

Analyzing How Preregistrant Pharmacists Navigate Workplace Disagreements Through the Lens of Politeness Theory

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Abstract

This research applies politeness theory to explore how preregistrant pharmacists handle conflicts in professional settings. A total of 56 students took part in two simulated workplace conflict scenarios. In scenario A (n = 25), the disagreement involved a colleague with lower status in the hierarchy, whereas in scenario B (n = 32), it involved a peer of similar status. Responses were analyzed using politeness theory across three levels: (1) whether to perform the face-threatening act (FTA); (2) selection of on-record or off-record strategies; and (3) specific communicative techniques. At the first level, motivations for performing the FTA were also categorized.

The vast majority (89%) of participants stated they would clearly perform the FTA. In scenario A, professional duties and obligations (40%) were the primary motivation, while in scenario B, concerns related to urgency and patient safety (65%) dominated. Participants in scenario A more frequently selected on-record strategies (80%) compared to those in scenario B (68%). Approaches showing empathy (56%) predominated in scenario A, whereas those providing explanations (64%) were more prevalent in scenario B. The findings indicate that preregistrant pharmacists demonstrate understanding of face management principles. Although the results capture only intended rather than actual behavior in real disputes, they align with existing evidence highlighting the value of low-risk simulation exercises to develop communication abilities prior to professional practice, particularly in urgent situations. Incorporating politeness theory into training sessions and feedback mechanisms may bridge the gap between theoretical awareness and practical application, though the framework would benefit from further development to account for urgency as an influencing factor across all stages of communicative choices.

Keywords: Politeness theory, Preregistrant pharmacist, Pharmacy, Workforce

Introduction

Effective patient care and organizational functioning rely heavily on collaboration both within and across professions, yet pharmacy trainees frequently encounter inter- and intra-professional disagreements as they develop their professional roles [1]. Pharmacists commonly experience ethical and professional challenges, and evidence shows that both students and

qualified pharmacists often find it difficult to address workplace confrontations directly [2, 3]. Consequently, pharmacy curricula must prioritize the development of communication competencies [4, 5] to ensure graduates possess the necessary abilities for teamwork and dispute resolution [1].

Research further suggests that educational programs could better equip learners to deal with professional disagreements [3]. A number of standards from the Accreditation Council for Pharmacy Education explicitly or implicitly emphasize the importance of fostering skills in collaborative interaction (e.g., Standard 3.4 on interprofessional communication) and handling interpersonal tensions (e.g., Standard 11.1 on interprofessional relationships) [6]. Existing literature reveals that avoidance is a typical reaction among

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Received: 27 August 2022; Accepted: 03 December 2022

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How to cite this article: Horvat K, Novak PJ. Analyzing How Preregistrant Pharmacists Navigate Workplace Disagreements Through the Lens of Politeness Theory. *Ann Pharm Educ Saf Public Health Advocacy*. 2022;2:240-9. <https://doi.org/10.51847/q0UCjjAZTa>

healthcare workers in hostile situations [7–9], with acknowledged deficiencies in preparation for managing discord [10]. Inadequate handling of inter- and intra-professional exchanges, including evasion of conflict, frequently contributes to mistakes that compromise patient outcomes [11].

By employing politeness theory, the present investigation seeks to provide deeper insight into the management of disagreements in pharmaceutical professional interactions, thereby contributing to the design of curricula that better prepare learners for workplace disputes [3]. Politeness theory [12], rooted in pragmatics—the study of language in real-world contexts—offers a lens for examining the linguistic decisions people make to preserve interpersonal relationships across varied situations. Building on the notion of ‘face’ as an individual’s public self-presentation that requires protection (Goffman, 1967) [13], the theory proposes that every communicative act risks damaging either positive face (the wish to be appreciated and affiliated) or negative face (the need for autonomy and freedom from imposition). Thus, all exchanges constitute potential face-threatening acts (FTAs). Rather than pertaining to traditional etiquette, politeness theory concerns the strategic linguistic options speakers select to honor others’ fundamental needs for belonging and independence.

