

Where resonance exists, alignment follows: Resonance as verbal engagement in China's rural medical consultations

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Abstract

Little existing research explains resonance as verbal engagement to establish an alignment in rural China's medical consultations, which are characterized by a knowledge asymmetry between village doctors and patients, a mismatch schema in disease conceptualization between rural and urban areas, and age-related expression barriers in discovery accounts. In this study, we investigate the discursive strategies and functions of resonance as used by village doctors in China's rural medical consultations based on the naturally occurring doctor-patient conversations collected from 32 rural medical institutions in 11 provinces of the P. R. China. By using grounded theory and discourse analysis, the findings reveal two sets of strategies: explicit resonance in the form of content recurrence, structural replication and sentence-final particles, and implicit resonance in the form of backchanneling tokens, discourse markers and relevance acknowledgment. These strategies blend to form an allied voice that balances the village clinician-patient knowledge gap, rural-urban cognitive divide, and intergenerational communicative dissonance by cognitive and affective alignment.

Keywords: Resonance, alignment, verbal engagement, China's rural medical consultations.

Resumen

Cuando hay resonancia, se produce alineación: la resonancia como implicación verbal en las consultas médicas rurales en China

Existe poca investigación previa que explique la resonancia como una forma de

implicación verbal orientada a establecer alineación en las consultas médicas rurales de China, caracterizadas por una asimetría de conocimiento entre médicos rurales y pacientes, un desajuste en los esquemas de conceptualización de la enfermedad entre zonas rurales y urbanas, y barreras expresivas asociadas a la edad en los relatos de los síntomas. En este estudio se investigan las estrategias discursivas y las funciones de la resonancia empleadas por los médicos rurales en las consultas médicas de China, a partir de conversaciones médico-paciente espontáneas recopiladas en 32 instituciones sanitarias de 11 provincias de la República Popular China. Mediante el uso de la teoría fundamentada y el análisis del discurso, los resultados revelan dos conjuntos de estrategias: una resonancia explícita, en forma de recurrencia de contenido, reproducción de la estructura y el uso de partículas finales de oración, y una resonancia implícita, en forma de marcas de retroalimentación, marcadores discursivos y reconocimiento de la pertinencia. Estas estrategias se combinan para conformar una voz aliada que, mediante la alineación cognitiva y afectiva, equilibra la brecha de conocimiento entre el personal clínico rural y los pacientes, la división cognitiva entre lo rural y lo urbano y la disonancia comunicativa intergeneracional.

Palabras clave: Resonancia, alineación, implicación verbal, consultas médicas rurales en China.

1. Introduction

Making alignment with others is important in both the workplace and everyday life. In recent decades, there has been an increasing number of studies of discursive practices in institutional encounters, especially in medical consultations, in which doctors who have not previously met patients attempt to establish a working alliance with them (Zhao, 2024). With a glance at the concept of a working alliance between doctors and patients emerging in modern medicine (Bordin, 1979), some of these studies have tacitly treated the congruent expressive acts between doctors and patients as default acts to establish a working alliance (Waitzkin, 1985). Others put more emphasis on how discursive efforts are used to soften the illocutionary force of performing some highly face-threatening speech acts (Zhao, 2024). In reality, the concept of the working alliance is a complicated trans-theoretical term derived from the notion of a therapeutic alliance. It not only includes doctor-patient agreement on explicit treatment goals, but also the extent to which there is doctor-patient agreement and collaboration on specific tasks needed to achieve treatment goals, and the extent to which there is an emotional bond creating doctor-patient trust (Bordin, 1979). However,

previous research has tended to overgeneralize, using the concept of congruent expressive acts without pinning down the specific language forms used to build a working alliance. Resonance, which refers to how participants in a conversation receive and process information, is now considered a ubiquitous factor in assessing patient satisfaction with doctor-patient interaction (Tantucci & Lepadat, 2024). It highlights how the content and structure of a conversation are recreated, reformulated or reshaped by the participants. This concept is crucial for understanding how doctors and patients build their working relationship. Resonance was initially defined as a form of dialogic imitation, in which speakers reiterate the interlocutors' utterances (Du Bois, 2014). Tantucci and Lepadat (2024) expanded upon this notion, considering peripheral markers of intersubjectivity and overt strategies of relevance acknowledgment as distinct dimensions of the doctor's verbal engagement. Although previous studies have examined the role of resonance in doctors' empathic discourse and its discrepancies among different types of urban medical consultations, such as the comparison between Traditional Chinese Medicine (TCM) and Western Medicine (Tantucci & Lepadat, 2024), limited investigation to date has focused on the association between resonance and alignment in rural doctor-patient interactions. Rural medical consultations are an underexplored context, marked by geographic isolation, aging populations, and long-term doctor-patient relationships. As demonstrated in Liu and Mao's (2019) investigation, patients residing in rural China exhibited a high level of satisfaction with the medical services they received. The domains of medical service attitude and illness explanation were identified as the most satisfying aspects of these services (Liu & Mao, 2019). However, the way in which this satisfaction is communicated through the building of resonance remains unexplored. Against this backdrop, by using discourse analysis and grounded theory (Glaser & Strauss, 1967) to examine 55.6 hours of conversation between village doctors and patients, we investigate village doctors' discursive strategies of resonance and discuss their functions in China's rural medical consultations. Theoretically, this research is positioned to make a theoretical contribution by developing a more nuanced, context-sensitive understanding of resonance, which accounts for the huge knowledge asymmetries and challenges inherent to doctor-patient communication in under-resourced rural settings. Practically, the research findings offer evidence-based strategies showing how using resonance enables village doctors to establish a working alliance with patients in actual medical practices, which are relevant for medical communication training programs.

