than the other retail staff means these sentries have a precarious role and boundary work is difficult. Staff did rotate through these sentry positions but more senior or experienced retail staff members were given priority to work in their area of expertise (CAM, beauty, OTC). I labelled these specialist retail staff as **guides** as they guide the customer through the maze of potential choices. I observed many examples of the retail staff helping customers with health interactions without the pharmacist. For example, "*A mother shows the retail staff the rash on her child's leg and the staff member gives advice on the product. CW helps the mother locate an OTC cream and the mother purchases the product and leaves"* [field notes, Unichem 2, 3.6.15]. There was a sense of pride from the guides because they were the 'expert'. This expert status meant that they could deal with health issues without the pharmacists reinforcing their status as guides.

Figure 30: Prime areas for the sentries to stand in Life pharmacies

While role boundaries were clear and adhered to most of the time for the retail staff, there were other times when boundaries were abandoned. In all four specific pharmacies customers would tend to come into the pharmacy in waves; some of these were expected and planned for (e.g. in Unichem 1 retail manager said – "*you wait, at 4pm it will get busy, all the men come in then" and they did* [field notes, Unichem 1, 16.10.13]). Unichem 2 was more consistently busy as it was located next to the medical centre and customers would come out of the doctors and into the pharmacy all day so the waves revolved primarily around 15-minute doctor's appointments. There were unplanned busy periods in all the pharmacies where a sudden influx of customers increased everyone's work pace. During the busy periods, the role boundaries had to be temporarily collapsed until the rush passed. Interestingly, in all the pharmacies the staff kept apologising when the pharmacy was quiet. They would use these times to clean, talk to me and would usually have explanations for why it was quiet. The explanations, such as "it's hard to get a park, it's winter so a lot of oldies travel, or it's always quiet on Monday morning" indicated they knew the ebbs and flows of the pharmacy and displayed their experience. This apologising was also a timely reminder to me that the staff knew they were being observed and wanted to seem busy and valuable.

> *On a Saturday at the Life Pharmacy in the mall, each of the beauty houses will have a beauty consultant standing in front of their dedicated beauty house in anticipation of sales. In the weekends these consultants seldom move from their beauty house (field notes, Life 1, 12.9.14)*

Beauty house consultants are different from the other retail staff as their employment arrangements varied. Some of these staff were employed by the pharmacy and some were jointly employed by the beauty house and the pharmacy. Regardless of the employment arrangements, all beauty house consultants had sales targets and responsibilities for their beauty house. This had several implications. Firstly, the beauty staff members have to meet sales targets from both the pharmacy and the beauty house. This requires balancing time and sales; "*Make-up requires longer consults – more trying of products, more persuasion required and harder sales techniques*" (field notes, Life 2, 5.8.14). Secondly, this keeps these women on the boundary of pharmacy – in and out. Beauty consultants' loyalty lies with the beauty house they work for but also with the pharmacy. While beauty staff may be able to help on the health side of the pharmacy, one beauty consultant describes it as "*not my area of expertise. While I can go to the OTC and CAM training if I am not busy, I am not a specialist in these areas and would probably refer the customer to someone from the other side*" [staff interview, Life 1, 29.7.14]. Referring to the health side of the pharmacy as 'the other side' clearly shows the division between beauty and the rest of the pharmacy in the Life pharmacies.

> *The Estee Lauder person has worked at the pharmacy for 26 years. She is a true sales person. She said 'you don't wait around for the customers to come to you and you must be proactive'. She tells me very early on that Estee Lauder is a premier brand that can turn $40,000 in a couple of weeks when they have specials. She told me she would cover the other beauty houses on certain days of the week (field notes, Life 2, 17.3.14).*

The beauty staff use their separateness and role exclusion in their boundary work and other retail staff were excluded from working in the beauty houses. This allows the beauty staff to maintain their professional boundary around their dedicated beauty house. Gesler

(1992) would describe this as being territorial. Being territorial and maintaining boundaries for the beauty consultants is complex. When the pharmacy is quiet, the beauty consultants may talk with each other but when it is busy, the other beauty houses are competition. In addition to this, if the health side of the pharmacy becomes extremely busy the beauty consultants worked in other areas of the pharmacy. I note "*BC helping out in gifts and floating near the front of the pharmacy however she must keep an eye on her beauty house*" (reflective journal, Life 1, 19.10.14). Working on professional boundaries is complex for all retail staff but particularly challenging for the beauty staff.

While the expertise of many of the retail staff members is extensive, retail staff are still lower on the pharmacy hierarchy. The retail staff know they are not medical professionals and that they are on the margins of the pharmacy for many reasons. Their pay, responsibilities, education, gender, and the products they sell - some of which are not health products - all contribute to their marginality and social inequality (Gieryn, 1983; Petersen et al., 2015). Vallas (2001) found that the boundary work of high status employees directly shapes the behaviours of lower status employees. This is because the power and knowledge differentials created strong physical and symbolic boundaries that were difficult to overcome. This was the case in the community pharmacy for the retail staff. The community pharmacy as a workplace embodies structured hierarchies based on medical and scientific foundations and Apesoa-Varano (2013) argues boundary work should be understood within these complexities. Within this environment staff who work in medical spaces, with medical products or in interactions that involve medicines have higher status. Apesoa-Varano (2013) argues this de-values the caring or softer skills in health care. In the pharmacy, this also devalues staff who do not deal in health or medicines. Certain spaces in the pharmacy have clearer boundaries and others are blurred and movable. The access and boundary work varies depending on the sub-space in the community pharmacy (Table 5). For example, the pharmacists never sold beauty or gift type products and the retail staff stayed out of the dispensary except to collect completed

prescriptions. The dedicated beauty house consultants in Life Pharmacies kept to their side of the pharmacy and rarely helped on the health side of the pharmacy. In Unichem 1, the retail staff members worked in all areas on the shop floor with some specialisation.

Table 5: Different spaces showing boundaries of restriction

AREA	Dispensary	OTC	Counter	CAM	Beauty	Consulting Room	Gifts/other
Staff use	Pharmacist Technician Intern Dispensary manager	May have specialist retail staff member or staff to cover all shop	All staff – limited use by the technicians	May have specialist retail staff member or staff to cover all shop	Primary responsibility of beauty consultant	All staff, pharmacist takes priority	Retail staff
Access	Never helped by dedicated beauty staff, limited access by retail staff	Never helped by dedicated beauty staff, occasional use by pharmacist	Used by all but amount of use varied.	Never helped by dedicated beauty staff, occasional use by pharmacist	Never accessed by pharmacist Occasional use by retail	Used by all staff, customers invited in	No use by pharmacists. Mostly used by retail staff but sometimes beauty staff

The retail staff in the community pharmacies did attempt some resistance to the dominant power of the pharmacist's professionalism and medical knowledge. One way all the retail staff challenge this power is to build their specialist knowledge, customer and community service to claim a 'conditional' expert status. Expert status was connected to length of time on the job, training, responsibilities and hours. The staff members or guides in their speciality area develop expertise in their speciality over time (such as CAM, OTC, fragrance, or beauty). I note that RS has been at the pharmacy for 10 years – knows the community, knows the products and knows the locals [field notes, Unichem 1, 25.3.14]. The retail staff members who are responsible for specific spaces such as CAM, OTC or beauty told me that they like being in that space and that they get the most enjoyment by being in their specialist spot. As TW told me, "*I prefer working in OTC. I know the most about this area but I have to work in other spots sometimes*" [staff interview, Life 1, 9.4.15]. Boundary strategies for these staff included role expansion by attending training sessions, reinforcing knowledge boundaries by using health and medicines discourses, and being in

charge of the space. The training is usually in CAM or OTC products and is provided by a sales representative from the company that produces the product. This makes the training session a professional retail encounter rather than medical training session highlighting the hierarchal differences again between dispensary and shop.

> *RS in charge of CAM area talked to me about this [staff training], all staff attend and she organises this. "I decide what training to organise as I know the products. How can they sell something they know nothing about?" [Staff interview, Unichem 1, 2.4.13].*

> *"The training is great; I go to everything. There is so much to remember as there are new products all the time and you forget seasonal information such as allergy or cough or cold medicines. It's important to know the products – you don't want to look stupid" [staff interview, Life 2, 16.3.15].*

The retail managers use role expansion to expand their work boundaries, including skills such as human resources management, budgets, ordering, and stock management, and they may let more experienced staff take on elements of this role. The retail managers also used general health knowledge to demonstrate that they work in a healthcare space, not just a shop. The retail manager discussed with me that she is proud that she is knowledgeable and makes an effort to stay up-to-date "*I stay on top of current trends such as what is safe for pregnant women and children under two years*" [staff interview, Unichem 1, 16.4.13]. She also displayed her professionalism through narratives of historical and current knowledge of the community pharmacy as a shop space, including what products sell. Knowing trends and sales figures is a retail and managerial task, so it simultaneously helps this manager show her experience but constrains her into the shop side of the pharmacy.

> *RA mentioned that lotions and potions sales were down because people can buy these from the grocery store. Same with OTC, she mentioned Sudafed being available in supermarkets. She said "OTC used to be huge, – now, not so much". Hair dye was one thing she mentioned that she would cut back on. "Have to bear this". She tells me that has the good shaving brushes and soap for the oldies [field notes, Unichem 1, 29.10.13]*

CAM sales and consultations are predominantly handled by retail staff. Retail staff working in the CAM area are not constrained by the same epistemological dilemmas faced by the pharmacists about scientific effectiveness or the boundaries of what medicine is. Finding the '*right product for the right person' and sales are the priority* (field notes, Life 2, 12.2.15]. Iyer, McFarland and La Caze (2016) found CAM sales by pharmacy support staff require a level of knowledge about products as well as the ability to know when to seek the pharmacist. The present research also found this but in addition, the expertise of the pharmacist and the culture of the pharmacy was important. For example, in Unichem 1, there was a retail staff member in charge of CAM but one of the pharmacists had a specific interest in CAM, so these two staff worked together frequently. Similarly, for minor ailment advice, the retail staff require a set of specific skills that requires on-the-job training and knowing when to seek advice from the pharmacist. Banks et al. (2007) found that retail staff have a role of risk assessment and transforming the meaning of the medicine in OTC sales. In this research, this risk assessment developed with experience. One of the retail staff said to me "*you have to ask all those questions like who the medicine is for, what other medicines you take, you know. It is about keeping the customer safe. Of course then you have to know what to recommend*" [staff interview, Unichem 2, 26.8.15]. The retail staff, particularly those working at the counter, are pivotal to the running of the pharmacy because they are quite often the only person a customer deals with. I describe this role as a **gatekeeper** as they link the customer to the pharmacists. Being a gatekeeper required specific expertise, was a skill that had to be developed and could be used to assert expert status. As a retail manager said, "*It's about knowing when to get the pharmacist - it takes time to build that knowledge* [staff interview, Unichem 2, 14.1.15]. Therefore, the retail staff build a rather precarious professional boundary using medicines knowledge alongside the knowledge of when to get the pharmacist.

In conclusion, retail staff work in defined areas and claim a conditional expert status in OTC, CAM or beauty. Retail staff are limited as the boundaries around medicines are

inflexible and consequently there is little room for boundary negotiation in the community pharmacy. The retail staff do resist the power of the pharmacist and the dispensary space by being gatekeepers between the pharmacist and customer, becoming conditional experts in specialist areas in the pharmacy, and using role expansion into business or managerial positions. The beauty staff are in precarious positions as they work on the margins of health in the pharmacy space, however, they also become experts in their field of expertise. This research has highlighted how retail staff are maintaining, breaching and modifying physical, social and symbolic boundaries around health and non-health service.

Emotional labour and impression management

Up until this point the different occupational groups have been separated, however all community pharmacy staff work together to create a health and pharmacy impression to the customers. All staff build relationships, promote holistic health and create a sense of community. The theories of professionalism and boundary work are insufficient to capture the complexities of this work or the multiple performances available and expected of community pharmacy staff. Therefore, this section discusses the intricate and different ways the staff work to create, manage and display the pharmacy performance. The type of performance, emotion and display are complicated in the community pharmacy because it has multiple spaces, purposes, occupational groups, and varying individual ethos of customer care. I propose that staff use emotional labour and impression management to put the community into pharmacy.

There has been extensive research on emotional labour of retail and other service occupations and in health care settings, predominantly on the caring professions such as nursing (e.g. Lopez, 2006; Riley & Weiss, 2016; Yang, 2017). The role of emotion or emotional labour has not received much attention in the pharmacy setting, with a few exceptions, and only with the pharmacists (Thompson & Bidwell, 2015). The concept of emotional labour was initially developed by Hochschild in 1983 (and 2003) when she

considered the work that flight attendants did to create a sense of feeling through specific emotional displays. Hochschild (1983, p. 7) defined emotional labour as "the management of feeling to create a publicly observable facial and bodily display: emotional labor is sold for a wage and has exchange value". Employment of emotional labour is frequently hidden, taken-for-granted and undervalued illustrating that emotional labour can reflect gender inequalities and power differentials. Women fill over half the jobs that require emotional labour, particularly in healthcare or retail settings (Duffy, Armenia & Stacey, 2015). The qualities associated with these jobs such as niceness, caring and sociability are also usually associated with women. Most of these roles are lower on the occupational hierarchy and further highlight the role of gender in emotional labour (Wharton, 2009).

A key aspect of emotional labour is the idea that workers' emotions can be commodified, or managed, to present a unified organisational impression. For example, Hochschild (1983, p. 139) suggested that every service act of a flight attendant is "an advertisement" for the airline. Workers are expected to act and feel in ways to meet organisational demands and Hochschild refers to these as 'feelings rules'. This illustrates that institutions and other social structures influence workers' practices through power and control of emotions, and emotional labour in a commercial environment can act as a commodity or resource (Wharton, 2009). Alongside rules, Hochschild (1983) differentiated between public and private displays of feeling. Public displays require a level of acting and Hochschild (1983) describes deep acting ("privately held emotions aligning with normative expectations") and the surface acting ("outward expression of the feelings") (p. 83). Grandey, Diefendorff and Rupp (2013) and colleagues argue that emotional labour should be theorised considering face-to-face contact, display and managed feelings because "emotional labour emerges as a result of dynamic interplay of occupational expectations, expressed emotions and emotion regulation strategies" (p. 17). They clearly argue emotional labour is performed at work, in response to organisational demands and is a "job-based emotional requirement" intended to produce an emotion in another (p. 18).

There have been critiques of Hochschild's theories largely around the lack of agency she credits towards the people in the roles that require emotional labour (Lopez, 2006; Riley & Weiss, 2016). However, I propose the concept of emotional labour is still relevant in the community pharmacy because theoretically, emotional labour captures the complexity of the work the pharmacy staff are doing to firstly, create a healthcare space within a retail environment and secondly, because the staff work as a coordinated team to put the community and caring into the pharmacy. In a professional and public setting, like the community pharmacy, the staff may use both deep and surface acting in an effort to present a professional, warm and caring impression to the customer and this is important for both health and other interactions. I suggest there will be some element of control by the pharmacy itself, the profession and wider health structures. I will continue to use Goffman's (1959) theatre metaphor throughout as many of the elements of Hochschild and Goffman's impression management align in terms of emotional management and teamwork. However, Hochschild (1983) highlights inequalities and organisation control more, which is important in a hierarchical and a branded space like the pharmacy. I also want to explore the role of aesthetic labour by the pharmacy staff in presenting their image to the public. Aesthetic labour is defined as the "relentless exhortation to be active, entrepreneurial, self-optimising subjects" in a neoliberal society (Elias et al., 2017, p. 1). Using these theoretical frameworks allows me to be critical of the underlying assumptions of gender, roles, and power.

The next sections explore how staff members use emotional labour in the pharmacy using the three key elements that Hochschild (1983) considered important: 1) face-to-face contact; 2) display; and 3) emotional feelings and their management. Unless clearly stated retail staff includes beauty staff.

Face-to-face contact and occupational expectations

Face-to-face contact with customers is a key requirement of emotional labour because emotional labour is public (Riley & Weiss, 2016). Hochschild (2003) emphasises the labour and considerable effort required in interactions with people. Within the community pharmacy, the main front-end staff are the retail staff (including beauty consultants). However, the pharmacists also have face-to-face contact with customers when they emerge from the dispensary. Each occupational group is involved in different types of interactions based on pharmacy space they work in, their role and responsibilities, the customers, and products and services. For example, the role of the retail staff on the health side of the pharmacies is to inform, educate, and sell medicines and health advice while being professional, pleasant, friendly and caring. Retail staff who have multiple functions and cover both health, beauty and gift areas on the shop floor have an added complexity of meeting retail and health needs in professional and friendly way. Beauty staff are in more traditional sales roles, and have to entice and persuade through care and relationship building. Pharmacists are required to be professional and friendly in predominantly health interactions to encourage medicine compliance and impart expert medicines knowledge. Therefore, it is complex considering the role of emotional labour in face-to-face contact in the community pharmacy, because of the range of emotions, spaces, products and staff groups. What is consistent across all occupational groups is that all face-to-face contact involves creating a caring and community focused impression through being professional, caring, friendly and helpful. The emotional labour required can be easy but also difficult and all staff have to manage their emotions in the pharmacy workplace. When there were long waits, crying children or grumpy customers, staff members were expected to present (or act) happy, calm and helpful, creating the impression of community service through care in the pharmacy.

