Directness and Deference in Pharmacy Students' Messages to Physicians

Bruce L. Lambert

Bruce Lambert (Ph.D., University of Illinois at Urbana-Champaign, 1992) is an Assistant Professor in the Department of Pharmacy Administration and the Department of Pharmacy Practice, University of Illinois at Chicago. This essay was presented at the 78th Annual Convention of the Speech Communication Association, November 19, 1993, Miami, FL.

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Address: (M/C 871) 833 South Wood St., Rm. 241, Chicago, IL 60612-7231
Phone: (312) 996-2411
Fax: (312) 996-7242
Internet: bruce@ludwig.pmad.uic.edu

Abstract--The profession of pharmacy is in the midst of an attempted role expansion. Advocates of a philosophy of practice known as pharmaceutical care want to expand the traditional role of the pharmacist to include patient counseling, drug use monitoring, clinical consultation with physicians, and responsibility for patient outcomes. Other health professions are resisting this role expansion, and it has proven difficult to socialize students into a professional role that is not yet widely accepted. To better prepare students for the workplace, pharmacy educators need a way of assessing the extent to which students have accepted and begun to enact the expanded clinical role. Since role and identity disputes are negotiated in routine interactions between pharmacists and other health professionals, an assessment tool was devised to mimic a common interprofessional interaction.

Written messages to physicians were gathered from pharmacy students in response to a hypothetical drug allergy scenario. Pharmacist-physician communication is especially problematic because many of the acts pharmacists routinely perform (e.g., correcting, reminding, reporting, etc.) are intrinsically threatening to a physician's professional identity and sense of self worth. Brown and Levinson's politeness theory explains how situational factors influence peoples' choices in dealing with such identity threatening acts. As an act becomes more threatening, the degree of politeness accompanying the act also increases. Detailed content analysis of pharmacy students' messages to physicians determined that allergy reports were more likely to be made directly than alternative drug recommendations. Recommendations were more likely than reports to be omitted entirely. Implications for pharmacy students' emerging professional identities are discussed.

Key words --Clinical pharmacy, professional socialization, role expansion

INTRODUCTION

There is a powerful movement underway in the United States to expand the traditional dispensing role of the pharmacist to include patient counseling, drug use monitoring, clinical consultation with physicians, and responsibility for patient outcomes [1-8]. The new philosophy of practice is known as pharmaceutical care. This movement was initiated and continues to be most strongly advocated by academic pharmacists, especially those practicing and teaching at academic medical centers. Not surprisingly, attempts to expand pharmacy's professional role have met with resistance. This resistance has come from physicians and nurses, who see pharmacy's expansion as an infringement on their professional turf, and even from practicing pharmacists, who are not comfortable with the new, more clinical role [8, 9]. In this context, pharmacy educators are faced with the difficult challenge of socializing students into a professional role that is not yet widely accepted.

This essay adopts a symbolic interactionist perspective on the development and legitimation of professional roles [10, 11, 12]. On this account, real changes in professional identity are only achieved when individual pharmacists accept different roles and begin to project different identities on a day-to-day basis. Identities are formed and sustained in interaction, not in the abstract. Pharmacists define themselves by the way they act and talk in the context of routine, everyday interactions. Recurring patterns of language use in pharmacy students' messages to physicians create and sustain power relationships and role expectations. To illustrate this point, a detailed analysis of pharmacy students' messages to physicians is presented. By examining patterns in pharmacy students' strategic communicative choices, the extent to which

pharmacy students have accepted and begun to enact the newly expanded clinical role can be assessed.

INTERACTION BETWEEN PHARMACISTS AND PHYSICIANS

It is important for pharmacists to manage the impressions they make on physicians because physicians occupy a central role in health care systems. Pharmacists routinely define their identities during discussions with physicians about medication allergies, contraindications, and other potential errors or misunderstandings [13, 14]. The frequency and value of pharmacists' interventions with physicians are well documented [15, 16]. In the Netherlands, more than half a million telephone conversations took place in one year between pharmacists and physicians, 40% of which were "for reasons of medication surveillance" [17]. Despite the pervasiveness of these contacts, physicians do not value pharmacists' services until they have repeated positive experiences with such services [18-22]. Role and identity disputes will be negotiated at this interprofessional interface, and if pharmacists are to succeed in expanding their roles as patient counselors and as clinicians, it is imperative that they communicate tactfully and professionally in their contacts with physicians [20-25].

