An applied linguistics study of how students prevent embarrassments and impositions during interactive examination OSCEs

Article

Accepted Version

Abstract

Aim: To assess the effectiveness of politeness strategies used by pharmacy students to avoid embarrassing or imposing on others during Objective Structured Clinical Examinations (OSCEs).

Methods: A total of 19 OSCE video recordings of 10 students (participants) interacting with mock patients were examined using the framework of Politeness Theory (PT). All relevant participant acts (speech activities) were coded using PT into a) type of Face Threatening Acts (FTAs) (i.e., potentially sensitive situations—as regarded by PT) and b) politeness strategies used to mitigate them. Conversation Analysis (CA) was then used to examine the effectiveness of conversational strategies by judging the 'patient' responses to these strategies.

Findings: Most acts had the potential to impact on patients' negative face needs (i.e., desire to act autonomously, e.g. upon the practitioner making a request), positive face needs (i.e., desire to be liked, e.g. upon the practitioner making a diagnosis), or both. Despite applying a variety of positive politeness strategies (e.g. avoiding disagreement, or expressing understanding) to prevent embarrassment to the patient, and negative politeness strategies (e.g. being indirect, using hedging or minimizing the imposition) to avoid directly imposing on them, 'dis-preferred responses' showed participants mostly focussed on avoiding impositions, corresponding to what they have been taught, rather embarrassments.

Conclusion: Participants were less aware that discussing sensitive topics could cause embarrassment to patients, with potential to upset them. Developing teaching and evaluation methods to consider patients' face needs could help in assessing and improving pharmacy students' communication skills.

INTRODUCTION

Modern pharmacy teaching includes developing and assessing students' communication skills, which has been shown to have a significant positive effect on improving competencies.[1,2] Thus, Objective Structured Clinical Examinations (OSCE) have been implemented in many pharmacy schools. OSCEs use interactive examination stations representing various clinical scenarios that simulate real-life encounters, while assessing students' clinical and communication skills.[1,3,4] However, many studies call for further research to improve the use of OSCEs as an assessment tool within pharmacy practice.[1,3,5] This is because the focus of OSCE assessments is usually on general communication skills rather than the details of behaviour,[5] and there is low inter-rater reliability in relation to scoring the communication skills component of OSCEs,[6-9] which relies on evaluating the student's performance at a more subjective level. This results in difficulty in pinpointing subtler communication deficiencies, especially those relating to discussion of sensitive topics. Dealing well with sensitive interactional components, known within Politeness Theory (PT) as Face-Threatening Acts (FTAs), has the potential to increase compatibility and rapport, yet this topic is rarely investigated within studies examining dynamic patient-pharmacist interactions.[10]

To examine sensitive interactional components in this study, FTAs within OSCE interactions and strategies used, if any, were highlighted using the Politeness Theory (PT) framework, a fundamental sociolinguistic theory proposed by Brown and Levinson .[11] Here, face is defined as "*the positive social value a person effectively claims for himself (sic.) by the line others assume he (sic.) has taken during a particular contact*".[12] PT suggests that everyone has a sense of their *positive* face, which relates to wanting to be desirable to (liked by) others, and *negative* face, which relates to wanting to be unimpeded by others (ie, to maintain autonomy). FTA is any act that inherently interferes with someone's face. While interactions within OSCEs may appear relatively straightforward, there are many micro-elements that potentially threaten both the negative and positive face of patients. For example, providing patients with appropriate recommendations could affect negative face needs (ie, patient freedom and autonomy), because the patient might not want to accept the advice provided or disclose the information requested. Likewise, providing patients with a diagnosis (giving bad news about their condition, eg high blood sugar) or expressing disapproval for inappropriate behaviours (eg, excessive alcohol consumption) could affect positive face needs (ie, causing patient embarrassment) because these carry an inherent judgement about the patient, albeit in relation to their health. The PT framework highlights numerous approaches people use to redress the face needs of others in social interactions.[11] Five broad types of strategies are:

- Acting bald on-record: to carry out FTA directly without any effort from the speaker to mitigate the face needs of the hearer
- Using positive politeness: to express that the speaker respects the positive self-esteem of the hearer (expressing empathy toward the patient).
- Using negative politeness: to express that the speaker respects the hearer's freedom (obtaining patient consent).
- Being off-record: to complete the FTA in an indirect way using hints.
- Avoiding performing FTAs in the first place.

