

Achieving visibility? Use of non-verbal communication in interactions between patients and pharmacists who do not share a common language

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Abstract Despite the seemingly insatiable interest in healthcare professional–patient communication, less attention has been paid to the use of non-verbal communication in medical consultations. This article considers pharmacists’ and patients’ use of non-verbal communication to interact directly in consultations in which they do not share a common language. In total, 12 video-recorded, interpreted pharmacy consultations concerned with a newly prescribed medication or a change in medication were analysed in detail. The analysis focused on instances of direct communication initiated by either the patient or the pharmacist, despite the presence of a multilingual pharmacy assistant acting as an interpreter. Direct communication was shown to occur through (i) the demonstration of a medical device, (ii) the indication of relevant body parts and (iii) the use of limited English. These connections worked to make patients and pharmacists visible to each other and thus to maintain a sense of mutual involvement in consultations within which patients and pharmacists could enact professionally and socially appropriate roles. In a multicultural society this work is important in understanding the dynamics involved in consultations in situations in which language is not shared and thus in considering the development of future research and policy.

Keywords: pharmacist–patient communication, non-verbal communication, video-recorded consultations, multilingual consultations, interpreted consultations

Non-verbal communication in social interaction helps to maintain a sense of mutual involvement and sustain integration between participants (Heath 1984). A literature review conducted by Lepper *et al.* (1995) highlighted the importance of non-verbal communication in the medical setting from the perspective of both patients and physicians. They concluded that attention to non-verbal negotiation deserves a key place in future research endeavours. Yet, despite the seemingly insatiable interest in healthcare professional–patient communication, less attention has been paid to the use of non-verbal communication in medical consultations.

There is a link between non-verbal behaviour and the topic under discussion. For example, non-verbal behaviour is important in conveying pain (Hyden and Peolsson 2002, Rowbotham *et al.* 2012). As pain itself is not visible, only people’s expression of pain, the focus on non-verbal behaviour in relation to pain is unsurprising. Similarly, using gesture to convey emotion in medical consultations makes sense as emotion is most powerfully conveyed non-verbally (Roter and Hall 2006). The importance of non-verbal behaviour in conjunction with talk is clearly

demonstrated in Heath's (2002) work. He used data from general practice consultations to illustrate the ways in which through gesture, bodily comportment and talk people render visible what would otherwise remain hidden and unavailable for inspection, transforming symptoms such as pain into suffering. Symptoms are given a presence then and there within the consultation, allowing the doctor to see the patient's suffering. Gestural activity also works to realign the gaze of recipients and encourage their participation in talk (Heath 1986, 2002, Pasquandrea 2011). The realignment of gaze is important because involvement in medical interactions has to be sustained in the face of simultaneous and often competing demands (Heath 1984).

Non-verbal behaviour is no longer treated as a distinct channel of communication, unconnected to talk and other aspects of human interaction. Heath (1997) argued that while visual aspects of participants' conduct are not, unlike vocal action, organised on a turn by turn basis, the sequential relations between visual and vocal actions remains a critical property of their organisation. He points to the use of resources such as body movement, objects and artefacts to accomplish activities alongside talk. These arguments are in keeping with Goffman's (1990) work on the importance of impression management in relation to social action. Goffman (1990) referred to the use of props in everyday life to perform the interactional tasks necessary to maintain the presentation of self and to indicate expected conduct. These ideas have subsequently been applied in medical settings. For example, White *et al.* (2012) point to the use of fixed props such as glass screens and waiting time displays in hospitals, which hint at expected conduct.

The importance of recognising the communicative contribution of gestures and props may be even more pronounced in consultations between people with a limited vocabulary in a shared language. Rowbotham *et al.* (2012) used the example of the communication of pain, in which they argued that the problems inherent in the verbal communication of pain are exacerbated by language difficulties. Similarly, Watermeyer and Penn (2009b) argued, based on their study of 26 cross-cultural pharmacist–patient interactions in a public antiretroviral clinic in South Africa, that non-verbal behaviour constitutes a vitally important component of each interaction. In particular, they highlighted the facilitative nature of props in interactions across barriers of language, culture and literacy, arguing that combining verbal instructions with non-verbal reinforcement of instructions using props allows for the simplification of the verbal content of interactions.

Non-verbal communication is also important in interpreter-mediated interaction. Pasquandrea (2011) analysed doctors' behaviour during episodes in which patients and interpreters engaged in dyadic conversations in a language not spoken by the doctor. He argued that interpreter-mediated interactions require an analysis that goes beyond the verbal and takes account of the bodily resources used in managing and coordinating interaction, such as gaze, gesture, posture, body movement, object manipulation, proxemics and spatial arrangement. He concluded that such an analysis reveals that what may look like disengagement on the part of the doctor contains a richness of non-verbal practices employed in order to remain in touch with conversations happening in a completely unknown language. In addition, it provides insights into the development of certain courses of action, for example, showing that verbal initiation is often preceded and prepared for by non-verbal signals.