This essay focuses on messages produced by pharmacy students who need to address a potentially problematic drug allergy situation. The need to address multiple goals in this type of situation makes communication between pharmacists and physicians especially challenging [26, 27]. When a pharmacist discovers a drug allergy, the pharmacist must resolve the allergy issue (i.e., Does the physician know about the allergy? Should the medication be changed? Does the physician have an alternative in mind?). At the same time, however, the pharmacist must manage his/her own identity (i.e., appear professional, be helpful if necessary, assert own authority,

etc.) and guard against offending the physician. It is difficult to design a message that simultaneously achieves these goals. The next section describes how such difficulties are strategically managed in everyday interaction.

CONCEPTUAL FRAMEWORK

In this investigation, threats to pharmacists' and physicians' identities are conceptualized in terms of the concept of face [28]. Goffman defines face as "the positive social value" a person claims for him/herself by acting in a particular way [28, p. 5]. The concept is evident in everyday expressions that refer to "losing face" or "saving face". That which is "lost" or "saved" is the sense of value or self-worth that every individual claims for him/herself. Because it is embarrassing to lose face or to witness someone else losing face, a great deal of everyday talk is shaped by interactants' cooperative commitment to preserving face.

Brown and Levinson's influential analysis of linguistic universals in the expression of politeness illustrates the pervasiveness of concern for face [29]. On Brown and Levinson's account, face is understood as a set of persistent wants possessed by every member of a culture. There are two aspects of face: negative face and positive face. Negative face is defined as "the want of every 'competent adult member' that his [or her] actions be unimpeded by others" [29, p. 62]. Positive face, on the other hand is "the want of every member that his [or her] wants be desirable to at least some others." [29, p. 62]. By assuming people are rational in their attempt to minimize the damage done by face threatening actions (FTA's), politeness phenomena can be elegantly explained.

Brown and Levinson identify four strategies for managing FTA's: (a) to do the FTA baldly on the record; (b) to do the FTA on the record with

redress; (c) to do the FTA off the record; or (d) not to do the FTA. To do an FTA baldly on the record (strategy (a)) is to do the act directly, explicitly and without regard to its consequences. Strategy (b) calls for the FTA to be accompanied by attempts to minimize any potential face-threats. This strategy requires redressive action of some kind, action aimed at minimizing the damage done by the on the record performance of an FTA. The two primary categories of redressive action correspond to the two types of face wants and are known respectively as negative and positive politeness. Strategy (c) requires the FTA to be done indirectly, through hints, implication, etc. [30, 31]. Not doing the FTA, strategy (d), involves outright avoidance of the face threat by abstention from the threatening act.

Negative politeness

Negative politeness strategies minimize threats to others' negative face wants. Any act which threatens another person's want to be left alone is an occasion for the expression of negative politeness. Most familiar forms of politeness are paradigm cases of negative politeness. When one person bumps into another, the words "excuse me" or "pardon me" or even "sorry", function as negative politeness forms. Many routine communicative actions threaten negative face (e.g., requests, questions, invitations, commands, etc. [29]).

Brown and Levinson describe several negative politeness strategies. When one violates another person's desire to be left alone one can simply apologize (e.g., "Sorry to bother you"). One might also hedge on a presumption (e.g., "I wonder if you realized the patient was allergic"), be pessimistic about a request being granted (e.g. "You wouldn't want to change therapies, would you?"), give deference (e.g., "May I please suggest

an alternative drug, doctor?"), and so on. Each strategy attends in one way or another to the offended person's desire to be left alone; each has advantages and disadvantages, and the choice of one over another has different consequences for interactants' identities.

Positive politeness

Acts that suggest the speaker does not share the hearer's wants, or that imply that the hearer is not valued or approved of, threaten positive face and are dealt with by the expression of positive politeness. Criticism, disagreement, and mistaken forms of address (e.g., calling a female doctor "Nurse so-and-so") are among the everyday acts that threaten positive face. Brown and Levinson have identified several positive politeness strategies [29]. For instance, bad news can be accompanied by praise (e.g., "Your choice of therapies was excellent, but the patient is allergic to this drug"), corrections can be accompanied by assertions of common experience (e.g., "You must have overlooked this, I know how busy things get at the clinic") suggestions can include both parties in the suggested action (e.g., "Let's try Drug Y"), etc. [29].

