Journal of Pragmatics 238 (2025) 4–18

Contents lists available at ScienceDirect

Journal of Pragmatics

journal homepage: www.elsevier.com/locate/pragma

Delivering reassurance in online medical consultations: The stance marker *Hao-bu-hao* (HBH) in spoken Chinese

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ARTICLE INFO

Article history:
Received 23 June 2023
Received in revised form 10 January 2025
Accepted 13 January 2025

Keywords:
HBH
Reassurance
Conversation analysis
Online medical consultations
Contingency

ABSTRACT

This article examines doctors' delivery of reassurance in online medical consultations. It focuses on the Mandarin *A-not-A* structure *hao-bu-hao* (*HBH*), equivalent to "alright" in English, and observes how it contribute to the delivery of reassurance. Data include typed texts and audio recordings. Using conversation analysis, we differentiate two environments where HBH is used: in delivering a no-problem diagnosis and an optimistic prognosis in the context of bad news. We argue that HBH allows the doctor to maintain control over the interaction while appearing less directive by acknowledging the patient's contingency without genuinely seeking their input.

1. Introduction

A central medical task of health professionals is to reassure worrying patients. There is abundant evidence of how effective reassurance moderates a collaborative therapeutic relationship and secures better clinical outcomes (for review, see Pincus et al., 2013). Reassurance takes different forms, but frequently includes statements suggesting that symptoms are not due to serious diseases; for example, a "no-need-to-worry" statement or a general positive assessment (Stark et al., 2004; Traeger et al., 2015). Numerous studies across multiple disciplines have been conducted to examine various issues related to reassurance. Health professionals and psychologists are interested in methods of reassurance, underlying motivations, and clinical effectiveness of such strategies (for review, see Akyirem et al., 2022). Communication scholars and linguists are interested in various aspects of communication and language use that convey emotional support to the recipient; for example, conversation analysts are keen on how issues of normality (Bredmar and Linell, 1999; Sarangi and Gilstad, 2014), uncertainty (Anderson et al., 2020) and reassurance (Sansone et al., 2022) are negotiated in clinical interactions. This interest in the intricate organization of reassurance in medical interactions has only started recently, and is predominantly centered on face-to-face (F2F) encounters where participants' stances have been broadly recognized as a gestalt of various modalities (Beach, 2019; Muntigl et al., 2023; Weiste and Peräkylä, 2014). As Sansone (2021) argues, "there has yet to be a detailed conversation analytic exploration into the contexts that make reassurance a possibly relevant next action" (p. 23). Beach (2019) also states

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https://doi.org/10.1016/j.pragma.2025.01.011

that "a notable lack of attention has been given to how patients and doctors collaborate to minimize illness and promote good news" (p. 1698).

Expanding on this small but burgeoning body of interactional research on patient uncertainty and reassurance, our study explores how reassurance is provided in asynchronous computer-mediated interactions (CMIs) where conventional rules governing turn-taking practices in F2F conversations may not be easily adapted (to be discussed in sections 2.3 and 3.2). The current data consists of online medical consultations (hereafter: OMCs). We focus on a morphosyntactic structure in Chinese: *hao-bu-hao* ("right-not-right", hereafter: HBH). Thus far, HBH has been most thoroughly examined in construction grammar (Li and Thompson, 1981) and pragmatics (Hagstrom, 2006). It involves a juxtaposition of an affirmative and its negation, whose function is most akin to that of an invariant tag (e.g., *right*, *isn't it*, *eh*, *okay*, and *hunh*, see Parviainen, 2016 Table 3), often produced to seek the recipient's proposition-affirming (i.e., accepting) responses (Robinson, 2020). To our knowledge, this is the first study that examines how reassurance is given in OMCs. Such understanding is essential given the growing trend of *e*-health that allows medical consultations beyond spatial and temporal limits (James et al., 2021). Of particular relevance to our study are three areas of research: 1) the delivery of reassurance in interactions, 2) knowledge, power, and emotion in interaction (Stevanovic and Peräkylä, 2014), and 3) the ways participants exploit adapted practices of turn-taking and sequence organization to indicate their emotional stance in online environments.

2. Literature review

2.1. Patient uncertainty and reassurance

Within conversation analytic (CA) research, reassurance has been described as a type of online commentary that "describes or evaluates the signs which physicians are encountering during the physical examination" (Heritage and Stivers, 1999, p. 1502). Previous research indicates that reassurance is typically provided in response to patients' displays of worry or anxiety, affective states that are bound up with uncertainty around their health (Anderson et al., 2020; Pino and Parry, 2019; Sansone et al., 2022). In F2F encounters, these epistemic and emotional stances are often conveyed via multiple modalities such as words and grammar, tones of voice, facial expressions, and other embodied actions (for a list of patient cues of uncertainty, see Giroldi et al., 2020). For example, in paediatric hearing habilitation appointments, Ekberg et al. (2020) note that parents indicate their concerns and uncertainties via questions that invoke a comparison to a norm. The researchers conclude that although these questions initially appear to be aimed at gathering information, they are fundamentally requests for reassurance. Uncertainties can also be conveyed via what Pino and Parry (2019, p. 226) call "statement formats" which often comprise a plain statement like "I'm a bit concerned" or an indication of insufficient knowledge (Beach and Metzger, 1997).

To address patient uncertainty and mitigate the perceived necessity for apprehension, professionals employ multiple practices directed at providing and inviting a reframing and reappraisal or what Beach (2019, p. 1698) calls "alternative stances" of the patient's concern. These include minimizing the count of individuals affected by the same illness (Gill et al., 2001), suggesting normality (Bredmar and Linell, 1999; Gutzmer and Beach, 2015), obviating the need for diagnostic testing (Toerien et al., 2020), offering explicit positive assessments of one's progress (Ekberg et al., 2020), using gestural depictions and diminutives to raise hopeful possibilities (Beach, 2019), and providing an alternate account for the unfavorable outcome (Sansone et al., 2022).

