Original Research

Using qualitative methods to explore the dynamics of patients' perspective sharing in community pharmacy counseling– conversation analysis and video-stimulated recall interviews

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Abstract

Background: For patient centered counseling to take place in community pharmacies, patients should feel encouraged to share their perspectives, yet studies show that this rarely happens. The process of patient perspective sharing relies on the interactional details that unfold during an encounter i.e. how patients verbally and nonverbally are encouraged to share their perspective, which in turn is affected by patients' and pharmacy staff members' psychological processes in the situation, i.e. how they perceive and feel when acting. Therefore, employing complimentary methods that study both interactional and psychological processes could deepen the understanding of the dynamics governing patients' perspective sharing in pharmacy encounters. **Objective:** The objective of this study is twofold: 1) a methodological consideration of the benefits of employing Conversation Analysis (CA) and Video-Stimulated Recall Interviews (VSRI) in parallel, 2) to use the methodological combination to understand patient perspective sharing in community pharmacy interactions. **Method:** A single case study of one pharmacy encounter to explore the objectives in-depth. This was done through video recording of pharmacy encounters and subsequent CA-analysis; VSRIs were conducted with the involved patient and pharmacy staff member and analyzed using a qualitative thematic approach. **Results:** By exploring detailed interactional and psychological processes in parallel, specific occurrences which might hinder patients' perspective sharing were revealed. CA demonstrated that staff member's listening activities restricted the patient's perspective sharing. VSRIs with patient and staff member supported this result: the staff member had a narrow conception of what counted as suitable answers and did not consider listening an active process. The patient harbored shame about needing to take the medication which affected her behavior during the encounter. **Conclusion:** The novelty of the methodological combination is promising in order to grasp the complex process of patient perspective sharing in pharmacy encounters, as it affords aspects such as emotionality to be considered a central part of pharmacy encounters. As a consequence, it is suggested that the psychological concept of mentalizing is added to pharmacy education, as it is a trainable capacity enabling staff to become aware of the mental states that affect both patients and staff themselves during the pharmacy encounter.

Keywords
Qualitative analyses; Emotions; Communication; Mentalizing; Single case-study

INTRODUCTION

Patient-centered communication (PCC) is considered relevant to community pharmacy practice due to pharmacy staff transitioning from a medication dispensing to a counseling role.[1,2] The concept of patient-centeredness has many definitions. Typically it is derived from the context of consultations between physicians and patients, and this model has been transferred to community pharmacy practice.[3]

Across definitions, review studies point to a process that is common in PCC: namely that of patients being asked for and sharing their perspectives in the consultation. In their review, Langberg et al. uncovered the use of patient-centeredness from 2000—2015, and found that two of the most frequently mentioned dimensions were 'Sharing power and responsibility' and 'Patient as person', which both reflect the need to gain the patient's perspective.[4] Based on 18 articles, Wolter et al. provided an overview of the concept of PCC. They identified 5 main categories which were then modelled in the Utrecht's Model for Patient-Centered Communication in the Pharmacy. The first category 'Shared problem defining' described the process of 'exploring and understanding the patient's view'.[2] A similar focus on engaging patients' perspectives can be found in different pharmacy guidelines which specify the communication behavior needed to obtain PCC. For example, the Patient-Centered Communication Tool (PaCT) was developed to measure pharmacy students' skills and includes five tools for measuring specific communication skills. One of these

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tools measures the ability to explore and integrate the patient's perspective.[5] The process of engaging patient's perspectives can then be seen as a fundamental aspect of patient-centered communication. Thus throughout this article, the engagement of patient perspectives will act as an indicator of patient centeredness in the pharmacy interaction.

Despite the demonstrated agreement that PCC is pivotal to community pharmacy practice, and despite the fact that patient-centered counselling is essentially defined by patients bringing forward their perspectives, studies show that patients' views are rarely engaged in the pharmacy encounter.[2,6–9]

The lack of patients engaging their perspectives is not caused by a lack of guidelines for communication in pharmacy practice.[3,6] However, it might be caused by an absent focus on the components of interaction when studying pharmacy encounters. Even more fundamentally, it could be related to a lack within pharmacy practice research to consider essential psychological processes as the basis for all interactions, including those in the community pharmacy, i.e. that all humans, also staff members and patients, are affected by emotions during their encounters.[8]

Interactional details such as advice giving, question production and responses, or information conveyance in a pharmacy encounter can be explored through the method of Conversation Analysis (CA), whereas the method of Video-stimulated Recall Interview (VSRI) enables an overt exploration of interactants' feelings and considerations as they participate in the encounter, i.e. psychological processes. However, the methods have rarely been used in pharmacy practice separately and not at all combined, even so the combination might prove valuable in exploring in-depth why patient perspectives are not integrated more in pharmacy counseling today.

The aim of the present article therefore, is to combine the two methods in order to explore how employing both in parallel might provide more detailed insights to the exploration of the barriers and motivations for the sharing of patient perspective in pharmacy encounters and thus, ultimately performing patient-centered pharmacy communication.