PURPOSE

The purpose of this study was to assess the extent to which third year doctor of pharmacy students have accepted and begun to enact the expanded clinical role advocated by proponents of pharmaceutical care [2, 3]. Specifically, an attempt was made to find out how strategic communicative choices in pharmacy students' messages to physicians were influenced by the type of act being performed.

In their study of politeness, Brown and Levinson identified three factors that influence the so-called weightiness of a face-threatening act and thereby influence the selection of one politeness strategy over

another. The three factors are power, social distance and culture-specific ranking (severity) of the face threatening act [29]. Brown and Levinson claim that the sum of these three factors gives an index of the weightiness of the FTA being contemplated (i.e., W = P + D + R). As the weightiness of an FTA increases, a speaker is expected to choose a more polite strategy (with bald on the record being least polite followed by two forms of on the record redress: positive politeness then negative politeness, then off the record politeness, and the most polite strategy, abstention from the FTA). The objective of the present study is to examine the influence of one of these three factors, culture-specific ranking (R) of the FTA, on the type of politeness strategy used by pharmacy students.

In an earlier analysis [32], it was found that drug allergy messages typically consisted of two main acts: allergy reports and alternative drug recommendations. Within the context of contemporary medical practice, it is far less face threatening for a pharmacy student to report an allergy than it is to recommend an alternative drug. Reporting an allergy lies within the scope of the traditional professional role of pharmacy; whereas, recommending an alternative drug is the type of active intervention in therapeutic decision-making that is characteristic of the new role. Physicians are most resistant to this type of active intervention [8]. If students have accepted and begun to enact the new role, then there should be no difference in the amount of politeness used when making reports versus recommendations. In generating the hypotheses, however, it was assumed that students have not yet fully accepted or learned to enact the expanded role. Generally speaking, then, one would expect recommendations to be made more politely than allergy reports. Specific hypotheses are given below:

H1: Bald on the record reports will be made more frequently than bald on the record recommendations.

H2: Positively polite reports will be made less frequently than positively polite recommendations.

H3: Negatively polite reports will be made less frequently than negatively polite recommendations.

H4: Off the record reports will be made less frequently than off the record recommendations.

H5: Recommendations will be omitted more frequently than reports.

METHODS

Participants

The participants in this study were *N* = 86 doctor of pharmacy students in the final term of their third year of didactic coursework at a large midwestern college of pharmacy. Students were to begin the experiential component of the program immediately following the end of the term when the data were collected. Thus, the data reflect the students' orientation toward their professional role just before they have their first clinical experience. Volunteers were solicited from among the students enrolled in a behavioral pharmacy course.

Message elicitation

Written messages were gathered in response to a hypothetical drug allergy situation. The method is closely analogous to that used by Robins and Wolf in their study of politeness in physician-patient confrontations [33]. The validity of such hypothetical written communication tasks has been demonstrated in several investigations (for a review, see [34]). The text of the drug allergy situation is reproduced below:

> Imagine that you are an outpatient pharmacist in a large

hospital. This morning you get to work and there is a prescription for Dr. Jones that needs to be filled. Dr. Jones is a new physician at the hospital. During a routine check, you discover that the patient (Mr. Smith) is allergic to the prescribed medication (Drug X). You are unable to fill the prescription as written, but you know of a good alternative (Drug Y). You pick up the phone and call Dr. Jones.

What would you say to Dr. Jones? In the space below, write what you would say; DO NOT DESCRIBE THE GENERAL ACTION YOU WOULD TAKE--instead try to PUT IN YOUR OWN WORDS WHAT YOU WOULD ACTUALLY SAY to deal with the situation.

In addition to the drug allergy situation, each participant read and responded to two other situations. One a hypertension compliance-gaining situation and the other, a group problem-solving situation, are being analyzed separately. Only the analysis of drug allergy messages is reported here. Hypothetical drugs (Drug X and Y) were used in the scenario so that students would focus on the interactional aspect of the task rather than focusing on the therapeutic complexity of choosing an appropriate alternative.

Message coding

Messages were first segmented into message elements, which are roughly equivalent to independent clauses [35-37]. Each phrase containing both a grammatical subject and a verb was counted as a single unit. Phrases with compound predicates (e.g., "Drug Y is a good alternative and could be used in this case") were broken into separate message elements (e.g., "Drug Y is a good alternative" and "[Drug Y] could be used safely in this case"). To assess the reliability of this unitizing procedure, two coders

independently unitized a sample of 25 messages. Unitizing reliability, according to Guetzkow's U was .022, indicating a discrepancy between coders of 2.2% over the entire reliability sample [38]. Values below 0.10 are conventionally regarded as acceptable, and therefore no unit-by-unit analysis of disagreements was undertaken. The author's units were used to resolve disagreements, and the remainder of the messages were unitized by the author alone.