Other work on interpreter-mediated interactions has revealed how people who do not share a common language may attempt to interact directly with each other despite language barriers rather than speak through an interpreter (Watermeyer 2011). Direct interaction with patients across a language barrier is a potentially important way of creating rapport and strengthening the therapeutic relationship.

This article considers consultations in pharmacies in which the patient and the pharmacist did not share a common language and consultations were conducted with the help of multilingual pharmacy assistants. The study presented here is unique in a number of ways. There is

limited research documenting the communicative characteristics of pharmacy interactions (Watermeyer and Penn 2009a) and none in which, as was the case in this study, pharmacy assistants acted as interpreters for pharmacists and patients, with the additional complication of managing multiple roles (Stevenson, McNulty, and Leontowitsch 2012). Much of the work in this area has focused on interactions in general practice. General practice and pharmacy consultations are fundamentally different in the type of work they do. General practice consultations generally consist of a number of stages that include agenda setting, diagnosis and prescribing. Pharmacy consultations focus on advice about, and the sale and dispensing of, medicines. Here we focus on the provision of advice about, and dispensing of, medicines prescribed by doctors.

The analysis follows Goffman's (1990) observations of the centrality of props in everyday interaction. It considers how props aid communication across a linguistic divide and at the same time support pharmacists' and patients' enactment of professionally and socially appropriate roles. The analysis also develops some ideas from work in monolingual general practice consultations. Heath (1984) argued that movements are designed to assist the talk with which they occurs, not to replace it, and we consider whether this also holds for the pharmacy consultations examined here, given that the pharmacist and patient do not share a common language. We are also interested in the idea that the topic under discussion (Hyden and Peolsson 2002, Roter and Hall 2006, Rowbotham *et al.* 2012) may be important when considering the use of non-verbal communication in consultations.

Methods

Our study

The research took place in 2007 in a single pharmacy in London, in an area with a large concentration of Sylheti speakers. The pharmacy employed five pharmacy assistants who spoke Sylheti, three of whom took part in the research. They were all accredited as both pharmacy assistants and medicine counter assistants and therefore trained in the use of medicines and the provision of health advice.

The work rota was designed so that someone was always available to interpret for Sylheti-speaking patients. The provision of interpretation was initiated by the pharmacist who asked a pharmacy assistant to interpret even if the patient spoke some English, based on the belief that a person is better able to describe their symptoms and concerns and discuss medical matters in their own language. Pharmacy assistants provided interpretation throughout consultations and were not just called upon to resolve specific difficulties in understanding.

Six pharmacists took part in the research, two men and four women. None of the pharmacists spoke Sylheti, although one spoke a similar language and said she could sometimes understand some of what was being said. All the pharmacists worked on a part-time basis. Ethical approval for the study was obtained from the local research ethics committee.

The study setting

Data were collected using existing video recording equipment originally set up in the pharmacy for training purposes. Although this was cost effective and convenient, a major drawback was that at times it was difficult to see facial expressions and identify who was talking. Consultations took place in the back of the pharmacy, in a space that was untidy and crowded with boxes and supplies. It was also used as a thoroughfare to other parts of the pharmacy. There was a desk but only two chairs so the pharmacy assistant generally stood or sat on boxes. The pharmacy assistant was therefore outside the consultation space, allowing the tradi-

tional practitioner–patient dyad to be spatially maintained. The environment was noisy with the telephone ringing, the operation of electronic equipment and work such as dispensing and consultations over the counter audible in the background.

Recruitment of patients

The study focused on patients who were judged by the pharmacist or pharmacy assistant, on the basis of their spoken English, to require an interpreted consultation about a newly prescribed medication or a change in their medication. The pharmacy assistants briefly explained the study to patients fitting this profile. Those who agreed were then formally enlisted into the study. The recruitment of patients proved difficult. The most common problem was that many of the Sylheti-speaking patients who were approached spoke English sufficiently well not to need an interpreted consultation. In other cases the prescription was delivered to the patient's home address so an interpreted consultation was not possible. In slightly fewer cases the prescription was collected by another member of the family. Five patients eligible for inclusion declined to take part. The patients were assured they could withdraw their consent at any time and that their participation or otherwise would not affect their treatment in any way.

Consultation data

In total, 12 consultations for a new prescription were video-recorded; seven with women and five with men. The participants ranged in age from 27 to 80 years.