METHODS

Design

A single case study was chosen to investigate a typical, real-world pharmacy encounter in detail.[10] The advantage of using a single case study is that it allows for assessing multiple perspectives, achieved through various methods, on a specific, complex issue. As such, the use of CA allows a thorough investigation of how pharmacy staff and patient interact with each other in the given case: which words and sentences are produced, and with which

consequences for the progression of the interaction. The inclusion of VSRI, allows the involved parties to articulate their experiences related to the interaction, thus contributing a unique first-person perspective of the interaction – why they interacted as they did. This specific case study has the potential to reveal otherwise inaccessible aspects, which might in turn have a profound effect on whether or not patients share their perspectives during pharmacy encounters. The single case design thus allowed for a parallel implementation of two methods, in the quest of uncovering both the interactional and psychological intricacies involved when patients bring forward their perspectives. Thereby the research design yields a deeper and more detailed understanding of the complex social phenomena involved in patient-centered counseling than previously investigated.[11]

Conversation Analysis

CA is rooted in ethnomethodology and rests on the assumption that social meaning and order are locally enacted by people (interactants) in their everyday lives. In CA, orders and procedures that underlie spoken interaction are demonstrated and explicated. It enables an analysis of processes in social interaction, including a focus on both verbal and non-verbal aspects.[12–14]

CA focuses on actions that interactants perform. These actions are identified by closely studying both the linguistic and non-linguistic aspects of whatever interactants do.[15] In CA, talking turns are considered to be interlocked with each other: as a next speaker talks, they are assumed to produce a turn that is relevant to the preceding turn. This acknowledges the so-called next turn proof procedure, where speakers' interactional contributions are not absolutely open to interpretation: the speaker displays with their next turn how they understand the preceding speaker's turn.[16] In CA then, a talking turn should always be considered in its sequential context, i.e. in the context of an utterance that precedes or follows it.[17]

As shown by previous studies, applying the method of CA to pharmacy encounters enables an exploration of the activities of community pharmacy staff and patients as interlocked.[18,19] Hence, the ways in which community pharmacy staff questions, advises, or informs, shapes the context for how a patient acts and answers. The staff member's ways of responding to a patient's contributions continuously affect the patient's ways of engaging in the dialogue. Therefore, CA enables an analysis of the specific actions of patients and pharmacy staff that might either promote or hinder patients' perspective sharing.[19]

Video-stimulated recall interviews

While CA enables an exploration of the actions of pharmacy staff and patients and how they interpret and respond to each other during the interaction, the method does not directly target their inner experiences as they interact, and thereby why they choose to interpret

and respond in given ways to each other's activities.[20] Hence, through CA it is possible to observe how the interaction proceeds but not to understand why. To gain this understanding, acquiring insights into internal psychological issues, i.e.the thoughts and feelings that staff and patients experience, is needed. For this the method of VSRI has been suggested.[21]

VSRI is a method that aims at evoking informants' perceptions of an interaction in which they previously participated. It stimulates them to explicate experiences they had on a moment-to-moment basis.[22] The method has been applied mainly in psychological counseling and teaching contexts, but VSRI has recently been suggested as relevant to community pharmacy counseling.[8] The procedure involves an interaction that is video-recorded (interaction 1) and a subsequent interview (interaction 2). In interaction 2 a participant from interaction1 is stimulated to recall experiences from interaction1 by watching video-sequences of that interaction. The participant is prompted by questions or cues by an interviewer with the aim of helping the participant to talk about specific experiences.[21] Traditionally, the method is supposed to bring the participants back to the 'there and then'of interaction1 and stimulate them to explicate previous experiences with profound accuracy. However, in recent versions the method is not used solely to bring back what happened during interaction1, but also to encourage reflection on the participants experiences as they watch the video in the 'here and now' of interaction2.[8,23,24] Thus, VISRIs are conducted with the aim of identifying descriptive categories characterizing informants' experiences. The categories can be pre-defined or inferred from the interviews by using a thematic analysis approach.[25]

In summary, while CA addresses interactants' (external) actions, VSRI enables an exploration of their (internal) experiences, and thus the reasoning governing their actions.[24] Together, the two approaches can be used to illuminate a) the specific processes in community pharmacy encounters where patients are invited (or not invited) to engage in sharing their perspectives, and b) the reasons behind.

Data collection and management

Data collection

The data is part of a wider study to explore patient-centered counseling in prescription encounters in Denmark.[8] Video recordings were used as primary data and collected at two community pharmacies. The community pharmacies came from two different regions, one located in the countryside and the other in the suburbs of a major city in Denmark. Encounters between staff and patients were video recorded over a period of 3 days in each pharmacy. Prescription encounters were emphasized due to a higher occurrence of drug related problems among this population, thus making the sharing

of the patient perspective even more vital.

Informed consent was given by all staff and patients prior to recording (interaction1). This covered both the video recording and the VSRI (interaction 2). The study was approved by the Danish Data Protection Agency administered by the Faculty of Health, University of Copenhagen, ref. no. 514-0310/19-3000.

From a total of 64 video-recorded encounters, a selection was made for the subsequent interviews of the VSRIs, and, in total, 12 VSRIs were conducted in the study.

Selection of single case

Since the aim of this study was to explore in detail interactional processes that restrict patients perspective sharing related to their medication in a pharmacy encounter, it was decided to select a single encounter, which could then be explored in depth employing both methods.