A classification system was then developed to group synonymous message elements. Message elements were placed in the same category when they differed only in using alternative terms to refer to the same aspect of the situation or when they expressed the same idea with alternative syntactic structures using a common vocabulary. These abstract categories of message elements are referred to as message frames or simply frames. This system contained 27 substantive categories and one "other" category for low frequency elements. Table 1 displays the frames in descending order of their frequency of occurrence. Table 2 displays the elements categorized as "other."

Table 1 about here

To assess the reliability of the message frame classification system, two coders independently coded a sample of 25 messages consisting of a total of 137 message elements. Exact agreement was reached in 125 cases (91.2%). Reliability, according to Cohen's kappa, was .91 [39]. Disagreements were resolved by using the author's codings, and the rest of the messages were coded by the author alone. This is unusually high reliability for a system with so many categories. The high reliability is

explained by the simplicity of the coding rules and by the relatively low within-frame variability. That is, elements of the same frame were virtually identical to one another and clearly distinct from other frames.

Table 2 about here

ANALYSIS AND RESULTS

The first step in the analysis was to interpret the 28 drug allergy message frames in terms of Brown and Levinson's [29] politeness strategies. Content analysis of the message frames suggested six broad categories of content: (a) introductory remarks, (b) allergy reports, (c) alternative drug recommendations, (d) requests for permission, (e) refusals, and (f) closing remarks. The conceptually sorted frames are given in Table 3. While refusals and requests for permission are interesting both from a theoretical and practical standpoint, the primary focus of this study is on reports and recommendations. Thus, only those frames pertaining to reports and recommendations are analyzed. Table 3 groups each report and recommendation frame under the politeness strategy it exemplifies. The next several sections describe the rationale for grouping each report and recommendation frame under a given politeness strategy. Hypotheses 1-6 are tested.

Table 3 about here

<u>Bald on the Record Politeness</u>

A message was said to contain a bald on the record report if it contained at least one message element from the frame "Mr. Smith is

allergic to Drug X." A message was said to contain a bald on the record recommendation if it contained at least one message element that belonged to the frame "I recommend drug Y." These elements were coded as bald on the record because each did the face threatening act directly and without redress. Each message was coded only for the presence or absence of the respective strategy types. Even when an element from a specific frame appeared more than once in a single message, the frequency for that strategy type was incremented only once (i.e., a strategy could appear at most $N = 86$ times in the sample). For the bald on the record strategy, each message was coded as containing one of the following patterns of reports and recommendations: (a) a bald report and a bald recommendation, (b) a bald report but no bald recommendation, (c) a bald recommendation but no bald report, or (d) neither a bald report nor a bald recommendation (see Table 4.A). Using this procedure, all 86 messages were examined and the frequency of each type of strategy was tallied and displayed in a 2 X 2 contingency table.

Table 4 about here

For a pharmacist operating within the culture of contemporary American medical practice, reporting a discovered allergy to a physician is intrinsically less face-threatening to the physician that recommending an alternative drug. Therefore, Hypothesis 1 predicted that reports would be more likely than recommendations to be made baldly on the record. To test this hypothesis, the proportion of bald on the record reports was compared to the proportion of bald on the record recommendations using a chi-square test for dependent samples [40]. Hypothesis 1 was strongly supported ($\chi 2(1)$

= 14.22, P < .0001). Messages containing bald on the record reports were much more common than messages containing bald on the record recommendations. In fact, only one bald on the record recommendation was present in the entire sample. Such low frequency elements were not generally assigned to their own frames. This element was assigned to its own frame because it was a clear example of the strategy type and because of its theoretical centrality to the present investigation.

Positive Politeness

Positive politeness is used by pharmacy students who interpret the drug allergy situation as an occasion to challenge, contradict, or disagree with the physician. Such acts are intrinsically threatening to the physician's positive face [29]. Elements in this category attempt to redress FTA's by demonstrating that the physician is valued and approved of and that his/her enduring wants are shared (in spite of any fleeting disagreement, contradiction, etc.). Several sub-strategies were used to accomplish this objective for reports and recommendations respectively.

