

Discursive Practices of Complaints and Complaint Responses in Chinese Doctor-Patient E-dialogues

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Abstract. This paper adopts both quantitative (frequency counts) and qualitative (discourse analysis) methods to examine the recurring discursive-pragmatic strategies and the underlying social/interpersonal functions of complaints and complaint responses in Chinese online medical consultations. The results indicate that, in terms of the level of directness, complainers (patients) predominantly employed more indirect complaint strategies, particularly the expression of annoyance/disapproval/dissatisfaction. According to the orientation of complaints, non-hearer-oriented complaints, especially patients' self-oriented "chief complaints," were most frequently observed. Furthermore, complaint response strategies can be categorized based on the distinct functions they serve in medical interaction, namely affective (e.g., rapport-building) and instrumental (e.g., problem-assessing) functions. These findings contribute to a deeper understanding of the discursive practices shaping doctor-patient e-relationships.

Keywords. pragmatics in healthcare; discourse analysis; level of directness; orientation of complaints; response strategies serving different functions; doctor-patient communication

1. Introduction. Pragmatics plays a significant role in healthcare communication research and practice (Bigi & Rossi, 2023). However, prior studies paid little attention to the use of potentially face-threatening acts (FTAs), especially complaints (e.g., House & Kadar, 2021; Murphy & Neu, 1996; Trosborg, 1995), in doctor-patient interactions including e-dialogues. A complaint is defined as "the action of complaining; the utterance of grief, lamentation, grieving" (Oxford English Dictionary, 3rd edition). Among all sorts of FTAs, complaints appear very frequently in doctor-patient interactions including e-dialogues, especially when the patient tries to make their "chief complaints" (Cole & Bird, 2013) at the stage of "problem presentation" (Heritage & Maynard, 2006a) by telling their doctors a narrative about their pain, bodily symptoms, signs of illness, and even unhealthy psychological state. Sometimes there might be a conflict when the patient tries to perform hearer-oriented complaints directly oriented to their doctor about their medical disbeliefs or their dissatisfaction with the medical services their doctor provided. Non-

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hearer-oriented complaints about the healthcare/insurance systems and the previous treatment the patient received at another hospital (e.g., Ruusuvuori & Lindfors, 2009) have also been observed during the process of online medical consultation between the doctor and the patient.

Nevertheless, most previous studies focused more on the formal written complaints filed for customer/patient systems (e.g., Chen, 2024; Chen & Shao, 2024; Råberus et al., 2019; Reader, Gillespie, & Roberts, 2014) and the healthcare institutions' responses to those filed complaints (e.g., Hsieh, Thomas, & Rotem, 2005; McCreddie, Benwell, & Gritti, 2021). Thus, there is still a lack of studies exploring the other two types of complaints [i.e., “(informal) expression of grief, grievance, or dissatisfaction” and “(of a patient) complaining/patients' chief complaints”] and their responses as a co-constructed activity in medical discourse in general, let alone in online counseling contexts or doctor-patient e-dialogues. Beyond the recurring discursive strategies of different sorts of medical complaints, the social function (Halliday, 1978) of complaints/complaint responses in this specialized/institutional discourse is under-explored as well.

To address these research gaps, this paper examines the discursive practices¹ of complaints and complaint responses in Chinese asynchronous doctor-patient e-dialogues, particularly concerning the recurring discursive-pragmatic strategies, the accompanying lexico-grammatical patterns, and the underlying social/interpersonal functions.