2.2. Knowledge, power, and emotion in interaction

Prior research on reassurance in health contexts categorizes reassurance into two types: affective and cognitive, where affective reassurance provides emotional support and cognitive reassurance alters people's understandings and beliefs through patient education (Pincus et al., 2013). That said, the action of doing reassurance concerns how people orient to epistemics and emotion in interaction (Stevanovic and Peräkylä, 2014). For example, doctors' explanation for adverse outcomes (Sansone et al., 2022) appeals to the epistemic domain of interaction (Heritage, 2012). Meanwhile, providing such explanations to reassure the patient addresses the emotional or affective domain. Reassurance also deals with deontics (Stevanovic and Peräkylä 2012), as by reassuring the patient, the doctor recommends a course of action, such as alleviating their anxiety.

One type of utterance that has been extensively studied on how it manages participants' epistemic and deontic status and stance and is relevant to current investigation is directives (Stevanovic and Svennevig, 2015). A widely-cited definition of this term is provided by Goodwin (2006) as "utterances designed to get someone else to do something" (p. 517). This definition is later challenged by Craven and Potter (2010) for not differentiating directives from requests. They define directives as "an action where one participant *tells* another to do something" (p. 420). Previous research has established that directive formulations vary in the degree of speaker entitlement and recipient contingency (Antaki and Kent, 2015; Kent, 2012; White, 2020). Such entitlement and contingency in actions can be modified through syntactic forms. For example, Curl and Drew

(2008) note that "I wonder"-prefaced forms indicate the speaker's orientation towards greater recipient contingency associated with the request compared to modal verbs.

Another type of utterance relevant to the current investigation is tag questions. Previous work has established that the fundamental action that a tag question serves in interaction is to seek agreement to an action, a stance, an understanding, an assessment, and the like, deferring to the recipient's epistemic authority based on knowledge or experience (Ekberg et al., 2022; Heritage and Raymond, 2005; Jenkins, 2015; Wiggins, 2023). A typical feature of tag questions in spoken conversations is that the tag formulation has a weak response requirement and does not make the absence of a recipient's response accountable (Ekberg et al., 2022; Hepburn and Potter, 2010, 2011). In other words, the tag formulation does not provide an interactional slot for the recipient to respond but instead sequentially positions the recipient as already agreeing, confirming, and supporting the declarative to which a tag is appended (Hepburn et al., 2023).

2.3. Displaying emotional stance in OMCs

A myriad of studies in recent decades have emerged and applied CA to OMCs (e.g., Ekberg et al., 2013, 2016; Stommel and Lamerichs, 2020). In asynchronous text-based encounters, one consistent theme that runs through many papers is the non-interruptive nature of the speaker's turn, often posted in the form of an entire unit that goes undefined in length and contains multiple actions (Andersen, 2017). While the conventional legacy of the turn-taking systems might not be directly adapted to asynchronous interactions, scholars have suggested a different focus that exhibits a unique form of orderliness in this type of interaction: the relational ordering between posts (i.e., how posts are sequentially presented) and the constitutive ordering within individual posts (i.e., the sequence of talk within individual contributions) (Gibson, 2009).

There is a paucity of research on how participants display and make sense of each other's emotional and deontic stances (Du Bois and Kärkkäinen, 2012) in asynchronous OMCs. Seminal work includes Ekberg et al.'s (2013) study in online sessions, which examines how therapists orient to clients' emotional experience through the design of their "third-position object" (p. 6) to the client's prior writing as either making relevant or not an emotional response. In a separate work, Ekberg et al. (2016) further differentiate two types of therapists' emotional responses in the same sequential environment designed to suit the client's prior descriptions of their emotional experience. In online counseling, Stommel and Lamerichs (2020) examine counselors' empathic responses to clients' posts with descriptions that imply a negative state. They find that empathy display seldom occurs as a stand-alone post; instead, it often emerges in combination with problem formulations or questions and thus does not always project a response.

3. Data and methods

3.1. Data and ethics

The data for the analysis we present here were selected from a larger study on OMCs through an online health provider called DX Doctor (DXD) in China (https://dxy.com/). DXD is the largest licensed national internet hospital that provides consultation, prescription, and dispensary delivery with over 5.5 million users (Guo et al., 2023). Doctors providing services on DXD have to be specialists on duty at public hospitals in Mainland China. Their identities (names, clinical positions, and medical expertise) are accessible to all users. This affordance of the website allows clients from remote areas to have access to medical services that might not be provided otherwise in their regions. Using Python as the web-scraping tool, we have collected a substantial corpus involving 24 medical specialties and 156,104 doctor-patient dyads.

The OMCs in our data are asynchronous and post-like. What is particular about the data is how clients and professionals are allowed (incorporated as a designed feature of the platform) to respond to each other. First, for each consultation, patients (or clients) are only allowed to type their messages, whereas the doctor can reply verbally or via text. Thus, the data consists of both typed and vocal texts, reflected in our transcripts. We decide to maintain this feature in our illustrations for a truthful presentation of the data. Second, patients seeking health services via this online provider are allowed only three turns of undefined length to raise their concerns. Therefore, each turn often contains multiple actions and makes relevant an extensive response from the doctor.