The standalone application of PT to OSCE scenarios was judged by the authors to be insufficient for the current study, because that would not enable the additional assessment of the *effectiveness* of students' interactional strategies. Non-verbal communication is not included within PT, and the sequence of action relating to the FTAs is not considered within PT, meaning patient responses would go unchecked. To address these limitations, Conversation Analysis (CA) was used here alongside PT. CA is effective in exploring the finer details of interactions within pharmacy practice and can be applied to the analysis of both non-verbal communications and the sequences of acts within pharmacy practice, meaning it can help assess the effectiveness of students' PT strategjes.[10] CA uses transcription and interpretation to identify what

happened and how it happened.[13,14] The application of CA together with PT is a novel approach, which allows responses to politeness strategies to be considered too.

Thus, the aim of this study was to assess pharmacy students' ability to recognise and deal with sensitive interactional components (FTAs) and identify recommendations for future educational practice. The objective was to assess the effectiveness of politeness strategies used by pharmacy students to avoid causing patient actors' embarrassment or imposing on them.

METHODS

This is a qualitative study that used OSCE interactions for a baseline micro-linguistic analysis. The study used CA to analyse turn-taking and sequence organization, and to examine the effectiveness of the politeness strategies. This study was performed from March 2021 to December 2021. This work is considered to fall within an interpretive paradigm. The study was reviewed and approved by the University's ethics approval procedures (study no. 14/19).

Nineteen video-recordings of pharmacy-student-actor (role-playing pharmacist-patient) interactions during final-year OSCEs at our pharmacy department were included. These videos had already been recorded as part of the assessment process and were stored in the university archive. All pharmacy students who had already taken part in OSCEs in years 2017-2018 and 2018-2019 were invited by PD (chief investigator) to participate in the study by allowing access to their recorded OSCEs. Ten students agreed to participate in this study. There was a total of four male and six female students, six of whom were British South Asian, one was British Caribbean, one White British, and two were international students, one from Africa and one from South East Asia. 'Healthy Living Assessments' (HLA) [4], and 'Responding to Symptoms' (RTS) stations were included in this study. Within these stations, students assume the role of a pharmacist and are put in charge of soliciting sensitive information and giving behaviour-change or other advice, both of which involve negotiating FTAs.[4] These interactions encompassed a range of scenarios (eg, high blood pressure, high cholesterol, or high blood sugar), and involved a mix of staff and actors, who had been provided with detailed information about the role they played via a script. However, the staff/actors playing the part of patients had not been trained on *how* exactly to perform their role other than to give straight answers to questions or disclose information as requested according to the script, so their automatic responses could still be seen within the confines of the broader script. Each student is represented by a letter from A to J to maintain their anonymity within the current study. One interaction was lost to follow up, meaning 19 were available to use.

The videos analysed were transcribed using ELAN software.[15] Data were transcribed by SA based on the Jeffersonian transcription system,[16] widely used in CA studies. This system records the finer details in interactions, including silences, overlapping speech, voice volume and speed of talk. All transcripts were kept in Microsoft Word. SA

and PD had access to the videos and transcribed and coded the data. The coding of the data was checked by a PhD student working within the pharmacy department, who sampled 20% of the data and provided feedback to SA.

The analysis involved coding the utterances of participant into three distinct types, according to the PT framework[11]: negative FTAs (ie, any acts potentially impose on the hearer's autonomy; requesting, advice-giving, ordering, suggesting, offering, and making promises), positive FTAs (ie, any acts potentially endanger the hearer's sense of self-worth; bringing bad news about patient condition and expressing disapproval) and acts that threatened both types of face needs (ie, any acts threaten both the patient's self-esteem and their autonomy at the same time; requesting personal information eg, sexual activity, alcohol consumption, or smoking status).Utterances of participants were coded, using the PT framework, according to four politeness strategies used in relation to the FTAs: bald on-record, positive politeness, negative politeness, and off-record.

CA was then applied to test if a conversational strategy used by the participants was effective. The responses within OSCEs are usually scripted, so that the patient actor is instructed to give a very specific answer (usually agreeing to students' requests). However, as mentioned above, the automatic reaction of the patient actors to the politeness strategy used by the participants could still be identified (because this is less controllable). Thus, patient responses were analysed based on work by Pomerantz,[17] which is widely used in CA research. According to Pomerantz's (1984) work, a preferred response is inherently marked as being a quick response, one that agrees with the previous speaker, and even upgrades their assessment of a situation. A dis-preferred response is indicated where there is a delay in reply, contrastive evaluation, or even no response. The search was conducted by SA and verified by PD.