When choosing to carry out an FTA, individuals select from various strategies to lessen threats to their own or the interlocutor’s positive or negative face. As illustrated in the adapted three-tier model derived from Brown and Levinson [12] (**Figure 1**), the initial decision involves whether to undertake the FTA at all, such as initiating a discussion to settle a professional disagreement. Next, speakers determine whether to express the FTA directly (on-record) or indirectly (off-record). For instance, an on-record confrontation might start with a straightforward statement like “I disagree with...,” while an off-record version could use subtle suggestion, such as “I’ve noticed you haven’t seemed quite yourself recently.” In cases where an on-record strategy is chosen, the speaker may opt for a bald approach without mitigation (“I’m really upset with you”) or employ softening linguistic elements to minimize threats to positive or negative face.

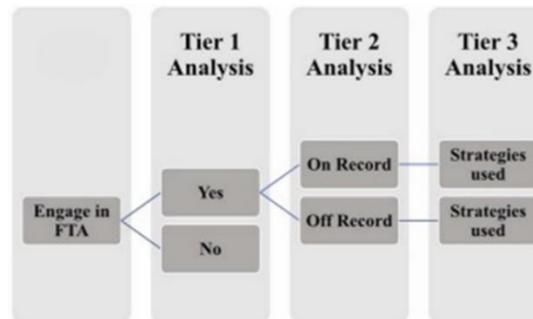


Figure 1. Our 3-tier coding version (adapted from Brown and Levinson) [12]

According to Brown and Levinson [10], the perceived seriousness of a face threat is influenced by three main contextual elements: (1) power differences, such as differences in hierarchical position; (2) social distance, such as the degree of familiarity between speakers; and (3) the degree of imposition, such as the extent to which the act interferes with the other person’s autonomy or requests something significant.

In addition to the desire to perform an FTA and the desire to protect the hearer’s face, Brown and Levinson [12] identify a separate motivation: the need for efficiency or urgency. When urgency or efficiency takes priority, both parties may temporarily set aside face concerns, allowing the speaker to deliver the message directly on-record without any mitigating redress (**Figure 1**). Direct expression without redress also eliminates the risk of misinterpretation. The only other circumstance in which bald on-record communication is typically used is when the speaker has clear and substantial authority over the hearer.

Politeness theory has been applied in several studies within healthcare to examine communicative practices, including the strategies employed by medical students in simulated virtual patient consultations [14], in written feedback during medical assessments [15, 16], and in real professional exchanges [17–21] both among healthcare providers and between providers and patients [22–25]. Research specifically involving pharmacists remains limited [5, 26–28]. Alsubaie and colleagues [29] found that students performing Objective Structured Clinical Examinations (OSCEs) that involved pharmacist–patient interactions with high imposition and face threat employed a range of positive and negative politeness strategies. Other pharmacy-related studies have explored politeness in written OSCE assessor feedback to students [30] and in patient information leaflets [31]. Across all

healthcare professions, existing research has concentrated exclusively on the politeness strategies selected after the decision to perform an FTA has been made; no studies have examined the prior decision-making process of whether to initiate the FTA at all, especially in conflict situations or under time pressure [32]. In a related approach, Robins and colleagues [33] used hypothetical scenarios to explore medical students' willingness to address patient non-adherence to treatment, collecting written responses scored against a communication index, though without applying politeness theory as an analytical framework.

Employing politeness theory, the current research examines how preregistrant pharmacists would approach professional disputes in the workplace. Findings from this work are expected to inform strategies for better preparing pharmacists to handle inter- and intra-professional disagreements, ultimately contributing to enhanced patient care.

Materials and Methods

Study design

The researchers adopted an interpretivist paradigm [34], which acknowledges diverse perspectives in primarily qualitative material, and employed an observational design to explore varied approaches to conflict resolution. Consistent with interpretivism, this observational method enabled the collection of naturalistic data without intervening in participants' behaviour. All individuals provided informed consent, and the study received approval from Monash University's Human Research Ethics Committee (Project ID: #25740).