A preliminary analysis of the 64 video recorded prescription encounters, showed that talk about medication was initiated by pharmacy staff between zero and seven times in each encounter, and concerned topics such as side effects, use of medication and the patients' knowledge about the medication.[8] In order to thoroughly understand how pharmacy staff tries to engage patients in dialogues, we therefore decided to investigate one encounter, where there was substantial discussion about the medicines between the two parties. The single case should thus comprise of a prolonged encounter in which interactional and psychological processes are available to be explored in-depth. The selected encounter for the single-case study was one out of four encounters in which talk about medication was initiated six times. Further, the specific encounter was selected because the medical topics that were addressed were typical for these types of conversations (such as discussing side effects) including the fact that it was mainly the staff member who initiated these topics. The single case thereby represented a typical encounter in several aspects and at the same time provided the possibility to study patient engagement in detail.

Analysis of data

Interaction 1: The selected pharmacy encounter (interaction1) was video-recorded and transcribed according to CA conventions (Appendix A). The analysis process payed special regard to the interactional contributions following questions asked by staff, in particular how staff's responses to patients' answers shaped the subsequent interaction. Thus, paying special attention to these contributions allowed the analysis to focus on how the pharmacy staff member seeks to understand and make room for the patient's appraisals of the conversational topics.

Interaction 2: The VSRI with the pharmacy staff member

who took part in the specific encounter that was selected, was conducted later on the same day in which the video of the pharmacy encounter was recorded, whereas VSRI with the patient from the encounter was conducted the next day. Language psychologists conducted the interviews. According to the protocol, participants were informed that they would watch a replay of the pharmacy encounter in which they had previously participated, and that the aim of the interview was to learn about their experiences regarding the encounter. The recording was played in two rounds:

Round 1) the participants were asked to stop the recording whenever they experienced that something was unsaid, that something was comfortable or uncomfortable, or that something was surprising.

Round 2) based on the conducted CA, the interviewer stopped the recording at places that were related to counseling activities in the selected encounter where the patient either shared or did not share her perspectives. The interviewer probed on reasons for the participants exploring/ sharing or not exploring/ sharing perspectives in these situations during the encounter. The interviews were then verbatim transcribed using ordinary spelling standard and analyzed using a qualitative thematic approach[8] to capture the essence of which psychological processes in pharmacy encounters stir the interactional processes.

In the following, the results from the CA of the pharmacy encounter are presented first illustrating the interactional processes, followed by a detailed explication of each of the findings. Then results from the analysis of the VSRIs are presented, demonstrating the psychological appraisals motivating participants' interactional processes, first from the patient's interview, and afterwards from the staff member's interview.

RESULTS

The single case involved a pharmacy desk encounter with a female patient collecting regularly prescribed anti-depressive medication, and a male pharmacy technician with 6 years' experience who had been working at the same community pharmacy since graduation.

CA of the pharmacy encounter

Overall, the results of the interaction analysis revealed that the community pharmacy staff member asked several questions during the encounter. The questions seemingly had the potential to encourage the patient to share her experiences of the medication. Asking questions, however, did not ensure that a patient-centered approach was enacted, as the staff member's way of responding to the patient's answers directly affected the potential ways in which the patient could/would continue the interaction. As long as the staff member responded with attention

and did not redirect the patient's storyline, the patient continued to share her experiences. Essentially, what hindered continuation and elaboration of the patient's perspective was that the staff member did not stay within the patient's displayed experiences or concerns. At times, the staff member was inattentive toward the patient's telling of her story. At other times, he did seem to pay attention but redirected the patient's answer by either completing her utterance or by normalizing her experience, thereby leaving her specific representations to one side, with the consequence that the patient's perspective was suspended. The pharmacy staff member, therefore, missed cues displayed by the patient and so he missed opportunities for exploring the patient's perspective which could have turned the desk meeting into a patient-centered counseling consultation.

In the following, the encounter is presented in its entirety, starting with the first question posed by the pharmacy staff member (Ph) as he returned to the patient (Pa) with the medication. To demonstrate the results summarized above about the interactional dynamics leading to or hindering the patient's perspective-sharing, the dialogue is continuously analyzed turn by turn and explicated.[13] In the presentation below, the encounter is divided into four parts (extracts). Each extract is presented by a heading characterizing the emphasized interactional occurrences as presented in the summary above. The headings thus reflect the specific ways in which the staff member responds to the patient's answer during the extract.

Extract 1: How 'yes' and 'sure' as responses to the patient's medication telling affect engagement of the patient's perspective

1. Ph: how does it work for you
2. ((Ph looks at Pa))
3. Pa: it works well
5. Ph: yes
6. Pa: I take one every second day
7. ((Pa and Ph look at each other)
8. Pa: [during the summer
9. Ph: [yes]
10. Pa: and then now when it gets darker
11. I take one each day
12. Ph: yes ((looks down))
13. Pa: >°to manage°<
14. Ph: >sure<oh:m are you ((looks up))

In line 1 the staff member poses an open question and looks at the patient. The patient answers that the medicine works well. The staff member responds with a 'yes' in line 5 which the patient treats as an invitation to continue the talk as she starts explaining how she takes the medicine: in summer she takes one every second day and in winter she takes one every day. During the patient's account, the staff member once more responds with 'yes' in line 9, and again the patient responds by continuing her account. 'Yes' can be characterized as

an acknowledgement token, a group of responses that claim 'no problem' in understanding what the speaker is telling, and also that they are "…making a claim to adequate receipt of the prior turn".[26] In lines 5 and 9 the acknowledgement tokens are uttered in a way that apparently encourages the patient to continue talking.