2. Literature Review.

2.1. DOCTOR-PATIENT INTERACTIONS/RELATIONSHIPS. Doctor-patient interactions or doctor-patient communication, which is oftentimes manifested as the “medical interview,” plays an extremely important role in healthcare, as it is the “major medium of care,” and “determines the problems addressed and helped” (Cole & Bird, 2013: xiii). Although prior studies have already touched upon doctor-patient interactions from linguistic/pragmatic perspectives with the adoption of Conversation Analysis or Discourse Analysis methods (Garfinkel, 1967; Heritage & Maynard, 2006a,b; Labov & Fanshel, 1977; Waitzkin, 1991; Xu, Zhang, Xiao, 2022; Zhao, 2020; Zhao et al., 2020), little attention has been paid so far to the *(informal) co-constructed complaint-response sequences* in doctor-patient consultations. Among Heritage & Maynard's (2006a) six phases of doctor-patient interactions, only a few previous studies (e.g., Beckman & Frankel, 1984; Marvel et al., 1999) specifically paid attention to the elicitation of the “problem

¹ “Discursive practices” typically refers to the recurring interactional strategies/patterns or normative structures with sociocultural significance in specific interactional contexts or to a specific community of speakers, but the present study also treats underlying functions (carried by strategies/patterns) as part of discursive practices (see also: Zhu, 2019, 2021).

presentation” stage. Even so, they did not fully address how patients’ self-oriented medical complaints (or “chief complaints”, see also: Cole & Bird, 2013) are constructed or how physicians deploy various communicative strategies to respond to their patients’ medical complaints/concerns at that stage of doctor-patient consultations, especially in e-dialogues.

Beyond the immediate dynamics of doctor-patient interactions, the doctor-patient relationship has long been a central concern in both academic research and broader societal discourse, especially in Chinese healthcare settings. From a more strictly medical perspective, the Three-Function Approach (Bird & Cohen-Cole, 1990; Cole & Bird, 2013) identified “building an effective relationship/rapport” as the first and foremost function of the medical interview—an *affective* function that takes precedence over the other two *instrumental* functions: “gathering information for assessment and understanding” and “facilitating collaborative management” of the patient’s medical issues. Unlike rapport building/management (Campbell, 2005), on a negative side, there are also studies investigating disagreements, conflict, mistrust, and even violence between patients and physicians. For instance, Levinson et al. (1999) explored the tools for improving communication in managed care in order to resolve disagreements. Nie et al. (2018) and Tucker et al. (2015) specifically examined the “vicious circle” of patient-physician’s dispute/mistrust/violence happening in contemporary physical healthcare settings through case studies conducted in a Chinese province.

2.2. COMPLAINTS AND COMPLAINT RESPONSES. As one type of speech act, complaint can be regarded as a way of negative attitudinal expression (Austin, 1962). Just like insults, criticisms, accusations, and other neighboring communicative acts, complaints can also potentially threaten the addressee’s positive face wants/desires by conveying disapproval (Brown & Levinson, 1987: 66), especially when the face-threatening characteristics of complaints (e.g., the complainer/speaker’s direct attacks on the complainee/addressee) are foregrounded in confrontational communication settings. Therefore, considering its face-threatening nature, the definition of “complaint” can be extended from its original meaning indicating the action of complaining or the utterance of grieving (Oxford English Dictionary, 3rd edition) to many different levels of complaint-related *head act strategies* including (implicit) annoyance or disapproval, (explicit) complaint, accusation, warning, and even immediate threat according to the increasing level of face threat, especially when coding the act of complaining (House & Kadar, 2021: 131). This definitional system of complaint can be further complemented by some other neighboring communicative acts such as accusation, criticism, and blame, based on the increasing level of directness that a given act of complaining can reach (Trosborg, 1995). These definitional and coding systems also echoed the observations of both *more direct complaint strategies* (e.g., accusation, criticism, blame, threat, etc.) and *more indirect complaint strategies*

(e.g., hint, disapproval/annoyance, etc.) from our day-to-day communication practices including healthcare communication (House & Kadar, 2021; Olshtain & Weinbach, 1987).