Analysis

Audio data from video recordings of the consultations were initially transcribed by an external company, with the Sylheti parts translated into English. The translation of Sylheti was checked for accuracy by one of the pharmacy assistants involved in the study. For the purposes of this analysis consultation videos were viewed repeatedly alongside the translated transcripts. Instances in which either the patient or pharmacist attempted to communicate directly were re-transcribed to include additional detail of verbal and non-verbal content. Additional transcription drew on the conventions laid down by Jefferson (Atkinson and Heritage 1984).

The analysis focused on instances of direct communication initiated by either the patient or the pharmacist, despite the presence of a multilingual pharmacy assistant acting as an interpreter, and on how pharmacists and patients responded to attempts to communicate directly. It drew on ideas of the presentation of self and the enactment of professionally and socially appropriate roles (Goffman 1990), the interdependence of talk and bodily conduct (Heath 1984) and the consideration of the topic under discussion when direct communication occurred (Hyden and Peolsson 2002, Roter and Hall 2006, Rowbotham *et al.* 2012).

The data

The following codes are used in the data extracts. 'P' indicates pharmacist, 'PA' indicates pharmacy assistant and 'PT' indicates the patient or the patient's representative. These are followed by either 'm' or 'f' for male or female and a numerical identifier, for example, Pf1 = female pharmacist 1. Extracts are reproduced here without the original Sylheti with the translation into English reproduced in italics. For transcription symbols see Appendix 1. As the study focuses on advice in relation to the use of prescription medicine we have used the term patient (or parent acting as a proxy for the patient) throughout.

Results

Initially, instances of direct engagement are presented in order to consider the circumstances and ways in which pharmacists and patients directly interact. This is followed by a series of interactions from a single consultation containing a dispute about taking medicine. The dispute is considered using the idea of epistemic status (Heritage 2012). An epistemic status concerns the relative access of two (or more) individuals to a targeted element of knowledge or information at some point in time. The analysis considers the process of negotiation as to whose knowledge or information takes primacy.

Instances of direct engagement

In the first four extracts, instances of direct communication are evident between the pharmacist and the patient or carer. The first two interactions involve a medical device; demonstrating the value of props in interaction (Goffman 1990) and particularly in interactions across language barriers (Watermeyer and Penn 2009b). Extracts 3 and 4 illustrate the facilitative nature of gesture in enabling direct communication, however brief, to occur across a linguistic divide.

Prior to Extract 1 the pharmacist addresses the parent directly (albeit in English) at a number of points in the consultation and animates what he is saying, for example by touching his head when talking about fever and headache. The parent, however, does not engage with the pharmacist directly either verbally or non-verbally, responding instead to the pharmacy assistant who is stood slightly behind and to one side of the pharmacist. The parent, however, does engage by nodding when the pharmacist demonstrates an inhaler (line 5).

Extract 1: Woman aged 29 consulting for asthma inhalers for her child with male pharmacist and female pharmacy assistant

1	Pm1	((starts shaking inhaler 4 sec))
2		so you give it a really good shake ((2 sec pause while she
3		continues to shake)) put it into (1 sec) the spacer,
4		[so that goes in ((indicates pushing something in))
5	PTf8	[[nodding head]]
6	Pm1	do the sprays
7		((indicates pressing with his finger four times on inhaler))
8		four sprays and then just get him to just breathe it in
9		normally for about er sort of half a minute or a one minute
10		just breathe it in ((indicates with hands in and out of
11		mouth))

The pharmacist demonstrates how to use the inhaler by shaking it and placing it in the spacer device (lines 1–4). This is accompanied by an explanation in English (lines 2–4) with no translation provided. However, despite the lack of verbal explanation in her own language, the parent responds directly with a nod (line 5). A possible explanation for the parent's engagement at this point but not earlier is that difficulties of understanding are likely to be less severe with a device, as there is less need for linguistic understanding when something is being demonstrated. This conjecture is supported by Watermeyer and Penn's (2009b) work in which they suggest the demonstration of a device allows an interactional space to open up for direct interaction.

The extent to which patients and pharmacists attempted to communicate directly varied. Some pharmacists tried to engage patients by, for example, addressing them directly when speaking in spite of the language barrier. In Extract 2 the pharmacist directs her talk (in English) towards the

parent, with her talk supported by her actions in unpacking and demonstrating the use of an inhaler. The parent responds by nodding even though the verbal interaction is all in English.