> *A couple comes in with a young child for a passport picture. The baby is not happy about being there so the parents make loud wahoo'ing noises as they try to cheer the baby up.*

> *Reverberates throughout the store, people look up from what they are doing. The family are quickly moved by the retail staff into the consulting room – she looks vaguely embarrassed [field notes, Life 1, 15.4.15]*

All staff have a role to play on stage in the community pharmacy, as staff work towards presenting a united or collective impression to the audience. Pharmacy staff have multiple performances, scripts and roles to play to create the impression of caring, professional service within the community pharmacy, and this is not always easy. Goffman (1959) emphasises the role of the stage, script, plot, and actors in managing the impression to the audience. The community pharmacy staff as actors have to be creative, know multiple scripts, and work together, as they work on a retail and health stage with different props and plots. Each product and script requires a different sort of emotional labour or acting. Added to this is the complexity that the customer brings to the interaction as the customer can influence, change and lead the performance.

> *They know personal details of their customers and their lives; ask personal questions and seem interested. I was told a story of a woman who comes from across Auckland to shop at the pharmacy who had bad news (cancer diagnosis) and how sad they were for her; another woman had bought her wedding album into the store to show the "girls". And another story of the staff attending a funeral of a customer [field notes, Unichem 1, 4.6.13].*

For all actors on stage in the pharmacy there were times when the acting was superficial (surface acting) usually because the expectation of a quick and efficient service. However, there were also instances I observed genuine (deep acting) interest and care in the customers. Genuine, caring and interested interactions were more common for retail staff and I observed this more in Unichem 1, which was the smallest pharmacy. These staff had more time to build relationships and they personally knew more of their customer's lives. Pharmacists also had long-term relationships with customers, built over time, but this was less common and was centred on medicines management for the customer or a customer's family member rather than discussing life events, which the retail staff did. I also observed

this more commonly in Unichem 1 because these pharmacists came out of the dispensary for almost every prescription, so they were more accessible. In Unichem 2, the sheer volume of dispensing and work required in the dispensary meant the retail staff did most of the face-to-face work. In the two Life pharmacies, the retail staff also did most of the face-to-face work. For these staff the emotional labour reflected staff hierarchies as care was expected as part of service work, while the pharmacists stayed in the sacred dispensary space.

> *Very busy in the pharmacy so there is a long wait for prescriptions. It looks like a prescription was mucked up so the customer is going to wait even longer while the pharmacist sorts it out. The customer is not happy – no retail staff to protect the pharmacist from the annoyed customer in this instance [field notes, Unichem 2, 23.7.15]*

In the four specific pharmacies, the gatekeepers (retail staff) at the counter acted as an emotional buffer between the customer and pharmacist, protecting the pharmacist's professional role in the dispensary. This part of the retail staff's role was discussed as being "*part of the job. I have to deal with customers, you know, let the pharmacists do their job. At times I feel like a go between but other times I feel valued for my expertise*" [staff interview, Unichem 2, 27.7.15]. The emotional labour for this task illustrated the inherent power differentials between staff and dispensary and shop spaces. The pharmacists when working in the sacred dispensary needed protecting from annoyances, much like management in an office building being protected by receptionists. Other research has shown how different emotions are required when pharmacists are required on the shop floor and managing customer embarrassment is paramount (Thompson & Bidwell, 2015). Pharmacists are expected to work out of the dispensary more and more, suggesting that understanding the role of emotional labour for pharmacists will only become more important.

> *RS told a story of women who bought henna (hair treatment) online, the application had gone wrong and she had come for advice. RS said the woman had been in the store to buy the product but that she had not endorsed this product as she was unsure how it*

would react. Said woman was strong-willed and was going to purchase it no matter what she said. The woman then came back to the pharmacy to get advice on how to fix the problem when it all went wrong. "I didn't tell her I told you so but I wanted too (laughs)" [field notes, Unichem 1, 10.11.13].

There is a wide variety of performances for staff in a community pharmacy and it is important to remember that pharmacy staff are not always selling goods and services. What makes the pharmacy a unique space is the accessibility of free advice, not just for medicines but also for other products such as hair dyes, natural medicines, gifts, or wider health knowledge and other regulations such as passport requirements. This means that face-to-face contact in a pharmacy is not always linked to a sale or profit but often to advice giving. Whilst the pharmacists predominantly sell medicines, they also give advice, consult and attempt to nudge people towards healthy behaviours. Retail staff sell goods that can be purchased elsewhere; they might be assisting with non-health items or even giving directions to customers. Successful interactions then come down to being pleasant, helpful and giving good advice even with no guarantee of a successful sale. "P*eople still come in for advice but then openly say they will go and get the product cheaper somewhere else*" [staff interview, Unichem 1, 10.11.13]. Providing customer care in the pharmacy is complicated because it is a retail and health care space, so the staff have to find a balance between community service, profit and care.

"A man rang up asking for the location of a canoe race and I said you have rang the pharmacy. He said, "I know - do you know where it is on at?" [Staff interview, Unichem 1, 23.8.13].

For emotional labour in the community pharmacy to be effective, it has to be seen to be authentic and trustworthy. As the retail manager mentioned, "*community pharmacy is about trust and building relationships. Without it why would people come to this pharmacy*?" [Staff interview, Unichem 1, 22.11.13]. Trust in the pharmacy can be trust in professional expertise from both pharmacists and retail staff. Trust is difficult to achieve in the community pharmacy due to the constraints of the pharmacy space. For example, face-to-

face contact requires the staff to create a sense of intimacy and trust where there is physically a lack of privacy. This is not always possible and can lead to embarrassment or humiliation. Handling these situations was a skill that requires time to develop and was tied to the sense of expertise of the retail staff and the pharmacist intern. The pharmacist intern told me "*at the end of the day it is just dealing with a patient who's in need and whose come to you for advice. So that side of things I have learnt, just being here, seeing other pharmacists practice. It's been a huge learning curve*" [intern interview, Unichem 1, 12.12.13]. Customers may also have to display body parts or reveal hidden facts that could elicit disgust or stigma (people coming in for emergency contraceptive pill, smokers or non-compliant medication users, methadone users and so on) which requires hiding or disguising these emotions. Hochschild (1983) suggested emotional labour could involve suspicion and not just the display of happy emotions. I did witness examples of all the staff showing distrust towards customers. Often these customers were known and labelled as risky, involving for example, needle exchanges, potential for prescription abuse, or previous shoplifting. This was problematic as the level of care decreased for these 'risky customers'. Lastly, the retail setting and scepticism towards the professionalism of the pharmacist in the retail setting can mean the customers or audience question the trust-worthiness of the pharmacy.

Display – expressed emotion

Hochschild (1983) would argue staff must be trying to elicit an emotion or feeling in the customer in emotional labour. I believe the complicating factor in the community pharmacy is there are different sorts of emotional displays required in the pharmacy due to the different spaces and range of goods and services available. In Goffman's terms this means the props (medicines, cosmetics, passport photos, gifts), stage and scripts (selling cosmetics, caring for cancer patients filling prescriptions, helping customers buy gifts) will then influence the impression the staff are trying to display and also the feeling they are

trying to elicit in the customers. The display required by the staff in pharmacies will be further complicated as the emotional labour depends on whether the interaction is a health, beauty or a retail interaction. For example, pharmacists tend to avoid selling non-health items and services (e.g. passport pictures, greeting cards) so their interactions are largely ones of medical professional and patient. This requires the pharmacist to display and enact a professional and helpful demeanour to inspire trust, change health behaviours, and elicit compliance to medication regimes.

> *"Customers trust a white coat to get expert advice. Our pharmacist has wonderful and great knowledge. She knows more than doctors about medicines. It is amazing" [interview business manager, Life 1, 29.4.14]*

Aesthetically, the pharmacists have to project professionalism and while the white coat may do some of this work, the female pharmacist, in particular, is constrained into "*well-dressed professional but not too made-up*" [field notes, Life 1, 143.16]. Having heavy make-up has been associated with sexuality and lower status (Elias et al., 2016) so this is suitable for the beauty consultants but not the female pharmacists. When the safety of the patient lies with the pharmacist there has to be a level of authority and expertise behind this knowledge for it to have legitimacy (Thompson & Bidwell, 2015). Medication reviews, prescribing and health promotion consultations require emotional labour that is seen as more authentic and caring although most interactions I observed were for OTC sales and prescriptions. *I did see a customer get very annoyed when the pharmacist tries to sell a CAM product in addition to the prescription they filled, a rather loud no thanks reverberated throughout the pharmacy* [field notes, Unichem 1, 12.5.13]. Sales techniques such as on selling of CAM products were seen as inauthentic displays and this was annoying for customers. This highlighted to me the different sorts of emotional work pharmacists need within the different spaces (dispensary, counter, or consulting room) in the pharmacy and the image that they need to present to the public to inspire trust. In addition, the performance of the pharmacist has clear expectations by the customers, one that is not

sales related. In interactions with sales consultants or other staff, the same level of care and expertise is not expected. As one pharmacist said to me "*I keep them [sales reps] waiting while I do a couple of prescriptions, it is good to keep them waiting*" [interview, pharmacist, Life 2, 14.8.14]. It will be important for future research to understand the emotional labour in the hidden consultations such as those in the consulting room.

Much of the time, retail staff are front stage in the pharmacy performance even with OTC and CAM medicines. This requires emotional labour and work that goes into selling OTC medicines, good health and the potential to be a healthy citizen. For the OTC retail staff, and CAM to a lesser degree, emotional labour was one of sympathy and empathy which are 'softer skills' stereotypically associated with caring and femininity (Wright, 2005). In addition, Cooper (2013) suggests orthodox medicines and medical products have an element of risk management so surveillance and suspicion are then required. This complicates the performance and display for certain products, such as some OTC medicines, prescriptions, pharmacy-only and pharmacist-only medicines. The emotional labour of any staff processing these interactions meant that the friendly face of the retail staff and the pharmacist was replaced by that of a serious professional. I reflect in my journal that caring/sales face is replaced by '*do you know how serious I am and the consequences of not following my instructions are?*' [Reflective journal, 26.2.15]. This is particularly difficult for the retail staff actors as they present a different impression than the medically dressed professional pharmacists. Retail staff had the advantage as they often had more time for consultations than the pharmacists so could develop a stronger relationship with the customer. Overall, the acting and emotional labour required of retail staff is more caring focused, reflecting role boundaries and staff hierarchies.

> *RA talked to me about helping cancer patient (woman) to find beauty products that would not irritate her skin. "It is important as so many products can be harmful to people going through chemo" [field notes, Unichem 1, 18.11.13]*

The performance expected of the beauty consultants was quite different to the retail staff. Interestingly, the dedicated beauty consultants also displayed a level of deep acting and caring. Kang (2003) suggests that being personal, sociable and attentive are emotional requirements for beauty work and that these requirements are gendered. Some beauty consultants have had clients for many years and have developed close relationships with these women. The consultation then becomes more one of support, friendship and genuineness. While the beauty consultants had lower occupational status in the pharmacy, they talked to me of their expertise, professional knowledge and their relationship skills. Being professional was strongly linked to making their clients "*look better than you do now*" but also about making them "*feel better than they do now*" [field notes, Life 2, 12.6.15]. The beauty consultants were particularly required to "*look the part*" [field notes, Life 1, 19.1.15] or stylish, to use the products they are selling and to reflect the brand of the cosmetic. Elias et al., (2017) suggests this requires aesthetic labour, where the look of the staff is commodified and intentionally used for profit of the beauty company. In the community pharmacy all the staff are expected to aesthetically labour, not just the beauty consultants. As a colleague said to me, "*they all look like flight attendants*". This suggests that the community pharmacy requires a specific emotional display and performance with clear roles for the retail staff and beauty consultants.

There are a variety of emotional displays and performances expected by the staff in community pharmacies from selling, persuasion, care, concern, smiling, serious and professional. Pharmacists are seen to be inauthentic if they are too sales like whereas the expectation of customers is that beauty staff will be persuasive. This highlights how interactional emotional labour is and how the customer influences the display of the staff. I observed pregnant women, babies and small children, and older adults inspiring more genuine care and interest and longer interactions. Products and services also influenced the level of emotional labour required because customers expect a different service for

different products. For example, gifts and services such as passport photos did not require the same degree of deep acting or 'genuineness'.

Emotion regulation and control

The last important aspect of emotional labour according to Hochschild (1983) is that the employer and management has a degree of control over the emotional activities of the employees. Hochschild would term this "'trained management of feeling" (p. 14). Green Cross Health has a business interest and varying degrees of control of all Unichem and Life pharmacies. I argue that being part of a Green Cross Health brand (Life or Unichem) leads to a set of standard expectations by Green Cross. For example, the retail manager of Unichem 2 indicated to me "*Green Cross has got all the suppliers in their pockets. They run all the promotions. We have limited control over what we can get beyond the quantities of things. They control the pricing, everything*" [interview, Unichem 2, 30.5.15]. Green Cross also expects compliance and defines a set of behaviours for all the staff, including pharmacists. A pharmacist mentioned to me "*being a corporate pharmacy means it can be more about sales and it is not health focused at times. But it means the pharmacy is well run*" [interview, pharmacist, Life 1, 12.12.15]. The business manager in Life 1 says, "*This (being with Green Cross) is good because we can access more stock now. However, it does mean that we have to be more compliant*". This highlighted to me the level of business control by Green Cross Health over some of these pharmacies in how the pharmacy looked, was run and the products and services for sale. The other way Green Cross created expectations was in the way they marketed the two brands of pharmacies and this influenced the staff performances and practices. The staff in Life pharmacies were expected to represent the brand of prestige and luxury, whereas Unichem are promoted as family pharmacies.

In addition to Green Cross Health, owners and managers influenced the emotional labour and the aesthetic display of staff. The way the pharmacy is run and the expectations of management filters into all work practices and expectations. The pharmacy dictates role

expectations, demeanour, who deals with certain customers, and outward displays of emotion. For the pharmacist this influenced time out of the dispensary. "*That is GB's philosophy. That's that role that the pharmacist should be doing. We always go out if there is a change in their medication, look at their history*" [pharmacist interview, Unichem 1, 16.8.13]. For the retail staff "*the pharmacy owner expects us to be proactive*" [staff interview, Unichem 2, 14.6.15]. The beauty consultants are also expected to be proactive and achieve sales figures. Aesthetically, before the rebranding of the pharmacy brands often the retail staff would wear T-shirts with logos from CAM or OTC companies as part of their uniform. This shows that in community pharmacies there are numerous controlling factors and that industries (OTC, CAM, and beauty) also have expectations on appearance, demeanour and ways of selling. While this means the 'feeling rules' and expectations vary from store to store because of the pharmacy owner, at a macro level there is less difference in emotional labour expectations due to wider controlling forces such as Green Cross Health, OTC and CAM companies, and beauty houses.

Customers also expect a uniformity of customer service regardless of pharmacy brand. These 'feeling rules' in the pharmacy are influenced by wider social and cultural understandings of health and illness and the symbolic role the pharmacy plays in healthcare. The rules, procedures and regulations in a community pharmacy are organised around building caring relationships and safe and efficient medicine dispensing. Grandey et al., (2013) also suggest there are cultural expectations that influence rules, which then creates different rules for men, women, different ages, ethnicities, occupations and cultures. This creates a set of feelings and emotional rules that can be difficult to negotiate for staff, as customers expect different things at different times. This again highlights the complexities of the staff's performances in the community pharmacy.

All staff had to change their performance in extremely busy periods becoming less caring and more efficiency focused. There were also times I observed staff displaying seemingly

inauthentic emotions, where the private feeling was visible, predominantly with difficult customers. For example, "*a woman rushes in with a prescription in her hand, almost throws it at the retail staff member at the counter, and when told it would be 10 minutes, angrily stomps out of the pharmacy*" [field notes, Life 2, 9.3.14]. Customers also reported getting annoyed "*he was quite rude. Mum would ask him a question and he would raise his eyes and look around the rest of the staff – quite sarcastic! I have always remembered that and I never liked him*" [customer interview, Life 1, 14.9.14]. In contrast, Sherman (2015) suggests that care workers in some professions (beauty therapists and paralegals) enjoy the emotional labour because they use this work as "the basis for claiming professionalism, seeing emotional work as a skill" (p. 167). This was certainly the case for the retail staff in this research as well. Emotional labour was seen as an important skill, one that developed over time and was related to their expert status and part of customer service. A retail staff member said to me "*I love helping people. It's the best part of the job*" [interview, Unichem 1, 16.5.13]. The pharmacist at the same pharmacy also valued developing relationships saying "*If you are a true community pharmacy then relationships are key. People come in to see me, they know me*" [pharmacist interview, Unichem 1, 16.5.13]. The cost of this emotional labour, predominantly staying pleasant in the face of angry customers, for the retail staff was expected and part of their service work. The cost of emotional labour for pharmacists was largely framed as an issue when their expertise was not recognised. For example, a pharmacist mentioned to me "*It is a bit frustrating when patients don't want to listen*" [interview, Life 2, 5.9.15]. Another pharmacist mentioned that doctors do not always recognise their expertise and how much of a surprise it is when they do "*And then every once in a while you'll get somebody that's super friendly and you'll think oh my goodness that doctor was just totally nice to me*" [interview, Unichem 1, 19.8.13]. These examples illustrate the complexity of emotional labour in the community pharmacy across and within staff groups.