Nevertheless, the degree of face threat or the level of (in)directness (Decock & Depraetere, 2018; House & Kasper, 1981) may not fully reflect every aspect of the notion of complaints. In daily verbal communication, there exist other types of complaints such as third-party-oriented complaints (Ferreira, 2021; Heinemann, 2009; Traverso, 2009; Wagner & Lewis, 2021) which do not necessarily potentially threaten or damage the addressee's (positive or negative) face wants/desires. As discussed above, during the doctor-patient interactional process, the patient's "chief complaints" (i.e., non-hearer-oriented complaints especially self-oriented complaints regarding their pains, symptoms, diseases, and signs of illness) or other types of their "problem presentation" (e.g., third-party-oriented complaints regarding their previous treatment, hearer-oriented complaints regarding their doctor, etc.) (Cole & Bird, 2013; Ruusuvuori & Lindfors, 2009; Stommel & Van der Houwen, 2014) may or may not be associated with FTAs. Based on this, the present study provides a more comprehensive operational definition of this key term: A *complaint* is the utterance(s) where the speaker expresses their negative attitudes towards a past or ongoing action by the hearer, a third party, the speaker him/herself, or related to a particular situation. In this case, even some self-oriented and situation-oriented complaints where no one or nothing is to blame or at fault can be categorized into this definitional system, which covers any type of "negative evaluation" made by the complainer (or the patient). In this study, I use a broader term *non-hearer-oriented complaints* (instead of indirect complaints) to cover any type/subtype of *self-oriented*, *other-oriented (third-party-oriented)*, and *situation-oriented complaints* appearing in doctor-patient e-dialogues.

Moreover, scholars also categorized and coded both hearer-oriented and non-hearer-oriented complaint *responses* by a "unified taxonomy" (Alberts, 1988; Alicke et al., 1992; Cousins & Vincent, 1983), with propensity to pick up a specific type of complaint response to react to a specific type of complaint. For example, the strategies of agreement, disagreement, justifications, noncommittal (neutral responding), no response (ignoring the complaint), sympathy, problem-solving, denial, and countercomplaints (complaining in response to the complaint) were most frequently occurring categories in their dataset and taxonomy, some of which were overlapped with Boxer's (1993a, 1993b, 1993c, 1993d, 1996, 2010) six major response categories (no response or topic switch; questions; contradiction/disagreement; joking/teasing; advice/lecture; commiseration/agreement).

Overall, prior studies of complaints have been focused more on the recurring patterns, but much less on the "discourse-pragmatic strategies/functions" of complaints or complaint responses especially from the linguistic perspective. The present study aims to bridge these research gaps on complaints/complaint responses by examining the discursive strategies

(including head act strategies and internal/external modification, see also: Trosborg, 1995) and the underlying intrapersonal/interpersonal functions (Boxer, 1993a, 1993b, 1993c, 1993d, 1996, 2010; Cole & Bird, 2013; Kowalski, 1996) of any type of “negative evaluation” (including “chief complaints”) made by patients and the complaint responses performed by their doctors in Chinese online medical consultations.

3. Data and Methodology.

3.1. SAMPLING AND DATA COLLECTION. Using convenience sampling and proportional quota sampling on *Hao-Daifu* (“*Good Doctors*”)—one of the major Chinese online medical consultation platforms with publicly accessible doctor–patient interactional data—50 patient complaints and 40 corresponding physician responses (with 10 complaints lacking responses) were identified, coded, and analyzed across various clinical departments.

3.2. CODING SCHEMES AND PROCEDURES. After the stage of sampling and data collection, I used the adapted coding schemes of the strategies/patterns of complaints and complaint responses for data coding and data analysis. I adapted other scholars’ coding schemes from their previous studies and made them fit better into the characteristics of my own dataset. Specifically, as shown in Table 3.1, the coding scheme of all sorts of complaints (strategies/patterns) has been adapted from Chen, Chen, & Chang (2011), House & Kadar (2021), Peñarroja (2020), and Trosborg (1995), based on the *level of directness* (or the degree of face threats in some contexts).