The Equator network was used to identify the most relevant reporting checklist for this work. The standards for reporting qualitative research (SRQR) checklist was used for the reporting of this study, with all 21 criteria being achieved.[18]

Researcher characteristics and reflexivity

The research topic was selected for investigation by PD who had undertaken formal training in CA and linguistics. All researchers believed it to be an area with unanswered questions worthy of detailed investigation. SA, a Kuwaiti pharmacist and doctoral student conducted the analyses. SA undertook specific training during her PhD, including how to analyse data using CA. PD is a female pharmacist academic and a psychologist who was able to bridge the academic pharmacy (use of OSCEs to assess pharmacy students) and methodological/investigative (conversation analysis) domains during the analysis. PD provided guidance and supported the analyses. DG, a male pharmacist educator, was a second supervisor and co-author of this paper. Working together increased trustworthiness.

RESULTS

There was a total of 850 FTAs identified by the researchers as occurring within the participants' interactions (average ≈ 45 FTA / interaction). A total of 737 acts were identified that had the potential to interfere with patient actor autonomy and impede their freedom: requesting patient permission, requesting information from patients, offering something, making a recommendation, giving instructions, and seeking agreement. Positive FTAs were less prevalent (n=39) and had the potential to interfere with patient actors' desire to be liked and potentially cause embarrassment, including expressions of disapproval, or bringing bad news about the patient's condition. In addition, 74 acts were identified where threat to face encompassed both face needs at the same time: asking patients personal questions or discussing sensitive topics (eg, alcohol consumption).

Participants appeared to intrinsically try to mitigate FTAs while interacting with patient actors during OSCEs; 556 (65.41%) of FTAs were performed using at least one politeness strategy, compared with 294 (34.59%) of FTAs were performed directly. Even when they directly performed task-orientated acts during OSCE interactions (ie, using 'Bald on record' strategy), the patients' permission had been mostly obtained in advance of the situation itself. For example, before the participants directly instructed the patient to do a test without any redress of FTAs, such as when stating "feet flat down, your hand relaxed on the table*" or* "remove your socks" the patient's approval had just been obtained by explaining the procedure and receiving a signed consent form from them. Similarly, in most cases, the participants had already obtained patient permission to discuss personal topics, for example, by asking "Is it okay to ask a few questions about your lifestyle?*"* This means that the bald-on-record strategy followed the setting up of some mutual understanding beforehand.

In addition to obtaining permission, participants frequently applied various negative politeness strategies to avoid directly imposing on the patient during these interactions; thus, the patient got the chance to not perform the negative FTAs. For example, using hedging (eg, "if you don't mind*"*), being pessimistic (eg, *"*you don't wish to...*")*, and minimizing the imposition of FTAs (by using 'just,' 'a little bit' or 'a few') were the strategies that participants most relied on to protect patient autonomy. The strategy of 'being pessimistic' was used mainly to obtain patient permission or agreement, particularly in cases of patients' weak agreement (eg, where a minimal response was expressed, such as saying "Ummm"). Other types of negative politeness strategies used are presented in Table 1.

Additionally, participants applied many positive politeness strategies to show respect for the patient, even if there was no potential threat to patient face. For example, participants widely gave encouraging feedback to patients during the conversation, such as "Perfect", or "that is great", which was coded using PT as 'Notices and attends to the hearer,' and

'Exaggeration' – these two strategies stress participants' approval and interest in the patients' answers. Other positive politeness strategies were widely used for different purposes, as presented in Table 2.

Despite participants' efforts to maintain the patients' face needs in terms of desirability and autonomy, there were some instances in which they still caused embarrassment or imposition by unintentionally impeding the patients' positive or negative face needs, or both. These incidents, where patient face was lost, were marked by patients' dis-preferred responses (ie, delayed, or no response). The participants mainly paid attention to patients' negative face needs, protecting their autonomy: there were 11.94% dis-preferred responses (from patients) accompanying negative FTAs. However, there were more dis-preferred responses (from patients) accompanying the positive FTAs (30.77%) and positive and negative FTAs (41.89%) as shown in Table 3. For example, some types of advice (negative FTAs) faced resistance from the patient. Such incidents were identified by patients' insistence eg on being given a medication when being referred to their GP instead (as shown in Figure 1), presenting the patients' desire conflicting with the participants' advice. In these cases, participants tried to convince patients to agree with their advice, before eventually providing an appropriate medication on the patients' insistence.