One debate in the literature concerning studies using online data is ethical issues, particularly on collecting informed consent (see Vayreda and Antaki, 2009 for a review). We are fully aware of these concerns. While the data are publicly available, we are careful in using online data without collecting consent (Stommel and de Rijk, 2021). First, DXD advertises it as a publicly accessible web-based resource for health consultations. As Zhang (2022, p. 33) states, the website "do[es] not prohibit the use of the publicly posted OMC texts for academic purposes (as inferred from their copyright claim)". Second, people who are using DXD are given the option to share their dialogues with the public or not; if not, their dialogues will not be published. Once published, these dialogues are open to all web users, but information revealing client identities and sensitive issues (e.g., name, age, laboratory reports, etc.) is only accessible to doctors. In other words, patient privacy has been

built into the platforms with their names replaced by a string that often consists of random letters and numbers (e.g., "a12345r"). In this study, although clients who chose to share were not individually asked to give consent (because they are anonymized and hence uncontactable), there is an implicit understanding based on the two points mentioned that their shared dialogues might be read by others and used in research (Zhang, 2022). In full awareness of the sensitivity of the data, we are particularly vigilant in maintaining data anonymity. We anonymize individuals' online and offline identities so that they are irretrievable by any information they provide (Stommel and de Rijk, 2021). We assign a number to all responses that will be used. In all illustrations, D stands for the doctor, and P stands for the patient. To preserve user privacy, we are also careful that any content in the consultation would be slightly modified if it has the risk of being traceable. For example, references to user names, institutions, previous health providers, and geographical places were omitted (Lundström, 2018) and transcribed as "redacted". To collect these consultations, ethical approval was obtained from the researchers' home institution.

3.2. Applying CA to OMCs

Methodologically, we adopt CA to OMCs. Whilst developed initially for oral communication, CA is now widely applied to CMIs (Meredith, 2019). Numerous studies have reported broad differences in the turn-taking system between online and offline interactions (e.g., Gibson, 2009; Paulus et al., 2016; Meredith, 2019), which shall not be repeated here. One notable difference, also observed in our data, is the striking linearity of participants' turns, a feature that is afforded by the mediated interaction that allows participants the capacity to put multiple messages within one post and send it in its entirety (Ekberg et al., 2016). A post is designed as one single turn containing multiple actions (Levinson, 2013). The publishing of a post thus makes relevance to, or "shapes a space (makes a context for)" (Vayreda and Antaki, 2009, p. 933), the next. Each post (except the initial one) is readably related to the prior one (see Gibson, 2009 for relational ordering). For these reasons, we use the terms "turn" and "post" interchangeably throughout our analysis.

We examined each HBH instance to determine the action it performs (Sidnell, 2013). In spoken conversations, the term action formation is understood as a practice through which a turn, or a TCU, is potentially made recognizable as a possible action; this recognition is based on an interpretation of different interactional (linguistic and paralinguistic, position, and context) properties (Levinson, 2013). Like in spoken conversations, in our data, each utterance does an action in the current speaker's extensive turn. Our judgment of action(s) is based on the immediate utterance to which HBH is attached, its preceding and subsequent actions within the doctor's longer turn (the constitutive ordering within individual contribution, Gibson, 2009), and the relatedness of the post with other posts (the relational ordering between posts, Gibson, 2009).

As our data contains both typed and vocal texts (doctors only), they are transcribed in a system that combines both the Jeffersonian convention (Jefferson, 2004b) and a CMI-friendly format that reproduces what is visually available on the screen (Stommel, 2016). Thus, while translating the typed texts, we keep the punctuation marks consistent with those in the original texts. As this work focuses on qualitative discussion about the action that HBH performs in the momentary interaction where some broader interactional projects are ongoing, no record has been kept of the frequency of interrogative or non-interrogative HBH. For our current analytical purposes, and partly due to space constraints, we have selected a small number of extracts. Extracts are chosen not only as clear and concrete illustrations of a phenomenon but also on the basis that they incorporate different medical specialties, which allow multifaceted illustrations.

4. Analysis

All consultations in our data start with the patient's turn, which often contains a minimum greeting (optional), problem presentations, and an explicit request for diagnosis and treatment advice. Within the dataset, reassurance is predominantly delivered after two actions: delivering a no-problem diagnosis and offering an optimistic assessment. Our analysis is thus structured around this observation. One major action HBH performs is that its syntactic form and interrogative tone allow the speaker to maintain some control over the interaction while appearing less direct or demanding. It treats agreement and compliance with the recommendation as contingent on the recipient's desire and capacity while not genuinely seeking their input (Curl and Drew, 2008). To illustrate how HBH contributes to reassurance delivery, we end the analysis with an illustration where reassurance is given without HBH.

4.1. Reassurance in no-problem diagnosis

In medical consultations, receiving a no-problem diagnosis provides the greatest reassurance to patients, as it indicates there is no medical cause for alarm. Fig. 1 is a case in point. P is the mother of a girl who has experienced years of eye problems, which are later diagnosed as pigmentation (line 6).

```
01 21:22 P 医生，您好，我女儿 4 岁 4 月，从小婴儿时候就发现眼睛巩膜有黑团，
           doctor, hi, my daughter is four years and 4 months old,
           we noticed dark spots in her sclera since she was a baby
02         现在随着长大还是很明显，
           and they are still quite noticeable as she grows
03         她自己眼睛感觉没什么不舒服，视力也正常，
           She doesn't feel any discomfort in her eyes,
           and her vision is normal.
04         请您看视频帮忙看看这是什么病，
           could you please watch this video and help identify what
           condition this is?
05         严不严重？ 要怎么治疗啊？
           is it serious? what kind of treatment is needed?

06 21:26 D zhezhong qingkuang ne kaolv shi:: jiemo de sesu chenzhuo
           her case would be considered as conjunctival pigmentation.
07         wenti bu DA ye BUyong chuli
           it is not a BIG program and does NOt require treatment.
08  →      buyong danxin de hao-bu-hao?
           there is no need to worry alright?
09         MEIYOU shenme zhiliao ye BUYONG zuo shenme zhiliao
           there is NO treatment and NO treatment is required.
10         =jiu YIGE sesu chenZHUO
           it's just a pigmentation
11         keneng:: daqilai keneng hui: xiao<xiao yidian qilai
           it may:: may: get small<smaller as she grows
12         jiu sesu tuodiao (.) tuodiao ZHIhou KEneng hui xiao yidian
           just need to take off the pigment (.) it May become
           smaller after it is removed.
13         buyong zuo chuli buyong zuo zhiliao
           no treatment no treatment is required.
14  →      FANGxin haole °hao-bu-hao?°
           rest assured °alright?°

15 21:27 P 好的，谢谢医生，这我就放心了😀
           alright, thanks doctor, now I rest assured 😀

16 21:29 D MEI guanxi de FANGxin ba
           it matters NOT, rest assured.

17 21:42 P 嗯嗯٩( •㉨•´)و get! 谢谢医生!
           umm umm ٩( •㉨•´)و ((smiley face)) Got it! thanks, doctor!

18 21:43 D keqi le fangxin ba
           you're welcome rest assured.
```

Fig. 1. Conjunctival pigmentation [PE5].