Outcomes

The main outcome was the percentage of students who reported they would perform an FTA in response to a presented workplace disagreement, along with their stated reasons for that choice. Among those who indicated willingness to perform the FTA, the analysis further examined whether they would explicitly voice a complaint (scenario A) or point out a professional error (scenario B), and whether they described strategies designed to attend to the colleague's positive and/or negative face needs.

Study participants

The study involved 56 preregistrant pharmacists enrolled in a year-long work-integrated learning extension course (the Intern Foundation Program) [35], which offers structured workplace assessments and feedback to build additional competencies such as leadership. At the time of data collection, participants were undertaking their preregistration training in hospital or community pharmacies across Victoria, Australia, during 2022. Seventy percent of participants were female and 30% male; 45% were placed in hospital settings, while the majority were in community pharmacies.

Data collection

Participants encountered two situational judgement scenarios (**Tables 1–3**) depicting workplace conflicts during a mock job interview exercise. Their responses were video-recorded and later transcribed. Each scenario required participants to describe how they would handle a disagreement with a colleague who held either lower hierarchical status (scenario A) or equivalent status (scenario B).

Table 1. Engagement in the FTA

FTA Engagement Levels	Pharmacy Student Responses	Scenario A (n = 25): "You notice that the dispensary technician you work with is underperforming in the last week and has not been helping you answer the phone or dispense scripts, which has led to your workload increasing. How would you handle this situation?"	Scenario B (n = 31): "You overhear one of your pharmacist colleagues counsel a patient on a medication with incorrect instructions. How would you handle this situation?"
		Enter FTA	Yes
	No	1 (4%)	5 (16%)
Reasons for Engagement	Teamwork/Collegiality	7 (28%)	4 (13%)
	Pharmacist Role/Responsibilities	10 (40%)	9 (29%)

Situational Urgency/Safety	0 (0%)	20 (65%)
Efficiency/Workflow	7 (28%)	0 (0%)
Patient Satisfaction	3 (12%)	8 (26%)

Abbreviations: FTA, face-threatening act.

Table 2. Data excerpts

No	Participant Excerpt
1	As pharmacists, we are accountable not only for our own actions but also for the actions of the staff we oversee. (A04)
2	I aim to ensure that the team works in a supportive environment [...] focusing on making the workflow comfortable for everyone. The key point is to show care for staff, which also helps maintain their motivation. (A11)
3	Although it might be challenging, I feel it is necessary to discuss it with colleagues [...] allowing patients to leave without accurate instructions would be unethical. (B32)
4	I probably wouldn't intervene unless the information was seriously dangerous; otherwise, I might not disrupt the counseling. (B13)
5	I would first reflect on my own values [...] ensuring patient care and outcomes is my top priority. (B11)
6	If a patient has already left, I would follow up, apologize for any possible misinformation from our students, and provide the correct instructions. (B22)
7	I would approach the person first, letting them know I've noticed certain issues and suggesting ways they could improve. (A03)
8	Addressing the situation indirectly allows the technician to reflect on their performance, making them more receptive to feedback, especially if they recognize similar patterns themselves. (A04)
9	I would speak to my colleague, explain what I think was incorrect, and provide the correct information, maintaining transparency. (B15)
10	I would ask the colleague about the sources of their instructions to ensure it wasn't my error, discuss the correct guidance respectfully, and allow them to follow up with the patient. (B13)
11	I would take the dispensary technician to a private area, ask how they've been managing their work, and discuss how to better support them. (A04)
12	During less busy periods, I would pull the technician aside to talk privately. (A22)
13	I might suggest next time checking the prescription and medication box during counseling to avoid missing critical details. (B07)
14	I would inquire about the sources used for the instructions to clarify whether it was my mistake, fostering a discussion rather than assigning blame. (B13)

Table 3. On/Off-record interactions.