In line 12 the staff member once again utters 'yes', but this time it is produced as he looks down and starts managing the medication. The patient responds to this shift in focus in the staff member's attention as she finishes her turn in line 13 with a lowered volume and an increase in tempo. In this way, the staff member's third utterance of 'yes' as a response differs in its interactional work: as it co-occurs with his bodily orientation toward the medication suggesting attention towards the medication, it contributes to the patient closing the topic. This allows the staff member to grab the floor and define what is to be talked about next.

In his next turn, the staff member responds with a 'sure' and then transits directly into a new question, rendering 'sure' a topic pre-closing function. The staff member does not stay with the patient's representation; instead he controls the agenda, and decides to ask if the patient has had any of the side-effects that are related to the medication. The result is that the patient's account, and her reasons for taking the medication as she does, are not further responded to or explored.

Extract 2: How staff's maintenance of talking turn affects the engagement of the patient's perspective – inattention to in breaths and pre-emptive completion

14. Ph: >sure<oh:m are you ((looks up))
15. bothered by any of the side effects
16. [related to it]
17. Pa: [.hhh]
18. Ph: there are some people who
19. [talk] awfully much about dry mouth and that kind
20. Pa: [.hhh]
21. Pa: it it I have had a little of that but ((shakes head))
22. I don't think it it is like (.) it is like
23. ((shakes hands in front of face))
24. Ph: nothing special
25. ((Pa and Ph look at each other))
26. Pa: well ((shakes head and shoulders))

In lines 14 to 16 the staff member poses a question related to side effects, leaving behind the patient's telling about her personalized use of the medication. Overlapping with the staff member specifying the side effects in line 17, the patient takes a deep, audible in-breath, and as the staff member continues talking she takes yet another audible in-breath in line 20. In-breaths typically signal that the next speaker is about to answer. However, the staff member does not attend to this but continues his own line of reasoning and starts listing a specific side effect that some people talk a lot about. Thus, the staff member

does not leave room for the patient's perspective.

The patient confirms that she has experienced the side effect to a small extent and continues in line 22 'I don't think it is like it is like'. After the repetition of 'it is like', the staff member finishes the patient's turn and produces a pre-emptive completion, stating 'nothing special'. In an article about pre-emptive completions, Lerner states that they "… are ordinarily produced as a rendition of 'what the other was going to say' but are not composed as a guess…".[27] Pre-emptive completions could be argued to display staff sensitivity toward their patients; they are attentive toward what patients say in a way that enables them to collaboratively construct a talking turn. However, by stating what the patient was about to say, the staff member could also be seen as claiming knowledge about the patient's experiences with the medication.

Even though a pre-emptive completion by definition is not designed as a guess it is treated as a guess, in that the first speaker normally accepts or rejects it.[27] In line 26, the patient utters a 'well' which implicates hesitation and doubt, indicating that she does not fully commit to the staff member's completion of her utterance. This lack of commitment is, however, not noticed by the staff member as he goes on to list additional side effects (line 27, extract 3). The patient's signal that what she was about to say might have been something contradictory is not noticed, and thus, the patient's perspective is potentially missed. It could then be suggested, that the interactional effect of the inattention to in-breaths, pre-emptive completion and subsequent knowledge claim, deprives the patient of an opportunity to share her actual perspective.

Extract 3: How 'normalizing' as a response to a potentially essential side effect affects engagement of the patient's perspective

27. Ph: ohm (.) headache sweating (.) oh
28. Pa: sweating ((wrinkles nose and eyebrows,
29. squeezes lips, closes eyes))
30. Ph: yes (.) that is totally normal
31. Pa: oh
32. Ph: well but I don't know for how long have you
33. taken the medication
34. Pa: ohh I have taken it for some years
35. Ph: yes yes because the none should say that most
36. of the side effects should most likely have decreased
37. Pa: yes
38. Ph: but there are some that will persist
39. [and it is] one of them
40. Pa: [yes]
41. Ph: together with headache and dry mouth
42. Pa: yes but fortunately I don't have headache
43. ((looks down and handles the medication))
44. Ph: no no well I would also say
45. [what what is it called the dry mouth]
46. Pa: [.hhh]
47. Ph: it can also be rather bothersome to many people

48. Pa: yes (.) it has been but I don't think it is that any
49. more
50. ((Ph continues to look down at the medication during

51. Pa's turn))

In line 28 the patient repeats one of the two side effects listed by the staff member, 'sweating'. As she repeats it, she wrinkles her nose and eyebrows, squeezes her lips and then closes her eyes. These non-verbal cues can be considered clues that display the patient's mental state; that this specific side effect is in some way salient to her. The staff member displays that he understands the patient's repetition as indicating that she has experienced sweating, and he responds by normalizing it: 'that is totally normal'. Across contexts in which professionals help citizens, normalizing is a common practice.[28,29] Svinhufvud et al. argue that by normalizing, others are brought into the conversation, and in this way professionals construe themselves as experts in the relevant field; they have the required experience and knowledge to comment on the help-seeker's experiences on a more general level.[29] One could argue that normalizing re-contextualizes the patient's experience by turning it into something that is now established as no longer patient-specific.