In conclusion, all staff use emotional labour in the community pharmacy for face-to-face customer service and as a way of building relationships. There were times when this was genuine and other times when the busyness of the pharmacy led to changes in the emotional labour, to be more about quick, safe and effective service. Differences in spaces in the pharmacy and different products required different forms of emotional labour and display. Green Cross Health, pharmacy owners and management have feeling expectations that require emotional management by the pharmacy staff. There is a constant balancing act for staff in community pharmacies where displaying the right emotion at the right time can lead to a better outcome for the individual staff member (e.g. linked to sense of worth, pride, and professionalism), for the customer (e.g. better health outcomes, look better), for the pharmacy space and the pharmacy brand. In the face of complaints or abuse, the veneer of professionalism and caring covers up problems with service work. This is not a problem unique to community pharmacies. What is unique is the range of emotions the retail staff may have to elicit in customers and the range of performances the staff may have to utilise. This suggests that service work in pharmacies is both constrained and expanded by the healthcare aspect of pharmacies. For the pharmacists, the business of pharmacy, the value attached to the dispensary work and the dominance of science influence emotional labour. When medicines are prioritised in the name of service this actually marginalises the value of caring and the time it takes to be customer focused (Apesoa-Varano, 2013; Thompson & Bidwell, 2015). Therefore, in trying to provide a caring and community focused service the boundary work and emotional labour of all the staff ends up reinforcing dominant gender hierarchies and role boundaries.

Conclusion: The collective representation

This chapter has considered the specifics of how space, boundaries, professionalism and emotional labour of staff interact to produce the community pharmacy production. Staff practices are complicated as they work within a complex hybrid space with discrete

spaces with power differentials. All staff on the stage of the community pharmacy are important in playing a role in the production of pharmacy. Dispensary staff work centre stage but often do not interact with the customers but use the dispensary as a space to work on their professionalism. Role expansion and reprofessionalism of the pharmacist was evident in an increasing number of roles for the pharmacist outside the dispensary. This illustrated how the performance and professionalism of the pharmacist is moving. Retail staff build conditional expertise in OTC, CAM and beauty areas but this is a precarious status. Retail staff have more face-to-face contact with customers than other staff, which requires more emotional labour. These staff are more likely to be female and constrained into roles lower on the staff hierarchy. The brand of the pharmacy, the culture and workplace philosophy, and the location of the pharmacy all influence the performances of staff. In addition, the staff all use emotional labour in interactions with customers and other people in the pharmacy to create a sense of community, in effect adding care and community to the pharmacy.

This chapter has demonstrated that the staff members in community pharmacies work together to create a collective representation of community pharmacy. Goffman (1959, p. 27) describes the collective representation as the social front that becomes "institutionalized in terms of the abstract stereotyped expectations to which it gives rise, and tends to take on a meaning and stability". I suggest the community pharmacy work in a team environment and create a collective front to the audience who are the customers. Therefore, while there are distinct roles and spatial boundaries and staff hierarchies related to the different spaces in the pharmacy, the staff cohesively present and display a unified performance to customers through boundary work and emotional labour. The next chapter explores how the customers use and interact with the community pharmacy and the staff.

Chapter Six

Customer experiences: Shopping and consuming health in the pharmacy

The overall purpose of this chapter is to explore the dynamic and inter-relational practices and performances of the customers with and within the pharmacy space. Research on pharmacy customers tends to focus on what sorts of individuals use pharmacies, medicine use, or interactions with the pharmacist. This all positions the customers as rational, resourceful, generic beings whose sole aim in the pharmacy is to consume health and medicines responsibly (Harvey, 2013; Roy, 2008). Pharmacy users are then grouped according to gender, age, ethnicity or disease (such as older adult, asthmatic, Asian), or by the amount of medications they are on and time of use (such as long-term user). This ignores that individuals are active social beings who develop health knowledge over time, and who incorporate health objects and information into their lived worlds (Harvey, 2013). This also ignores the other retail consumption that occurs in pharmacies. Data on customer use of pharmacies also tends to be collected via surveys and questionnaires so the experiences of how customers engage with the pharmacy space, the products and the staff are not fully explored.

I argue that customers have a range of performances open to them in the community pharmacy and these performances are driven by consumption. As with any performance this is dependent on the stage (different spaces in the pharmacy), plots (scripts and dialogue), props (product or service), and other actors (staff members). Pharmacy customers are not passive users of either medicines or other health or non-health products or services. They also frequently resist dominant neoliberal medical and health

discourses. De Certeau (1984) suggests there are externally imposed rules of operation on space and I propose this is particularly relevant to health and beauty, two primary functions of the pharmacy. Customers actively and tactically engage with the many established rules and ideas in community pharmacies and it is by attending to these that de Certeau would argue we can analyse the micro-subversive tactics employed in resistance to these rules. It is important for this research to frame consumption as active and productive (de Certeau, 1984). This research therefore explores the active processes of production of medication, beauty, and other practices in a hybrid space by health and non-health consumers. I continue to emphasise the performative elements of the customer's interactions with space using Goffman's (1959) dramaturgical metaphor.

For the rest of this chapter I will refer to the users of community pharmacies as customers rather than consumers or patients. This is for three main reasons. Firstly, customers as a term is more suited to the theatre metaphor than consumers. Customers are an interactive audience in the social production of the community pharmacy whereas consumers implies a more passive audience. Secondly, customers as a term removes the focus on medicines consumption and captures the complexity and range of performances open to people visiting the pharmacy. Lastly, customers keeps the terminology homogenous, simpler and forefronts consumption. I acknowledge that individuals may use the pharmacy as a patient, a client and/or a consumer and each role has different connotations and meanings, but I did not want to privilege medicines or health over other forms of consumption but explore the range of experiences and practices of pharmacy customers. Different pharmacy staff members also have a tendency to refer to customers in certain ways, depending on their location within the pharmacy. Retail staff members talk of their customers even when helping people with OTC or CAM products. The customer is someone who uses the pharmacy for a range of services and goods (gifts, remedies, cosmetics, ear piercings and so on) which imply service, sales and consumption *("it is important to have good customer service" [field notes, Unichem 1, 14.11.13]).* Beauty staff

members typically referred to the customers as clients and, to a lesser extent, as customers ("*I have regular clients, women I have known for years" [field notes, Life 2, 11.1.15]*). When the staff label the customer as a client, it suggests a professional and commercial interaction. Lastly, the dispensary staff normally called the customers patients, as the patient is in the pharmacy primarily for medicines and health advice. Of course, a person may be all of a patient, client and a customer in the same pharmacy visit and this research considers these experiences as well.

The overall aim of this chapter is to explore how customers consumed both health and non-health in the community pharmacy. I begin this chapter by firstly discussing the customer's health-related consumption including medicines and other health products and services. I then discuss non-health related consumption. It is important to note that in addition to observations I also interviewed a small selection of long-term customers about why they used their pharmacy. The interview data informs the previous sections but I forefront the interview data in the next section where I summarise why customers are using the community pharmacy. Lastly, the chapter uses hybridity to discuss how the customers use tactics and strategies to consume in the community pharmacy.

Health consumption in the community pharmacy

Most health consumption is performed in five distinct spaces in all community pharmacies. Three of these spaces sell medicines; the dispensary, and the OTC and CAM areas. The other two spaces involved are the counter area and the consulting room. These spaces are the most medically aesthetic and contain medical products and the staff who specialise in these products. For health consumption in the pharmacy, there are distinct routines, rituals, and performances associated with both the spaces and the products in the spaces. I begin the discussion of health consumption with the dispensary space as, even though the customer does not enter the dispensary, there are clear routines and rituals associated with obtaining the products from the dispensary. I then move onto the

other controlled medicines; pharmacist-only and pharmacy-only medicines and most of the performance for these products occurs at or near the counter or the consulting room. I discuss the performances in the OTC and CAM areas next and lastly discuss the role of the consulting room in health consumption in the pharmacy.

Before a customer can fill a prescription all customers have to locate the dispensary and the counter in front of the dispensary, which requires navigating the rest of the pharmacy, passing retail displays and having the knowledge of where to locate the dispensary. This is of note especially in the Life pharmacies when the dispensary is not immediately evident from the outside looking in, as even the prescription sign is not evident from the mall entrance [field notes, Life 1, 17.9.15]. Figure 31 shows the predominant pathway of most customers towards the dispensary area and counter. This pathway was the most common way customers moved through the pharmacy regardless of the brand of the pharmacy. This highlights how important the dispensary is to the social production of the community pharmacy even for customers who are restricted from this space.

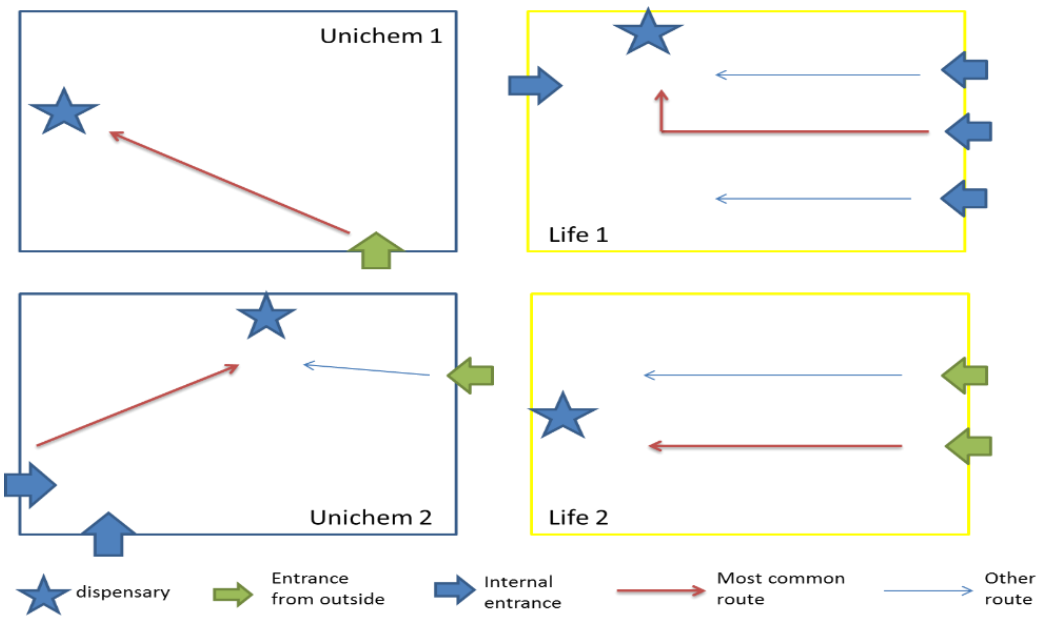


Figure 31: Customer movement in the four pharmacies

Observing the pharmacy space highlighted routines and rituals that were common across and within pharmacies. Filling a prescription is one routine that is seemingly well known and understood but I found that there are three elements to the prescription routine - handing it over, waiting and collecting. I will explore each of these elements as they illustrate the complexity of completing a supposedly routine task for customers starting with handing it over, which is the only time that the routine is consistent across pharmacies. Customers head instinctively towards the rear of the pharmacy with little hesitation, looking for a staff member to hand the prescription to regardless of whether they are familiar with the pharmacy or not, and regardless of gender, ethnicity and age [reflective journal, 12.8.16]. Customers showed no preference as to which staff member they handed the prescription to (retail or pharmacist). Handing the prescription over, as a ritual, is ingrained into the social meaning of the pharmacy. This part of the ritual does not require previous knowledge of the pharmacy as the largest signage is always 'prescriptions' and all dispensaries are located at the rear of the pharmacy. The complicating factor is that most of the time a customer will have a paper prescription so there is a need to seek a staff member to handle that piece of paper too. Having a material prescription adds to a customer's ease, even in an unfamiliar pharmacy, because their role in the pharmacy fulfils symbolic expectations and '*customers know what to do with a prescription*' [reflective journal, 19.5.16]. At times though, doctors faxed prescriptions to the pharmacy or a person may be returning for a repeat prescription and may not have an actual piece of paper. In this instance, the routine is disrupted and the customer has to prove need through other means such as discussions and story-telling, showing medicine boxes, using photos on their mobile phones or relying on the staff remembering key details about their lives and looking up their medical records.

Once the prescription is handed over, I observed distinct gendered behaviour of customers waiting for their completed prescriptions. The customers either left the pharmacy (usually men), stayed in the pharmacy and browsed (usually women), or waited

on provided seating or stood rather uncomfortably somewhere near the dispensary counter or OTC areas (usually men) (Figure 32). Part of the waiting behaviour was dictated by the space itself. For example, Unichem 2 always had some seating but they introduced more seating during my observations and the more seating there was the more likely the customers were to stay in the pharmacy while they waited [field notes, Unichem 2, 8.6.15]. Prior to this, many of the customers dropped their prescriptions off and then they retreated into the medical centre to wait. There was an area with toys in the medical waiting room so many parents with children retreated to this space as well. This required the retail staff to say names very loudly to ensure that the customers in the medical centre could hear. I was surprised how loudly the retail staff would almost shout the customer's full name, as it was clearly audible from the medical waiting room, raising privacy issues.

Figure 32: Male waiting for female companion outside Life 1

Life 2 had four seats located perpendicular to the counter area and dispensary and these seats were used regularly for people waiting for prescriptions. I noted there was a box of rather sad looking toys near the seating in Life 2 and three tatty magazines on the floor next to the chairs [field notes, Life 2, 23.4.15]. The other Life pharmacy had no seating in the store and Unichem 1 had one chair next to the OTC area that I never saw anyone use. For men who stayed in the store to wait, they stayed primarily near the medically aesthetic OTC area or close to the counter. I did not observe men waiting in other areas.

Women customers were more likely to use the waiting time to shop and use the entire pharmacy space. More women also purchased more than one product in the pharmacy and showed shopping type rituals. "*A woman hands her prescription in to RS, pulls out a piece of paper, glances at it, looks up at the signage above the skincare area and heads there. She selects a tube, looks down at her paper again, and heads to the beauty aisle. I lose sight of her as she kneels to collect something. She stands up and turns her head towards the counter when she hears a name being called*" [field notes, Life 2, 23.4.15]. Simple functional and spatial elements can keep customers in a space, can be more inclusive and welcoming, and are therefore important in all pharmacies. Observing customers waiting for prescriptions highlighted the gendered differences in how customers use the pharmacy while they wait for a prescription. This difference was not observed for the other two aspects of the prescription routine.

The greatest variation in the process of filling a prescription is when the customer collects their completed prescription. Up until this point, there could have been minimal verbal contact with staff so it is at this stage that language, cultural expectations and familiarity become more important. There is inconsistency across pharmacies in whom customers talk to, what information is exchanged, and even the type of conversation. Sometimes customers talked with a pharmacist but many times a retail staff member would give instructions and run through medical information. Staff also often sought more information from the customer at this time. This part of the transaction varied in length and there were either long discussions or the extent of the transaction was the customer paying for the prescription and then leaving. I noted that it is at this moment of paying that there is the most annoyed looks, confused faces or smiles. I suggest these differences of what to expect contributes to customer uncertainty in all pharmacies, as the customers are not sure of what performance is required. The uncertainty also comes from the product itself, familiarity with the staff and pharmacy, and or the health system. I noted a woman's confusion at the time of paying for her prescription. *After the customer left I asked the*

pharmacist why the customer was confused. The pharmacist told me there were two reasons. The funding had changed to a generic so the name and packaging of a previously familiar medicine had changed. Also, it was March and the customers Pharmaceutical Subsidy card had run out so the customer had to pay for the prescription [field notes, Unichem 1, 14.3.13]. If the customer was familiar with the medicine, knew the pharmacy or staff and knew the wider health system such as why certain medicines costs more, then they were less likely to get annoyed or be confused [reflective journal, 19.9.16]. This moment in the routine is complex because there are rules and regulations to ensure customer safety, around pricing, and around surveillance. There is little resistance open to customers in this moment beyond either open or quiet rejection of advice or requests for more information.

In summary, the routine of filling a prescription at a pharmacy is widely known, regardless of pharmacy or customer differences. Customers always headed to the rear of the pharmacy without hesitation to fill the prescription, as they know what do to with a prescription. However, there were gendered differences while waiting for a prescription and differences in how the completed prescription was handled by staff and customers. It is at collection stage that there were the most differences in staff and customer performance leading to uncertainty. It is also at collection that customers resist being given information, or take back the power of the interaction by leading the conversation or seeking information.

The performance of the customers is different for medicines that are controlled but available without a prescription (pharmacist-only and pharmacy-only medicines) because the customers cannot rely on the prescription to display their need or breach the boundary between customer and patient. These medicines were stored either, behind the counter (Unichem 2, Life 1 and Life 2), or in shelving near the dispensary (Unichem 1) so these interactions primarily took place at the counter. The added complication for these

medicines is that retail staff can sell pharmacy-only medicines but a pharmacist is required for pharmacist-only medicines. This requires the customer to use the retail staff member as a gatekeeper. I observed customers telling their health story twice leading to embarrassment and annoyance. "*Well, I had to ask to see a pharmacist but I didn't tell the girl much, I just insisted. The pharmacist took me into that room that is kind of hidden. They had a set of questions that they asked me – pretty embarrassing but I got the pill and left"* [customer interview, Unichem 2, 14.10.15]. Customers also told me they did not understand the different regulations for medicines or understand why they were asked questions about certain types of medicines. "*So why do they ask you inane questions for some medicines and not others – it seems to change all the time. And the price seems to change without warning*" [interview, customer, Life 1, 9.4.14]. This was especially relevant when the customer was familiar with and had used the medicine before. I observed resistance and annoyance to staff asking questions of customers asking for OTC medicines as well.