On/off record interaction	Scenario A (<i>n</i> = 25):	Scenario B (<i>n</i> = 31):	On/off record interaction
	“You notice that the dispensary technician you work with has been underperforming in the last week and has not been helping you answer the phone or dispense scripts which has led to your workload increasing. How would you handle this situation?”	“You overhear one of your pharmacist colleagues counsel a patient on a medication with incorrect instructions, How would you handle this situation?”	
On-record (initial interaction)	20 (80%)	21 (68%)	On-record (initial interaction)
Off-record (initial interaction)	5 (20%)	10 (32%)	Off-record (initial interaction)

On-record (secondary interaction)	1 (4%)	2 (6.5%)	On-record (secondary interaction)
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Data analysis

A 3-tier coding process was developed (adapted from Brown and Levinson [12]). After familiarizing themselves with the data through content analysis [36], the researchers mapped participant responses to the first two tiers of the coding flowchart for the speaker's evaluation of face and introduced a third general tier centred on the strategies employed. Tier 1 coding categorised whether the student would or would not perform a face-threatening act (FTA), along with the reasons for this choice. Tier 2 codes examined whether, upon deciding to perform the FTA, the student would adopt an on-record approach (e.g., a direct complaint in scenario A) or an off-record approach (e.g., a general enquiry about health and well-being). Tier 3 coding explored the specific on-record or off-record strategies participants reported using to address the workplace disputes when performing the FTA. Following the tiered codebook, four authors independently coded a subset of the data (30%) and discussed results with the full team. The codebook was refined, and the authors then coded another 30% of the data. The team reconvened to discuss findings; once consensus was achieved, one team member coded the remaining data. Any outstanding issues were resolved through team discussion until agreement was reached.

Results and Discussion

Tier 1 analysis: yes/no engagement in the face-threatening act (FTA)

As presented in **Table 1**, in both scenarios, 50 out of 56 participants (89%) clearly stated they would perform the FTA, citing teamwork and efficiency, roles and responsibilities, patient satisfaction, and situational urgency/safety as key motivations. In scenario A, the primary reason for performing the FTA was the pharmacist-in-charge's roles and responsibilities within the healthcare team (**Table 2**), Excerpt 1).

Participants in scenario A also noted that collegiality influenced their decision to perform the FTA, relating to the well-being and satisfaction of team members (**Table 2**), Excerpt 2) and to "ensure that the dispensary process is running as smoothly and as efficiently as possible" (A02). Here, 'collegiality' was generally linked to the

pharmacist's duty to foster a collaborative environment, rather than to their own personal professional relationships.

Additionally, three of the 25 scenario A participants mentioned patient satisfaction as a factor in performing the FTA, emphasising avoidance of patients becoming "irritated" (A10) or "upset" (A20) due to inefficient or slow pharmacy workflows.

In contrast, none of the scenario A participants cited urgency, whereas 20 scenario B participants (65%) identified patient safety as a major driver for performing an FTA with their colleague. The level of urgency was assessed based on whether the patient would remain in hospital (**Table 2**), Excerpt 3) and the potential harm from the misinformation (**Table 2**), Excerpt 4).

Roles and responsibilities contributed to the decision to perform the FTA in both scenarios. However, scenario A participants primarily emphasised managing workflows and colleagues, while scenario B participants focused on ethical obligations towards patient safety rather than colleagues. Scenario B participants also highlighted the role of familiarity or a 'friendly rapport' with the colleague, instead of positional power. Thus, scenario B showed a shift in emphasis from team efficiency, workflows, and general patient satisfaction to the ethical priority of patient care (**Table 2**), Excerpt 5).

Overall, across both scenarios, 6 participants (11%) expressed hesitation about performing the FTA (**Table 1**). In scenario A, the one participant (A09) who might avoid the FTA would delegate to their deputy (in a higher power position), especially if the issue mainly concerned workload allocation causing underperformance. However, for pure underperformance, A09 would address the dispensary technician directly in a "non-confronting manner". The main driver was the overall effect on dispensary workflow.