I. Head act strategies [ordered by the increasing level of directness]	
A. Indirect strategies:	
1. Hints/Opting Out, e.g., “可是我的心肌酶谱2各项指标都处于临界值了。”	‘However, all indicators of my myocardial enzyme spectrum 2 are at critical values.’
2. Annoyance/Disapproval/Dissatisfaction, e.g., “我这个是不是前间壁心肌梗塞？”	‘Is this myocardial infarction of the anteroseptal wall?’
B. Direct strategies:	
3. Questioning/Interrogation, e.g., “我想请问一下为什么查不出出血点？”	‘Could I ask why no bleeding points can be found?’
4. Accusation, e.g., “他们不会读片子，没有专科。”	‘They didn’t know how to read medical images, and they didn’t have any specialists.’
5. Blaming for Behavior/Person, e.g., “是因为吃了您给开的药症状才加重的。”	‘My condition worsened because I have taken the medicine you prescribed.’
II. Internal modification	
1. Syntactic downgraders	
a. interrogative, e.g., “需要……吗？”	‘Do I need to...?/Does it need to be...?’
	“我想请问一下……？” ‘Could I ask...?’
2. Lexical/Phrasal downgraders	
a. cajoler, e.g., “这个...”	‘this...’
3. Upgraders	
a. emotional exclamation, e.g., “啊 (a)”	‘Ahh’
b. lexical intensifier, e.g., “为什么”	‘why’; “特别/非常/很” ‘very’
c. time intensifier, e.g., “天天/每天”	‘every day’; “老是” ‘always’
III. External modification	
1. Alerter	
a. attention getter, e.g., “您好”	‘Hello’
b. title/role (surname+title), e.g., “医生”	‘Doctor’ “杨主任” ‘Director Yang’
2. Mitigating supportive moves	
a. grounder, e.g., “因为曾感受过肌无力的痛苦”	‘Because I have experienced the pain of myasthenia gravis’
3. Aggravating supportive moves	
a. threat, e.g., “要不然我膝盖会疼死的”	‘otherwise my knees will be painful to death’

Table 3.1. Adapted coding scheme for all sorts of complaints

On the other hand, complaint strategies/patterns can also be coded and categorized according to the orientation of complaints (Boxer, 1993a, 1993b, 1993c, 1993d, 1996, 2010). Table 3.2 below demonstrates my adapted coding scheme of complaints based on the orientation of complaints with examples (and their English translation) from the current dataset.

I. Non-hearer-oriented complaints 1. Self-oriented complaints (including patients' "chief complaints"), e.g., “老是有缺氧的感觉” ‘I always have shortness of breath’ 2. Third-party-oriented complaints, e.g., “他们不会读片子，没有专科。” ‘They didn't know how to read medical images, and they didn't have any specialists.’ 3. Situation-oriented complaints, e.g., “可是我的心肌酶谱2各项指标都处于临界值了。” ‘However, all indicators of my myocardial enzyme spectrum 2 are at critical values.’; “我现在该如何处理这个现状？” ‘How should I deal with this situation now?’ II. Hearer-oriented complaints e.g., “我的这个症状是不是吃了您给我配的药就会出现犯困的状态？” ‘I (often) feel very sleepy, and is it because I have taken the medicine you prescribed for me?’

Table 3.2. Adapted coding scheme of complaints based on orientation of complaints

Likewise, Table 3.3 below demonstrates my adapted coding scheme of complaint responses based on the orientation of complaints.

I. Non-hearer-oriented complaint responses A. Bigger Categories: 1. Self-oriented complaint responses 2. Third-party-oriented complaint responses 3. Situation-oriented complaint responses B. Specific Strategies (across the three bigger categories above): a. no response or topic switch b. questions c. contradiction/disagreement, e.g., “几乎不可能” ‘[Your worry is] almost impossible’ d. joking/teasing e. advice/lecture, e.g., “如果不放心，当地三甲医院做个增强CT就可以了” ‘If you are worried, just do a contrast-enhanced CT at the local tertiary hospital’ f. commiseration/agreement/sympathy g. empathy h. consolation/comforting, e.g., “不用太紧张” ‘Take it easy’ i. explanation/justification, e.g., “这种局部的用药作用很微弱” ‘This kind of local medical has very weak (side) effect’ j. persuasion k. problem-solving l. combinations of the above II. Hearer-oriented complaint responses Specific Strategies: a. taking responsibility b. no deflection c. mirroring clients' (patients') own words	d. incongruences e. negligence f. explanation/justification, e.g., “是的，有些患者会出现犯困感，渐渐会好的” ‘Yes, some patients will feel sleepy, but it will get better gradually’ g. persuasion, e.g., “绝大多数都会好的，要有信心和信任” ‘Most of them will be fine; have confidence and trust’ h. contradiction/disagreement i. combinations of the above
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Table 3.3. Adapted coding scheme of responses based on orientation of complaints