In line 31, the patient responds to the staff member's normalization with an 'oh' representing a change-of-state token. The patient displays that she has undergone a change from not-knowing to knowing, and she displays to the staff member that this is new information to her.[30] However, in what follows (lines 32 to 41), the staff member continues to normalize, in that he refers to how others normally experience side effects. In doing this, he also leaves the introduced side effect of sweating, which the patient apparently has had some issues with, and instead he re-introduces headache which he previously mentioned along with sweating, and which the patient did not respond to as relevant. In line 42 she explicitly confirms that headache has not been an issue. The staff member then states that dry mouth (which he formulated as nothing special in line 24) can be quite bothersome for many people. As he mentions dry mouth, the patient again takes an audible in-breath, but this does not stop the staff member from talking. In this way, he does not seem attentive toward what the patient said previously, nor toward her in-breath here and now. The staff member's apparent inattentiveness might be related to the fact that from line 43 on, he is looking down and handling the medication. The sum of these interactional contributions adds to the notion that the pharmacy staff member is meeting the customer based in his own perspective. His interactional point of departure remains within his own context as he provides medical information which objectively correct, but is not tailored to the specific patient. This might hinder the patients' perspective sharing.

Extract 4: How bringing the consultation to an end as a response to an emotional display affects engagement of the patient's perspective

50. Ph: so do w- do you have ((looks up))any other
51. questions
52. regarding the medication the treatment here
53. Pa: mtl °no°
54. Ph: °no° ((looks at computer))
55. Pa: I actually don't
56. (.) that is I am happy that something works ((laughs))
57. ((Ph looks up))
58. the treatment
59. Ph: ((smiles)) sure
60. Pa: because otherwise I would black out
61. ((smiles, looks down))
62. Ph: yes and it is important that it is something that
63. works for you
64. ((Pa and Ph looks at each other, smile))
65. Pa: yes [luckily it does]
66. Ph: [ohm is there]anything else I can do to help
67. Pa: no thank you not today
68. Ph: then it is twenty two and a half
69. Pa: here you go
70. I don't have the exact money so this is what you get
71. Ph: no: ((smiles))

The staff member asks the patient if she has any other questions which she declines in line 52. Yet, she takes turn again in line 54 and (re)states that she does not have any further questions, and in line 55 she presents an assessment 'I am happy that something works'. She laughs and the staff member looks at her and replies 'sure'. Apparently, it is not obvious to the patient what 'sure' reassures; she treats the staff member's response as an expression of deficient understanding as she now states 'the treatment', hereby specifying what she referred to in her previous turn. She then continues by accounting for her being dependent on the medication 'otherwise I would black out'.

The patient's sharing of her dependency on the medication as a response to having any further questions seems marked, and maybe indicates a potential cue to her personal perspective on medication, which is possibly confirmed by her laughter. Typically, in medical interactions if patients initiate laughter, it co-occurs with activities that are somehow delicate or sensitive to them.[31] It could be that laughter works in the same way in pharmacy meetings, potentially indicating that patients are emotionally affected in some way.

Apparently, at this point the staff member is attentive; he responds to her laughter by suddenly looking at her, and as he replies 'sure' in line 58, he reciprocates her laughter by smiling. In line 61, he agrees with the patient's assessment that she is happy that something works by presenting an assessment himself 'it is important that something works for you'. Thus, in extract 4 the staff member supports the patient's emotional stance in different ways: by looking at

her, smiling at her, and agreeing with her. However, even though he apparently notices and is responsive to her emotional stance, he does not explore further neither her stance nor her stated reasons for taking the medication. He might have gone on to contribute to the establishment of a safe and trusting environment, but instead he is left with no further understanding of the patient's method of taking the medication or of her need to elaborate on her emotional experience related to her medication usage.

VSRI of the pharmacy encounter - an exploration of informants' experiences expressed during VSRI

Overall, the results of the VSRI showed that the patient points to an emotional state of shame when characterizing her encounter experience. By relating her feelings of shame to her actual behavior during the encounter, it could be argued that shame acts as a barrier for her perspective sharing and thus as a barrier for engaging fully with the patient's perspective.

Further, by also exploring the staff member's statements during the VSRI, his appraisals of the interaction were made available for overt exploration as well. He names (the mental state of) surprise as characterizing his experience. The surprise is rooted in the staff member's conception of the interactional activities tied to when patients answer questions and staff listen during pharmacy encounters. These conceptions of how the interaction may progress following questions asking and answering are seemingly rather fixed and narrow, meaning in the pharmacy staff member's understanding of interactions there is little room for courses of interaction which deviate from the assumed course of (inter)action. Based on this it could be argued that it is exactly these conceptualizations which prevent him from engaging with the patient's perspective. Below, the results from the thematic analysis are illustrated in detail. Shame and surprise, were found to be central themes in the patient's and the pharmacy staff member's mind respectively during the encounter. Thus, understanding shame and surprise as psychological motivations for the interaction was a result of the thematic analysis.