The first HBH occurs at line 8 where D produces a no-need-to-worry assessment (Shaw et al., 2015). Sequentially, the assessment is given after D's diagnosis (line 6), a non-serious assessment, and a recommendation for no treatment (line 7). The position of this assessment invites P to hear it as a logical conclusion. When considering the design of the assessment, it is crafted as an advice-implicative assessment (Shaw et al., 2015), which indirectly suggests that not worrying is a favorable course of action. As an assessment, it indexes D's knowledge and authority (Heritage, 2012). This authority is also conveyed through her delivery of the diagnosis as a plain assertion (Peräkylä, 1998) and the treatment as a pronouncement (Stivers et al., 2018). Given the design and position of the assessment, it is likely that the articulation of HBH serves to align P with D's overall non-serious stance (Stivers, 2008), as conveyed through D's previous actions.

Before the second offering of reassurance, D strengthens her stance by repeating her diagnosis (line 10) and treatment recommendation (line 9). With the use of extreme case formulations "NO treatment" and "just a pigmentation" (Pomerantz,

1986), D further highlights her certainty of the assessment (Edwards, 2007). The second HBH occurs at line 14 and is attached to a reassurance statement formulated as a directive – "rest assured", instructing P to adopt a certain state of mind. While this utterance differs from those in Goodwin's study, as the action directed at P is intended to reassure her, it also implicitly instructs P to stop worrying or to refrain from worrying. Sequentially, the directive is produced in an environment where D displays an orientation to strengthen P's alignment by providing an optimistic prediction about the progression of P's daughter's condition (lines 11–12) and repeating, for a third time in her current turn, the "no treatment" pronouncement (line 13). Our interest, then, is on D's actions in lines 14, 16 and 18. Common to these three lines is that the reassurance is produced as the last action in D's current turn and is audibly closing-implicative. However, while the doctor uses HBH in his initial reassuring action (line 14), it is not present in his final closing reassurances (lines 16 and 18). The syntactic form of HBH and its interrogative tone interactionally make relevant two types of response: agreement and resistance; whereas the directives aims "'to tell' rather than 'to ask'" (Craven and Potter, 2010, p. 419). When considering P's response in line 15, it may be difficult to determine whether P's agreement "alright" is responding to HBH or merely acknowledging receipt of information receipt. However, her indication of a reassured state and the smiley face clearly demonstrate an acceptance of D's overeall stance.

Although D could stop here, she continues to produce reassurance in close succession, this time without using HBH (lines 16, 18). It is difficult to determine why D continues to offer reassurance, but based on P's response, the two directive reassurance are perceived as a closing device (West, 2006) that receives P's thanks (line 17). In P's previous turn (line 15), she expresses thanks, but this instance is different as it occurs before P suggests a change-of-state "now I rest assured" (Heritage, 1984), making it more likely a gratitude for D's reassurance. In line 17, the expression of thanks is the final action in P's current turn, likely serving as a satisfactory assessment of D's service and an indication that no further actions to be expected (Raymond and Zimmerman, 2016). Seen in this light, D's reassurance after addressing P's assessment (line 18) is likely aligning to P's closing orientation.

Fig. 2 (1–3) illustrates a stronger evidence where HBH sequentially positions the recipient's alignment as the only relevant response. P has been left with "a residue of symptoms" (Maynard and Frankel, 2006, p. 272) since her last visit concerning hypertension risks. The residue is clinically significant as it suggests that the diagnosis does not achieve its intended reassuring effect, leading to doubts and uncertainties about the accuracy of D's assessment and requests for clarifications (Ijäs-Kallio and Ruusuvuori, 2010). Fig. 2.1 is taken from the first post in the consultation.

```
--- ((lines omitted. P reports her latest blood pressure: 120/70. P tells
the doctor that she feels dizzy and nauseous. She feels, as always, anxious
when checking her blood pressure, though much better than before)) ---

07 10:15 P 你说我不用再测血压了吧?
            I don't need to check my blood pressure again, do I?
            what do you say?
08          我感觉我又有点一头不舒服，一有情绪造成的躯体反应就想测血压，
            i feel that every time i experience pressure in my head,
            or any other physical discomfort that seems to be triggered by
            emotional stress, I feel the urge to check my blood pressure
09          但是又想到你告诉我血压不会马上增长那么快。
            but i remember you told me that it will not rise so quickly.
10          我就是因为测血压才吃的抗焦虑药，
            to check the blood pressure i took the anti-anxiety medication,
11          所以我不敢再测了，怕重蹈覆辙，而且现在恢复不错.
            so i dare not check it again, not to trip over the same
            stone twice, and it is getting pretty well.
12          况且距离上次问诊你测血压也还没一周，
            and it is less than a week since our last measurement,
13          所以我想问问你，我现在处理的方法对吗?
            so i want to ask if my solution was correct?
14          是不是不用管身体反应忽略他，不用测血压了。
            Is it right or not that I shall ignore the physiological
            symptoms and not to check my blood pressure anymore.
```

Fig. 2.1. The first post [CO7].