Both qualitative and quantitative methods were employed for data analysis. Quantitative analysis involved frequency counts, while the primary qualitative approach was Discourse Analysis (DA), with a particular emphasis on Interactional Sociolinguistics (Gumperz, 1982a,

1982b, 1999), which explores how language users construct meaning through social interactions by analyzing discourse strategies and various types of contextual cues.

4. Results and Data Analysis. This section presents both the quantitative findings (descriptive statistics) and the qualitative analysis, organized around three key dimensions used to examine complaints and/or complaint responses.

4.1. LEVEL OF DIRECTNESS. Quantitative results indicate that, in terms of the level of directness, complainers (patients) predominantly employed more indirect complaint strategies—such as expressions of *annoyance*, *disapproval*, or *dissatisfaction* (32/50)—whereas more direct strategies were used less frequently but still notably, such as *questioning/interrogation* (18/50). The (expression of) *annoyance/disapproval/dissatisfaction* typically does *not explicitly* identify the complaineer who is being complained against, or it may simply reflect dissatisfaction with a non-human object, issue, or situation (Chen, Chen, & Chang, 2011; House & Kadar, 2021). On the other hand, responders (doctors) seemed to follow the level of directness regarding the discursive strategies their patients have deployed and then employed certain strategies and/or their combinations such as [*consolation* (e.g., “Take it easy”) + *disagreement* (e.g., “There are no signs of...no treatment is needed”)] and *advice/lecture* (31/40) to address those complaints. Consider the following episode from my dataset:

Episode 1

(Context: The patient has a 2.5-year history of recurrent dizziness, migraines, and depression. His symptoms have now recurred, prompting him to seek a follow-up consultation with his neurologist via the platform.)

医生：最近工作上是不是有不顺心的事情，或者还有哪些外界的诱因和刺激？

Doctor: Have you been experiencing any challenges at work lately, or are there other external factors that might be affecting you?

患者：是的，工作上的，去年 10 月份升职了，但觉得自己没有能力胜任这份工作，新的工作没有成就感，没有以前那么快乐，因此这接连几个月就情绪比较低落，然后变得自卑和不自信了。我想调整可是情绪一直低落，所以很烦恼。

Patient: Yes, it's mainly work-related. I got promoted last October, but I feel like I'm not capable enough for the new position. I don't feel a sense of accomplishment in the new role, and I'm not as happy as I used to be. As a result, I've been feeling down for the past few

months. I've become more self-doubting and insecure. I want to make a change, but my emotions have stayed low, which has been really frustrating.

To respond to the doctor's information-gathering questions, the patient in this episode employs the strategy of *annoyance/disapproval/dissatisfaction*, which is the most typical indirect strategy for self-oriented patient complaints performed in clinical interactions. With the pre-posed grounder/justification stating that the patient did not get a sense of achievement in his new position as expected, he then moves forward to the head act of his medical complaint "which has been really frustrating" more explicitly, indicating that this whole set of (emotional) symptoms can be boiled down to a feeling of "annoyance." The strategy is considered "more indirect," mainly because it reflects the complainer's dissatisfaction with a non-human situation directly related to his subjective emotions or feelings, rather than with a targeted human complaine. In the patient's turn, the pre-posed grounder also serves as the personal account of his life experience with depression, which both triggers and softens his actual concerns about his recent depression flare-ups. This accompanying lexico-grammatical pattern further reinforces the indirectness and implicitness of the complaint strategy of *annoyance/disapproval/dissatisfaction*.