> *Harassed looking mother with two young children says yes, yes when asked if she knows the weight of her children so she can get the paracetamol dosage correct. Retail staff member backs off and processes the transaction [field notes, Life 2, 23.2.15]*

For OTC medicines area there is a wider range of customer performances because of the enormous range of products and conditions that these products treat, from pain relief, digestive care, cough and cold, and first aid. As discussed in chapter 4, the OTC space is highly mediated and commercialised. While there were clear displays of medicines these were interspersed with displays offering a gift with purchase, posters announcing competitions, and other seasonal retail displays. Certain customers were the focus of this marketing or displays at times, such as pregnant woman, men, babies, or parents, while others remained generic to any person with a cough or pain. Despite this overt commercialisation of health, there were still certain routines associated with the OTC area. I observed customers coming into the pharmacy and heading to a specific set of shelves in

the OTC area, taking a product with no hesitation and heading to the counter, paying and leaving. I also saw customers heading directly to staff and asking for help and then being taken into the OTC area. In addition, I saw customers not seeking any assistance of the staff, but rather I observed them standing in the OTC area pondering the wide range of pain relief or cough syrups. These customers would make their own choice, even when asked by the retail staff if they would like help. The other areas included in the health and medicines areas were men's health, first aid, and baby care, which were located either within or alongside the OTC areas (Figure 33). These spaces were largely ignored by the customers unless they needed those products but the performances were similar (seek help, self-serving, offered help).

Figure 33: Men's section (Life 1), first aid (Unichem 2), & baby care (Unichem 1)

When customers wanted assistance for OTC products, customers used bodily displays, story-telling and presented symptoms to the staff. I observed customers coughing, showing rashes, wounds, and pointing to parts of their bodies such as *the customer will go 'here I'll show you my cough" "Blagghh" [field notes, Unichem 1, 19.3.13]*. At times, this was in response to a request to see problem and this could be from either the retail staff or the pharmacist. For example, *Yes, I did tell the pharmacist that this is what I am looking for and she said "do you mind if I have a look so that I can see what exactly you need or if you need to see a doctor before you get this". So I did show her and she showed me how to put it on [customer interview, Unichem 1, 12.4.13].* This process happened in the OTC area and in

areas near the counter. The initial display or description of a health issue was always done on the shop floor of the pharmacy and depending on the story, symptoms or display the staff may take the person into a more private space. This was often the consulting room or a quieter area in the pharmacy but there was always some discussion on the more public areas of the shop floor first. For more hidden or private conditions, I observed staff and customers using lowered voices and leaning in closer to each other as privacy tactics. Other tactics involved strategic timing as one woman said, "*I wanted Canesten I think it is, you know for thrush, so I waited till there was no one else at the counter before I went up. Luckily the pharmacist was behind the counter so I could just tell her, not tell the other woman first* [customer interview, Life 2, 12.2.16]. I also observed staff attempting to minimise visibility of the product by having the product on the counter for as short a time as possible and getting it into a bag quickly [field notes, Life 1, 19.8.14]. This suggested certain products and conditions were seemingly subject to more judgements and potential for stigma and required certain strategies to ensure as much privacy as possible in a public space.

> *A man comes in to the pharmacy, heads directly to retail staff in charge of CAM. She looks up and sees him, greets him by name, reaches under the counter for a box of CAM product (cannot see what), takes him to the counter, he pays and leaves. When he leaves, she tells me he has a special standing order that they get in each month especially for him (Unichem 1, field notes, 19.5.13]*

> *I observe a couple in the CAM area taking pictures on their phones of the products. BF notices them and goes over. Then they had a long 20-minute consultation on the merits of the different fish oils. They left with four bulk containers – the one on special. I approach BF, say "that took a long time", and she said, "The couple wanted all the information. So you want it idiot proof, I say that to the reps when they come in. You want bullet points about the research and want to be able to back it up" [field notes, Life 1, 19.8.14]*

The consumption of CAM products was similar to OTC products as the range of performances is similar. There were certain customers who knew what they wanted,

where to locate the product and what brand and would use the CAM space with no hesitation. Other customers sought guidance and help, and others looked a little lost and waited for help to come to them or customers decided for themselves. "*You see many customers reading the back of boxes/bottles etc. looking at ingredients in OTC and CAM. There is a lot of comparison across the boxes and products*" [field notes, Life 1, 14.3.16]. There were differences in CAM consumption because the products are laid out in brand groups so customers needed to look in multiple areas if they wanted to compare products. I also observed more women than men using the OTC and the CAM space. There were additional demographic differences of people using the CAM space and I observed different ethnic groups buying in bulk and having longer consultations with staff. I also observed younger people using the CAM area more.

CAM products are spread throughout the pharmacy, which moves CAM out of the designated medicines areas. This was the case for all four specific pharmacies. The consequence of extending the stage for CAM is that these products are further commercialised and the customer performance changes. Figure 34 shows the sales bins situated at the entrance to Life 2 pharmacy. Most customers walked past sales bins and proceeded into the pharmacy towards the counter and dispensary. Other customers stopped, picked the products up, some pulled out their phone and either looked at the phone or called someone, and other customers glanced at these products in passing and walked on. I noted that CAM products in particular had photos taken of them, phones seemed to be used to research products and I overheard part of a conversation of a woman asking her mother if she would like fish oil as it was on sale [field notes, Life 2, 29.11.15]. In addition, there is more CAM marketing throughout the entire pharmacy, not just in the CAM area (Figure 34). A limited part of the marketing for CAM involved customers trying CAM products in the store as illustrated by the free tasting station in Life 2 (Figure 34, middle frame). I observed customers trying CAM products or being offered products to try by staff in Unichem 1 and Life 2 and this did not happen for OTC products.

Figure 34: L-R, CAM window display (Unichem 1), CAM display and sales tubs by entrance (Life 2)

Other health consumption involved getting health advice that may or may not involve medicines including accessing general health advice and using the additional services on offer such as needle exchanges, flu vaccines, or getting a medications review. The customers had to seek a staff member for this type of health service and would usually have to access the pharmacist through the retail staff first. I observed one customer doing a needle exchange and this was clearly a familiar process for both the customer and the staff. *The customer headed without hesitation to the gap between the counter and dispensary, the pharmacist recognised her and fetched the sharps container* [field notes, Unichem 1, 9.8.13]. The needle exchange was one of the few interactions where it was clear what the interaction was. Other times I observed longer interactions between staff and customers but I was unable to hear what consultations were taking place. I rarely observed pharmacists or retail staff taking the customers to the consulting room for services, which was surprising. Most consultations took place by the counter or in medicines spaces.

The other aspect of health consumption in pharmacies is health promotion. Health promotion services varied across the pharmacies as illustrated in Table 6. Unichem 1 and Life 2 had BP machines visible to customers for them to purchase and try (Figure 36). The only health promotion activities I observed on the shop floor were customers using the blood pressure machines either by themselves or with assistance from the retail staff. I

never witnessed anyone using the 'check your own hearing' stations (Figure 36). In addition, in all my hours of observations, I did not observe any weight loss management or smoking cessation consultations. This could have been because they did not happen, I missed them, or they took place in consulting rooms outside of my sight. Interestingly, all the customers I talked with were unaware of the full range of health promotion services available at the pharmacy they used and these customers were regular and loyal users [reflective journal, 3.7.16].

Table 6: Health promotion services as advertised on their websites (May 2017)

Unichem 1	**Life 1**	**Unichem 2**	**Life 2**
• Blood Glucose Testing • Blood Pressure Testing (BP) • Bowel Health Screening Zinc Testing Smoking Cessations Weight management	Men's Health Week Coeliac Testing Blood Pressure Testing (BP) Zinc Testing Weight management	Coeliac Testing Blood Pressure Testing (BP) Smoking Cessation	Men's Health Week Coeliac Testing Blood Pressure Testing (BP) Bone Density Scanning Bowel Health Screening Zinc Testing Smoking Cessation Weight management

For consumers accessing health promotion services in a community pharmacy there is the issue of privacy and stigma. For consumers to use self-diagnostic stands shown in Figure 35, there would be an element of 'standing out' or being noticed that potentially is putting customers off. An audiologist (in an informal conversation with me) was very sceptical of the 'check your own hearing' stations, saying they compromised the profession by linking hearing problems to a retail space and "cheapens their service" [field notes, Life 2, 22.3.15]. The stigma associated with being overweight, a smoker, or not being able to hear means that addressing these health promotion activities in pharmacies is difficult. There has been a lot of research investigating whether the pharmacy is an appropriate place for health promotion activities and most research has shown that health promotion programmes can be delivered effectively in community pharmacies (e.g. Brown et al., 2016). The problem is that the studies used a range of measures of effectiveness across a variety of services, pharmacies and countries. This research has also highlighted that

many of these services are invisible as they are not advertised, they occur in hidden spaces so people do not know they happen, and involve conditions with a high level of stigma (Brown et al., 2016). This complicates the performance of the customer seeking help in the community pharmacy. Thompson and Bidwell (2015) suggest customers in the community pharmacy experience worry about standing out in a public space. This may contribute to customers being unwillingly to try health promotion services in the community pharmacy in view of other customers. I suggest that these services have not been routinized into the social production of the pharmacy. They are not well known about or advertised openly in the four specific pharmacies.

Figure 35: Visible health promotion (L-R Life 2, Life 2, Unichem 1)

There is a range of health performances for customers in the community pharmacy ranging from accessing medicines to seeking health advice or using other health products. Goffman (1959) would suggest these performances are dependent on the stage, actors, props and available scripts and I discuss the impact of these factors on the customer. Firstly, the consumption of health in the pharmacy depends on the stage and setting. The stage sets the impression and expectation of the customer before they even enter. The impression created by Life is very different to Unichem pharmacies even from the external façade (Figure 36). Life 1 at first glance does not advertise itself as a pharmacy (beyond the Life pharmacy sign) unless the customer is aware of the Life branding. The window

displays were huge floor to ceiling advertisements for beauty products and any products near the front of the store were beauty-related. Life 2 had advertisements for flu shots, huge window displays of beauty products and two mobile advertising boards (one advertising all pharmacy services and one selling beauty services). Unichem 1 had a child's ride, an advertising board with seasonal OTC products, and window displays of CAM, OTC and beauty products outside their shop. Unichem 1 staff also carried out a sales table every morning and I saw customers looking at the products on the table before entering, on the way out and just in passing. For Unichem 2 there were mobile displays of hats, bags, shoes and other gifts to create a physical barrier to the shop, as there was carpet only to separate the pharmacy from the medical centre. It was clear that all four specific pharmacies use the retail elements (sales tables, tubs, and marketing) to create a welcoming environment, but in the process then create a retail landscape. This was more evident in Life pharmacies complicating the customer's health performances in Life pharmacies. The customer has to then either avoid non-health areas or resist them or they can incorporate non-health experiences in addition to health consumption. Health is less visible in Life pharmacies compared to Unichem pharmacies.

Figure 36: Outside visage (L-R, Unichem 1, Unichem 2, Life 1, & Life 2)

Secondly, in order to understand health consumption in the pharmacy it is important to consider the actors on stage. Pharmacy customers are interactive and play an important role in creating meaning for the pharmacy. This is a rather difficult role within the pharmacy because of the range of performances may vary depending on who the customer

is interacting with. The customers may be a patient, client or consumer (or all three) in the same visit and may have to enact all roles with both the retail staff and the pharmacist. All three roles involve power differentials and different expectations. When with the pharmacist the customer may value the expertise and symbolic power of the medical professional and seek help, fill a prescription, and enact the good patient role. In contrast, the customer may also be deviant and push back at attempts to be informed, asked or sold products, even with the pharmacist. Interactions with retail staff members and customers were also complex with some customers valuing the health expertise of the staff and other treating the staff as sales clerks because these staff do not have the same symbolic power as the pharmacist.

Health consumption is also related to the props or products and services being used. Shopping for pills within pharmacies is rule bound because of the regulations surrounding dispensary medicines, which leak into the OTC space and some OTC products (is this product safe for children, pregnant women, sensitive skin etc.). The well-known routine of filling a prescription reveals the complexity of this one important performance in the pharmacy. Part of knowing what to do with a prescription is knowing how to use the pharmacy space. There were very few differences in the first part of the prescription routine – handing the prescription over. There were gendered differences while waiting and a wide variety of performances when collecting a completed prescription. Other medicine and health consumption is remarkably consistent regardless of product. Firstly, customers were purposeful and familiar with the pharmacy heading to an area, selecting a product, purchasing and leaving. Customers also sought help from staff immediately on entering, knowing they wanted help selecting products and seeking advice. Lastly, customers entered, looked a little lost as they scanned signage, and were often approached by staff members asking if they wanted help. This movement with and within the community pharmacy was used in OTC and CAM areas. However, customers needing health promotion services or health advice would still have to seek help for these services

from a staff member. This illustrates there are certain health scripts or plots that are well-known and those that are not, some interactions require staff help and at times the customer can resist and use their own expertise.

In summary, health consumption is complicated in the community pharmacy. The wide range of products, services, the pharmacy space itself and the staffing all influence the customers experiences. The customer's performances also change depending on the stage (space). This highlights the different stages set by Life and Unichem pharmacies. The more retail aesthetic of Life pharmacies and Unichem 1 created more spaces that are feminine and affected the customer's movements and interactions with the pharmacy. Women then stayed in the pharmacy for longer and used more of the pharmacy space. Despite the differences, health was performed in remarkably similar ways across the pharmacies. Health interactions required story telling or the display of symptoms or the use of a boundary object to prove need and to move into a patient role. Customers moved through the pharmacy and used the spaces, products and staff in three main ways indicating they were either familiar with the pharmacy, staff or product or unfamiliar. Being unfamiliar led to more help seeking, product comparisons and browsing. In addition, there are specific routines and rituals expected of and enacted by customers in the pharmacies; primarily about accessing controlled and restricted medicines and health advice, or to use the pharmacists for clinical services such as the emergency contraceptive pill. Inconsistencies in service lead to annoyances and uncertainties. Increasingly as more and more health consumption occurs in the pharmacy (medication reviews, health promotion services, and limited pharmacists prescribing); customer's use of the pharmacy will change from counter consultations to consulting room consultations. This will change the performance required of the customer to firstly access the pharmacist, and then access the consulting room. Health consumption in the pharmacy is a complex, interwoven, relational and interactional performance between people, product and space.

Non-health consumption

Customers using the pharmacy for non-health reasons use different spaces and perform differently to those consuming health in the community pharmacy. Table 7 shows four examples of non-health experiences. These experiences highlight the different staff involved in these transactions in comparison to health interaction. The pharmacist is never involved in non-health interactions (except on rare occasions). The examples also illustrate the different spaces and staff used in the interactions highlighting that these non-health experiences can be more time consuming and complicated than some health experiences. The experiences in Table 7 also illustrated gifts and other services share spaces within the pharmacy. For example, in Unichem 1 passport pictures were taken against a hidden screen in the CAM area, in Life 2 pictures were taken in the consulting room, in Life 1 photos were taken against a door next to the counter and first aid area, and in Unichem 2 pictures were taken against the door to the consulting room.

Table 7: Example of shopping experiences in pharmacy (from field notes)

Experience	Example	Spaces and people used
Passport picture (Life 1)	Family (man, woman, and baby) come in for passport pictures. Seek retail staff member at counter who is free immediately. She fetches the camera, closes consulting room door (as background). Instructions given, shots taken, re-taken. Baby starts crying while waiting so retail staff moves them into the consulting room. Computer for viewing the pictures is in the consulting room	Counter, retail staff, door and consulting room. Camera and computer.
Ear piercing (Life 2)	Three teenage girls come in discussing what style of earrings. Head to back counter, seek retail staff member who fetches the board displaying earrings. Discussing at the counter, when chosen they head to consulting room where ear piercing takes place	Counter, consulting room, Retail staff Specialised equipment and knowledge (accredited)

Experience	Example	Spaces and people used
Gifting (Unichem 1)	Woman comes in looking for a gift. She is spotted by the retail staff member who asks if she needs help. She then walks the store with the customer, giving her suggestions. Leaves her to browse. Customer picks something and takes it to the counter – waiting for the retail staff, who spots her, meets her at the till, takes payment and then gift-wraps the item.	Half of shop floor, counter, and retail staff member.
Make-over (Unichem 1)	Woman (40+ years) enters the pharmacy and heads directly to LS (beauty consultant). They are excited to see each other, smile at each other and start talking. Woman sits on the tall chair and LS starts pulling out her make-up brushes.	Beauty house, beauty consultant

The aesthetics of the gifting and beauty spaces was different in the two Unichem pharmacies as shown in Figure 37. Unichem 2 encourages efficiency as customers come from the medical centre and want quick and efficient prescription services. I observed very little browsing of the beauty stands and gift items in Unichem 2 compared to Unichem 1. Unichem 1 inspires pleasure and browsing, primarily for women as the products and displays are aimed at women. The hedonic atmosphere of Unichem 1 also encouraged customers to touch and try the products.

Figure 37: Non-health areas in Unichem 1 and Unichem 2

The aesthetics of beauty and gift areas in the Life pharmacies were different again from either Unichem pharmacy (Figure 38). A customer using the Life pharmacy solely for a

non-health purpose may only use the front end of the pharmacy although the customer would have to move to the rear counter to pay. There were very few medicines or health related products at the street or front end of the Life pharmacies (with the exception of some sales tubs of CAM products) illustrating that health is primarily performed in the rear of the pharmacy and non-health at the front. In addition, the products at the front of the Life pharmacies encouraged more interaction than medicines spaces, encouraging more browsing and trying of products. Customers could be on the border of the pharmacy and still engage with non-health items such as fragrances (Life 1, and Life 2). I noted that "*Sometimes the customers can hover on the boundary of the store, fragrances is a good area to do this, kind of in, but can leave again without staff interaction. This area is monitored quite closely though – guess for shop lifting*" [field notes, Life 1, 26.4.14]. Customers stop at the sales table in Unichem 1 to look at the soaps, lipsticks, perfumes, CAM products, and gift items such as a wheat pack that looked like a giraffe [field notes, Unichem 1, 15.9.13].