The five scenario B participants who described conditions under which they would not perform the FTA did not delegate to authority but considered speaking to the patient alone (B22, B09) or not raising the mistake at all (B02). Key factors included workplace power hierarchies and processes—such as whether the person giving incorrect information was a peer pharmacist, student, or intern (B22, B16)—and whether other processes might allow the colleague to self-identify the

error, e.g., doctor review (B07). B16 explicitly noted that power differences were crucial, stating they “would not directly intervene” with an equal pharmacist but might respond differently to a student or intern. Similarly, B22 ((Table 2), Excerpt 6) preferred to preserve a pharmacy student’s face by avoiding direct correction, instead correcting the patient at a suitable moment to maintain patient safety.

As illustrated in Excerpt 6, like those certain about performing the FTA, hesitant participants balanced patient safety and satisfaction (B22, B09, B02, B07) against workplace power hierarchies and roles (B16, B22).

Tier two analysis: on/off-record engagement with the FTA

In scenario A, 20 out of 25 participants (80%) would use on-record approaches, explicitly signalling a complaint to the colleague (Table 3). In scenario B, participants were somewhat less inclined (21/31, 68%) to use bald on-record statements for correction. In both scenarios, a few participants described starting with an off-record approach before shifting to on-record in a subsequent interaction.

For instance, an on-record complaint in scenario A would directly address the technician’s underperformance ((Table 2), Excerpt 7). An off-record approach would indirectly raise the issue, e.g., by discussing the technician’s general performance and work experiences without mentioning underperformance explicitly ((Table

2), Excerpt 8). The FTA (complaint) is thus embedded in a general enquiry.

In scenario B, on-record approaches directly referenced the incorrect instructions given to the patient ((Table 2), Excerpt 9). Like scenario A, off-record participants in scenario B framed the correction as an enquiry to prompt self-realisation of the error ((Table 2), Excerpt 10).

Before examining strategies to mitigate face threats, it should be noted that bald on-record choices do not necessarily imply disregard for face. As shown in the self-quotes in Excerpts 7 and 9 (Table 2), participants planning on-record responses simultaneously described linguistic techniques to mitigate the FTA’s impact (i.e., redressive action). For example, in hypothetical quotes ((Table 2), Excerpts 7, 9), they used informal terms (e.g., ‘hey’, ‘you know’) and performative hedges [37] such as ‘I have noticed’ and ‘I think’. This reflects efforts to protect the colleague’s negative and positive face while maintaining clear communication of the speech act (complaint or correction).

Tier three analysis: conversational and nonconversational strategies

Participants described various conversational strategies or actions to mitigate and/or intensify on- and off-record FTAs (Table 4). In scenario A, empathetic approaches (14/25, 56%) or explanatory ones (12/25, 48%) were used to soften the FTA, while appeals to authority (6/25, 24%) involved escalating to the pharmacy owner or manager (A10).

Table 4. Conversational and nonconversational strategies.

Strategies	Scenario A (n = 25): “You notice that the dispensary technician you work with is underperforming in the last week and has not been helping you answer the phone or dispense scripts which has led to your workload increasing. How would you handle this situation?”	Scenario B (n = 31): “You overhear one of your pharmacist colleagues counsel a patient on a medication with incorrect instructions. How would you handle this situation?”
	Conversational strategies	
Explanatory approach	12 (48%)	20 (64%)
Advisory approach	0 (0%)	4 (13%)
Questioning approach	0 (0%)	8 (26%)
Empathy approach	14 (56%)	2 (7%)
Appeal to authority	0 (0%)	0 (0%)
Nonconversational strategies		

Protecting face	7 (28%)	23 (74%)
Protecting privacy	13 (52%)	27 (87%)

Empathetic strategies primarily revolved around supporting the dispensary technician and inquiring about their overall well-being ((Table 2), Excerpt 11), often involving collaborative approaches such as “working out a solution together.” In scenario A, over half of the participants (n = 13, 52%) preferred addressing the error in a private setting, away from patients and other colleagues ((Table 2), Excerpt 12). This could occur immediately, for instance, by quietly pulling the colleague aside (e.g., B22), or during a later follow-up discussion. Participants aimed to respect the technician’s positive and negative face, emphasizing approaches like being “firm but non-vilifying” (A22) and clarifying that their intention was “not to patronize the underperformer” (A16), thereby avoiding embarrassment or humiliation (A10).