In contrast, when patients disclosed undesirable lifestyles (positive and negative FTAs), such as heavy smoking, physical inactivity, or excessive alcohol consumption, they usually expressed some dis-preferred features in their own responses, such as long hesitation, a delayed response, minimisation of their acts, or justification of the behaviour. Figure 2 presents an excerpt of patients' efforts to save their own positive face (to be desirable). However, participants, in most of these particular cases, responded insensitively by either showing their surprise about the behaviour (eg, by saying "interesting", or "really?") or asking more detail, without considering patient face, resulting in the loss of the positive face of patients as shown in Figure 2.

DISCUSSION

A higher number of negative FTAs were observed during the OSCE assessments compared with situations where the patients' positive face needs were threatened. However, while participants generally succeeded in maintaining patients' negative face needs (ie, avoiding imposing on the patient), this was not the case for patients' positive face needs (ie, avoiding patient embarrassment), particularly when discussing sensitive topics. Participants appeared unaware that the patient's positive face had been lost and generally did not try to lessen the patient's embarrassment or recover their face. Enabling students to become aware of FTAs and the application of strategies for saving patient face could help them to build better rapport and trust within their future work, arguably increasing patient satisfaction too.

One of the strengths of this study is the use of CA together with PT to consider the sequencing of acts as well the presence of FTAs and the politeness strategies used. Although the sample size is sufficient for this type of study, there

was potentially selection bias in examining data from one setting only, where the local culture and teaching practices could have impacted on the findings. It is also possible that only certain types of student volunteers to take part in the study, although it is not possible to know for sure. Another weakness of this study was that we were unable to divulge information about the students' performance and work experience history which, too, may have impacted on the results.

To our knowledge, this study is the first study that has examined the concept of 'patient face' by applying PT and CA within pharmacy practice. This concept has not been explored extensively in pharmacy practice. The two studies that have previously applied the politeness theory of Brown and Levinson [11] in a pharmacy setting were conducted by Lambert[19] and Wilby, Govaerts, Austin and Dolmans.[5]Lambert [19] examining written communication, stated that the degree of politeness was more noticeable in communications where recommendations were made than when just reporting information, as recommendations are more face threatening than reports. This attests to pharmacists' ability to recognise and deal with sensitive situations impacting negative FTAs, at least in written communication. Wilby, Govaerts, Austin and Dolmans [5] also applied PT but to examine the degree of politeness used by assessors in their written narrative comments to justify the marks they had awarded in OSCE assessments. They concluded that assessors were less likely to provide their comments using politeness strategies such as hedging and more likely to use no politeness strategy. This is clearly understandable since the situation in which OSCEs are marked is time limited (thus requires succinct writing) and importantly there is no face consideration involved as the written comments are normally internal to the assessors only. Two recent studies also explored face needs and demands in pharmacy settings,[20,21] by applying other theories. These studies corroborate the general finding from our work, which is that, upon recognising them, participants intrinsically attempt to mitigate FTAs through a range of politeness strategies while interacting with patients.

In this study, the identified FTAs were considered to be directly related to the pharmacists' duties as a healthcare professional.[22] This reflects the high frequency of FTAs identified when interacting with patients. However, in our study, the patient actors' responses were mainly to agree to the participants' requests (often by using minimal responses, eg, Ummm, Yaa), which does not reflect the reality of healthcare practice. Therefore, our findings in this regard are different to the study by Murad, A. Spiers and Guirguis [20] based within practice, which found that pharmacists did face some challenges from patients who, for example, rejected their advice. Educating patients about the nature of pharmacist roles could enhance the acceptance response and decrease resistance by patients within real practice.[20] However, a more pragmatic approach would be to teach students to use conversational politeness strategies to help them deal with patient conflicts in real practice.