Extract 2: Woman aged 27 consulting about a prescription for asthma inhalers for her child, female pharmacist and female pharmacy assistant

1	Pf3	so to use it its: important that you err I'll show you how to use it.
2		((opens packaging noise 9 sec)) so you [give it a really good shake.
3		[(shakes it 2 sec)
4	PTf7	((nods once))
5	PAf1	()
6	PTf7	((two quick nods looking at P))
7	Pf3	((takes off cap with a pop sound and shakes it again)) and then take that
8		off. ((gets mask out of packaging 8 sec)) It'd probably pay to give
9		this uh uh clean.
10	PTf7	((nods twice))
11	Pf3	um Just a ((indicates little with fingers)) tiny drop of soap
12	PTf7	((nods))
13	Pf3	into some hot water. Just a tiny drop ((indicates with fingers))
14	PTf7	((3 small nods))
15	Pf3	then ((indicates curricular movement with hand – 1 sec)) swish it
16		around and leave it to dry
17	PAf1	what everyday or:
18	Pf3	no just the first time using it and maybe once once a week
19	PAf1	<i>for the first time, you wash like this and then once weekly</i>
20	PTf7	((nods))

Aside from a brief and unclear verbal intervention from the pharmacy assistant at line 5, it is not until line 19 that there is any talk in Sylheti. Despite this, the parent nods in response to shaking the inhaler (line 3), to the instruction to clean the mask (line 8) and to the pharmacist's instruction to clean the mask, with the verbal repetition of 'a tiny drop of soap' accompanied by a gesture to indicate a small amount (lines 11 and 13). The parent's repeated nodding suggests that she understood the pharmacist's talk with its non-verbal accompaniment. As in Extract 1, this extract focuses on a device, allowing for less reliance on verbal communication.

Although instances of communication may be fleeting, they allow the patient and pharmacist to become visible to each other as participants performing role-appropriate behaviour. In Extract 3 we see how non-verbal communication accompanying talk allows the pharmacist to develop an understanding of the patient's talk.

Extract 3: Man aged 67 consulting about pain killers with male pharmacist and female pharmacy assistant

1	Pm1	yeah, the other thing is maybe look at what's available in terms of
2		exercises ((moves hand towards back)) to help strengthen ((.))
3		the back like at the (name) Centre or
5	PAf2	<i>don't you have it for back pain?</i>
6	PTm2	((nods))
7	PAf2	<i>do you go to exercise anywhere?</i>
8	PTm2	<i>I go for this side ((gestures with hand to his side)), now if exercise</i>

(continued)

9		<i>this side, it hurts on the other side</i>
10	Pm1	does the exercise [it hurts yeah ((gesturing to his side))
11	PAf2	[yeah it's the side right he when he doing the
12		exercises like he thinks it's other side is getting hurt
13	Pm1	it hurts yeah okay well.

Prior to this interaction there had been some discussion about back pain and using exercises to strengthen the back. The patient replies in Sylheti that he has tried exercising but it just caused the pain to move to a different place. The use of gesture by the patient when responding to the pharmacy assistant's question about exercise enabled the pharmacist to at least partially follow what the patient was saying. The patient touches his side when answering the pharmacy assistant's question about exercise (line 8). The pharmacist notices this and is able to present his understanding of the patient's talk (line 10). The presentation is tentative, indicated by the pharmacist's reformulation of his talk from 'does the exercise' to 'it hurts yeah' (line 10). It is, however, important, as the pharmacist makes a direct connection between himself and the patient by verbally presenting his understanding and reproducing the patient's gesture. The connection between the patient and the pharmacist is made despite the fact that the pharmacy assistant also produces talk in overlap in order to refine the pharmacists' talk.

Extract 4 comes from a consultation conducted between a carer, a pharmacist and a pharmacy assistant. The patient appeared to be disengaged throughout the consultation. However, when the pharmacist produced a gesture indicating the body part under discussion to accompany his talk the patient's attention was secured and for a brief moment he participated in the interaction, albeit in a limited way. Thus non-verbal communication enabled a direct connection, however brief, to be made between the patient and the pharmacist. This example is of particular note as the interaction overcame both the patient's general disengagement and language barriers.

Extract 4: Man aged 60 attending with female carer for pain-relieving cream, male pharmacist, female pharmacy assistant

1	Pm1	backache okay, whereabouts on the back? coz ((reaches hand around to touch his back)) it might be difficult for him to put it (directed at carer and PA) ((turns around, catches patient's eye and points to area on
2		back)) down down there yeah ((directed to patient))
3		
4		
5	PTm10	((starts moving as if to touch his back and nods))
6	Pm1	is he able to reach it okay

The pharmacist, when discussing the use of a cream to ease pain associated with backache, reaches around and touches his own back (lines 1–2). In so doing he shifts in his chair and makes eye contact with the patient (line 3). The pharmacist then repeats the word 'down', saying 'down there yeah' directly to the patient who starts moving as if to touch his own back and nods (lines 4–5). The pharmacist continues with 'is he able to reach it okay' (line 6) directed at the carer and the pharmacy assistant but the eye contact, talk and gesture in lines 3–5 provide an instant of direct communication between the patient and the pharmacist. This extract is in keeping with the work of Pasquandrea (2011). He illustrated the way in which doctors who do not share a language with their patients may appear to be disengaged but monitor the consultation so they are able to interject appropriately. Here we show how patients may similarly wait for an opportunity to engage.