In scenario B, appeals to authority were not reported. Similar to scenario A, many participants (n = 20, 64%) favored an explanatory approach, highlighting the error to the colleague while framing it as “a learning opportunity for everyone involved” (B26; B31). In some cases (n = 4, 13%), this was combined with an advisory strategy, offering suggestions for future behavior ((Table 2), Excerpt 13). Unlike scenario A, the explanatory method in scenario B was sometimes implemented through a Socratic teaching style (8/31, 25%), using questions to address mistakes without directly accusing the colleague, thus safeguarding both positive and negative face needs ((Table 2), Excerpt 14).

Although only two participants explicitly mentioned demonstrating “empathy and respect to this pharmacist” (B13), attention to face was clearly evident. A majority (87%, 27/31) indicated they would minimize face loss by taking the colleague aside for a private discussion. One participant noted they were more comfortable raising issues privately with colleagues they had a “friendly rapport” with (B04). Participants highlighted the importance of approaching the situation with kindness, ensuring the colleague did not feel criticized or at fault (B03). For those who deemed immediate intervention necessary to prevent misinformation during a patient encounter, there was a strong awareness that such interruptions “can seem unpleasant” (B27) or “disheartening and embarrassing” (B04). Consequently, they emphasized taking care to protect the colleague’s

face both during the intervention and afterward, following up privately to ensure “no hurt feelings” (B05). The majority of participants (89%) in both scenarios A and B stated they would definitely perform the face-threatening act (FTA), though motivated by differing factors. In scenario A, the primary driver was the pharmacist’s roles and responsibilities (40%), while in scenario B, it was situational urgency and safety concerns (65%). In scenario A, with clear hierarchy between the pharmacist and the dispensary technician, participants viewed addressing the issue as a professional duty to their team and organization. In contrast, scenario B involved interaction with a peer of equal or unclear status, where patient safety and urgency served as the main trigger for initiating the FTA. Participants in scenario B demonstrated greater sensitivity to familiarity, often specifying in their responses whether the other pharmacist was someone with whom they had a “close rapport” and how varying hierarchies (e.g., peer pharmacist versus student) would influence their communicative choices. The substantial engagement in FTAs across both scenarios implies that participants prefer to confront and resolve intraprofessional conflict rather than evade it. This finding differs from prior research showing that healthcare professionals tend to avoid conflict in confrontational situations [5–7]. The role of patient safety and duty of care in prompting students to overcome conflict avoidance has implications for designing conflict management training resources and incorporating scenario- or simulation-based elements into university curricula. That said, since participants were describing responses to hypothetical situations, their stated intentions may not align with behavior in real antagonistic encounters. Future research should investigate if knowledge of handling hypothetical confrontations corresponds to actual choices to engage in and navigate FTAs in professional settings.

In scenario A, the pharmacist occupied a superior position, holding higher status than the dispensary technician and overseeing a full team of colleagues. Smooth workflow contributes to team and patient satisfaction, reflecting the lead pharmacist’s leadership skills, such that the four identified factors influencing the decision to perform the FTA connect to both managerial authority and face needs tied to organizational

effectiveness [38]. In scenario B, by contrast, power dynamics were equal (or similar), and this reduced differential could make participants less inclined to use direct, on-record strategies initially compared to scenario A. Certain students noted they would be direct if speaking to a student (leveraging power advantage) but less so with an equal-status colleague. Scenario B featured high situational urgency, where safety imperatives likely supersede other factors in deciding to enter the FTA—for instance, unlike scenario A, appealing to authority was not an option. Yet, counter to Brown and Levinson's politeness theory [12], this urgency did not lead to bald on-record statements without mitigation. Rather, participants opted for on-record entry into the FTA while heavily attending to face needs (e.g., conducting the discussion privately or framing it as an inquiry or teaching moment). This suggests the theory could be extended to incorporate situational urgency as influencing not just interaction style (e.g., on/off-record, with/without redress) but also the initial decision to perform the FTA. Since urgency likely considers the costs to the hearer of non-intervention, it might be integrated into "imposition" or added as a separate factor beside power and social distance.