According to PT, it is acceptable to perform task-orientated acts without mitigating the threat,[11] using bald-on-record strategies. Pharmacists, in some cases, provide important information in a direct manner to patients.[20] By

reviewing the sequences of acts in which participants applied a bald-on-record strategy, it was noted that the patients' permission had been already obtained in advance. In fact, participants appeared to be mainly interested in maintaining the negative face needs of patients. This is perhaps because meeting negative face needs is considered a part of the rights of all patients.[22,23] Accordingly, obtaining patient consent and agreement with healthcare goals are considered a standard part of practice, [22-24] and given prominence within our pharmacy programme's training and assessment. In fact, participants were provided with a copy of the marking criteria in advance of the OSCEs, which focus mainly on assessing clinical skills with some global assessment of communication skills.[23,24] Thus, some of the nature of their acts is skewed by a desire to meet all of the marking criteria relating to clinical skills, which mainly focus on asking questions and obtaining patient's consent and agreement. This potentially explains the high prevalence of the negative FTAs within the observed scenarios and the students' general success in maintaining negative patient face. Even when patients were resistant to advice, such as when being referred to their GP within RTS scenarios, participants eventually met patients' negative face needs and fulfilled their request to be supplied with medication. Thus patient autonomy and respect for their freedom was well-maintained by participants.[20]

However, there were certain failures to maintain patients' positive face needs. For example, patient actors disclosing their seemingly inappropriate lifestyle experienced a high level of threat to their positive face needs despite the setting being scripted OSCE scenarios. Participants, apparently unaware of losses to patients' positive face, did little to lessen the patients' embarrassment or help them recover their face in these instances. This might be because, in our programme, students are trained in general communication and consultation skills but are not taught about patient face needs nor how to respond to patient responses in a way that considers these face needs. The positive politeness strategies, that were applied by participants to express their respect and trust to the patients (such as introducing themselves by mentioning their names to the patients at the beginning the consultation, warmly welcoming the patient, thanking them for visiting, or expressing sympathy),[20,21,24] had been taught within the context of consultation structure models rather than in the specific context of Politeness Theory.

This study highlights an important challenge in communicating with patients, which is the inherent threat to patients' positive face while discussing sensitive topics. Thus, there is a need for pharmacy students to be taught to recognise FTAs and work to mitigate these for more concordant consultations. In fact, educating future pharmacists and other healthcare professionals about politeness strategies could enable them to express their empathy and understanding of the patient's position, hence decreasing the risk of causing embarrassment to patients (eg, when discussing sensitive topics) within real practice. For example, recovering patient face would involve saying something to acknowledge and redress the threat to the patient's face and make them feel better, such as "Oh, we've all drank a glass of wine on a Friday

night!". This type of training has the potential to improve rapport with patients and increase their engagement in the health conversation. How to conduct this teaching, from an educator's perspective, can be identified by drawing on existing knowledge. For example, how to teach others to use politeness in their communication, has been a topic for many researchers in the field of linguistic pragmatism.[26-28] Many models have been suggested for this purpose, which include steps such as raising awareness of politeness and face concepts, enabling the comparison between different situations (eg politeness with (im)politeness), giving leaners the opportunity to analyse, discuss and reach a conclusion, and providing them with appropriate pragmatic examples to use in different situations for effective communication.[26,28] Also, recognising inter-cultural similarities and differences in relation to politeness could help students develop their cultural and communication competence.[28] This is because cultural and personality factors affect the degree to which face is threatened. It has also been concluded that instructional methods are more effective than exposure methods in learning politeness pragmatics.[26,27] Thus, students need to be instructed about using politeness strategies and being assessed on them. For example, this would involve teaching then assessing how a student deals with any acts that highly impact patient face needs, particularly noting if there are delays in the patient response, hesitations, or any minimisation or justification of their act. This is because patient responses can be considered as indicators that the patient feels embarrassed necessitating supporting strategies to be used to enhance the patient's positive face.

A future study could further focus on: examining the effectiveness of such new training programmes on trainees' communication skills before and after the course, and analysing patients' dis-preferred responses and pharmacists' handling of these dis-preferred responses in real practice using CA and PT. In addition, pharmacy professionals' positive face needs are affected when patients refuse their recommendations.[20,29] Thus, a future study might also examine how pharmacy students, and healthcare professionals more generally, preserve their own face needs, particularly where there is conflict with patient face needs.

CONCLUSION

Participants intrinsically exerted efforts to mitigate threats to patient face during OSCE interactions, especially where patient autonomy was under threat. Patient actors' face needs were not addressed in some cases, but need to be managed appropriately for rapport to be maintained. This study has the potential to increase pharmacists' and educators' awareness of face threatening acts, so that addressing them can be embedded within communication and consultation skills training. The findings of this study can be applied more broadly to patient communication within pharmacy practice and other medical fields.