In summary, extracts 1–4 show how props and non-verbal communication enable communication across a linguistic divide and support pharmacists' in enacting their primary professional role of informing people about their medicines.

Extended engagement

Having examined four instances of direct engagement across four consultations the article now shifts to consider a series of interactions between a pharmacist and a patient in a single consultation. This was the only consultation in which a pharmacist and a patient communicated directly in English. Verbal communication was supported by non-verbal communication. The extracts below show the unfolding of a dispute about what counts as knowledge about taking medicine; what Heritage (2012) terms a dispute over epistemic status. The disagreement was expressed verbally and non-verbal. Non-verbal communication was used to support the verbal interaction due to the constraints imposed by not sharing a language.

Extract 5 shows the initial reference to the topic of what constitutes an acceptable basis for a claim of knowledge about taking medicine. The extract starts 22 seconds into the consultation with the pharmacist asking the pharmacy assistant if the patient knew she had been given a new medicine.

Extract 5: Woman aged 52 attending for a prescription for a new iron tablet and other repeat prescriptions, female pharmacist, male pharmacy assistant

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- 1 Pf2 err:::m does she know she's been given new tablets?
 2 PAm1 *do you know you've been given new medicine?*
 3 PTf5 *no, which one?*
 4 ((pharmacist looking for medicine, [rattling bag])
 5 PTf5 [body is ill so gave a lot isn't it?
 6 PAf1 I've got it out on the bench
 7 Pf2 oh okay (2 sec) there's nothing (1) okay=((shakes it once)) ((patient reaches out and points
 8 to it))
 9 PTf5 =*what is this? Is this the new one?* ((pointing with finger at medicine))
 10
 11 PAm1 *these are new iron tablets*
 12 PTf5 *I've had this before*
 13 PAm1 *oh ok have you*
 14 PTf5 *yes yes*
 15 PAm1 ((touching the medicine)) she's had them before ((patient touching medicine bottle and
 16 pulling it towards her)) she said.
 17 Pf2 she had them [(before)?
 18 PTf5 [I had them before, two times isn't it?
 19 Pf2 does she know how often she takes it?
 20 PAm1 *how many did you take?*
 21 PTf5 *two one in the morning and one in the afternoon.*
 22 PAm1 she took one in the morning and one in the afternoon
-

The pharmacy assistant asks the patient if she is aware she has been prescribed a new medicine (line 2) and the patient responds with 'no which one?' (line 3), indicating that the fact she has been prescribed a new medicine is news and also her interest in this news. The pharmacy assistant does not reply to the patient's direct question, or her prompt that she might expect another medicine as she is ill, which is produced in overlap with the pharmacist searching for the medicine in a plastic bag (line 5). Rather, the pharmacy assistant addresses the

pharmacist and tells her the medicine is already out on the bench (line 6). When the new medicine is identified in line 11 the patient immediately challenges the idea it is new, stating she has been prescribed the medicine before (line 12). When the pharmacy assistant reports that the patient says she has had the medicine before both the patient in line 18 and the pharmacist in line 19 topicalise the idea that knowledge of how a medicine is taken based on previous experience marks the teller as competent in relation to that medicine.

Throughout Extract 5 the patient appears very engaged with her medicines, indicated by her physical interaction with, and gestures towards, the medicine (lines 7–10 and 15–16) and requests for clarification about the medicine that has been described as new.

Despite the patient's obvious interest in the medicine, evidenced by her reaching for and then touching it (lines 9–10 and 15–16), the pharmacist does not directly engage with the patient. Of particular interest in this regard is that in lines 15 and 16 the patient touches the medicine bottle the pharmacist is holding and pulls it towards her. The pharmacist allows the patient to pull the bottle but still addresses her talk to the pharmacy assistant, confirming that the patient has had the medicine before and then asking 'does she know how often she takes it' (line 19). The pharmacist does not visually orientate towards the patient or address her, even though she is physically pulling the medicine that the pharmacist is holding. Interestingly Watermeyer and Penn (2009a) in their work on the use of props to facilitate communication in multilingual pharmacy consultations present a similar incident in which a patient reaches for a syringe a pharmacist is holding and attempts to move it. Despite the possibility this could be construed as an intrusive behaviour, as showing disrespect towards the pharmacist's personal and professional space and as potentially interfering with the task she is trying to perform, the pharmacist permits it. They suggest this is likely to be because the pharmacist perceives this as curiosity rather than as a threat and also that it performs an important task in helping the patient to interact with their medicine and may therefore promote better understanding of its use. Similarly, in Extract 5 the patient's physical engagement with the medicine may be judged as an attempt to engage both with her medicine and the consultation more generally.