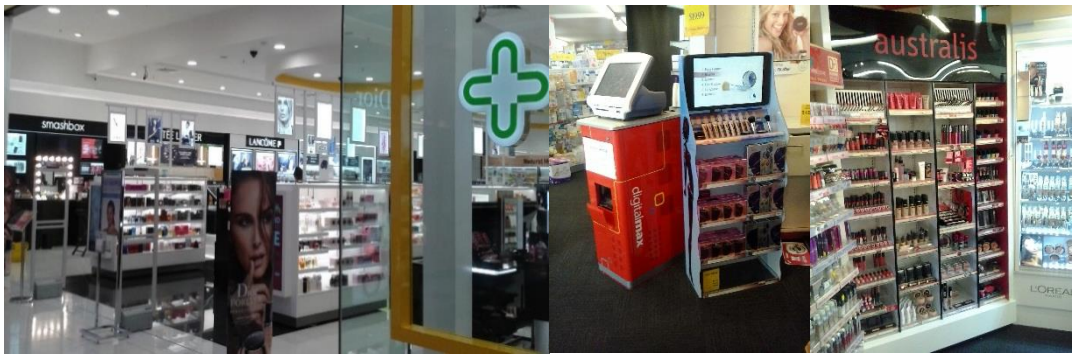


Figure 38: L-R Aesthetics of the front end of Life 1 and Life 2

There were similarities between Life 1 and 2 and Unichem 1 when I concentrated on my senses other than sight. Smell, in particular, was one sense that highlighted the gendered aesthetic of pharmacies. There is a distinct feminine smell to the more aesthetically overwhelming pharmacies, such as Unichem 1 and Life 1. Floral with hints of vanilla are the scents that spring to mind [field notes, Unichem 1, 18.6.13]. This was in contrast to the lack of smell in OTC or CAM spaces or in Unichem 2, which smelt like cleaning products. Products with scent also inspired a different, more embodied performance from

customers. Customers could sniff, spray and rub scents and lotions into their skin. Tester infuser gifts sets were set up in defined gift areas and entering these spaces was overwhelming with the scents being strong and pervasive [field notes, Life 1, 2.13.15]. While there were more masculine fragrances and after shave lotions for sale in Life 1 and 2 and Unichem 1, I only observed one man trying a product in the pharmacy. Unichem 2 did not stock fragrances or premium make-up but did have skincare products that customers could try (e.g. hand lotions). In Unichem 2, the skincare products were for skin problems, such as eczema, and it was clearly advertised that these creams were scent free. This removal of scents for sensitive skin types and baby products suggests certain customers are at risk from scent, and that the removal of scent is regarded as 'healthy' and more natural. Thereby in having a more fragrant, floral space, the two Life pharmacies and Unichem 1 create a different 'unhealthy' experience for customers. Gorman (2017) argues that smells are important in therapeutic landscapes and whilst I found that all my senses were engaged in the community pharmacy visits, it was not necessarily suggestive to me of a therapeutic space, but rather of a nice, feminine shop.

> *I am overwhelmed with sensation – smells of lotions, skincare products and fragrances. It is noisy with people talking and after almost an hour, I notice a radio station is playing in the background. I touch some of products, necklaces that I like, a scarf that is soft, a cappuccino mug – such a strange thing to have in a pharmacy that I pick it up almost to confirm it is what the label says it is (field notes, Unichem 1 28.4.13).*

Non-health consumption was gendered, with the exception of procuring passport pictures. Typically, it was women who browsed the pharmacy while they waited for a prescription or it was women who used the pharmacy just for non-health items such as gift shopping and beauty purchases. Consequently, women spent longer in the pharmacy and interacted with the gift and beauty spaces more, touching, trying and using the products. Browsing, touching, and smelling were common in beauty and gift spaces. I note, "*A woman strokes a soft scarf then moves along the aisle and selects a hand cream, takes the top off smells,*

replaces the tube, picks another and puts a little on her hands. She rubs the lotion in her hands and then sniffs her hands again" [field notes, Unichem 1, 18.5.13]. There are very few products for men that encourage this type of experience beyond fragrances and colognes. The other reason non-health consumption is gendered is because of the beauty services which I only ever observed being utilised by women. I did note one man coming with a woman into the beauty area as she purchased a product [field notes, Life 1, 9.6.15]. I made special note of this, as it was the first (and only time) I observed this.

> *"I enter the pharmacy and see MW busy with a client. The customer sits on a high chair, eyes closed; MW is standing close and is applying foundation. MW does not stop talking except to allow the customer to answer the odd question. I cannot hear specifics but when I ask her later she tells me she is informing the customer about what she is doing, the products, and also she knows this woman well so is asking her about her family. The consultation takes about 30 minutes and the customer buys some product" [field notes, Unichem 1, 6.9.13]*

Consumers of beauty products used the community pharmacy space in ways that are unique and different to all other customers. Beauty customers use the pharmacy space differently, seeking out specific consultants and embracing the beauty experience rather than actively avoiding the beauty spaces. Secondly, the beauty interaction is quite often an embodied, intimate experience, and one that takes longer than other transactions. This is partly because beauty and skincare products are some of the few products that are tried and consumed in the pharmacy. Thirdly, beauty users may be invited into hidden beauty spaces, with some customers taken to back rooms for services that require privacy while others are seen on the shop floor. I note, "*Some face work can be done in the shop but the rest of the body and some facial services require hidden spaces*" [field notes, Life 1, 12.9.15]. Unichem 1 and Life 1 and 2 offer some beauty services in hidden rooms. Lastly, long-term beauty users have a loyal relationship with their particular consultant and this may be stronger than their loyalty to the pharmacy, as illustrated by the quote below. For these

customers the beauty consultants will help them negotiate the whole pharmacy space and assist with finding other health products or seek out other staff on behalf of the customer.

> *Well we used to use the chemist in Brown's Bay and MW who works in the chemist down here was a young girl of about 18. She had just started out in the beauty world and I used to take my two children into the shop in Browns Bay where she worked. Then of course, when this chemist opened and she moved here that was fantastic,* ***so obviously we go to this chemist now****. One day I took my grandchildren in to buy a present for my daughter for Mother's Day and I saw MW wander off with them and I thought, hang on, she used to do that with their mother. This is weird (small chuckle) [customer interview, Unichem 1, 10.12.13]. (Emphasis added.)*

There is a hierarchy of beauty products with the dedicated beauty houses having the premium brands and offering special services. This hierarchy of products directly affects the customer's experience with the beauty space and the required performance to access the products. The customers who use the pharmacy for premium brands get a more personal, intimate and devoted experience than the customers who buy the supposedly cheaper cosmetics. Many of these customers were long-term users of a certain brand of product and were known to the beauty consultants. The beauty houses always have new products to try, so customers would try new products as well as sticking to familiar products.

> *Some of the beauty customers know the products well, know the staff and the space and use the pharmacy like a familiar friend – but it is usually for the expensive brands of cosmetics. It is a different experience to those customers browsing the 'cheaper' brands – in this case, the other retail staff can help. Premium brand means personalised help [field note, Life 1, 13.7.15]*

Beauty interactions also involve a higher degree of persuasion and coercion for purchase than other products in the pharmacy. The strength of the relationship with the beauty consultant was important in dictating how welcome this persuasion was. If the relationship was strong then the customer did not mind being shown new products. "*OP always shows me the new products, tries them out on me. It's part of the service* [field notes,

Life 2, 22.9.15]. However, if the customers did not want a beauty product or the experience or did not have a relationship with the consultant then I observed the customers could get irritated. "*The Thin Lizzy consultant set up a stand at the entrance. Many customers got annoyed being asked if they would like to see the product* [field notes, Life 1, 22.6.14]. I also observed numerous customers purposively using alternative aisles to avoid the beauty consultants. For beauty products, some of the other marketing was valued and influenced when the customer bought a product. One customer told me "*I usually wait for a free gift with purchase*" (customer interview, Life 1, 13.2.15). Accordingly, beauty consumption is shaped by the relationship with the staff and marketing strategies in the community pharmacy.

There is no doubt that the beauty spaces are highly commercialised and reflect dominant gendered, culturally and socially located beauty and appearances ideologies. Customers used various tactics to resist these dominant ideologies. The main tactic by both men and women was avoidance of the beauty space and the staff even when approached. For the women who engaged with beauty in the pharmacy, they used the experience for practical reasons (product on sale, gift with purchase) or because of a personal relationship with the beauty consultant. Women also resisted the premium brands and browsed all beauty brands comparing price and product. This was similar to how customers browsed the CAM products as both products are grouped in brands and not products. For example, if you want to compare prices of a red lipstick you have to cross brands, the customer does not head to the lipstick section. In this way, customers resisted, embraced and changed the boundaries of beauty and skincare in the community pharmacy in ways to suit their needs.

There are distinct differences between non-health and health consumption in community pharmacies. Non-health consumption was a more complete experience including touching, smelling and trying of products than health experiences. Interactions were often longer for non-health consumption and used different spaces at the front of the pharmacy. Many

non-health experiences in community pharmacies are gendered and shaped by factors that encourage labour and individual responsibility for appearance. This is reflected in the more feminine aesthetic of the beauty and gift spaces. There were similarities between non-health and health consumption. Customers still sought help from staff in negotiating the pharmacy space and products and customers used, modified and avoided the areas and products in personalised ways.

Why do customers use the community pharmacy?

> *If you've got any issues like you cannot wait for a doctor, so if it's a weekend, a Saturday/Sunday the doctors aren't available and it's not an emergency, so you can always consult the pharmacy and see that if it's safe to take something to, or is it necessary to go to the doctors. They do suggest to you if you need to go to the doctor or if you are fine with any other treatment" (interview, Unichem 1, 12.12.13).*

Up until this point, I have purposely kept health and non-health consumption separate to highlight the differences and similarities in health and non-health consumption in my four specific pharmacies. I now discuss the complete customer experience beginning with a summary of the main reasons customers used my four specific pharmacies drawing on both interview and observational data (Figure 39). The purpose of this is to highlight how diverse and complex the customers experiences are and to give more voice to the interview data.

Figure 39: Main reasons customers use the pharmacy

Unsurprisingly medicines and prescriptions remain the main reason for why the customers use pharmacies and are the first thing that customers mention when asked about their pharmacy experience. Other practical matters also influence pharmacy use, from convenience to opening hours. Customer interviews also revealed differences and similarities in why long-term customers used their pharmacy. Unichem 1 was not convenient for the customers due to a lack of easy parking but customers stuck with the pharmacy because of the staff and the service. Customers valued the strong relationship they build with staff members, the overall atmosphere, and the service.

> *I would think the main reason I would stick to that pharmacy for everything is the atmosphere, and the people and the service. They are fantastic. And I can be in the shopping mall and I think oh I need some more hand cream and I will not go in there. I will come and drive the 15 minutes to get a park here, try to go in there and do it. Because I give them all my business (interview, Unichem 1, 13.2.14).*

In contrast, Unichem 2 was a convenient and professional space, but primarily a space for medicines. Relationships with staff were not as important for these customers. One customer said, "*I go to the doctors there so it is convenient and fast to use that pharmacy*" [interview, Unichem 2, 12.6.14]. There were fewer mentions of strong relationships for the customers in Unichem 2, although two customers mentioned that the retail staff were

excellent "*they are always helpful and very knowledgeable* [customer interview, Unichem 2, 14.6.14]. Another customer used her local pharmacy (another Unichem) for most of her pharmacy needs but used the larger more anonymous Unichem 2 for the morning after pill. She said, "*I used the Unichem pharmacy -not my local - for the morning after pill in the weekend as the condom broke. I didn't want to use my local for that one!*" [Customer interview, Unichem 2, 23.6.14]. Life 1 and 2 customers also valued staff relationships with both the pharmacist and the retail staff. In addition, customers valued the services offered, the prestige beauty brands and the range of gifts.

> *"They are good here; all the staff are very nice. I use the naturopath sometimes as they get one in every now and again. And RT (pharmacist) has been here for years and knows what he is talking about. Oh and they usually have things I can give as gifts too" (customer interview, Life 2, 23.12.15).*

Therefore, while medications remain the core reason customers use pharmacies, the main reason long-term customers stick to a pharmacy is more complicated than medicines alone. Loyalty to a pharmacy was very dependent on the customer's relationship with the staff as well as the overall atmosphere and service. Going above what is expected for a health or retail store was valued. For example, Unichem 1 hosted their annual Christmas party one evening after the store had closed. There was food, music, drinks, specials throughout the store, representatives from different companies (CAM and beauty) stationed throughout the store, and sales of seasonal goods plus a storewide discount [field notes, Unichem 1, 14.12.13]. The customers valued these events where they were treated as more than a customer but rather a friend.

> *It is much more than a service to people. It stood out the other evening. Everyone was so friendly. It was not just a whole lot of customers you saw every now and again; it was almost as if they were having their own party (customer interview, discussing Christmas party, Unichem 1, 12.2.14)*

Well, all the staff are wonderful but MW and LB stand out because they have been there so long, they know everything about it, they are personal friends now really [customer interview, Life 1, 6.8.15]

We know them down there, they know us, and if we have any queries, they are there. They have also been a shoulder to cry on at times [Customer interview, Unichem 1, 13.2.14]

The problem for customers is that the pharmacy is not a consistent space. Staff change and move, the layout of pharmacy may alter, product choice may vary from visit to visit, and at times, the busyness of the pharmacy can be annoying. I note, in Life 1 on a Sunday afternoon in a mall when the pharmacy is very busy and everyone is rushed, the customer is less likely to have a long personal interaction unless they are getting a beauty service [field notes, Life 1, 12.9.15]. I suggest this is partly why pharmacies value and hold onto beauty service; the staff can give more one-on-one attention to the customer so that the customer may feel valued and cared for. Customers also liked feeling known and recognised. For one long-term customer of Unichem 1, going to the pharmacy in the weekend was a very different experience than a weekday because the staff were unfamiliar and did not know her.

I do not go much at the weekends but if I have to go in for a prescription or something they sort of, treat me like a stranger. That sounds terrible because I am a stranger to them, but if I have been going there for so many years I rather think well you know, but that is probably because the permanent staff do not want to work on the weekends [customer interview, Unichem 1, 26.1.14]

Chronic conditions or serious illnesses also change the relationship of the customer to the pharmacy. For conditions such as Parkinson's or palliative care medications, the relationship with the pharmacist became integral to the care of the patient. This demonstrates how customers use the pharmacy and pharmacist for complex medical conditions where there is little room for trial and error with medications as the implications are too serious. For these customers and their carers, perception of genuine care is an important element in how customers perceive value in community pharmacies.

"At the end he was on so many pills. It was a full-time job, just keeping track of them all. Without the pharmacy and the staff there I wouldn't have coped." [Customer interview, Unichem 1, 13.12.13]

"So if any new medication comes in - we have to work out when to take it, and that's what they do with me. We go through everything. I'd be lost if I didn't have them" [customer interview, Unichem 1, 12.2.14] (Husband has Parkinson's)

"The pharmacist and the pharmacy are actively involved in my daughters care. The pharmacy does not stock the fluid I need for my daughters nebuliser but they get it in stock just for me, they work with me" [customer interview, Life 1, 26.1.14]

Conversely, in opposition to feeling valued and genuinely cared about, there is also irritation that can arise in the pharmacy. Irritation arises when the pharmacy does not have products or services the customers expect, such as not having enough of a particular prescription medication so you have to return to collect the balance [field notes, Unichem 1, 12.5.13]. Customers also get annoyed when they are targeted in a sales or inauthentic manner, or they perceive inefficiency (long waits), or when they cannot see the staff member they want to in a timely manner. As one customer notes, "*I just wanted my pills [prescription], I did not want any other medicines. It was a little annoying to be targeted like that. I was in a hurry you know"* [customer interview, Life 2, 6.9.15]. Customers also stopped using particular pharmacies if they got sufficiently annoyed or if the pharmacy changed substantially, in either staffing or the overall aesthetic. As one customer noted, "*all the old girls have gone now and the atmosphere of the pharmacy changed so I use whatever pharmacy is convenient now*" [customer interview, Life 1, 9.2.16]. Lastly, if something inspires fear or worry about health and this occurs in the pharmacy, a customer is limited in their ability to be reassured. "*The pharmacists told me I should see a doctor and it always says on medicine boxes see your doctor if symptoms persist so I guess I should see my doctor"* [customer interview, Unichem 2, 10.5.15]. Some health and medicine risk or uncertainty is negotiated by the customer in the pharmacy, through discussions with staff, using product marketing and label information, and brochures and self-care sheets.

However, health and beauty knowledge is not just developed from the community pharmacy but other spaces and people outside the pharmacy.

In summary, customers use the community pharmacy for both health and non-health consumption and a mixture of purposes. Medicines are the main reason customers use the pharmacy but for long-term customers the relationship they have with the staff can be as important as the medicines expertise. While the community pharmacy is used as a site of both health and non-health expertise it can also just be used as a medicines depot and shop. Therefore, while there are functional reasons for pharmacy use related to the pharmacy brand, location, price, and the purpose for their visit, there are also affective attributes that are also important for customers such as the relationship they have with the staff, loyalty, and emotional ties to the pharmacy. All these factors are important in how and why customers use the community pharmacy.

Hybridity

I have consistently argued that we need to move beyond the community pharmacy as a hybrid space and theorise community pharmacy as a performative space. It is only then that the range of experiences and performances on offer to the staff and customers can be understood. In this framework, while the dispensary may be off limits to customers, it is still part of the pharmacy stage. The dispensary is symbolically and powerfully important, it pulls the customers into the pharmacy, it requires specific rituals to access the medicines in the dispensary that are ingrained into the everyday meaning of the pharmacy experience for customers – in essence without the dispensary the pharmacy space is a health or beauty shop. For the rest of the pharmacy spaces there are a range of performances available to the customers, some health and some non-health related. All customer practices within the community pharmacy are driven primarily by consumption, whether that be health, beauty, or retail consumption, such as gift shopping. Within this framework, customers use and appropriate the pharmacy as a shop, as a healthcare space,

and as a beauty salon in ways unique to each customer. Therefore, to capture the complexity of the customer's consumption practices and behaviours I draw on Latour's (1993) idea of hybridity. I also draw on de Certeau's (1984) idea of tactics to explore the role of power and resistance by customers as they use the community pharmacy.