Allergy reports

Show understanding. These messages attend to the physician's need to be understood and approved of. This strategy redresses acts of criticism or correction. By explicitly acknowledging extenuating circumstances, these elements undermine the potentially face-threatening implication that the doctor was irresponsible or lax in his/her duty to review the patient's history. In most cases, the doctor's failure to note the allergy is explicitly assumed, but it is placed in a broader context (of a busy, overworked professional) that reduces the doctor's culpability. A message was said to contain a positively polite report if it contained any message elements belonging to the frame "I understand your constraints/situation".

Alternative drug recommendations

Include both parties in the act. These message elements attend to the physician's positive face by asserting commonalty and collegiality between the pharmacist and physician. Such elements refer to "we" when discussing a proposed course of action. By posing the suggestion as an opportunity to engage in cooperative activity, these messages imply that the physician and pharmacist share common goals and wants, and this straightforwardly redresses the doctor's desire to have his/her wants shared. Therefore, a message was said to contain a positively polite recommendation if it contained a message element or elements belonging to the frame "We could try an alternative".

Comparison of reports and recommendations: Positive politeness

The frequency of occurrence of positively polite reports and recommendations strategy was tallied in the same manner as above. The results of this tally are given in Table 4.B. Hypothesis 2 predicted that recommendations would be made more politely than requests and, thus, that positively polite recommendations would occur more frequently than positively polite reports. This hypothesis was not supported ($\chi 2(1) = 3.27$, n.s.). Statistically speaking, positively polite reports and recommendations occurred with equal frequency.

Negative Politeness

Negative politeness is used by pharmacy students who interpret the drug allergy situation as an occasion to interrupt, impose, or encroach on the physician. Such acts are intrinsically threatening to the physician's negative face and are redressed by emphasizing the minimal, unintentional, regrettable nature of the FTA [29].

Allergy reports

Negatively polite allergy reports were expressed in three different ways:

(a) by apologizing, (b) by hedging (and being pessimistic), and (c) by distancing the FTA from the point of view of the speaker doing the act. Each type is explained and illustrated.

Minimizing and apologizing for the FTA. To some pharmacy students, the mere act of calling and speaking to the physician was treated as a significant threat to the doctor's negative face. Messages tended to redress such threats with a negative politeness strategy that explicitly minimized the size or severity of the FTA. The use of the particle "just" and the phrase "a small problem" reflects an attempt to minimize the impact of the FTA on the physician. Therefore, elements belonging to the frames "Sorry to bother you" and "There is a small problem" were counted as negatively polite reports.

Hedging. Another negative politeness strategy was to hedge any assumptions about the physician's knowledge, ability and/or willingness to respond to the discovery of the drug allergy. The elements below all explicitly question whether the doctor was aware of the allergy. It is, of course, possible that the physician might already have known about the allergy and deemed it an insignificant risk. If so, hedging the assumption about the physician's awareness of the allergy guards against appearing to question the doctor's judgment. Apparently, many pharmacy students still regard the discussion of patient data as an encroachment on the physician's territory and thus as a threat to negative face. Hence, hedges are used to redress the negative face threats associated with encroachments and reminders. Elements belonging to frames "Are you aware that Mr. Smith is allergic to Drug X?" and "It seems Mr. Smith is allergic to Drug X" were counted as negatively polite reports.

Point of view distancing. By distancing one's self from a face-

threatening action, in this case an allergy report, one can show respect for another person's negative face wants. Elements belonging to the frame "I noticed/discovered Mr. Smith is allergic to Drug X" and "Our records indicate that Mr. Smith is allergic to Drug X" both employ this strategy. The phrase, "I noticed" pays respect to negative face by suggesting that the threatening act was not done intentionally or maliciously but was necessitated by something the pharmacist noticed during a routine check. Similarly, saying "Our records indicate ... " displaces responsibility for the act away from the pharmacist and onto the records.

Alternative drug recommendations

Conventional indirectness. Conventional indirectness involves doing an act which, under the circumstances, has only one plausible interpretation, but, if interpreted literally, would not be face threatening. In this case, the intentional departure from purely literal communication signals respect for the hearer's negative face. For example, "I can recommend an alternative" and "I would like to recommend an alternative" are, if taken literally, statements about the pharmacist's desire or ability to recommend an alternative, though both are unambiguously heard as offers. Most of the negatively polite recommendations fall into this category: "Drug Y is a good alternative", "Drug Y has the same indication as Drug X", and "Mr. Smith can tolerate Drug Y" are each conventionally indirect recommendations vaguely disguised as hints. "May I suggest/recommend an alternative" is more of a hedge on the physician's willingness to entertain alternatives. Messages containing elements belonging to any of these frames were coded as negatively polite recommendations.