Following on from Extract 5, there was some discussion of the dosage and how it had changed following a hospital stay (data not shown). The pharmacist then moved to pick up another medicine ready to continue with the consultation. At the same time the pharmacy assistant excused himself and left the room. The pharmacist remained holding the medicine but did not speak, possibly waiting for the pharmacy assistant to return. In the absence of the pharmacy assistant it is the patient, not the pharmacist, who initiates interaction (Extract 6).

Extract 6: Woman aged 52 attending for a prescription for a new iron tablet and other repeat prescriptions, female pharmacist, male pharmacy assistant

1	Pf2	errmm
2	PAm1	[can you just hold it one second ((hand towards P's arm))
3	Pf2	[((picks up medicine box and PA leaves the space))
4	PTf5	[two tablets four times
5		[((moves hand, indicates four fingers and points at meds))
6	Pf2	<u>twice</u> two tablets <u>twice</u> (0.5) morning and night
7	PTf5	((moves her hand))
8	PTf5	be[fore four times
9		[((indicates four fingers))
10	Pf2	no ((shakes head and looks to PA returning and then hands him the medicine))
11		

Although the pharmacist is holding a medicine box indicating the next topic for discussion, she does not speak. Instead, the patient speaks to indicate the dosage of the prescribed medicine (line 4). The fact that dosage is a relevant subject is supported by the prior topicalisation of taking medicine (Extract 5). Only then does the pharmacist address the patient (line 6). The patient supports her talk with hand gestures (lines 5 and 9) (see Figures 1 and 2). The pharmacist initially only responds verbally, in the same shortened format used by the patient, emphasising the word *twice* and reiterating her statement with ‘morning and night’, clearly expressing her disagreement with the patient. The patient shows she understands the nature of the disagreement, as she restates her view as to the dosage, adding the word ‘before’ (line 8) and again uses her fingers to support her verbal statement of the number of times she should take the medicine. This time the pharmacist supports her direct statement of disagreement ‘no’ with a non-verbal gesture; shaking her head (line 10). She then waits, still holding the medicine under dispute, for the pharmacy assistant to return.

Extracts 5 and 6 both contain a discussion of the dosage and frequency of medicine taking. There are, however, key differences in the constructions of these interactions. In Extract 5 it is the pharmacist who asks if the patient knows how often she should take the medicine, with dosage and frequency used as a proxy for her knowledge of the medicine. The verbal interaction is conducted in the patient’s own language, translated by the pharmacy assistant, and there is no evidence of a mismatch in the views of the pharmacist and the patient. In Extract 6 the patient initiates an interaction in an area generally regarded to be the preserve of the pharmacist, namely the dosage and frequency of medicine-taking. This can be seen as potentially disruptive to the pharmacist’s presentation of her primary professional role of providing advice about medicines. The consultation is conducted in English due to the temporary absence of the pharmacy assistant. As in Extract 5, the patient states what she believes to be the correct schedule based on her past experience; however, unlike in Extract 5, the pharmacist does not agree with the patient about the medicine-taking regimen. The patient responds to the pharmacist’s resistance by communicating the epistemic basis for her statement, namely her previous experience of taking this medicine (line 8). The pharmacist does not produce any evidence to support her disagreement; rather she waits for the pharmacy assistant to return. The difficulties in this interaction may be seen to relate to a dispute over primary access to a targeted element of knowledge or information. The pharmacist possesses the socially sanctioned authority to primary epistemic status in this situation (Heritage 2012); however she does not refer to this or provide an account for her position. The pharmacist’s stance may be based on the practical feasibility of meaningfully communicating across a language barrier, particularly when the



Figure 1 Patient indicates how often she thinks the medicine should be taken



Figure 2 Patient points to medicine box to indicate it is the subject of her talk

pharmacy assistant could interpret on his (imminent) return. In Extract 7 the dispute about medicine dosage continues but is channelled through the pharmacy assistant.

Extract 7: Woman aged 52 attending for a prescription for a new iron tablet and other repeat prescriptions, female pharmacist, male pharmacy assistant

1	PTf5	<i>I used to take this four times a day before</i>
2	Pf2	((hands tablets to pharmacy assistant and places her hands on her hips))
3	PAm1	before she used to take it four four times a day ((takes the medicine packet in his hand))
4		
5	Pf2	she <u>should not</u> take two four times a day=
6	PAm1	<i>two at a time</i>
7	Pf2	= <u>maximum</u> is only twice a day two twice a (day)
8	PAm1	<i>two tablets ... the most is two twice a day. You used to have two four times a day?</i>
9		
10	PTf5	<i>yes, for pain I had before</i>
11	Pf2	if she's getting pain, she should go back to the doctor and he can give her something else because she will develop opium toxicity with that
12		
13		I mean erm you know because it's a <u>strong</u> [painkiller and it's slow release
14		
15	PAm1	[strong
16		slow release

Interestingly it is the patient, not the pharmacist, who verbally indicates her disagreement (in her own language) (line 1). Meanwhile the pharmacist continues standing holding the tablets under dispute. She looks at the pharmacy assistant but remains silent, hands him the tablets and places her hand on her hip, her posture indicating irritation (see Figure 3).