P's initiating turn displays a persistent and unresolved anxiety about the potential impact that any health issue might have on her blood pressure. This residue is displayed at multiple moves: a request for D's confirmation regarding the need for blood pressure measurement (line 7), a proposed association between her behavior (blood pressure measure and medication) and physical discomfort (lines 8, 10), the presentation of her worry as both intense ("urge", line 8) and persistent ("every time", line 8), and a "so"-prefaced announcement of the reason for her revisit (lines 13–14). D tailors his response to re-reassure P (Fig. 2.2), after several attempts ("SO many times," line 5), that condition P worries about is not present and, therefore, not a cause for anxiety.

```
01 10:26 D haode (.) ni zhege bushi gaoxueya de   wenti   a
          fine(.) this is not a problem of hypertension
02        zhengzhuang biaoxian shang KENDING bushi gaoxueya
          DEFINITELY not hypertension based on the symptoms
03        shouxian xueya ye bu gao
          first, the blood pressure is not high
04        qici zhengzhuang ye bu fuhe gaoxueya de biaoxian
          besides, these are not hypertension-associated symptoms.
05        zhege wo juede yiji::ng HEN queding le a (.) ZHEME duo ci
          i think this is alrea::dy VERY sure (.) SO many times.
06        QUEshi shi zheyang de
          TRUly it is
07  →     BUYONG danxin xueya de wenti le °hao-bu-hao?°
          NO NEED to worry about the problem of blood pressure
          °alright?°
08        suoyi wo xianzai jianyi ni buyao ZAI ce xueya le
          therefore now i suggest you no MORE measurement.
09        nide zhengzhuang gen xueya zhijian Meiyou guanlian
          there is No association between your
          symptoms and blood pressure.
10        ni xianzai zhexie zhengzhuang ne (.) HAIshi yige::
          your current symptoms (.) are STIll a::
11        gongnengxing de zhengzhuang (.) jiushi zhezhong:
          functional symptom (.) that is the ki:nd of
12        women yiqian jiao SHENJINGshuairuo
          ((what))we used to call NEURasthenia

--(( lines omitted: D describes the nature and causes of the disease))--

18        wo juede ni keyi bishang yanjing zuozuo mingxiang
          i think you could close your eyes and have some meditation

---((lines omitted: describing its benefits))---

24        shengli jiaodu ni BUYONG danxin (.) meishi de
          physiologically, NO NEED to worry about it (.)
          it doesn't matter
25        shenti de fanying bu ba ta dangzuo quti zhengzhuang jiu xing
          don't interpret your normal physical reactions as
          signs of a medical condition
26  →     °hao-bu-hao?°
          °alright?°
27        na jiu xian zheme shuo (.)
          then that's for now (.)
28        you shenme biede wenti keyi lianxi wo
          if you have other problems, you could let me know.
```

Fig. 2.2. The second post in a consultation [CO7].

D's response contains multiple reassuring actions: offering a no-problem and "no-association" diagnosis (lines 1–2, 4), suggesting normality by citing evidence from the test (line 3), emphasizing the truth value of the diagnosis and the consistency of blood pressure measurement results (lines 5–6), obviating the need for additional diagnostic testing (line 8, Heritage and McArthur, 2019), denying the association between symptoms and health risks (line 9), providing an alternative account for the patient's experience (lines 10–12).

Similar to Fig. 1, HBH is attached to two forms of reassurance statements: an advice-implicative assessment (line 7) and a combination of an assessment and a directive (line 25), both occurring in an environment where a no-problem diagnosis is provided. Yet, what makes D's response unique is that it arises from previous unsuccessful attempts at reassurance. In line 7, D indicates, in an emphasizing tone ("NO NEED"), that P's worry is not warranted. The placement of this assessment after presenting clinical facts and reminding P of the consistency of the diagnosis and test results works beyond merely reassuring P. Rather, it serves to convince P that the diagnosis is a logical and authoritative inference based on various facts (Fatigante et al., 2016). The articulation of HBH here thus serves to firmly align P's agreement and compliance with D's stance.

In line 26, HBH is appended to a combination of an assessment and a directive that together suggests a course of action: not to worry (line 24) and not to relate normal behaviors to medical conditions (line 25). After delivering the reassurance, D strongly implies a possible closure of the current consultation (line 27) while also allowing room for P to raise any "other" unstated concerns (line 28, Robinson, 2001). The phrase "other problems" in D's closing action indexes D's orientation towards the previous discussion as concluded and not actively seeking further input. In other words, D is expecting only P's alignment as the response. Fig. 2.3 selectively presents the rest of the consultation.

```
01 11:38 P 好，那我出现这种情况，可以跳舞运动慢跑吗？分散我的注意力
           alright, then can i do some sports like dancing and
           jogging to distract myself when
           it ((the symptoms mentioned earlier)) happens?
02         心里还是有一点害怕有点担心，
           still a little bit afraid and worried,
03         但是一想到人家血压不正常轻度的人，还可以通过运动缓解，
           but think about people whose bp is a slightly atypical,
           they can still do some sports to lower their bp
04         何况我一个健康人，
           not to mention a healthy person like me
05         是不是又瞎联想了？
           am i thinking too much again?

06 11:41 D dui a: DANGran shi keyi tiaowu yudong manpao de
           yes a: CERTAinly you are able to dance, jog,
           and participate in sports,
07         bingqie FEIchang guli ni zheme zuo
           and I HIGHly encourage you to do so.

--- ((lines omitted: D describes the benefits of sports)) ---
```

Fig. 2.3. The rest of the consultation [CO7].

P starts with an affirmative "alright" (line 1), explicitly agreeing with and accepting D's reassurance. Although later in her turn, P suggests that she is not fully reassured (line 2), she formulates her worry residue as an overthinking (line 5), thereby aligning with D's no-worry stance. Stronger evidence is provided by the comparison P makes between herself and individuals with "slightly atypical" blood pressure (line 3), through which P normalizes her condition.

4.2. Optimistic prognosis in bad news

In this section, we present illustrations when HBH is attached to a different type of action: offering optimistic assessments (Jefferson, 1988; see also Beach, 2014 and Peräkylä, 1991 on hopefulness, Holt, 1993 on bright-side telling) in breaking bad news (Maynard, 2003). Fig. 3 selectively presents the first three posts in a consultation. P receives an initial diagnosis of breast cancer based on imaging findings and a preliminary biopsy result, but the final pathology report, which provides a more detailed analysis of the cancer stage, size, type, and other important characteristics, is still pending.