4.2. ORIENTATION OF COMPLAINTS. According to the orientation of complaints, patients most frequently employed *non-hearer-oriented* complaints (47/50), particularly *self-oriented* "chief complaints" (Cole & Bird, 2013) (37/50), as compared to hearer-oriented ones. These complaints were often followed by doctors' response strategies such as *advice/lecture* (31/40), or a combination of *problem-solving and advice/lecture*. Consider the following complaint-response sequence from my dataset:

Episode 2

(Context: The patient has been experiencing occipital neuralgia and has already received treatment and prescriptions from an in-person consultation. She is now using the online platform to follow up with another doctor and provide updates on her condition.)

患者：每天早上醒来觉得好像不怎么痛了，然后洗漱忙活一阵，再走路坐车就又觉得痛

了。我这种情况严重吗？每天就很担忧，什么心情也没有。

Patient: Every morning, I wake up and feel that the pain is gone. Then I wash and work for a while, and then I feel the pain again after walking or riding in the car. Is my situation serious? I feel worried every day and have no mood at all.

医生：你这可能是血管性头痛。你手上的药物吃了如果效果不好可以换药，比如试试天舒

胶囊或者天麻素胶囊，平时生活规律思想放松好好休息不要熬夜清淡饮食。

Doctor: You may have a vascular headache. If the medicine you have is not effective after taking it, you can change the medicine. For example, try Tianshu Capsules or Gastrodin Capsules. Live a regular life, relax, have a rest, don't stay up late, and eat lightly.

According to different focused themes of complaints, the patient in this episode performs a *non-hearer-oriented* complaint, specifically a *self-oriented* “chief complaint” concerning his episodic symptoms of headache, which is a subjective expression of “annoyance” toward the functioning of his own body (or a particular body part).

In response, the doctor adopts the strategy of *advice/lecture*, one of the most typical self-oriented complaint responses, aiming to encourage the patient to maintain a healthier lifestyle and adjust medication if necessary. However, before offering concrete advice, the doctor first delivers a direct diagnosis as a “problem-solving” strategy, explicitly addressing the patient’s medical concern without providing any affective or empathetic response.

4.3. RESPONSE STRATEGIES SERVING DIFFERENT FUNCTIONS. Overall, *solidarity-/rapport-building functions* (Boxer, 1993a, 1993b, 1993c, 1993d, 1996, 2010) (45/50) instead of *conflictual functions* (3/50) were more often embedded in the discursive practices of complaint-response sequences, which tended to be much more *positive* than functions observed in the physical healthcare settings in China (Nie et al., 2018; Tucker et al., 2015). Specifically, in addition to the orientation of complaints, complaint response strategies can also be categorized based on the distinct functions they serve in medical interaction (Bird & Cohen-Cole, 1990; Cole & Bird, 2013). Consider the following complaint-response sequence from my dataset:

Episode 3

(Context: The patient has a medical history of myasthenia gravis and previously received treatment from a doctor working at a specific hospital in China. She is now consulting another doctor via the online consultation platform.)

患者：刚发现肌无力时，我曾有过睁眼费力、复视、手臂手指无力症状，服用溴吡斯的明

一段时间后症状逐渐改善消失，乙酰胆碱滴度也基本呈下降趋势，一般每半年查一

次(值分别为 41、25、18、4、10)。想请教您，滴眼液是属于局部吸收的吧，少量使用一般不会引起症状复发吧，因为曾感受过肌无力的痛苦，很担心复发。

Patient: When I was first diagnosed with myasthenia gravis, I experienced symptoms such as difficulty keeping my eyes open, double vision, and weakness in my arms and fingers. After taking pyridostigmine for a period of time, the symptoms gradually improved and eventually disappeared. My acetylcholine receptor antibody titers also showed a general downward trend — usually tested every six months, with results of 41, 25, 18, 4, and 10, respectively. I would like to ask: Eye drops are absorbed locally, correct? If used in small amounts, they generally wouldn't cause a recurrence of symptoms, right? Having gone through the pain of myasthenia once, I'm very worried about the possibility of a relapse.