Latour (1993, p. 2) suggests that individuals (moderns) may have beliefs of pure categories, such as science, economy, law, religion and politics, but everyday these same individuals cross boundaries of practice and mix up "all of culture and all of nature" to create "unruly hybrids" (Blok & Jenson, 2011, p. 55). This mixing or reassembling allows individuals to resist pure rule following and make decisions based on what works for them. This is particularly relevant in healthcare and goes a long way to explain why people do not adhere or comply with medication regimes or dominant health discourses or ideologies. De Certeau (1984) was concerned with the ways people resisted and actively engage with rules and dominant discourses. De Certeau suggests consumption is a form of production and he was interested in how people adapted and created their own rules, in effect being active producers. Dew and colleagues (2014) found the home was a site that could be conceived as a "hybrid centre of therapeutic practice" (p. 14) where people used resisted and adapted pure categories of science and medicine to create their own medication practices. In addition, people incorporated, rejected, and modified both orthodox and CAM practices, being active producers of wellness.

The community pharmacy is different from the home in that it is a public space and in addition to medication practices, it is a site for a range of other consumption performances and practices. The community pharmacy is still a space where the divide between "nature and culture – and between science and politics, technology and society" plays out (Blok & Jensen, 2011, p. vii). The pure categories of science and medicine sit alongside CAM, beauty and gifts, and customers of the community pharmacy use, reject, and modify the pharmacy services, goods and space in ways that support and challenge medicine. The

community pharmacy is a complex site where customers use interwoven networks of advice, different practices to access health and other information, and selectively use, reject or modify the expertise involved. The pharmacy is, in effect, both shop and healthcare site, and these are hybridised in use depending on the individual, his or her needs and beliefs. For example, one customer (with a long-term chronic health condition) uses her local Unichem for her medications, and has done for the last 30 years, and she uses Life 1 for gifts and other speciality items. She did not know the name of the pharmacist or any of the other staff in the Unichem even after all this time and she described "*the doctor as the expert in my medications and my health*" [customer interview, Life 1, 8.4.14]. This is in contrast with a customer from Unichem 1 who answered that she uses Unichem 1 for:

> *Well everything. Prescriptions, make-up, presents, whatever's going, cough drops, Panadol, anything. All pharmacy things and I get my multivitamin pills there. Whatever we've needed over the years we have brought it there. So, I really don't go anywhere else unless I am away out of Auckland [interview, Unichem 1, 26.1.14].*

Customers hybridise the multiple functions of the pharmacy in similar ways. These strategies of appropriation and assimilation are driven by consumption, as everything is for sale in the pharmacy, but networks and sources outside the pharmacy also drive these strategies. Family, friends, and other health professionals will guide and influence the customer's choices for both health and non-health interactions. Customer's performances around CAM products illustrated some of the hybridising tactics of customers. "*Well, I take vitamin C everyday but then I up that in the winter, and if I get sick then I might add a multivitamin*" [field notes, Unichem 2, 14.5.15]. Customers purchased CAM from pharmacies because they wanted advice and help choosing products from experts. "*It's hard to know what to buy, my friend recommended magnesium as I was getting leg cramps. There are so many different types".* This quote also highlighted how different sources are used for health advice. Another customer indicated she wanted assistance to choose the

most effective product but this had to be balanced with practical issues such as cost – "*Sometimes I want effectiveness so then I ask for help, other times I go for the cheapest option and then I see if the supermarket has it*". CAM and many OTC products are sold in supermarkets and on-line and customers used multiple places to get the same product. There was a degree of scepticism on effectiveness of CAM products in interviews with customers as they tried to negotiate the contested boundary around science "*I use natural products pretty selectively. They are expensive and it is hard to know if they work*" [customer interview, Life 1, 19.10.15]. If the customer is sceptical in the pharmacy, the customer may not use the CAM space, or they may seek advice and then buy the product or buy the product elsewhere. These same types of tactics were used by customers for all products in the pharmacy excepted restricted medicines illustrating the social production of pharmacy for customers was active, involved and personalised.

Community pharmacies are highly mediated and commercial spaces. Customers interacted with this mediation in many different ways. Customers ignored marketing but also used personalised marketing from Living Rewards schemes, in-store marketing and seasonal displays and competitions in ways to suit their needs. One customer told me "*I wait till things go on special now, especially my make-up and skincare. Sometimes I even wait for the gift with purchase deal*" [customer interview, Life 1, 17.9.15]. The main strategy customers used to resist beauty and other marketing was avoidance. There is avoidance of specific areas, avoiding staff who approached them and rejection of advice or requests for information by staff. Other tactics used by customers are discursive and practical showing resistance to firstly buying cosmetics at a pharmacy and secondly to the ideal of 'ideal appearance'. "*I am not a make-up type of person. Besides it is cheaper to get a mascara at the supermarke*t" [customer interview, 12.10.15]. For a customer filling a prescription, in browsing the CAM area and replacing a lipstick, they are using the pharmacy as both a shop and a health care space. The customers use all or part of the pharmacy including front-end browsing, dedicated beauty use, medicine and health advice. By doing this the

customers can both keep the science category pure and simultaneously disrupt it by embracing the retail side of the pharmacy. Therefore, customers actively produce meaning in the community pharmacy through hybridising strategies that use, modify and reject dominant health and beauty ideologies, marketing, and advice and expertise.

Conclusion

Customers display and enact a range of performances in the community pharmacy involving health, non-health, or a mixture of both. Health performances are similar across pharmacies regardless of the brand of pharmacy because there are routines around prescription medicines that are well known and familiar to all customers. In addition, minor ailment treatments, CAM purchases and other health performances were similar, depending on whether the customer is familiar with the pharmacy, the staff, the product and if their condition was new. The behaviours and practices around purchasing medicines were more bounded and controlled than CAM as these are "less formal" (Saukko, Reed, Britten, & Hogarth, 2010). Customers' lay understandings of health and illness become more important in how and what the customer will buy and how they will use CAM and OTC products and the pharmacy space itself (Prior, 2003; Stevenson et al., 2008). For non-health consumption, the performances of customers was strongly gendered, with more women using the pharmacy for non-health goods and services. Non-health consumption practices also varied more, and depended considerably on whether the pharmacy was a Life or Unichem pharmacy.

Consumption is an interplay between the consumer and the environment (Borges et al., 2013) and this was evident in the dialectical interaction between the customer and the pharmacy spaces. The overall aesthetic and physical aspects of the community pharmacy influenced the customer experience, the movement through the space, and highlighted routines and rituals. Consumption is also embodied, involving all the senses (Gorman, 2017; Healy et al., 2007; Iqani, 2013). Within the pharmacy, there are more spaces and

products that encourage a complete and embodied experience where all the senses are engaged for women. Consumption also involves work, and this is true for health and non-health consumption where the "relentless exhortation to be active, entrepreneurial, self-optimising", means that every individual is labouring (Elias et al., 2017, p. 5). For women in the pharmacy this work is framed within dominant ideologies of appearance and health.

Above all, consumption in the community pharmacy is an active production (de Certeau, 1984). Customers were active participants in creating meaning in the pharmacy, both contributing to and modifying the overall performance of the pharmacy. Customers use hybridising strategies and tactics to appropriate the pharmacy in ways to suit them. In this way, customers use the pharmacy as a shop, healthcare space and dispensary and then incorporate, modify or reject the products or advice they receive in the pharmacy. The practices of the customers showed they both resist and incorporate dominant views and ideologies surrounding health and beauty. Community pharmacies are also a relational and interactional space as strong relationships between staff and customers changed the performances and expectations of customers. Hybrid practices and consumption are therefore intertwined within the community pharmacy highlighting it is valuable to conceptualise the pharmacy as both a performative and hybridising space.

Chapter Seven

Pulling it all together: The community pharmacy as a performative space

This concluding chapter has two broad aims. First, to consider the strengths of the research and the value of my methodological approach. Secondly, to outline the contribution of this research for the community pharmacy, connect the analytical ideas from the previous chapters on space, staff and customers, and offer an account of the overarching performances and practices of the branded community pharmacy in urban New Zealand. With this in mind, the chapter is divided into three parts. In the first, I outline the benefits of adopting ethnography and spatial analysis for researching the community pharmacy. There were distinct advantages of being flexible, multidisciplinary and ethnographically focussed. The second section outlines the contributions this research has made to the social production of community pharmacy. While theorists of space can, and do, disagree on what constitutes space and place, my aim was to situate the community pharmacy as an inter-relational, contextual, practiced, and produced site where space and place co-exist (Agnew, 2011; de Certeau, 1984, Lefebvre, 1971, Löw, 2016). I have argued in each findings chapter that the community pharmacy is best understood as a complex social production to capture the interactions between space, people and materiality. De Certeau (1984, p. 118) says, "Space is a practiced place" and is composed of intersections of movements within the space. Lefebvre (1991) also argues that space does not exist in itself but rather it is produced by people and is fundamentally social. Therefore, framing the community pharmacy as a social production captures the concept of the community pharmacy being a performative space. I borrow Goffman's ideas of dramaturgy to discuss the community pharmacy as a performance (Goffman, 1959,

Brown & Bellaby, 2002). The benefits of doing this are that I can theorise the community pharmacy as an everyday postmodern cultural landscape that is socially constructed through complex interactions and relationships between physical place, people (staff and customers) and material objects (products) (Soukup, 2013). This leads to the contributions this research has made to broader debates on health, wellness and lifestyle consumption in the pharmacy. In the third section, I offer some directions for future research.

The advantages of ethnography

The overall purpose of this research was to explore if the community pharmacy was a conflicted site of healthcare because the pharmacy space is a hybrid space. Early on in the research process, I referred to my specific pharmacies as hybrids to capture this mix of healthcare and commercial enterprise. Hybridity is a rather loose term that could apply to most post-modern complex spaces but in this instance, I describe a mixing of cultures, ideologies, practices and performances between health and other consumption (Healey et al., 2007). Ethnography is uniquely suited to understanding hybridity in everyday spaces where the boundaries are blurred, moveable and permeable (Soukup, 2013). Latour would argue that culture and nature are "churned up" in everyday life, disrupting pure categories and creating unruly hybrids (1993, p. 2). At face value, the community pharmacy is an unruly hybrid as the retail aspects of the pharmacy disrupt the pharmacy as a healthcare space. However, this is only part of the story and ethnography allowed me to look beyond the obvious hybrid spatial assumptions and well-known aspects of the pharmacy to other experiences within and across the different pharmacies.

I also wanted to explore the community pharmacy as a social production and a practiced place (de Certeau, 1984; Lefebvre, 1991). The community pharmacy is an everyday space with multiple purposes and multiple meanings constructed about and with the pharmacies, the staff and the products for sale in the pharmacy. While there has been

other research in pharmacies using ethnography (e.g. Banks et al., 2007), space as a production or performance has not been the objective. In addition, the focus has been on the pharmacist (Brown & Bellaby, 2002; Duckett, 2013) or pharmacists in interdisciplinary health teams (Apesoa-Varano, 2013; Farrall et al., 2012). The research on pharmacy that has used space (Rapport et al., 2009; Thompson & Bidwell, 2015) has predominantly focused on the pharmacist as well. The contribution of this research is therefore, not a new methodology, but rather a critical application of a reflexive, visual and aesthetic ethnography to branded pharmacies in New Zealand.

In addition, the strength of ethnography is that it is not an "innocent practice" but rather political, pedagogical and performative (Denzin, 2006, p. 422). This is particularly important in the community pharmacy because of the countervailing powers operative, and the structural and functional constraints around the pharmacy profession and medicines. This research was able to make visible the routine moments of everyday in the pharmacy as well as consider the surprises or epiphanies - both of which can have "profound cultural meaning" (Soukup, p. 237) - all situated within the wider context of the pharmacy. To shed light on the everyday, I used visual, aesthetic, and symbolic data, field notes and interviews, all while being a customer, researcher, and observer. This method elicited rich data from my four specific pharmacies but allowed me to be informed by other pharmacies, marketing, news stories, industry newspapers, and informal discussions in and about pharmacies. Another methodological strength is the multidisciplinary nature of this research. Health geography, sociology, anthropology, aesthetics, semiotics and consumer culture were all disciplines that contributed to the research. I was able to gain invaluable insights into the research question and applied the disciplines at the epistemological, methodological and analytical levels. The value of investigating the community pharmacy using ethnography and analysing the community pharmacy as a space has allowed a freedom to look beyond medicines and pharmacists to explore the pharmacy as an everyday hybrid space. This methodology allowed me to

uncover the complexities of the community pharmacy relationships, performances and production of people, product and place.

Moving beyond hybrid tensions to performances

This research has illustrated that community pharmacies are complex spaces and that the practices and production of the pharmacy differ from space to space (within the different subspaces in the pharmacy and between the different pharmacies), between different staff members and in staff/customer interactions. It was difficult to find an effective way to encapsulate the different experiences, routines, products, emotions, aesthetics and symbols that make up the complete production of the pharmacy. One way to capture the complexity of the pharmacy performance was to borrow from Goffman's (1959) ideas of the theatre or dramaturgy. Goffman uses theatre as a metaphor to explore everyday interactions and uses theatrical terminology (e.g. stages, props, actors) to shed light on the complex relationships between actors, props, stage and audience. Brown and Bellaby (2002) illustrated the advantages of using the dramaturgical to analyse the pharmacy space by considering the role of a locum pharmacist. They showed how being visible all day compromised the medical professionalism of the pharmacist and how the customers expect a certain performance from the pharmacist. This research also highlighted how the performance of the pharmacist changed when they emerged out of the dispensary. This type of analysis also underlined how "pharmacists identify and are identified with their setting and stage props, especially the medicine" (p. 211). The main limitation from this research is that Brown and Bellaby did not consider all staff in the pharmacy, and the customer was only discussed as expecting a specific performance from the pharmacist.

The advantages of considering the community pharmacy using dramaturgical literature is that it brings to the forefront interactions, impressions, scripts (plots and dialogue) and relationships. This allowed me to look at how the different players in the pharmacy interact and enact with the pharmacy space, each other and the products (Brown &

Bellaby, 2002; Goffman, 1959; Visser, Beleijenbergh, Benschop & van Riel, 2017). The pharmacy performance is a team endeavour with all the actors presenting individually but also collectively to make the community pharmacy successful for the audience. This framework then does not necessarily privilege the pharmacist or medicines but rather allows for the fact that the pharmacy performance is interactional and complex. This approach also captures the everyday production of the community pharmacy space particularly well as the theatre metaphor allowed me to explore the routine or well-known scripts of the pharmacy. In addition, Goffman uses the theatre metaphor to explain how the performance is about creating a collective or team impression for the audience. The relevance of this for the community pharmacy is that the people (actors), space (front and back stage), products (medicines and other goods and services), all work together to create the impression of healthcare and community within a service or retail environment.

There is one distinct disadvantage of using the theatre metaphor in the community pharmacy. The theatre metaphor and the analogy of the stage implies a distance between performers and audience. In the community pharmacy the audience is the customer, the staff are the actors and the stage and the setting is the pharmacy. In a traditional play, the audience would watch and not interact directly, however, in the community pharmacy, the audience, as much as the actors and setting, create the production of pharmacy. Therefore, while the dramaturgical is an effective way to capture the multiplicities and complexities of the pharmacy performance it is important to remember that it is the interactions between people, place, product and customers that are integral to the social production of community pharmacy.

On stage in the pharmacy

Goffman (1959) identifies that setting, appearance and manner are all important in creating the impression of the performance. This immediately shows that Life and Unichem (the two brands of pharmacy) create different stages, performances, and

impressions. Every community pharmacy has different aesthetics, atmospheres, services, and products (props). These can vary even within the same brand of pharmacy, all of which change the performances of the community pharmacy. Of course, while the stages may look different, the main props and actors in all pharmacies are medicines and pharmacists, creating a "collective representation" (Goffman, p. 27) of the pharmacy as the place to get medicines. While there are differences in the settings, community pharmacy performances have a strong commonality in that the pharmacy performance is highly gendered. The atmosphere, the aesthetics, and many of the props are predominantly feminine. This is particularly the case in Life pharmacies due to the large amount of space devoted to beauty products. All Life pharmacies have more hedonic, feminine aesthetics and highly mediated shop fronts compared to Unichem pharmacies. Unichem pharmacies have more variation. For example, Unichem 1 was feminine and hedonic due to clearly defined gifts and beauty spaces, whereas Unichem 2 was more utilitarian in staging with limited beauty products and gift stands on the borders of the pharmacy. The stronger retail aesthetic of Life pharmacies and Unichem 1 affected the customer's movements and interactions with the pharmacy, with women staying in the pharmacy for longer and using more areas of pharmacy space.