--- ((lines omitted: P tells D that she was diagnosed with infiltrative breast cancer last month. She uploads a medical report.)) ---

07 17:24 P: 请问医生我这个情况有多严重？怎样治疗最好？
doctor, can you tell me how serious my situation is?
what is the most effective treatment?

--- ((lines omitted: D explains P's conditions and test results)) ---

13 17:58 D ni suan shi yi:ge (.) uh:m ZHONGWEI de yige huanzhe
you are a: (.) uh:m considered a
MODERATE-RISK (cancer) patient

14 ni ye bie TAI jinzhang
don't be TOO nervous.

15 ni zhege busuan shi gaowei de
you are not in a high risk.

16 women shi genju ta de fenqi lai panduan tade yanzhongxing
we assess the severity based on cancer staging.

17 yiqi dehua shengcunlv you baifenzhi JIUSHI
for stage 1, the survival rate is NINETY percent.

18 ni dehua uh:m (.) bingqing shi e'xing de=
for you uh:m (.) the tumor is malignant=

19 =DANSHI yiban zhiyulv ↑dou HEN gao de
=BUT generally the survival rate is ↑always VERY high.

20 → suoyi xiwang hai:shi HEN da de °hao-bu-hao?°
so it's sti:ll VERY hopeful °alright?°

21 name ni zhege nianji dehua ne? wo hui jianyi shuo
so given your age? i will recommend you

22 zuo yige ershiyi jiyin jiance
have the 21-gene test,

23 yinwei zhege jiancha YI fangmian ne
as it provides, on the one hand,

24 duiyu ruxianai de yuhou shi you HENda zhishi yiyi de
VERY VAUlable information about breast cancer prognosis.

--- ((lines omitted: D provides lengthy discussions on the benefits of the gene test)) ---

59 18:35 P 最终报告还在等，还没出来，
The final report is still pending, it's not yet ready.

60 化疗的作用是不是很大？能不能用中药的方式替代化疗？
Are the side effects of chemotherapy significant?
Can I use herbal medicine as an alternative?

61 后面报告出来要怎么咨询你？
How can I consult with you once I have the report?

Fig. 3. Breast cancer [BTS8].

Our focal line is line 20 where HBH is appended to a "so"-prefaced optimistic assessment. The emphatic use of "VERY" reinforces D's stance regarding P's optimistic prognosis. Sequentially, this assessment is made following D's repeated attempts to offer hope to P. These include, first, the formulation of P's condition as good news (Maynard, 2003), or at least not towards a clinical understanding of seriousness. This is achieved via the exclusion of P as a member of the "high risk" (lines 13–15). D then moves to educate P on the assessment criteria for cancer. By recruiting the self-referring "we" (line 16), D invokes his institutional identity (Drew and Heritage, 1992) and invites P to hear the ensuing talk as qualified and authoritative. What is interesting here is his actions in lines 17–19. In the context of P awaiting a pathology report, D conveys only the optimistic side of the story by "exposing" the high survival rate for stage 1 cancer (line 17) while "shrouding" other possibilities (Maynard, 2003). He grounds P's condition in optimism by invoking general statistics (line 19). The way this assessment is crafted and positioned encourages P to align with this optimistic assessment. While the assessment is given to promote alignment, the inclusion of HBH here further emphasizes D's orientation to seek P's alignment.

Our interpretation can be supported by D's action after the articulation of HBH. In line 21, D shifts to other activities in a way that formulates the optimistic assessment as the groundwork for that activity. This is achieved by using the discourse marker "name" (translated as "so", line 21). Previous research on spoken Chinese conversations (Liu, 2024) has suggested that this discourse marker often serves to introduce focal information (here: treatment recommendation) when used in the middle of a speaker's longer turn, with the preceding information providing the background or premise for that focal point. In other words, while providing the reassurance, D also indicates his stance towards what comes next as more clinically important and deserving of greater attention. Seen in this light, D displays an orientation towards P's alignment as already being secured. This usage is quite similar to what previous research has described about tag questions: they encourage participation from the recipient without holding them accountable for not responding (Ekberg et al., 2022; Hepburn and Potter, 2010, 2011). When considering P's response, it seems that P interprets HBH as not seeking her input, nor does she

feel responsible for showing explicit buy-in to the reassurance. P's response suggests that she aligns with D in considering treatment as more clinically important.

Fig. 4 presents an additional example that supports our argument. P, who has been diagnosed with lung adenocarcinoma, begins the consultation by uploading his recent pathology report (data inaccessible), sharing his medical history (line 1), and requesting an assessment (line 2).

((P uploads a medical report))
01 10:11 P: 肺腺癌，癌组织侵犯肺膜,说是要基因检测
Lung adenocarcinoma, cancerous tissue invades the lung membrane
I was told that I need to have a gene test.
02 想问医生我这个情况有多严重?
Doctor, I want to know how serious my situation is?
03 10.34 D: nihao ganxie ni de xinren
hello thank you for your trust.
04 uh:m ni zhege:: bingli ne uh:m
uh:m your: pathology report uh:m
05 limian hanyou weirutou de chengfen (.) name: jiushi
there is a micropapillary component in the
tumor (.) then: this suggests
06 qianzai de yige fufa huozhe zhuanyi de ↑gaowei yinsu
a potentially ↑high-risk factor for relapse and metastasis
07 ta muqian ne zai jige linbajie shang ye DOU you zhuanyi
at present, it HAS metastasized to several lymph nodes.
08 ↑BUGUO jinnianlai feixianai ZHENGTI cunhuolv DADA tigao
↑BUT in recent years, the OVERALL survival rate of lung
adenocarcinoma has GREATLY increased,
09 wunian cunhuolv keyi you sishi dao bashi
the five-year survival rate can be forty to eighty percent
10 → hai:shi HEN you xiwang de hao-bu-hao?
it is sti:ll VERY hopeful, alright?
11 suoyi zhege shihou women yinggai youxian zuo
thus, at present, we shall give priority to
12 shuhou de fuzhu zhiliao
postoperative adjuvant therapy
--- ((lines omitted: D recommends P to have the targeted therapy and explains why the gene test is a must)) ---
27 11.05 P: 中晚期，三期要如何治疗
Mid to late stage, stage-3, what will be the treatment plan?
28 11.39 D: uhm (.) zhege dei kan jiyin jiance de jieguo
uhm (.) this depends on the result of the gene test
29 shifou you heshi ni chi de fanying yao
to see if there is any medication suitable for you
--- ((lines omitted: D expands on the explanation of medications))
35 ruguo haiyou wenti huanying SUIshi lai zixun
you can come for consultation at ANY time
if you have further queries.