Patient experiences: shame affects ways of behaving during the desk encounter

During the first replay, the patient (P) stopped the recording only once. This happenedin line 59, extract 4, when she told the staff member that if she did not take the medication, she would black out. In the VSRI she said:

1. P: To me it has always been embarrassing to take
2. this kind of medicine (.) because I have
3. always considered myself as a person who was happy
4. and looked brightly at things. hh
5. and therefore I believe that I need to explain to him
6. that I black out if I do not take it
7. (.) and actually it is quite unnecessary and afterwards
8. I think that I do not need to

9. tell it toanybody right because it is still a little
10. shameful

Apparently, the patient is bothered by a shame issue taking the medication, and her feeling of shame also affected her during the pharmacy encounter: to maintain her belief and to establish in the eyes of the pharmacy staff member that she is a positive person, she told him that the medication is necessary for her to function.

During the second replay in the VSRI the patient once again reveals that the shame issue affects her interactional contributions, this time by talking about an opposite feeling to shame, namely that of feeling proud. The patient was instructed that the interviewer would stop the recording, however, during the replay at the point where she said 'I take one every second day during summer and then when it gets darker I take one every day' (line 11, extract 1), she started shaking her head and said:

1. P: Right there I am also thinking yes of course I
2. should have stopped that I don't need to
3. tell him that either ((laughs)) right (.) it's again it oh
4. about that I am actually a little
5. proud and happy that I only need to take one every
6. second day when it is light right

Hence, the patient's feeling of shame regarding her medication, accounts for parts of her behavior during the encounter; her shame of having to take the medication apparently led her to explain to the staff member how she took the medication and also that she would black out without it. Thus, the shame she harbors motivated the drug use explanation.

It could be argued that her feelings of shame might have influenced her in other ways as well. As shown in the interaction analysis above, the patient displayed in line 31, extract 3 that the information regarding the side effect of sweating was new to her. Also, this was confirmed during the VSRI; she told the interviewer that she had been bothered by the sweating problem for years, and she did not have a clue that it could be related to the medication. However, during the desk encounter, she did not ask the staff member to elaborate further on this relevant and new information. Her emotional state, her feeling of shame, could explain her hesitancy to ask and to involve the pharmacy staff in further discussion about a troublesome side effect.

Pharmacy staff member experiences: surprise reflecting conceptions of interactional activities

During the VSRI the pharmacy staff member (Ph) stopped the video-recording after line 59, extract 4 when the patient said she would black out without the medication; this was the exact point where the patient also stopped the video in her interview.

1. Ph: now that I am sitting here and looking at it it

2. surprises me how much they actually
3. expose themselves you know even though (.) it is just
4. something I am just asking
5. about and then I listen to their answers but now that
6. I see it again that she is uh
7. reacting on that tendency to sweat and then goes
8. into details about why and how
9. right (.) that surprises me a bit
10. Interviewer (I):   what surprises you
11. Ph: you know how much they expose themselves
12. I: hmhm
13. Ph: you know they don't need to (.) they could just
14. have said yeah I experience that

Besides revealing an emotional experience, surprises reflect pharmacy staff's conceptions and expectations regarding counseling opportunities.[32] In this extract, the staff member's surprise demonstrated his understanding of which dialogical aspects and activities were interactionally relevant during counseling. Hence, firstly the staff member revealed that he considered patients going into detail and displaying personal perspectives as doing something superfluous that they did not need to do. Specifically, he experienced that the patient went into detail about sweating. As shown in extract 2 and demonstrated in the analysis, all that the patient did was to repeat 'sweating' and respond with an 'oh' as the staff member said 'it is totally normal'. Thus, the staff member's experience that the patient was detailing her perspective seems to reflect a rather narrow conception of the space available for patients as they answer questions during a desk encounter. This is further substantiated by the staff member's statement: 'they could just have said yeah I experience that'. His narrow conception of suitable answers could explain why he redirected the patient's responses by either completing or normalizing her specific representations, with the consequence that the patient's perspective was suspended.

Second, the extract demonstrated that the staff member's conception of listening could be considered equally narrow. His statement, 'it is something I am just asking about and then I listen', explains his inattentiveness and his not staying with the patient's responses: he does not see listening as an active and explorative process where responses are thoughtfully considered. Listening is apparently considered a passive activity anchored in the assumption that when a question has been posed, the answer that unfolds is not dependent upon the subsequent actions such as (not) engaging with the answer and (not) allowing interactional space for the answer to be unfolded, even if it takes a deviating interactional course.

Thus, the VSRI with the pharmacy staff member reflected his conceptions of appropriate dialogical activities. These conceptions could be seen as related to his way of interacting with the patient. His understanding of the content and extent allowed for the patient's answers, and of the way such answers should (not) be engaged with, might have prevented him from furthering the extent to which the patient shared her perspectives on medication.