As with any stage and performance, some elements are more important and powerful than others. For the community pharmacy, these are the dispensary space, the pharmacists, and the medicines. While the dispensary may be the most important, hegemonic and powerful space, it is visible but veiled, always situated at the rear of the pharmacy space. The dispensary's position in the pharmacy, the clinical gaze and symbolic medical power means the dispensary is part of the pharmacy set and staging. The dispensary is necessary for the meaning of the pharmacy performance, visible but not necessarily front of stage. Pharmacists are also integral to the production of pharmacy. When the pharmacists work in the dispensary, they seem aloof in the higher space, as though watching the performance, like a judge at a ballroom competition, exiting only to proclaim and dispense

expertise. Being on view but half-hidden when working in the dispensary, with no audible dialogue to the audience, complicates the pharmacists' performance. There are difficulties in the community pharmacy when the drama or main scene is inaudible as this can lead to misunderstandings by the audience. Customers may not see the value of the pharmacist's expertise or even be aware of the range of services pharmacists can offer. This does not detract from the facts that the community pharmacy remains the only stage where customers can obtain controlled and restricted medicines, that medicines have power, and that people who work with medicines are powerful. The pharmacists, dispensary and prescriptions are all powerful symbols of the community pharmacy and set the pharmacy scene – without them, the performance is merely a retail experience.

Currently, the pharmacist is expected to conduct many clinical services by the counter in the community pharmacy. The counter is front stage in the pharmacy as it is where all transactions conclude (if the customer purchases a product). The performance of the pharmacist is complicated in counter consultations because the counter area has multiple purposes, limited medical props, other actors (retail staff) working there, and lacks privacy. Hattingh et al. (2016) also found there are issues around privacy in counter consultations. In an effort to expand the pharmacist's role there has been an industry and policy move to reprofessionalise and better utilise the clinical skills of the pharmacist in New Zealand and overseas (Braund et al., 2012; Harrison et al., 2012). The changing performance is not well known, or embraced by, much of the audience (customers) or even by some pharmacists on either the Life or Unichem stage. One reason for this is that services beyond the core services are not offered in every pharmacy and the advertising for these services is largely invisible within the pharmacy setting. Latif, Waring, Watmough, Boyd and Elliott (2018) also found that either these services were not advertised or sat alongside retail material in UK pharmacies. New services also require different scripts and performances by both staff and customers and will require changes in how these people use the pharmacy space. For the pharmacist, these new services bring

them out of the dispensary to a space that is centre stage, more visible, more interactional and more intimate with the audience. The props may still be medicines; however, the pharmacist will use these props in different performances, such as prescribing the emergency contraceptive pill or giving advice in long-term medication reviews. Professional knowledge and dialogue, a new space in the consulting room, and medical symbolism become more important, as costume, technology, and patient-centred care take top billing. Adding to the complexity of the performance is that the clinical space of the consulting room is itself backstage, out of site from the rest of the audience. For the pharmacist and customer to use the consulting room the pharmacist leads the customer from public view. In this plot, consulting in private, the customer moves from audience to uneasy actor. This puts the spotlight on this person and this is not always a comfortable place to be in the community pharmacy. Thompson & Bidwell (2015) also found that having the spotlight on the customers led to embarrassment. Currently, in community pharmacies the performance of consulting by the counter is largely taken-for-granted, not resisted and part of the everyday pharmacy performance. I suggest this practice needs to be disrupted, and new rituals developed for the pharmacist and customers in the pharmacy plot of using the consulting room (consulting in private). Of course, this is complicated by the essential performance, dispensing. For the audience to have a professional health experience in a community pharmacy there need to be actors in the dispensary (doing the fundamental job), symbolising pharmacy, trust, and ensuring safe and efficient dispensing.

It is important to remember the pharmacy performance involves actors other than the pharmacists to create pharmacy meaning and representation. The retail staff predominantly work on the shop floor and staff hierarchies and boundaries around the different pharmacy areas and products complicate their performances. The seven different spaces of the community pharmacy require different performances, dialogues and expertise so there are sentries, guides, experts, and specialist staff to assist and lead the

audience. Who leads the performance depends on the pharmacy sub-space, the pharmacy culture, the task, the props (medicines, cosmetics, services, or other) and the customer. There is often a complex set of moves involved that require the staff to watch, move as needed, cover each other, and pass on to other staff members when they do not have the expertise. This intricate and complicated dance between staff and customers has defined routines and rules. These guide who moves, where they move, what costume they wear, what parts of the pharmacy they may access, and how to achieve the desired outcome (prescription needed, symptom display, who can sell the product, and so on). Who is centre stage, who is leading, and under what conditions depends on the customer story, the staff hierarchy and role boundaries. The performance also varied depending on the individual pharmacy brand due to different staffing, work practices, culture, and the pharmacy space.

As with any performance, dialogue is very important in community pharmacies and varies depending on the props, storyline or staff involved. The script and script delivery influence the audience and their emotions. Many of the tensions within the community pharmacy performance are dissolved by the way the actors deliver their lines. The actors can create a sense of community and loyalty through relationship building and display of socially appropriate emotions, through their emotional labour (Hochschild, 1983; 2003). Emotional labour is fundamental to understanding service industries and health settings. Emotional labour requires face-to-face skills, is difficult, situational, rule-bound, and expected (Hochschild, 1983). Within the pharmacy, retail staff and pharmacists have customer contact, there are defined feeling rules set by the pharmacy owner and Green Cross Health, and the different parts of the stage require different sorts of emotional labour or displays. The expectation in the pharmacy is to be caring in health interactions, persuasive in beauty consultations, and efficient and trustworthy in medicines transactions. Retail staff have more customer interactions and deal with both health and non-health interactions complicating emotional labour, as in addition to dealing with

customers retail staff are expected to buffer the pharmacist from non-health consumption, decide when to access the pharmacist, and deal with minor ailments. This then reinforces staff hierarchies and role boundaries of the 'shop girls'. The audience in any retail setting expects a level of customer service and the audience in a health care setting expects customer care (Foster & Resnick, 2013; Lopez, 2006; Riley & Weiss, 2016; Wright, 2005). In the community pharmacy, all pharmacy staff have to manage their emotions in face-to-face contact with customers, display care, concern and professionalism, and meet organisational expectations.

For customers in the pharmacy their performances and practices are heavily driven by consumption. There were differences and similarities in the performances of customers using the community pharmacy for health and non-health consumption. Unsurprisingly, a lot of health consumption involved the key prop in the pharmacy, medicines. The consumption practices around medicines differed depending on whether the medicines were controlled, for general sale, or CAM products. Each type of medicine had a defined space on stage and required different boundary work and/or boundary objects (such as prescriptions, symptom display, or story telling) to access the medicines. Filling a prescription at a pharmacy is comprised of three distinct tasks, handing in, waiting and collection. Handing in was a well-known and routinized, but there were gendered differences for customers waiting as more women stayed in the pharmacy while waiting, displaying shopping type behaviours such as browsing and trying products. The collection stage revealed the most differences in staff and customer performance, leading to customer uncertainty. It is also at collection that customers resist being given information, or take back the power of the interaction by leading the conversation, or by seeking information.

The customers are interactive and integral to the pharmacy performance as they influence and help lead certain performances. There were three distinct ways the customers moved

through the pharmacy and used the spaces, products and staff for non-prescription health consumption. Customers either headed directly to a space, selected a product and left, or they headed directly to a staff member at the counter or in the space they wanted to use and sought help, or they stayed towards the front of the pharmacy looking lost and let staff approach them. These movements showed customers were familiar or unfamiliar with the pharmacy, the staff or the product/service. Being unfamiliar led to more help seeking, product comparisons and browsing. In addition, customers enter the pharmacy with different expectations, illnesses, and lay health beliefs that also influenced their performances in the pharmacy, changing power differentials. For example, customers with serious and chronic conditions requiring regular medications used the pharmacist and other staff in different ways to people using the pharmacy for CAM. CAM customers could compare and contrast products in the pharmacy and seek advice and then either purchase the product or use other spaces such as supermarkets or online shops to access the product. Other research has highlighted the importance of lay health beliefs, the wide range of sources used for health, and how users incorporate medicines into their lived worlds (Ballantyne, 2016; Dew et al., 2014). My research has highlighted there are a variety of strategies customers use in the pharmacy to either resist or use health information, marketing, and products that affects how the customers utilise the pharmacy space and consume health.

Non-health consumption takes place on the same stage as medicines and health but within defined beauty and gifting areas. Many non-health experiences in community pharmacies are gendered and this is reflected in the more feminine aesthetic of the beauty and gift spaces. These spaces encourage labour and individual responsibility for appearance. Non-health consumption was a more complete experience for women primarily, including touching, smelling and trying of products. In retail spaces, the atmosphere and store aesthetic are as much of the consumption experience as actual purchases illustrating both functional and affective factors are important (Gavilan et al. 2014; Iqani, 2013). In the

pharmacy, the interactions were often longer for non-health consumption and used different spaces at the front of the pharmacy. There were also similarities between non-health and health consumption. Customers often sought help from staff in negotiating the pharmacy space and products, and they used, modified and avoided areas and products in personalised ways.

Customers use and appropriate the pharmacy as a shop, as a healthcare space, and as a beauty salon. Customers use hybridising strategies and tactics to appropriate products and knowledge for both health and non-health reasons. Customers have the power of choice - to enter the pharmacy, to choose products, and to choose the person they talk to – but this is only in certain conditions and plots. If they need prescription and restricted medicines, the customer needs to take on the patient role and engage with the pharmacy space and staff in a ritualised way. Whether the customer resists or modifies how they take the medicine occurs in spaces outside of the pharmacy. Customers can resist, embrace or ignore the other scripts or plots within community pharmacies in beauty services, gifting, or even OTC and CAM products, as the customer has more power in these interactions as a consumer, not a patient. The customer can also disrupt the performances of the staff by disrupting workflow and routines, stealing, or challenging the actors. Of course, the product the customers wants or needs also is important and influences the script of the customer and staff members.

In the pharmacy production, it is important to consider the wider cultural, political, social and historical context in which the pharmacy performance takes place. The contemporary context is characterised and heavily shaped by neoliberalism, the power of medicines (and medical knowledge) and the market state. The lead actors would seemingly be the pharmacists, owners and managers as they have the medical training. However, in practice Green Cross Health, PHARMAC, OTC, CAM and beauty companies, governments and other organisations regulate and control pharmacy staff, the actual space, and the audience

(Abraham, 2010; Dew & Davis, 2014). Green Cross Health, beauty and CAM companies influence the community pharmacy aesthetics, management, staff and audience emotions, and marketing in both Life and Unichem pharmacies, although beauty marketing is more prominent in Life pharmacies. I argue that in particular Green Cross Health has created two distinct stages for community pharmacy that are divergent from one another and different from independent and hospital pharmacies. The expectations and actual performances that occur in both Unichem and Life pharmacy still revolve around the dominant script of dispensing medicines, but the aesthetics, marketing, feel and expectations of audiences attending and using each of these brands of pharmacy differ. Customers then use, modify and reject elements of the pharmacy in forms of resistance to this control. These interwoven and linked practices by customers are conceptualised as hybridising (Dew et al., 2014; Latour, 1993).

In summary, considering and discussing the community pharmacy as a performative space highlights the intricate and intertwined performances that occur between spaces, people, and products. The performance of pharmacy is an elaborate production that is not always, and not only, about medicines and health. This research has illustrated how health matters can sit alongside retail matters in a community pharmacy. In the community pharmacy, there is a range of plots and scripts, different actors take the lead at different times, the prop is not always medicines, the stage setting varies from pharmacy brand to brand and the audience is an interactive one. Accordingly, the community pharmacy is a unique site of healthcare, full of tensions because of the retail setting, but not necessarily conflicted. The community pharmacy works as a hybrid space with differing knowledge epistemologies, professional boundaries, and strong market ideologies, but any tensions are resolved by creating a community, and showing care and patient centeredness. The focus on the divide between dispensary and shop seems misplaced, as health and retail are strongly intertwined within the community pharmacy. In fact Ancuceanu and Bogdan (2016, p. 6) suggest this duality has been discussed for over 100 years and state, “an

absolute divorce between the two sides (commercial and professional) was impossible". I consider that we need to move on from the focus on the tensions of the community pharmacy operating in a retail space. There is value in conceptualising the community pharmacy as a performative space, one that is influenced by the setting (stage), who is on stage (front stage), who is backstage, and what props are in play. This does not then privilege medicines, pharmacy itself, or a type of pharmacy, but provides more informed insights into pharmacy practices and performances where meaning making is complicated and messy.

Future research areas

There will always be a place for research to ensure that medicines are dispensed safely and appropriately in the community pharmacy, that all New Zealanders have access to necessary healthcare services, and for research that focuses on pharmacists as primary health professionals. However, this research has also highlighted the potential for further research into the complexity of community pharmacy performances and research that includes exploring the intersections of space, people and products. There is undoubtedly a need for more situated and spatial research of all New Zealand pharmacies (branded, independent, and hospital) in different settings (rural, high SES, low SES) throughout New Zealand, and in countries other than New Zealand. This would highlight the boundaries and issues customers face when accessing medicines from community pharmacies and provide further understanding of the complexity of performances that occur in the community pharmacy.

This research has highlighted that pharmacist performance changes when the pharmacist leaves the dispensary but I did not observe interactions within the consulting room. It will be important to explore the interactions of pharmacists and patients in the consulting room as I anticipate more and more consultations will move from the counter to the consulting room. While it is clear that the pharmacist's role is expanding and they are

taking on more clinical tasks, there needs to be more research on how best to advertise this to customers, as even long-term customers are not fully aware of the range of services on offer in the pharmacy. The pharmacist profession continually reflects on how being in a retail setting compromises their professionalism (Bradley et al., 2018; Elvey et al., 2015; Mossialos et al., 2015). There is no doubt that you can be a good clinical pharmacist in a community setting, regardless of whether it is located within a supermarket, next to a medical centre, or on a high street. Some pharmacists may embrace the retail setting while others are still constrained to the dispensary and resistant to expanding services. Therefore, it is important for research to further explore the impact of the pharmacist working out of the dispensary, how best to use the community pharmacy spaces for new and existing services to manage privacy of customers, to offer the best patient care and still manage the pharmacist's professional identity. This research has shown how important inter-relational, dynamic, contextual and complicated staff experiences are, with each other and with customers, within the community pharmacy. A better debate and focus for future research could be – how can we make pharmacies more effective for all the staff and how does the community pharmacy meet the changing needs of their customers?

Within New Zealand, Life and Unichem, as brands of community pharmacy, are seemingly here to stay. All Life and Unichem pharmacies have some relationship with Green Cross Health and it clear that Green Cross Health is a strong prevailing power in healthcare in New Zealand. This research has shown that these two brands have two distinct target markets, and have a large share of the prescription market (61% in 2017) and over 1.3 million members in their Living Rewards loyalty programme (Green Cross Health, 2017). This means approximately 27% of New Zealand's population has signed up to this programme and every transaction is recorded, including prescriptions filled (Statistics New Zealand, 2018). Green Cross Health is therefore influencing the pharmacy stage, the props, the setting (aesthetics), and consequently, healthcare, wellness and beauty use by

consumers in the community pharmacy. More research into the level of Green Cross control of their pharmacies, pharmacy owners and the pharmacy profession is needed. In addition, research is needed into how the information recorded by the Living Rewards scheme is used beyond targeted emails and texts with marketing and health information. The impact of Green Cross Health on independent pharmacies is also worthy of attention.

This research has highlighted that certain consumers are privileged over others, particularly in Life pharmacies. By understanding the functional, symbolic and aesthetic barriers and borders that exist in community pharmacies, we can fully grasp the complexities of access to community pharmacies. For example, this research has found that something as simple as seating welcomes customers and keeps them in the pharmacy while they wait for their prescriptions, decreasing barriers created by feminine aesthetics. Future research could focus on addressing other functional and affective barriers for customers. Spatial analysis is particularly useful for highlighting power and social inequalities, and this research has shown that power can play out in both macro and micro ways in the community pharmacies. We need to challenge dominant health and consumption ideologies and enhance the experiences and production of pharmacy for all customers. There is also room for more research on how power is playing out in the pharmacy. This would be particularly worthwhile in exploring different sorts of interactions (such as CAM or beauty interactions), between the staff groups (such as management and retail staff), and at the macro level through key stakeholders influences (including drug, OTC, CAM and beauty companies).

Another important finding was the role of emotion in the community pharmacy. Future research could investigate how to keep the 'community' in pharmacies otherwise all pharmacies become dispensers of medicine in a retail space – not a community pharmacy. The role of emotion and emotional labour then requires further exploration with a particular focus on how emotional labour is constraining staff. More research is needed exploring the role of emotion for customers and how they manage their emotions in

pharmacies. It is also important to look at temporal elements in the pharmacy setting, as these have implications for both staff and customers. Certain performances in the community pharmacy require more time and have funding and business implications for pharmacies. CAM interactions, for example, take longer because of the way the CAM space is laid out, but these products usually have high mark-ups so are worth the extra time. Whilst Thompson and Bidwell (2015) have highlighted the importance of space, time and emotion for pharmacists, there is room for further research focusing on all staff in the pharmacy.

Lastly, the role of media and the commercialisation of health requires more research in the pharmacy setting. I anticipate the role of technology, social media and on-line pharmacies will only increase and the impact of this on community pharmacies and the pharmacy profession needs more attention. Consumers are almost constantly exposed to hyper-mediated spaces physically and virtually via the Internet, which may render mediated health messages less visible. It is therefore important to explore how customers are engaging with pharmacies in virtual worlds either alongside physical use or just in on-line experiences. It would be useful to investigate how other forms of technology, such as health apps, can be used in pharmacies for health promotion. While DTCA advertising has been highlighted as problematic, the everyday advertising within pharmacies has not received critical analysis and is worthy of further investigation.

The community pharmacy is a unique space to research because it is the only retail space that can sell and dispense prescription medicines as well as offer a range of other goods and services, some health and some non-health related. The overall aim of this research was to explore the community pharmacy as a complex hybrid space. This research has shown the value of exploring and understanding the community pharmacy as a performative space. This research has uncovered new aspects to well-known routines, highlighted the intersections between space, people and products, emphasised the important of emotion and relationships in the pharmacy, and bought to light how

customers use hybridising strategies and tactics to personalise their community pharmacy experience.