医生：不用太紧张，这种局部的用药作用很微弱。几乎不可能。

Doctor: Take it easy — the effect of this kind of local medication is very minimal. [What you're worried about] is highly unlikely.

患者：我懂了，谢谢您耐心问诊+详尽解释。得病很痛苦，但遇到您这样的好医生却很幸运。衷心感谢，铭记于心。

Patient: I understand now – thank you for your patient consultation and thorough explanation. Although living with this condition has been difficult, I feel truly fortunate to have encountered a compassionate and competent doctor like you. I am deeply grateful, and I will always keep this kindness in mind.

In this case, the patient prefers to use external linguistic build-ups (particularly pre-posed grounders or justifications related to her medical history) before proceeding to the head act of the complaint, which takes the form of “annoyance” toward the pain caused by myasthenia gravis.

In response, the doctor employs a combination of strategies, including consolation (“Take it easy”), explanation (“...is very minimal”), and disagreement (“What you're worried about is highly unlikely”). These response strategies respectively serve both affective functions (e.g., building relationships with the patient through consolation) and instrumental functions (e.g., assessing the patient's problems through explanation and disagreement) in the context of medical interaction.

Overall, the discursive practice of this complaint-response sequence carries the *solidarity-/rapport-building functions* to promote social harmony between doctor and patient. The positive rapport effects (Campbell, 2005) of this interaction are further reflected in the patient's subsequent utterance, where she expresses heartfelt gratitude (e.g., a big THANK YOU) to the doctor beyond the complaint-response sequence.

5. Discussion and Conclusion. Within the scope of discursive practices, some additional findings need to be presented and discussed as well. First, complaint strategies (e.g., *accusation* + *annoyance*) and response strategies (e.g., *consolation* + *disagreement*) occasionally co-occurred. In some contexts, a single discursive-pragmatic strategy may not be sufficient to serve multiple intrapersonal or interpersonal functions simultaneously, necessitating a combination of strategies. Second, as discussed in Section 4.3, complaint response strategies can be *functionally* divided into affective and instrumental types, depending on whether they aim to build rapport or to assess and address the problem. However, in some cases, both functions may be served simultaneously.

The present study also reveals both consistencies and inconsistencies with previous findings. For instance, the discursive practices of complaint-response sequences observed in the present study confirm Ruusuvuori & Lindfors's (2009) conclusion that complaints and complaint responses fulfill various institutional tasks (e.g., confirmation checks, requests for the repetition of previous tests, etc.). Furthermore, non-hearer-oriented complaints and their corresponding responses in online medical consultations tend to produce more *positive*, solidarity-enhancing interpersonal functions, thereby confirming Boxer's (1993a, 1993b, 1993c, 1993d, 1996, 2010) series of studies. However, these findings contradict previous research on conflict, mistrust, and even violence in face-to-face doctor-patient interactions in China (Nie et al., 2018; Tucker et al., 2015).

To better understand why online medical consultations generally carry more harmonious social functions than face-to-face doctor-patient interactions, additional perceptual data from both clinical doctors' and patients' perspectives would be valuable, particularly concerning how they interpret the use of complaints and complaint responses across different settings. Other limitations of the present study include the absence of inter-coder reliability measures and a relatively small sample size, which may affect the accuracy of frequency counts as well as the generalizability of discursive practices observed.

In conclusion, this study investigates the discursive practices—including recurring strategies and underlying social/interpersonal functions—of both patients' complaints and doctors' responses in online medical consultations, with a focus on the Chinese healthcare platform *Hao-Daifu* ("*Good Doctors*"). The speech-act-related findings may further shed light

on the co-construction of face, politeness, and rapport between physicians and patients in computer-mediated communication, especially in the context of this post-COVID era.

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