DISCUSSION

Listening as an active process

Thoroughly studying a single pharmacy encounter using CA has demonstrated that whether or not a patient brings forward their perspective is not just dependent on community pharmacy staff questions, but also on staff's ways of responding as the patient unfolds her answer. In this case study, questions regarding the medication did have the potential to encourage the patient to share her perspective, and even minimal but attentive responses apparently urged the patient to continue. However, the responses to the patient's answers which either displayed a lack of attention, normalized her experience, or in other ways did not stay with her perspective, caused the patient to stop sharing her experiences and thoughts. Thus, the potential for patients to bring forward their perspectives seems to be deeply embedded in the small details of the interactional exchanges, not least the staff member's responsive activities i.e. their ways of listening.

To explore the importance of listening to a greater extent, listening is not simply considered a passive activity that pharmacy staff do as they wait to ask another question but as an activity that unfolds over several turns and continuously affects patients' interactional engagement in the desk encounter.[26] By demonstrating that listening is something that interactants actively perform throughout a sequence in which the patient unfolds an answer, this study confirms and supports approaches which insist that communication processes are considered dyadic processes, in which interactional achievements are continuously co-constructed.[33] Listening persists and requires pharmacy staff to actively engage with the patients' answers throughout the telling of their stories if patients are to be engaged in patient-centered counseling.[36]

Despite the fact that pharmacy staff members have a responsibility to follow national communication guidelines, the focus on their interactional responsiveness, and hence listening activities, seems to be missing.[34] This does not imply that responses are not addressed in the literature on pharmacy counseling altogether. In their handbook on Communication Skills in Pharmacy Practice the authors outline how to respond to patients' utterances to establish rapport and build trustful relationships.[35] Urging pharmacy staff members to be attentive toward their response types, the authors differentiate between reactions based on the content of the response (judging responses, understanding responses etc.). While the authors point to staff responsiveness – and not just to

the questions they ask – they seem to disregard the fact that every action performed by pharmacy staff members is context-shaping, and thereby affects patients' interactional contributions. This not only accounts for longer talking turns, but also, as demonstrated in this study, to small response tokens such as 'yes' and 'sure', and non-verbal actions such as gaze and bodily orientation, e.g. looking at the patient, or turning away to handle medication. They all establish new contexts for patients' next turns and thereby affect whether or not patients engage their perspectives on medication.

As also demonstrated by the VSRI with the pharmacy staff member in this study, there is a lack of attention toward the staff member's own responsive actions including listening which had a defining effect on the patient's interactional contributions. Listening was not performed actively and was further not considered by the staff member to be an important way to engage the patient. Effectively raising pharmacy staff's awareness that all their interactional activities are pivotal to patients' engagement might involve not only teaching micro-analytic skills, but also a change in their mindset toward their own role and their efforts to understand patients. The concept of 'mentalizing' could be useful in this regard. Mentalizing refers to the ability to understand the mental state of others and oneself.[36–41] It is considered a central ability for health care professionals to establish a trustful relationship in which patients become capable of reflecting on their own perspectives and experiences. Mentalizing is essentially about being curious and attentive toward the other person, and a mentalizing stance is reflected in the way that one continuously addresses the other person. Professionals' mentalizing abilities can be trained and hence, their mindset toward the patient as a unique person and their self-awareness of their own role when meeting the patient can be affected.[37,38]

Emotionality in pharmacy encounters

The VSRIs with patient and community pharmacy staff revealed that both were emotionally affected during the interaction. The patient VSRI revealed that she was affected by a feeling of shame. This is not surprising as various studies have shown that patients' perspectives on medical treatment with antidepressants are related to a fear of being stigmatized.[42–44]

According to Fuchs, and from a phenomenological perspective, shame can be "considered the incorporated gaze of the other person", emphasizing the interpersonal aspect embedded in shame. Typically, it arises in situations of disclosure, situations in which a person takes a chance to "… dare coming out of his former neutrality and address another person…".[45] This encapsulates what can potentially happen in prescription meetings at the pharmacy desk. As they address staff with a prescription, customers become patients and reveal personal aspects

of themselves. In this way, prescription meetings might, in their essence, be prone to potential shame issues, e.g. touching upon the impact of depression, diabetes, heart disease etc. on the patient's life and relationships. Considering shame as the "incorporated gaze of the other", it could be that patients bothered by shame issues experience an increased sensitivity toward lack of attention from pharmacy staff and, as a result, they are more reluctant to ask questions regarding their medication.

If pharmacy staff acknowledge that patients' actions might be motivated by their given emotional state, staff might find it easier to detect cues that point to emotionality and how it influences patients' actions and perspectives during the encounter. Arguably, this not only applies to emotions of shame, but to other emotions such as, for example, frustration or anxiety taking medication. Thus, the pharmacy staffs' detection of concern cues from patients might be essential in understanding patients' willingness for perspective sharing in pharmacy interactions.

Pharmacy staff should also be attentive toward their own emotionality as they meet patients at the counter. As demonstrated by Author, Author 2021, pharmacy staff are also affected by patients' moods and they also respond emotionally to patients' interactional contributions: they express surprise, become impatient etc. These emotions affect whether or not they make room for or hinder patients from sharing their perspectives. By attending to their own emotionality, staff could use this awareness to circumvent potential barriers toward actually engaging with patients.