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Appendices

Appendix A – Information Sheets

The community pharmacy as a site of healthcare delivery

Information sheet for prospective community pharmacies

This information sheet is intended to tell you more about this project and to help you decide if your community pharmacy could take part. First, my name is Kathryn McGuigan and I am enrolled at Massey University as a PhD student based in the School of Psychology, Albany Campus. The research project I am interested in for my PhD is exploring the community pharmacy as a site of healthcare delivery. I am particularly interested in looking at the layout, function, and use of the actual pharmacy space and how staff and customers work, move, and purchase products from the pharmacy. I would like to invite your community pharmacy to take part in this research with us.

What does the research involve and what would you have to do?

I would like to gain an understanding of how the pharmacy works as a space and how it is meeting both health and retail demands. In order to do this I wish to explore how the pharmacy is running and who is doing what in the pharmacy. I do **not** intend gathering specific health information on your customers or seeing specifically what they purchase. Nor do I intend to gather any specific financial information or sales information. There are three phases in this project which are described in more depth below.

Phase one - observation

If you choose to participate I would like to come into your community pharmacy and observe the retail and dispensary spaces. This would happen over a period of two to three weeks in small blocks of time at different times of the day. These times will be negotiated ahead of time so you know I am coming. I will not be observing in consulting rooms, break rooms or any other private spaces. No conversations would be recorded during this time although extensive field notes would be written by me. I would be observing from spaces that are visible to the staff and customers but out of earshot of conversations. The intention is to gain information on work flows of both staff and customers, gain an understanding of who does what and who is responsible for specific spaces in the pharmacy, and how the layout of your pharmacy influences the function of the space. I would also like to take digital photos of the different spaces inside the shop, entrances and exits and any exterior window displays. There would be no people in these pictures and you would have the right to consent to the use of these images in any publications from the project. Staff will be informed of the project and written consent will be sought from all staff members for this phase.

Phase two – staff interviews

If you choose to participate in the research I would like to interview all staff, including yourself, working at the pharmacy. However, I understand that individual consent must be sought from each staff member and the project explained to them in detail first. The purpose of the interviews is to gain an understanding of each staff members' responsibilities and further my understanding of how the pharmacy works. I would like to use the photos I will take in the interviews to talk about each area of the shop and any responsibilities that staff have for that particular area. For those who consent I would to conduct one interview with them that will take approximately one to two hours and will be conducted outside their working hours at a venue to be mutually agreed. These conversations will be audio-recorded. I would also invite staff to draw a map of the pharmacy marking where they work and what each space is used for.

Phase three – customer interviews

I would also like to invite six to ten long term users of the pharmacy to talk with me. These customers would be identified by your staff. Invitation letters and information sheets would be provided to the pharmacy by me upon your approval. I would ask the staff to hand out envelopes to customers with the invitation letter and information sheet enclosed. The customers would then contact me directly if they were happy to be interviewed. Again, I would like to use the photos as prompts in the interviews to see if the customers have used or noticed each of the spaces in your pharmacy.

This research and your involvement is a potentially intensive process over a period of several months. I anticipate that I will develop at good working relationship with the manager where we can work together to resolve any issues and that we will keep you informed. I anticipate there will be minimal disruption for the pharmacy as I will not interact with the staff or customers during the observation times and all interviews will be conducted outside of work hours. However, during the observation phase it will be obvious to both staff and customers that I am in the space taking notes. The staff members will be aware that I am there as a researcher and they are free to tell customers that if they enquire. Both staff and I will have to use discretion in situations where privacy is necessary. In phases two and three staff and customers will be made aware that, if they agree to participate, they do not have to discuss anything with me that they don't want to. They will not be able to be identified in any publication and will be given pseudonyms. The pharmacy itself will not be named and will not be able to be identified. Any images that have any identifiable characteristics will not be used with the final right to use any images in publications from the research being at your discretion. We will go through a formal consenting process for this at the end of the research process in your pharmacy

The information collected will be analysed and the findings will provide the basis for a number of academic journal articles and presentations. On completion of the research, we will send you a summary of the research findings and I would be happy to discuss these with you. Also, if you request it, I will come and present to you the findings relevant to your pharmacy at a time convenient to you.

Your rights

With the above in mind, we would like to remind you that you are under no obligation to accept this invitation to participate in the research. Should you decide to take part, you have the right to:

- ask any questions about the research at any time;
- withdraw your permission for the project at any time, up to the end of the research process in your pharmacy;
- withhold permission to use any of images taken by me;
- know that all audio-recordings, transcriptions and images that are part of the data set will be treated with care and respect, stored safely and shared only among the project's research team; and
- receive a summary of the research on completion.

Contact details

The above provides a broad overview of the project and your rights with regard to taking part in this research. If you think you would like to participate, we can talk further about the issues that arise from the research. The research teams contact information is below and we would love to meet with you so that we can talk a bit more about the research. Please be assured that meeting with us doesn't obligate you in any way to take part in the research. Many thanks for taking the time to read this information sheet.

Kathryn McGuigan

[redacted]

Massey University, Albany, Auckland

[redacted]

Professor Kerry Chamberlain

09 414 0800 extn. 41226

Massey University, Albany, Auckland

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Professor Pauline Norris

03 479 7359

Otago University, Dunedin

pauline.norris@otago.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 12/090. If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43404, email humanethicsnorth@massey.ac.nz.

The community pharmacy as a site of healthcare delivery

Information sheet for prospective staff participants – interview (phase two)

This information sheet is intended to tell you more about phase two of my project which is to complete interviews with pharmacy staff. Community pharmacies are interesting places to research as they are a retail space that also delivers healthcare. I am particularly interested in looking at the layout, function, and use of the actual pharmacy space and how staff and customers work, move, and purchase products from the pharmacy. I would like to invite you to take further part in this research with me.

What does the research involve and what would you have to do?

I would like to gain an understanding of how the pharmacy works as a space, for you the staff, and how it is meeting both health and retail demands. I wish to explore how the pharmacy is operating and who is doing what in the pharmacy. In order to do this I hope to talk to you about your experiences, training, responsibilities, and get your story about working in a community pharmacy.

If you choose to participate in the research I would ask to conduct one interview with you that will take 15-30 minutes and ask you to complete a short survey. The interview will be conducted outside your working hours or in a break time at a venue agreed on by us. This conversation will be audio-recorded. I would also invite you to draw a map of the pharmacy marking where you work and what each space is used for. If you agree to participate, you do not have to discuss anything with me that you don't want to. You will not be able to be identified in any publication and will be given a pseudonym. The pharmacy itself also will not be named and will not be able to be identified.

The information collected will be analysed and the findings will provide the basis for a number of academic journal articles and presentations. On completion of the research, we will send you a summary of the research findings and I would be happy to discuss these with you.

Your rights

With the above in mind, we would like to remind you that you are under no obligation to accept this invitation to participate in the research. Should you decide to take part, you have the right to:

- decline to answer any particular question;
- withdraw from the study up to one week after the interview has been completed;
- ask for the recorder to be turned off at any time during the interview
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used;
- be given access to a summary of the project findings when it is concluded.

Contact details

The above provides a broad overview of the project and your rights with regard to taking part in this research. If you think you would like to participate, we can talk further about the issues that arise from the research. I hope you will consider taking part. I can be contacted using the information below. My supervisors contact information is also below. Please be assured that meeting with me doesn't obligate you in any way to take part in the research. Many thanks for taking the time to read this information sheet.

Kathryn McGuigan

[redacted]

Massey University, Albany, Auckland

[redacted]

Professor Kerry Chamberlain

09 414 0800 extn. 41226

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The community pharmacy as a site of healthcare

Information sheet for prospective customer participants

This information sheet is intended to tell you more about the project to help you decide if you would like to take part. The research project I am interested in for my PhD is exploring the community pharmacy as a site of healthcare delivery. Community pharmacies are interesting places to research as they are a retail space that also delivers healthcare. I am particularly interested in looking at the layout, function, and use of the actual pharmacy space and how staff and customers work, move, and purchase products from the pharmacy. I would like to invite you to take part in this research with us.

What does the research involve and what would you have to do?

I would like to gain an understanding of how the pharmacy works as a space, for you the customer, and how it is meeting both health and retail demands. I will **not** collect any specific health details but rather talk to you about why you use a pharmacy, what sort of services you use, what you do when you are in the pharmacy, what sort of products do you buy at the pharmacy and so on.

If you choose to participate, we will ask you to talk with me for approximately 30 minutes at a mutually suitable venue and time. These conversations will be audio-recorded. If you agree to participate, you do not have to discuss anything with me that you don't want to. You will not be able to be identified in any publication and will be given a pseudonym. The pharmacy itself also will not be named and will not be able to be identified.

The information collected will be analysed and the findings will provide the basis for a number of academic journal articles and presentations. If you request it on completion of the research, we will send you a summary of the research findings and I would be happy to discuss these with you.

Your rights

With the above in mind, we would like to remind you that you are under no obligation to accept this invitation to participate in the research. Should you decide to take part, you have the right to:

- decline to answer any particular question;
- withdraw from the study up to one week after the interview has been completed;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used;
- be given access to a summary of the project findings when it is concluded.
- ask for the recorder to be turned off at any time during the interview.

Contact details

The above provides a broad overview of the project and your rights with regard to taking part in this research. If you think you would like to participate, we can talk further about the issues that arise from the research. I hope you will consider taking part. If you would like to hear more about the research or think you might be interested in participating, I can be contacted using the information below. My supervisors contact information is also below. Please be assured that meeting with me doesn't obligate you in any way to take part in the research. Many thanks for taking the time to read this information sheet.

Kathryn McGuigan

[redacted]

Massey University, Albany, Auckland

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This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 12/090. If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43404, email humanethicsnorth@massey.ac.nz.

Appendix B – Consent Forms

Consent form for Pharmacy owner and/or manager to access pharmacy

I hereby give Kathryn McGuigan access to and permission to use _____

pharmacy to conduct her PhD research project under the following conditions:

1. The pharmacy's name or any identifying images will not be used in any publication or presentation and it will not be able to be identified from any description
2. All images that will be used will be shown to me the manager/owner and consent will be given to use these images
3. All participants will be anonymous in any publication, presentation or use of the material except to the researcher
4. There will be minimal disruption to the everyday running of the pharmacy
5. The researcher will not record any conversations during the observation phase and will not take notes on any specific health issues of customers or staff
6. The manager will inform the owner of any issues and keep the owner informed regularly on the project
7. The research will be conducted over the following months _____to _____
8. A summary of the research will be provided to the owner
9. A de-brief will be made available at the completion of the project

Signed

Owner's full name _____

Owner's signature _____

Date _____

Manager's full name _____

Manager's signature _____

Date_____

Kathryn McGuigan _____

Date_____

Community pharmacies as a site of healthcare delivery

STAFF PARTICIPANT CONSENT FORM

I have received a copy of the general information sheet and had the research project explained to me. I understand the three phases of this research project. I understand during phase one of this research that Kathryn will be in the pharmacy observing processes. I am aware of this and agree, during my time at work, to this.

Signature: ..... **Date:** .....

Full Name - printed .....

Signature: ..... **Date:** .....

Full Name - printed .....

Signature: ..... **Date:** .....

Full Name - printed .....

Community pharmacies as a site of healthcare delivery

PARTICIPANT CONSENT FORM FOR INTERVIEW (STAFF AND CUSTOMER)

I have read the Information Sheet and have had the details of the study explained to me. I have talked through this phase of the research with the researcher and all of my questions have been answered to my satisfaction. I also understand that I may ask further questions at any time during our interviews and discussions.

I agree to an interview that will talk about my experiences within a community pharmacy. I also understand that this interviewed will be recorded but that I may ask to have the recorder turned off at any stage.

Signature: ..... **Date:** .....

Full Name - printed .....

I would like to be provided with a summary of the research findings. YES____ NO____

If you have requested a summary of the research findings, please provide contact information below:

Either: Your address:_____

_____

OR: Your e-mail address: _____

Community pharmacies as a site of healthcare delivery

CONSENT TO USE PHOTOGRAPHS

In this study you will be aware that a number of photographs were taken of _____ Pharmacy. I would like to use these photos in the final copy of my thesis and related presentations, and any publications that arise from it. You do not have to consent to this use of these photographs; you are also free to consent to the use of only some of the photographs.

For each of the following photographs identified below please initial in the box provided if you consent to the release of the photograph, if you do not consent to its release write NO in the box.

Photograph	Initial
[small image]	

I agree for the above photos to be published as indicated by the insertion of my initials.

Full name: _____

Signature: _____ Date: _____

Appendix C – Invitation to participate

Community pharmacy

February 2015

To the Owner / Manager

INVITATION TO PARTICIPATE IN PHD RESEARCH PROJECT

My name is Kathryn McGuigan and I am currently enrolled at Massey University as a PhD student. I am currently looking for three community pharmacies in which to conduct my PhD research. I am particularly interested in community pharmacies as they are fascinating retail spaces that deliver specialised healthcare. There is limited research looking at the actual pharmacy space, including layout, function, staff and customer flows, roles of staff and customers and the tensions that appear to exist between commercialism and effective healthcare delivery. I hope to use three different pharmacies that have different commercial focuses to explore all these areas. I have enclosed an information sheet that outlines the project in more depth.

I am seeking access and permission from you as the owner to use your pharmacy in my research. My supervisor, Professor Kerry Chamberlain and I would be happy to meet with you to discuss any aspects of the project and to ensure that you are happy for me to use your pharmacy in my research. You could also contact my other two supervisors if you have any other concerns or queries.

I look forward to hearing from you.

Yours sincerely

Kathryn McGuigan

Appendix D – Sign for community pharmacies

PLEASE NOTE THAT THIS PHARMACY IS TAKING PART IN A RESEARCH PROJECT DURING THE WEEKS OF _____.

THIS WILL NOT AFFECT YOU OR THE SERVICE OFFERED TO YOU IN ANY WAY.

Appendix E – Observational checklist

OBSERVATIONAL PHASE

The purpose of the observational phase of this research is to understand the flow of people (both staff and customers) within the pharmacy including:

- How does the pharmacy operate?
- Boundaries created by the shop such as counters, display cabinets, exits, thoroughfares.
- Who does what and when?
- Who goes where and when do they do this? Roles and responsibilities
- Influences on the pharmacy (regulations, customers, Pharmac, prescribers, marketing) and what the pharmacy influences (customers, prescribers, community)
- Flows of people, products (including medicines and other products) and information
- What is happening in the unseen spaces
- Is there a hierarchy and how does this look within the day to day running of the pharmacy

I am also interested in who is doing what within the space and how the space impacts this. In particular for staff I am interested in the following:

- Which staff member deals with which customer
- What sort of roles and responsibilities does each staff member have in the space
- Role of the staff member with customers – transforming talk into health, medicines, information giving, information seeking
- Observe staff with other staff and these interactions and relations, what is the space doing to these interactions.
- What is happening in the space when there are no customers (unseen)

For the customers I am interested in observing the following:

- What general category of product are they buying, that is, prescription medicine, pharmacy only medicine, other medicine, first aid, CAM, gift, baby, beauty or other service
- Do they seek advice from a staff member, if so, which one
- What promotional material, if any, do they take notice of, take home, are directed to by staff
- Does the customer purchase anything, browse, do both
- Where in the shop do they move
- What age group do they roughly fall in

Appendix F – Interview schedules

INTERVIEW SCHEDULE FOR STAFF

The main aim of the interview with staff is to clarify anything that has arisen from the observation phase and to talk to staff members about their understanding of their role in the pharmacy. I wanted to talk to the staff about the following:

- Job duties, training and general responsibilities
- Time they have worked in this pharmacy
- Staff member draws map of pharmacy indicating of where they typically work and we talk about why this is and when this changes e.g. lunch time, someone ill etc.
- Most important and most enjoyable job role? Least important role and least enjoyable role and why?
- Role with other staff
- Role with customers – normal interactions, difficult interactions, relationships, loyality
- What do they like about working in this pharmacy and what do they not like?
- What would they like to do in their job that they don't do at the moment?
- How could the pharmacy be improved?
- How do they see the future of the pharmacy?

Specific questions would be along the lines of:

1) What are your main job responsibilities i.e. job description would say what?
2) How long have you worked in this pharmacy?
3) What training have you had (formal, informal, on-site, off-site)?
4) Can you draw me a map of the pharmacy layout and indicate where you typically work?
5) What is your most important job role you perform and why?
6) What is your least important job role and why?
7) Do you enjoy dealing with the customers/patients?
8) Do you find this challenging at all?
9) What do you enjoy about working in this pharmacy?
10) What do you find difficult or not enjoy about working in this pharmacy?
11) Would you like to have your role expanded at all or do something you are not doing at the moment and why?
12) What is your personal belief about medicine use in treating ill health and in health promotion, such as using alternative medicines to boost immunity?
13) How do you see the future of this pharmacy and pharmacies in general?

INTERVIEW SCHEDULE FOR CUSTOMERS

The goal of interviewing customers is to understand how they talk about and use the pharmacy.

USE MY PHOTOS TO GENERATE DISCUSSION OVER DIFFERENT AREAS OF THE SHOP. DO THEY USE THEM AND WHY, WHY NOT.

I am also interested in exploring the following:

- Why you use that particular pharmacy
- What type of services do you use and why (MUR, passport photos, hiring equipment)

- What staff member do you use the most and why
- Do you use the pharmacy for health advice
- What advertising have you noticed
- Do you take home any promotional material
- Potential uses of pharmacy or services you would like but don't have access to currently
- Do you use other pharmacies