Scenario A featured explicit power structures and responsibilities (pharmacist supervising technician), whereas scenario B involved equal power, uncertain familiarity, and greater imposition (i.e., significant urgent risk if unaddressed). Both were situated in community pharmacy with same-profession colleagues, potentially raising the odds of FTA engagement. In comparison, Lambert and colleagues found that community pharmacists employed more politeness when interacting with physicians and were less prone to offer recommendations than their hospital counterparts. In those interprofessional exchanges, pharmacists recognized their duties but worried that intervening could undermine other professionals' roles and authority, potentially harming collaborative relationships.

Participants in scenario A were more inclined to adopt an initial on-record strategy (80%) compared to those in scenario B (68%). Empathetic strategies were more prevalent in scenario A (56%), whereas explanatory strategies dominated in scenario B (64%). Regarding conversational tactics, empathetic methods were far more frequently cited in scenario A than in scenario B, suggesting that those in superior positions may feel entitled to inquire about the well-being of team members under their supervision. In scenario B, characterized by

minimal power distance, participants predominantly emphasized mutual learning along with explanatory, advisory, and questioning techniques. Moreover, across both scenarios, participants demonstrated attention to the colleague's face and privacy concerns; however, for some (though not all) in scenario B, situational urgency superseded considerations of privacy or face. This aligns with findings from Alsubaie and colleagues [29], who examined politeness strategies employed to mitigate embarrassment and imposition toward patients, revealing that 65.4% of interactions incorporated at least one negative politeness strategy to lessen threats to patients' face.

This research examines intraprofessional communication within health professional education using politeness theory, a relatively underexplored domain. One limitation is the reliance on hypothetical scenarios rather than real-time interactions. The artificial nature of these situations may introduce response bias, as participants might portray heightened empathy to align with perceived assessment expectations, differing from their behavior in genuine encounters [39, 40]. Furthermore, the scenarios did not specify demographic details of the interlocutors (e.g., age, gender, or precise practice setting), factors previously linked to variations in perceived power and social distance during pharmacist-physician interactions [28], though they may not invariably influence politeness variations. Since the study did not address prior instruction in conflict management, future investigations should explore optimal ways to incorporate conflict management into curricula, potentially employing politeness theory as an educational framework.

Like most professional skills, proficiency in workplace communication—particularly for handling disputes and conflicts—is optimally cultivated through deliberate practice and consistent feedback [40]. Despite learners often feeling inadequately prepared for managing workplace conflicts [3], well-designed experiential and simulation-based programs have proven effective in improving general teamwork communication [3]. Curricula could therefore integrate opportunities for observed practice and feedback on communication during conflict management in both simulated and real-world activities. To date, politeness theory has been applied to analyze communication among health professionals and students but has not been explicitly utilized to inform the design of communication-oriented activities or curricula for this population [15]. The

present findings indicate that curricular exercises simulating variations in power, familiarity, and imposition could offer learners safe environments to practice and receive feedback on conflict resolution. Situational urgency should be incorporated into such simulations, especially when it necessitates prioritizing unambiguous communication over face preservation.

Conclusion

Preregistration pharmacists tend to favor on-record strategies in conflict situations when situational urgency is present or when hierarchy clearly favors them. This research illustrates how politeness theory's concepts of face-work, power, familiarity, and imposition can elucidate preregistrant pharmacists' deliberative decisions in workplace conflicts. It further underscores the necessity to refine the theory by adding situational urgency as a critical element influencing the choice to initiate an FTA, to proceed on- or off-record, and to apply redressive measures even amid urgency. Additional studies should assess students' capacity to apply this insight in real professional disputes. This calls for university curricula to provide low-stakes, simulated settings for skill practice prior to workplace entry. Embedding politeness theory—especially the factors of power, familiarity, and imposition (including urgency)—into activity design and feedback mechanisms can bridge students' reflective understanding with practical application.

Acknowledgments: None

Conflict of Interest: None

Financial Support: None

Ethics Statement: None

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