Comparison of reports and recommendations: Negative politeness

As before, each of the 86 messages was examined, and the co-occurrence of

negatively polite reports and recommendations was tallied. Table 4.C displays the frequency data. Hypothesis 3 predicted negatively polite reports would occur less frequently than negatively polite recommendations. This hypothesis was not supported ($\chi 2(1) = 2.66$, n.s.). Negatively polite reports and recommendations occurred with roughly the same frequency.

Off the Record

No message frames were coded as off the record. Hypothesis 4 could therefore not be tested. Off the record communication exploits ambiguity, vagueness, and overstatement. Off the record utterances depend for their interpretation on the drawing of appropriate inferences, and they can easily be misinterpreted. Considering the legal and professional context of pharmacist-physician interaction, it is not surprising that no reports or recommendations were made off the record.

Abstention

A message was coded as abstaining from the report if it contained no message elements belonging to the report-relevant frames. Similarly, a message was coded as abstaining from the recommendation if it contained no message elements belonging to the recommendation-relevant frames. The number of messages that omitted reports and recommendations respectively was tallied and compared as above. The frequency data are given in Table 4.D. Hypothesis 5 predicted that reports would be less frequently omitted than recommendations. This hypothesis was strongly supported by the data ($\chi 2(1) = 18.18$, $P < .0001$). Recommendations were far more likely to be omitted than reports.

DISCUSSION

The most significant finding of this study was that alternative drug recommendations were treated by pharmacy students as significantly more face threatening to physicians than allergy reports. Pharmacy students were more

likely to be direct in reporting allergies than they were in making recommendations. Analogously, pharmacy students were much more likely to abstain from recommending an alternative drug than they were to abstain from reporting a discovered allergy. There are important implications to be drawn from these facts. First, in spite of the educational emphasis on asserting clinical authority about medication use, third year pharmacy students, at least, are not yet comfortable practicing what is being preached to them. The preceding analysis suggests that most pharmacy students are hesitant to offer advice and recommendations to physicians about drug therapy, though they are significantly more comfortable fulfilling the more traditional function of reporting drug allergies.

The second notable finding involves the high frequency of negative politeness strategies in both reports and recommendations. Students' perception that such communications will be regarded as an imposition or an encroachment is manifest in the consistent pattern of negative politeness in their messages. Seventy-two of 86 messages (84%) contained at least one negatively polite element to redress an allergy report. Sixty-four of 86 messages (74%) contained at least one negatively polite element that redressed a recommendation. In fact, every message that contained a recommendation (there were 64 such messages) also contained at least one negatively polite element to redress the recommendation.

Limitations

Based on Brown and Levinson's [29] analysis, the need to be polite is prompted by some combination of power, social distance, and the ranking of the FTA. The current study is limited in its ability to isolate the cause of such deference. This study examined the influence of R, the ranking of an FTA, implicitly, by comparing reports and recommendations. It did not explicitly

control for power and social distance, the other two factors that contribute to the weightiness of an FTA. In fact, the situation may have unintentionally inflated the perceived social distance between the pharmacy student and physician by referring to the physician as a "new" member of the hospital staff. In addition, by virtue of their relative inexperience professionally, and their status as students, it is likely that the subjects in the current study perceived a fairly high power differential between themselves and the hypothetical physician.

The perceived power differential would probably be smaller between older, more experienced pharmacists and physicians. It is also possible that power differences were not only the motivator of politeness in this situation. Similar patterns of deference might occur in messages of advice between status equals, as when pharmacists give advice to other pharmacists or physicians to other physicians. Deference in communication between equals would be expected when the severity of the FTA was high and/or when the equal status health professionals were not well acquainted with one another. Gender differences may also play a role. In summary, since power, social distance, and ranking are not manipulated explicitly in this study, firm conclusions about their influence on the politeness of pharmacy students' messages to physicians can not yet be drawn.

The use of hypothetical situations as a message elicitation technique is less than ideal. While it does afford the researcher a measure of control over the stimulus situation, this control is gained at the cost of some external validity. Though open-ended message elicitation methods have been shown to be resistant to social desirability biases [41], it is possible that student pharmacists responded as they thought their instructors would want them to respond rather than as they would respond in a real life situation. The best

way to surmount this difficulty is to record actual conversations between pharmacists and physicians, though concerns for privacy and the threat of malpractice litigation present significant practical obstacles to doing so.