The pharmacy assistant relays the patient's talk about medicine-taking together with the patient's basis for epistemic authority, namely her previous experience of taking the medicine (lines 3–4). The pharmacist responds by stating that the medicine should not be taken as reported (line 5) and restates her view of the dosage and frequency (line 7). The patient says in line 10 that she took the medicine at that dose for pain. The pharmacist immediately responds that if the patient is getting pain she should go to the doctor. It is only at this point that the pharmacist provides additional support for her statement about the dosage by using the medical jargon 'opium toxicity' and explaining the strength and action of the drug; it is 'a strong painkiller' and 'its slow release' (lines 11–13). In so doing she makes reference to her



Figure 3 Pharmacist directs her gaze to the pharmacy assistant: her posture suggests irritation

primary epistemic authority on medicines. The pharmacist's talk in lines 11–13 works to upgrade her previous statements about how the medicine should be taken. Interestingly, she makes no attempt to communicate directly with the patient. Instead she addresses herself to the pharmacy assistant and refers to the patient as 'she' (lines 5 and 11–12).

Extracts 6 and 7 focus on disagreement and difficulties in the consultation. This can be contrasted with Extract 8, in which the pharmacist directly addresses the patient, despite the presence of the pharmacy assistant. This extract takes place at the end of the consultation and agreement about how to take the medicine under discussion here has already been established.

Extract 8: Woman aged 52 attending for a prescription for a new iron tablet and other repeat prescriptions, female pharmacist, male pharmacy assistant

1	Pf2	((one shake of bottle))
2		only once a week huh? ((indicates one with her finger and puts medicine
3		in the bag))
4	PTf5	((single nod of head))
5		<i>I've been taking it for 14 years</i>
6	Pf2	((hands her the bag of medicine)) thank you very much.

The interaction between the patient and pharmacist in this extract is in stark contrast to those in extracts 5, 6 and 7, despite the fact they all originate from the same consultation. The pharmacist looks straight at the patient, holds the medicine she is referring to and shakes it once; directly indicating the subject of her talk (line 1). She then verbally and visually indicates that the patient should only take the medicine once a week (lines 2–3). The patient indicates her agreement with a single nod of the head (line 4). The patient's understanding may be seen as confirmed by her next statement that she has been taking the treatment for 14 years (line 5). Possibly the reason for this contrasting behaviour is that the medicine is a long-standing one and how it should be taken does not appear to be in dispute.

It is only here, in the closing stages of the consultation that the pharmacist directly addresses the patient, despite the presence of the pharmacy assistant. In the rest of the consultation she refers to the patient as 'she', with only an occasional glance towards the patient.

It is interesting to contrast Extract 6 with Extract 8. In both extracts the format used to establish agreement about taking medicine was similar. In Extract 6 the patient says 'two tablets four times' and in Extract 8 the pharmacist says 'Only once a week huh?' In both cases the questioner seems sure of agreement. Extract 6, however, demonstrates how in a dispute about medicine

taking professional knowledge takes primacy over experiential knowledge. Despite the apparent credence given to previous experience with medicines (extracts 6 and 8) this only holds when this knowledge is in accordance with professional knowledge. Thus, epistemic status is relative and its application is liable to shift as circumstances change (Heritage 2012).

This article focuses on instances of direct communication between pharmacists and patients across a linguistic divide. We did have instances in which the pharmacist and pharmacy assistant worked as a team, with the pharmacy assistant mirroring the pharmacist's gestures. Such consultations did not have easily identifiable instances of direct communication between patients and pharmacists alone, as the communication was a mix of vocal (multilingual) and non-verbal communication. Similarly in other consultations, although there were no easily identifiable instances of direct communication, there were occasions when non-verbal communication from the pharmacist appeared to be important. For example, in one consultation it appeared to be a gesture from the pharmacist that prompted the patient to present her arm for re-examination, although the pharmacy assistant also verbally prompted this action. In summary, a lack of clear instances of direct communication cannot be taken to indicate a lack of direct engagement between patients and pharmacists across a linguistic divide.