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Table 1. Summary of Negative Politeness Strategies Used during Healthy Living Assessment and Responding To Symptoms Interactions

Type of Politeness Strategy	Examples	Explanation for Reasons of Application
Hedging / Question	'could you'	To request agreement
	'would you like'	To request information
	'if you don't mind'	To provide recommendation
	'If you could'	To instruct to carry out the action or procedure
	Is that's okay?	To obtain patient agreement before performing HLA test
	Is that alright?	To obtain patient agreement before asking personal questions
Be pessimistic	If you don't wish to …	To obtain patient agreement before discussing any sensitive topic
Minimize the imposition	Just	
	Tiny	
	A bit of	To lessen the impact of action
Give deference	if you're happy to do that	To ask patient about their preference
	'please', 'sorry'	To show humility to the patient
State face threatening act (FTAs) as a general rule	'So, the actual test itself involves me umm using a needle called a lancet'	To explain the procedure
	'It's recommended to have about…...'	To inform the patient about the general recommendation
	'the result we normally aim for is five or below'	To inform the patient about normal/target result
Apologize	Pardon	
	Sorry I didn't hear you	To ask patient to repeat what they said
	Sorry, do you smoke cigarettes?	To ask the patient for sensitive information
	Sorry bear with me	To ask the patient for more time
	Sorry about this confusion	To fix incorrect information provided to patient

Table 2. Summary of Positive Politeness Strategies Used during Healthy Living Assessment And Responding To Symptoms Interactions.

Type of Politeness Strategy	Examples	Explanation for Reasons of Application
	‘All things you're doing are great. Um, maybe it might be best for you to increase the exercise a bit more’	To pre-give recommendation
	‘Healthy man’	To provide a compliment about patient
	‘You have the power to kind of’	To encourage the patient to change to a healthier lifestyle
Notices and attends to the hearer	you have lower risk of heart disease ‘in future which is very good, so you keeping on very healthy obviously’	To approve patient test results or behaviour
	by using ‘Exactly, absolutely that’s right’	Expression of agreement with the patient
Exaggeration	by using ‘Okay. Excellent, Perfect’	Expression of admiration for good behaviour (non-smoking, normal range of alcohol intake, or healthy diet)
	‘Umm, I'm just putting on gloves just because, umm, I will be using your blood’	To explain the instructions given by pharmacy student
	‘I would recommend a hydrocortisone cream because……’	To explain the recommendation of provided medication
Give or ask for reason	‘we can maybe lower your blood pressure because I think one of the contributing factors can be your diet’	To explain recommendation given by pharmacy student
	Using hedging: ‘you're actually drinking a bit too much?’	
	‘I'm a bit concerned about your alcohol’	Expressing disapproval about inappropriate lifestyle behaviour
Avoid disagreement	‘your reading is considered a bit low’	Bringing bad news about patient’s condition
		To ensure the patient’s cooperation with the procedure
	By using: ‘Let us start’	To stress cooperation in the healthcare plan
Include both in the same activity	‘Before we begin or start’	To assume cooperation with the recommendation
	‘How can I help you?’	In opening conversation, pharmacy student stresses that he will help patient to obtain what they want
Offer	‘Please feel free anytime to come back’	In closing the conversation, pharmacy student stresses that he will help patient anytime
	‘Hi there, I am (XXX) I am the pharmacist, how are you doing?’	By introducing themselves properly to the patient
	‘Nice to meet you,’ or‘I am glad to meet you’	By gently welcoming
	‘do you have any questions for me?’	
	‘Is that something you expected? or were you hoping to, fearing the worst?’	By considering patient questions, needs and expectations
	‘great thank you’	By expressing thanks to patient
	↓Sorry.	
	‘That looks like it hurt so I'll make sure I'll be quick.’	By expressing sympathy
	‘I see, I see’, ‘fair enough’	By understanding patient situation
	‘I'm confident to say it's nothing serious.’	
	‘we will explore it so don't worry too much’	By reassuring the patient
	‘Are you happy with everything I've said?’	By paying attention to patient satisfaction
	‘would you like to go into the consultation room?’	By offering privacy
	Keep eye contacts with patient	
Give gift	Being good listener to the patient (e.g. head nodding, or by using word ‘mmm’, ‘yeah’, or ‘okay’)	By showing their interest in listening to the patient

Table 3. The Frequency of Patient Actor Responses Versus the Type of face threatening act (FTAs).