Since emotionality is deeply embedded in the concept of mentalizing[40], it seems all the more relevant to include mentalizing in the training of pharmacy staff, not only when it comes to emphasizing their responsiveness, but also as a method of enhancing their awareness of emotions in the encounter. Mentalizing highlights the idea that understanding oneself and other people is, in essence, an emotional process. It is about inferring emotional states, and thus, by including mentalizing abilities in the training of pharmacy staff, their attention is drawn toward patients' emotionality as it is displayed in verbal and non-verbal actions. Raising staff attention toward emotional states might encourage them to better embrace and understand that patients' perspectives are embedded in their emotionality. Understanding and detecting patients' emotionality could be essential in furthering patient engagement in the pharmacy interaction. By training pharmacy staff in mentalizing skills, their attention will also be drawn toward their own emotional reactions as they meet patients. Training staff to understand and reflect on their capability to contain patients' frustrations, their own impatience etc., could potentially function to prevent their emotions from

hindering engagement with the patients' perspectives.[8]

PERSPECTIVES & LIMITATIONS

In combining CA with VSRI analytically, through the design of a single case study, it has become apparent that patients display visible cues in the community pharmacy interaction. With CA alone, the patient's motivation for expressing cues of concern can, at best, be hypothesized, as the approach of CA is designed to investigate interactional enactment, and not the psychological motivations behind the actions. But by conducting a VSRI in parallel, the interactants' unique perspectives on the interaction are actively engaged, which offers privileged perceptions to the aggregated analysis of this study to show how both the pharmacy staff member and the patient are interactionally affected by emotional experiences during the encounter. Further, and in accordance with a dialogical approach to communication and interaction, the results achieved through this specific study design has confirmed that how pharmacy staff listen and respond during the sequence that follows an initial question, affect show patients share their perspectives.[33] It can be considered a limitation that patient and pharmacy staff are aware that they participated in a study, since the awareness might have influenced their answers and responses. Thus, the participants' perspectives engaged by VSRI might be seen as affected by their conceptions of the research study and the interviewers rather than original reflections of their experiences, concerns and motivations. However, VSRI has the potential – in contrast to traditional non-stimulated interviews – to tap into interviewees more immediate and non-censored experiences and thus avoid statements that reflect what one believes is the appropriate answer in a given situation. [8,21,22]

Despite the fact that the single case study was selected so that it's unfolding reflected the entire dataset (64 pharmacy encounters and 12 VSRIs), in terms of how medical talk was initiated and by whom, it cannot be used to generalize that the identified responses will always have a limiting or a furthering effect on patients' sharing of perspectives. What this study has done is to point out central new hypotheses that could be further investigated. Hence, future studies of community pharmacy encounters could include: examining whether patients tend to stop sharing their personal perspectives in response to staff's normalizing activities; whether patients tend to refrain from re-introducing their own perspectives when they do not accept what staff have said as happened in this particular case; or looking at bodily (dis)orientation.

In the present case study, the staff member was a pharmacy technician. The study has not enabled an investigation of whether the interactional occurrences are characteristic of pharmacy technicians as opposed to pharmacists, and thereby related to the individual's educational background. In Denmark, pharmacy technician education comprises a 3-year degree with a blend of theory and practice education; whereas pharmacist education comprises a 5-year degree including a 6-month internship. Future studies could investigate if ways of interacting with patients are related to the educational background of staff.

CONCLUSION

The unique combination of the two approaches of CA and VSRI clarified that both patient and pharmacy staff were affected by psychological processes as they interacted in pharmacy desk encounters, and these processes influenced their ways of acting and responding towards each other. Thus, combining the two methods revealed that the process of patients sharing their perspectives is a complex process governed by emotionality.

More specifically through CA, the study has demonstrated the importance of the pharmacy staff member's responsiveness and their ways of listening to the patient's answers as the patient's answer is tightly connected to the staff member's listening responses. In this way, the listening activities of pharmacy staff affect whether or not patients share and unfold their perspectives on medicines.

Through VSRIs, the study has shown that as they interact, staff and patients alike are affected by their own considerations and emotions. To engage patients' perspectives, staff should be aware of the ways in which they conceptualize and operationalize listening activities, and also of their own and the patients' emotionality.

Training the mentalizing abilities of pharmacy staff could enhance their attention toward the dynamics of interactional activities. Therefore, it seems promising to include mentalizing in the interactional skills training of pharmacy staff.

ABBREVIATIONS

CA, Conversation analysis; VSRI, Video stimulated recall interview; PCC, Patient-Centered Communication; PaCT, Patient-Centered Communication Tool

APPENDIX

A: Transcription conventions
(.) silence< 0.3 seconds
: prolongation of the immediate prior sound
((xxx)) transcriber's comments
[xxx] overlapping talk
°xxx° decreased volume
>xxx< increased tempo

.hhh   hearable inbreath
.mtl   clicking of the tongue

CONFLICTS OF INTEREST

The authors found no conflict of interest and are solely responsible for the content and writing of the article.

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