Fig. 4. Lung adenocarcinoma [CS].

In response to P's request, D provides the diagnostic assessment: a significant chance of cancer relapse and metastasis (line 6) and the spread of cancer from its original site to several lymph nodes (line 7), suggesting that the cancer is more aggressive and has the potential to spread further. While such news is worrying, D's next action is to mitigate the severity of P's condition and highlights the optimistic side of the news (Beach, 2014). This is achived via the use of the contrastive “but” and a sudden utterance-initial increase in pitch and volume to attract P's attention (line 8, Couper-Kuhlen, 2004).

As in our last example, an optimistic assessment is produced with the use of HBH (line 10). The assessment is not presented abruptly; instead, it is preceded by authoritative evidence that underscores its validity, thereby making P's compliance relevant. This evidence includes information about the survival rate, specifically noting a five-year survival rate (line 9), and highlights the “OVERALL” trend of increasing (line 8). Together, these actions are given to present a positive perspective amidst darkness (see also Stivers and Timmermans, 2017 on bivalent equilibrium in news delivery) and account for the recommended treatment (line 11 and onwards). As in our previous examples, the articulation of HBH accomplishes a couple of things. First, it marks D's stance and evaluation of the information being given: “sti:ll VERY hopeful”. Second, and crucially, its interrogative form invites the recipient to consider and align with the hopeful stance, promoting engagement without directly soliciting their input. Third, it indexes D's intention to conclude the previous discussion, and this intention suggests

that D assumes P's alignment is given. This argument can be supported by the use of the discourse marker "suoyi" (translated as "thus", line 11). Similar to the use of "so" in Fig. 3 (line 21), "suoyi" constructs D's earlier reassuring action(s) as the groundwork for something more clinically important: treatment recommendation (lines 11–12). P aligns with this understanding by only responding to the treatment recommendation (line 27). The topic of hope and seriousness has not been raised again in the rest of the consultation.

4.3. Reassurance without HBH

This section includes an illustration where reassurance is given without using HBH and is hearable as a directive that takes the form of an imperative (Goodwin, 2006). Unlike previous illustrations where reassurance is offered after diagnosis, Fig. 5.1 presents an instance where reassurance goes first and diagnosis second. P begins the consultation by informing D about changes in stool color and expressing concerns about the possibility of having cancer and the fear of dying (lines 1–3).

```
01 11.09 P 最近便秘拉出来的粪便开头是黑色的，后面颜色正常。
           recently, i had constipation and my stool was black
           at the beginning, but normal color at the end.
02         并且其中还有类似小方块一样的红色，不清楚是辣椒还是血液。
           There were also small red cubes in it,
           but I was not sure if it was pepper or blood.
03         我是不是得癌症了，我是不是快死了？
           Do I have cancer? Am I dying?

04 11.44 D nihao (.) ganxie nide zixun he xinren
           hello (.) thank you for your consultation and trust.
05         yin gongzuo MANG danwu le yidian Shijian qing jianliang
           I am sorry that i was delayed a little due to my BUSY work.
06    →    SHOUxian ne xian bie danxin
           FIRst of all, don't worry.
07         kanle yixia ni de qingkuang jieshao uh::m
           ((i)) have read your medical records uh::m
08         fenbian limian you zhe:ge >fa hong fa hei< de dongxi
           ((there's)) red and black stuff in the stool.
09         bu YIDING jiushi aizheng =YOUQI shi nianqinren
           It is not NECESSARILY cancer =ESPECIALLY for young people.
10         qishi zhe ye HEN changjian
           This is in fact also VERY common.
11         keneng he yinshi ye you dian guanxi
           it may be related to diet
12         huozhe: guoqu jizhou qita yixie xiao maobing
           or some other minor problems in the past week
13         biru zhichuang ganglie huozhe zhichangyan
           including hemorrhoids, anal fissures, and proctitis
14         DOU hui chuxian leisi de zhengzhuang
           ALL may present similar symptoms
15         YOUQI ruguo zhishi ZUIJIN jici cai you zhezhong qingkuang
           ESPECIALLY if it has only appeared RECENTLY,
16         shi aizheng de kenengxing jiu GENG xiao le
           the possibility of cancer is EVEN smaller.
--(( lines omitted: D talks about potential non-serious causes of changes
in stool color, explains the progression of cancer, and advises P to
observe the situation for a few days and undergo specific medical tests to
further evaluate their condition if they're concerned.))–
42         suoyi ne: wo cong linchuang jingyan laikan
           so: from my clinical experience,
43         xianzai de aizheng de gailv FEICHANG feichang xiao
           the likelihood of developing cancer is
           VERY, very small at this point,
44         GENG buhui tandao zhege weiji SHENGming de qingkuang le
           LET ALONE life-threatening.
45    →    bie danxin you yiwen keyi suishi lai zixun
           don't worry, you can come
           for consultation at any time if you have further queries.
```

Fig. 5.1. The first two posts in a consultation [OC5].