Patient Response	Type of FTAs			
	Negative FTAs	**Positive FTAs**	**Negative and Positive FTAs**	**Total**
Preferred[1] Or Weakly Preferred[2]	649/737 (88.06%)	27/39 (69.23%)	43/74 (58.11%)	719
Dis-Preferred[3]	88/737 (11.94%)	12/39 (30.77%)	31/74 (41.89%)	131
Total	737	39	74	850

1 Preferred characterized by quick response, strong agreement.

2 Weakly preferred characterized by asking for clarification, requesting repeat of the question (What? Hm?), minimal response (head nodding), contrastive conjunction (but), hesitation (mmm), or displaying reluctance or discomfort (Uh, well).

3 dis-preferred characterized by not responding, long gap or delayed response.

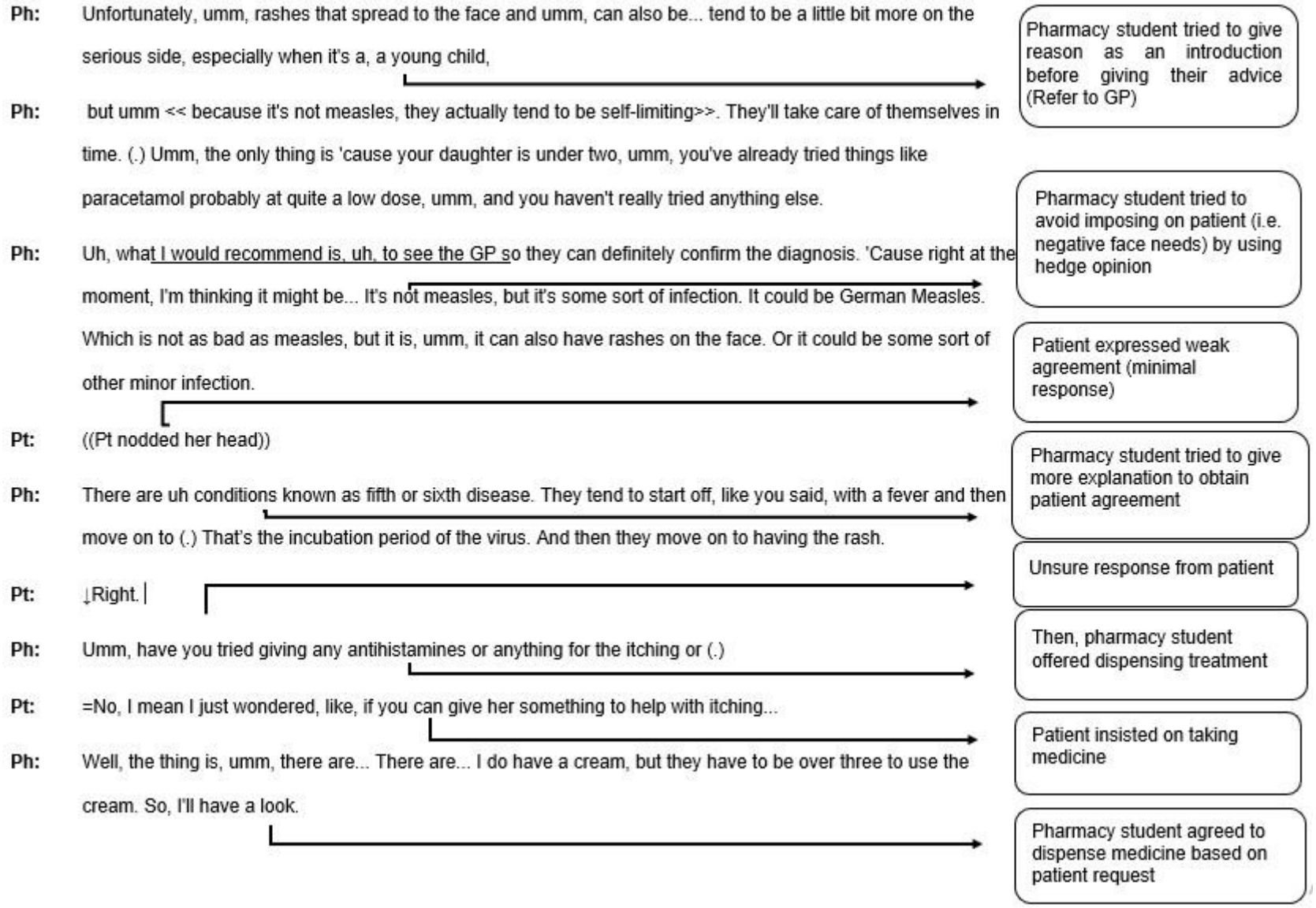

Figure 1. Excerpt showing student F maintaining the negative face of patient

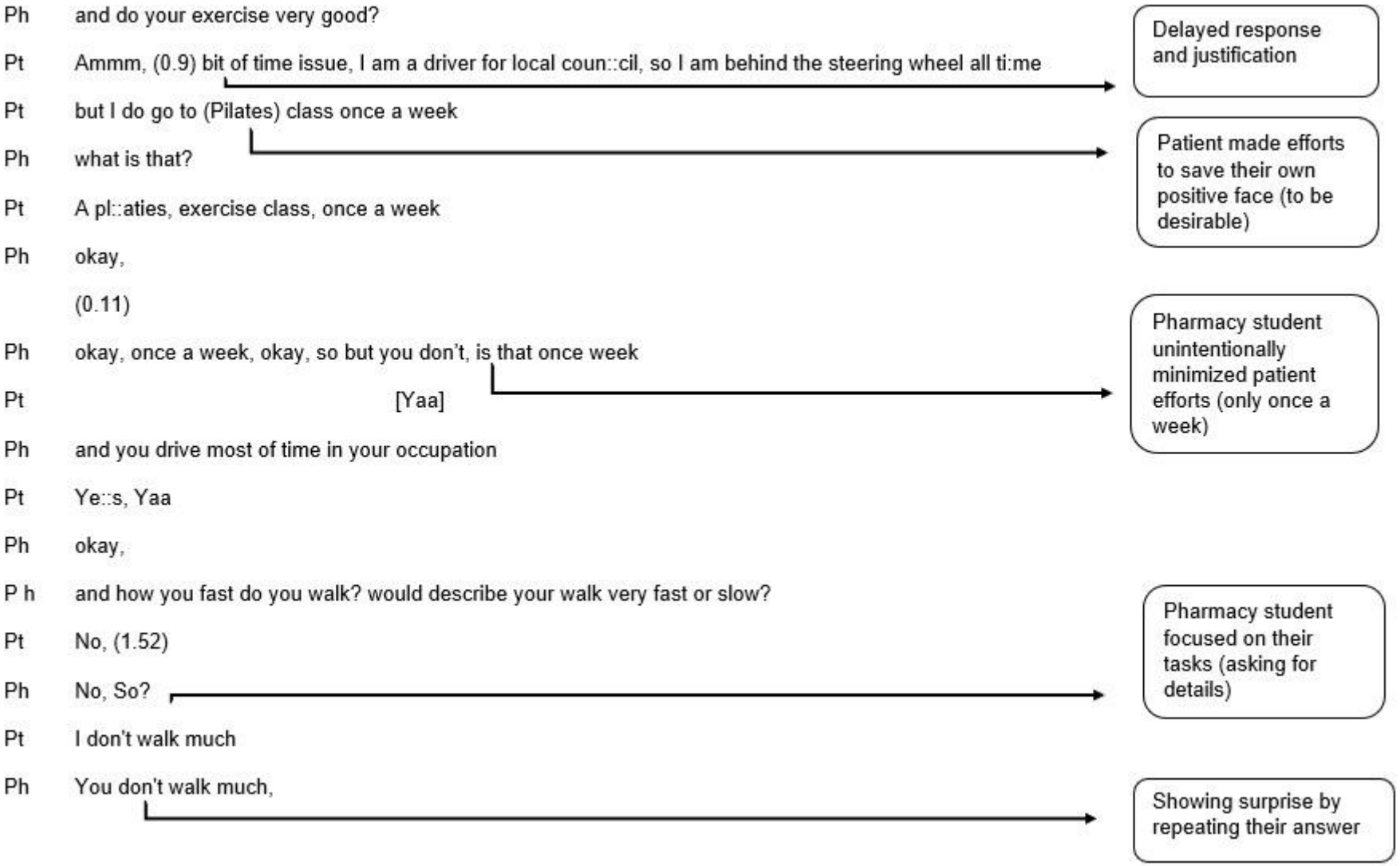

Figure 2 Excerpt showing student C was unaware that the patient's positive face had been lost.