This study artificially separated the therapeutic dimension of the task from the interactional dimension. In reality, the pharmacist must make a therapeutic decision and communicate tactfully. Future investigations will use a clinically realistic allergy situation with real drugs as the alternatives. To isolate different influences on politeness strategies and to produce more generalizable results, future research must examine messages from licensed, practicing pharmacists. Power, social distance, and culture-specific ranking of the FTA must be carefully controlled, and data on demographic variables such as gender, age, and degree type must be collected so the effects of each factor can be separated. Also, before one can unequivocally recommend the use of one strategy over another, a detailed message effects study must be conducted wherein physicians' impressions and evaluations of pharmacists' drug allergy messages are gathered and analyzed [42]. Such research in currently underway.

CONCLUSION

Pharmacy students (and pharmacists generally) must be wary of the strategic communicative choices they make because those choices directly impact on their professional identities, sometimes in unfavorable ways. Currently, rather than asserting expanded clinical roles in their interactions with physicians, the pattern of deference documented in pharmacy students' messages serves only to reinforce existing professional roles, divisions of labor, and power relations. Future educational efforts must focus on teaching pharmacy students about the link between everyday communication and professional identity generally, and about face and politeness specifically [33]. Only further

research will demonstrate whether these deferential interactional patterns are common among practicing pharmacists as well.

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REFERENCES

1. American Pharmaceutical Association. *The Role of the Pharmacist in Comprehensive Medication Use Management: The Delivery of Pharmaceutical Care*. Washington DC, 1992.
2. Hepler C. and Strand L. Opportunities and responsibilities in pharmaceutical care. *Am. J. pharm. Educ.* **53S**, 7s-14s, 1989.
3. Penna R.P. Pharmaceutical care: Pharmacy's mission for the 1990's. *Am. J. Hosp. Pharm.* **47**, 543-549, 1990.
4. Coster J. M. *Medicaid's New Prudent Pharmaceutical Purchasing Provisions: Political History and Policy Formation*. National Health Policy Forum, Washington, DC, 1990.
5. Kessler D. Communicating with patients about their medications. *New Eng. J. Med.* **325**, 1650-1652, 1991.
6. Kessler D. A challenge for American pharmacists. *Am. Pharm.* **NS32**, 33-36, 1992.
7. Kusserow R.P. *The Clinical Role of the Community Pharmacist.* OEI Publication No. 01-89-89160, US Government Printing Office, Washington DC, 1990.
8. Adamcik B.A., Ransford H.E., Oppenheimer P.R., Brown J.F., Eagan P.A. and Weissman F.G. New clinical roles for pharmacists: A study of role expansion. *Soc. Sci Med.* **23**, 1187-1199, 1986.
9. Conlan M. Doctors, R.Ph.s clash over Medicaid Rx counseling. *Drug Topics **137***, 88-89, 1993.
10. Blumer, H. *Symbolic Interactionism: Perpsective and Method*. Prentice Hall, Englewood Cliffs, NJ, 1969.
11. Goffman, E. *The Presentation of Self in Everyday Life*. Doubleday, New York, 1959.

12. McCall, G. J. and Simmons, J. L. *Identities and Interactions*. Free Press, New York, 1966.

13. Briggs G. and Smith W., Pharmacist physician drug consultation in a community hospital. *Am. J. Hosp. Pharm.* **31**, 247-253, 1974.

14. Ekwo E., Hendeles L. and Weinberger M. Those who make decisions about management of children with asthma: Pharmacist-physician interaction, *Am. J. Hosp. Pharm.* **35**, 283-299, 1978.

15. Rupp M., Schondelmeyer S., Wilson G. T. and Krause, J,. Documenting prescribing errors and pharmacists interventions in community pharmacy practice. *Am. Pharm.* **NS28**, 30-36, 1988.

16. Rupp M. T., DeYoung M. and Schondelmeyer S. W. Prescribing problems and pharmacist interventions in community practice. *Med. Care.* **30**, 926-940, 1992.

17. Kolloffel W., Leufkens H. G. M., Voesten M. T. P. J. and Bakker A. Apotel: A survey of telephone calls between pharmacy and physician, *Pharm. Weekbl.* 486-490, 1990.