D's response begins and ends with the same reassurance "don't worry" (lines 6 & 45), with a series of different actions in between that serve as the bases and sources for the reassurance (Pomerantz, 1984). Positioned differently, these two reassurance statements appear to perform distinct actions. The first statement occurs at line 6, following the discourse marker "first of all". This suggests the start of a sequence of actions designed to promote a worry-free stance. That said, the first

reassurance is less likely produced to invite an alignment, but rather works to indicate that the subsequent conversation will likely challenge P's candidate diagnosis (Stivers, 2002) of cancer and impending mortality. In lines 8–9, D summarizes (Houtkoop-Steenstra, 1986) what P has said and uses it as the grounds for the diagnosis. The phrase “especially for young people” reframes P's concern from an individual issue to a more general one, suggesting that the symptoms are less alarming for this age group and do “not NECESSARILY” lead to a cancer diagnosis. This generalizing practice aims to normalize the problem, making what might seem uncommon appear common (Jefferson, 2004a). This effort is explicitly highlighted in line 10 through the use of the extreme case “VERY common” (Pomerantz, 1986). D then proceeds to educate P about various conditions that could cause similar symptoms (lines 11–14), helping P understand that there are multiple potential explanations and why cancer is less likely at this point (line 16). With further efforts in patient education and advice on practical steps for monitoring the condition (lines omitted), in line 42, D offers a low-risk assessment. The assessment is based on D's direct experience (Pomerantz, 1984) and is prefaced with “so”, which ties it to the preceding actions as supporting evidence. With the emphatic use of the extreme case formulations “Very, very small” and “LET ALONE” (lines 43–44), D attends directly to the certainty of the assessment (Edwards, 2007). The design of the assessment, along with its placement, lends lends credibility and authority to the assessment, suggesting it is informed by practical, real-world knowledge, thereby discouraging dispute or challenge. This low-risk assessment prompts the second directive reassurance, “don't worry” (line 45).

The placement of the two directive reassurances as a bookending structure creates a sense of closure, suggesting to P that the response has come full circle. Our argument is supported by D's future arrangement following the second “don't worry”, which implies that P's concern has been resolved and no further questions remain. Thus, D is indicating not just a possible closure of the topic, but a closure of the encounter (Robinson, 2001; West, 2006). In response, P thanks D and moves to address other medical concerns, suggesting P's alignment with the reassurance (Fig. 5.2).

```
01 13.12 P 谢谢你医生，
            Thank you doctor
02          另外，我平时基本上不怎么运动的，而且经常久坐
            Additionally, I don't get much exercise
            and I tend to sit for extended periods.
03          然后最近半个月吃了很多辣的东西
            Over the past two weeks, I've been consuming
            a lot of spicy food.
04          因为久坐我也有痔疮
            Due to prolonged sitting, I've developed hemorrhoids.
05          这个痔疮会自愈吗？
            Will these hemorrhoids heal on their own?
```

Fig. 5.2. The third post in a consultation [OC5].

5. Discussion

We could see similarities and differences between Fig. 5 and other illustrations where HBH is attached to a reassurance statement. Common to these illustrations is that the articulation of a reassurance statement after a series of actions attempted at reassuring the patient (e.g., diagnosis and assessment) projects a possible closure of the current encounter. In other words, the reassurance statement, whether formulated as a directive or a request, sequentially positions the patient as the one providing compliance, leaving no room for negotiation about the matter being discussed. One possible explanation is its placement after information that falls within the doctor's expertise. Our interest lies in how HBH contributes to delivering reassurance when it assumes compliance is already given. What we can infer from Fig. 5 is that the imperatively formatted “don't worry” has a directive-commissive nature (Couper-Kuhlen, 2014), treating the action being directed here as “non-contingent on, or independent of, the capacity or desires of the recipient” (Etelämäki and Couper-Kuhlen, 2017, p. 220). However, in the four illustrations with HBH, the syntactic form and interrogative tone of HBH change the grammar of the utterance from an imperative directive into a request that seemingly acknowledges the recipient's contingency in granting the action being recommended to them (Craven and Potter, 2010; Curl and Drew, 2008). Given that the reassurance using HBH is placed after diagnosis and risk assessment, the actions could include accepting the diagnosis and assessment, aligning with the doctor's overall stance, adopting an optimistic mindset, and other actions that fall within the patient's own domain. Viewed in this light, HBH is primarily used as a stance marker (Du Bois and Kärkkäinen, 2012; Rauniomaa, 2007), similar to a tag. It anticipates compliance with the recommended action and mitigates its directness, rather than genuinely inviting negotiation. The variation in how patients respond to doctors' reassurance supports our argument for understanding HBH in the context of delivering reassurance.

The data also shows that HBH when produced as the last action of a series of reassuring attempts works to summarize the doctor's overall stance, making imminent topic transition within or closure of the current speaker's longer turn.

6. Conclusion

The research reported here builds on previous CA research by Sansone et al. (2022) to extend our understanding of reassurance in CMIs. Features of these interactions include extended turns where each is sent in full, multiple actions within a single turn, and the absence of an immediate interactional slot for the recipient to respond to each action. Previous studies on face-to-face interactions have noted the frequent use of declarative statements by doctors when reassuring patients (Sansone et al., 2022). We observed the same pattern, particularly when doctors explain the symptoms and progression of the patient's condition. But, we also observe instances when such statements are formulated in a way that transforms the reassuring action from a kind of unilateral pronouncement to one that is more collaborative. While these actions are reassuring, we focus on the specific utterance in which the doctor addresses the patient's uncertainties and how HBH modifies its directness while still maintaining the doctor's control over the interaction.

CRediT authorship contribution statement

Ying Jin: Writing – review & editing, Writing – original draft, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Dennis Tay:** Writing – review & editing, Supervision.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Declaration of Generative AI and AI-assisted technologies in the writing process

The authors declare that generative AI tools have not been used to prepare the submitted work.

Funding

This work was supported by the Hong Kong Polytechnic University under the funding scheme “Start-up Fund for New Recruits” (Project code: A0044036).

Declaration of competing interest

The authors report that there are no competing interests to declare.

Data availability

The data that has been used is confidential.

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