Discussion

This article has examined attempts by patients and pharmacists to communicate across a linguistic divide and considered how such communications are received. It has shown the value of non-verbal communication in circumstances in which verbal communication is possible, either through an interpreter or using limited knowledge of a shared language, but is constrained. The value of non-verbal communication when conveying topics such as pain and emotion (Hyden and Peolsson 2002, Rowbotham *et al.* 2012, Roter and Hall 2006) and the facilitative nature of props in interactions across barriers of language (Watermeyer and Penn's 2009a) have previously been noted. In keeping with other work on the use of interpreters in pharmacies (Watermeyer's 2011) this article outlines the ways in which patients and pharmacists communicate directly across a linguistic barrier even when there is an interpreter present. In summary, this article shows how non-verbal communication is used to help all participants maintain a single definition of the situation in consultations and sustain it in the face of multiple potential disruptions (Goffman 1990).

Visual cues, for example indicating the body part under discussion, were used to support statements made in a language that was not shared. This use of non-verbal communication was shown to result in fleeting connections that made patients and pharmacists visible to each other in the consultation. This worked not only to ease difficulties in communication due to the lack of a shared language but also supported the pharmacists' and patients' enactment of professionally and socially appropriate roles.

The analysis presented supports Pasquandrea's (2011) conclusion that:

What may look like disengagement, if analysed by a merely verbal perspective, reveals a richness of nonverbal practices, employed in order to remain in touch with conversations happening in a completely unknown language. (Pasquandrea 2011: 476)

Both pharmacists and patients could be seen to be monitoring the behaviour of others in the consultation, despite their lack of a shared language. This was most starkly illustrated in Extract 4. The patient appeared to be disengaged from the consultation; however, when the pharmacist touched his own back when discussing back pain the patient mirrored this gesture and the patient and pharmacist also made eye contact.

Differences in interactions across a linguistic divide may relate to who initiates the interaction and the topic of the interaction. This is illustrated in extracts 5–8, which were all drawn from the same consultation. Attempts at direct communication were made by the patient in extracts 5 and 6. In Extract 5 the pharmacist did not engage with the patient, despite the patient physically pulling at the medicine the pharmacist was holding. In Extract 6 the pharmacist engaged, rather reluctantly and in a limited way, with the patient in a discussion about taking medicine. It is likely that the pharmacist only engaged because the pharmacy assistant temporarily left the consultation, meaning interaction could not be directed through him. Following a disagreement with the patient about the dosage and the frequency of medicine taking the pharmacist waited for the pharmacy assistant to return to continue the consultation (Extract 7). In contrast, in Extract 8 the pharmacist initiated interaction with the patient confirming how an existing medicine should be taken (in English supported with gestures) and the patient responded directly to the pharmacist (by nodding, followed up by a statement in Sylheti) indicating her agreement.

When considering interactions between the pharmacist and the patient it is important to remain aware that the pharmacist is fulfilling a professional role. The article documents the way in which experiential knowledge in relation to taking medicine was successfully challenged by the pharmacist's explicit presentation of her professional expertise (her epistemic resources) as authority for her assertions (Heritage 2012). It is important to note that the pharmacist is not only in a position of authority based on her professional status and associated accredited expertise but also, crucially, has a legal responsibility to provide advice to ensure the safe use of medicines (Pilnick 1998, Stevenson, McNulty, and Leontowitsch 2012). Thus, from the perspective of the pharmacist, information about how to take medicines is generally non-negotiable, rendering debate pointless.

The findings presented here both support and extend Heath's (1984) work in which he argued that movements are designed to assist the talk with which it occurs, not to replace it. In Extract 6 the patient supported her statements in English with gestures, while the pharmacists spoke directly to patients in English alongside non-verbal communication in extracts 1 to 4 and 8. In summary, there was a connection between the visual and the vocal even where there was no evidence of understanding across the linguistic divide.

Conclusion

Non-verbal communication facilitates direct connection between people across a linguistic divide. This article demonstrates the ways in which direct communication may be achieved at a variety of levels by exploring attempts to communicate using limited English, seemingly direct communication when a medical device is being demonstrated and fleeting connections with shared understanding by indicating the relevant body part. All these connections work to maintain a sense of mutual involvement and sustain integration within consultations. Given modern multicultural society, particularly in major cities, this work is important in understanding the dynamics involved in consultations in situations in which a language is not shared. Moreover, the continuing focus on the development and maintenance of the healthcare practitioner–patient relationship makes these conclusions important when considering future research and policy.

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Appendix 1: Symbols used in transcription**Normal text spoken in English**

<i>Italics</i>	originally spoken in Sylheti; translated into English
(())	description of action occurring alongside talk
Underlining	emphasis on word or part of word
::	stretched sound
=	latching: no silence between speakers' turns
[overlapping talk
()	unclear talk that cannot be transcribed
(1 sec)	timed pause
(.)	micro pause of under a second