18. Knapp D., Knapp D. and Edward J. The pharmacist as perceived by physicians, patrons and other pharmacists. *J. Am. pharm. Ass.* **NS9**, 205-505, 1969.

19. Ortiz M., Thomas R. and Walker W. L. Attitudes of medical practitioners to community pharmacists giving medication advice to patients: Findings of a pharmacy practice foundation survey (Part 3). *Aust. J. Pharm.* **66**, 803-810, 1985.

20. Rausch T. The perceptions of Army Physicians and nurses on the relative importance of clinical pharmacy services. *Military Med.* **147**, 391-395, 1982.

21. Smith G., Sorby D. and Sharp L. Physicians' attitudes toward drug

information sources. *Am. J. Hosp. Pharm.* **32**, 19-25, 1975.

22. Wallace D. and Kradjan W. Physicians' opinions of pharmacist as dispensers of patient medication information, *J. Am. pharm. Ass.* **17**, 362-367, 1977.
23. Bender F. Enhancing pharmacist physician communication. *Hosp. Form.* **24,** 305, 1989.
24. Knapp D., Wolf H., Knapp D. and Rudy T. A. The pharmacist as a drug advisor, *J. Am. pharm. Ass.* **NS9**, 502-505, 1969.
25. Watkins R., Norwood G. and Meister F. Improving the quality of the pharmacist as a drug advisor to patients and physicians through continuing education. *Am. J. pharm. Ed.* **25**, 35-39, 1975.
26. O'Keefe B. J. and Shepherd G. The pursuit of multiple objectives in face-to-face persuasive interactions: Effects of construct differentiation on message organization. *Communication Monographs* **54**, 396-419, 1987.
27. Tracy K. *Understanding Face-to-Face Interaction: Issues Linking Goals and Discourse.* Lawrence Erlbaum Associates, Hillsdale, NJ, 1991.
28. Goffman E. *Interaction Ritual: Essays on Face-to-Face Behavior*. Pantheon Books, New York, 1967.
29. Brown P. and Levinson S.C. *Politeness: Some Universals in Language Usage*. Cambridge University Press, New York, 1987.
30. Grice P. Logic and conversation, in *Syntax and Semantics, Vol. 3: Speech Acts* (Edited by Cole, P. and Morgan J.), pp. 41-58. Academic Press, New York, 1975
31. Searle J. Indirect speech acts, In *Syntax and Semantics, Vol. 3: Speech Acts* (Edited by Cole P. and Morgan J.), pp. 59-82. Academic Press, New York, 1975.
32. Lambert, B. L. *Face and Politeness in Pharmacist-Physician Interaction*.

Paper presented to the 93rd Annual Meeting of the American Association of Colleges of Pharmacy, Washington, DC, 1992.

33. Robins L. S. and Wolf F. M. Confrontation and politeness strategies in physician-patient interactions. *Soc. Sci. Med.* **27**, 217-221.
34. O'Keefe B. J. and Delia J. G., Communicative tasks and communicative practices: The development of audience centered message production. In *The Social Construction of Written Communication* (Edited by Rafoth B. and Rubin. D.), pp. 79-98. Ablex, Norwood, NJ, 1988.
35. Hunt K. *Grammatical Structures Written at Three Grade Levels,* NCTE research report No. 3., The National Councils of Teachers of English, Champaign, IL, 1965.
36. Saeki M. *Refusals and Rejections: Designing Messages to Serve Multiple Goals*, Unpublished doctoral dissertation, University of Illinois, 1992.
37. Witte S. P. and Faigley L. *Evaluating College Writing Programs*. Southern Illinois University Press, Carbondale, 1983.
38. Guetzkow H. Unitizing and categorizing problems in coding qualitative data. *J. Clin. Psych.* **6**, 47-58, 1950.
39. Cohen J. A coefficient of agreement for nominal scales. *Educ. and Psych. Meas.* **20**, 37-46, 1960.
40. Glass G. V. and Hopkins K. D. *Statistical Methods in Education and Psychology.* Prentice Hall, Englewood Cliffs, NJ, 1984.
41. Burleson B. R., Wilson, S. R., Waltman, M. S., Goering, E. M., Ely, T. K. and Whaley, B. B. Item desirability effects in compliance-gaining research: Seven studies documenting artifacts in the strategy selection procedure. *Human Communication Research* **14**, 429-486. 1988.
42. Jackson S. *Message Effects Research*. Guilford, New York, 1992.