2. Background

2.1. From medical discourses to rural medical consultations in China

Since its formulation by Korsch and Negrete (1972), our understanding of doctor-patient interaction as one of the typical medical discourses has undergone considerable development (Heritage, 2011; Peräkylä, 1995; West, 1984; Wilce, 2009). The majority of medical encounters adhere to a consistent structure, initially delineated as initiating the session, gathering information, building the relationship, giving information, and closing the session (Riccardi & Kurtz, 1983). However, the venues in which medical discourse occurs have undergone further expansion, particularly in the 21st century, as evidenced by studies on telemedicine (Matusitz & Breen, 2007; Robinson et al., 2015; Whitten et al., 2000) and online consultations (Kessler & Schmidt-Weitmann, 2021; Zhang, 2020). These emerging contexts of medical interaction have transformed the ways in which doctors and patients communicate, calling for a more finely differentiated understanding of communicative contexts in medical encounters. Although a substantial body of research has previously examined data from urban hospitals, rural medical consultations, a term often used dichotomously with “urban”, have received considerably less scholarly attention. Indeed, a single discursive study by Nimegeer and Farmer (2016) touches on this context; their research in rural Scotland revealed that some participants leverage notions of local identity and tradition to enhance their trustworthiness and assert influence within health initiatives. According to the National Report on the Development of the Aging Career of 2020, rural residents aged 60 and above accounted for 23.81% of the total rural population in China, which was nearly eight percentage points higher than in urban areas. Although the exact rate varies depending on the treatment scenario, China’s rural cooperative medical insurance basically provides rural residents with no less than 50% reimbursement for their expenses. Nevertheless, the partial commercialization of rural medical institutions as a relatively independent part of the county healthcare consortium has to some extent led to an invisible economic hostility between doctors and patients. Therefore, the construction of doctor-patient alignment in Chinese rural medical discourse is both necessary and complex for both patients and doctors. Although China’s rural doctor-patient relationships are important for health policy-making (Liu, 2005), few empirical studies exist on rural medical consultations in China.

2.2. Alignment, resonance, verbal engagement

2.2.1. Resonance

As an emerging topic in the study of doctor-patient interactional engagement, resonance is an essential part of doctor-patient alignment (Tantucci, 2023). Such engagement has not been conceptualized as resonance before, although Stivers et al. (2011, p.21) made a vague connection between the construction of aligning responses and “facilitating the proposed activity or sequence, accepting the presuppositions and terms of the proposed action or activity, and matching the formal design preference of the turn”, which is similar to the original definition of resonance as a form of dialogic imitation where speakers reiterate the interlocutors’ utterances (Du Bois, 2014). The cooperative feature of resonance led to some early-stage research on performance of neurodivergent individuals in conversation. For example, Hobson et al. (2012) found that participants with autism were no less likely to show a basic form of dialogic resonance across successive utterances (the “frame grab”), but more likely to elaborate their responses in atypical manners. This study has been followed up in terms of manifestations, occurrence stages, characteristics, etc., based on the correlation with engagement and priming in diverse contexts (Tantucci & Wang, 2021, 2022, 2023).

The core definition of resonance is both the reproduction and reconstruction by the subsequent interlocutor of the content and structure of the previous interlocutor’s discourse, reflecting the process of receiving and processing what the two speakers say to each other. This process is also related to the content of one’s own expression, as a form of complex imitation (Arbib, 2012), inherently acknowledging the meaning of what has been said. Subsequent research has expanded the realm of resonance upon such a core definition, later paralleling with peripheral markers of intersubjectivity (sentence-final particles, backchanneling tokens, and discourse markers) and overt strategies of relevance acknowledgment (such as “according to your description”) as distinct dimensions of doctor’s verbal engagement (Tantucci & Lepadat, 2024). This study can be characterized as a succession of all previous studies on resonance, whether they were conducted in a medical context or not. The fine-tuned definition helps us to better examine such dialogical features in medical discourse, while the lack of previous studies calls for research on resonance, as a particular way of embodying verbal engagement, in rural medical institutional discourse.

2.2.2. Verbal engagement

The study of “engagement”, derived from Bakhtin’s conceptualization of dialogism and polyphony, establishes a resource for expressive engagement in discourse and was later developed by Appraisal Theory within the framework of Systemic Functional Linguistics (SFL). Even though most of the studies under the scope of SFL focus on the linguistic behavior of a single narrator or writer, the reader or voices from outside of the discourse have been attributed vital importance. Whether expanding (entertaining and attributing) or contracting (disclaiming and proclaiming), engagement in discourse more or less resonates with the positions and voices of others.

“Verbal engagement” in this research is understood as the moment-by-moment collaborative work through which speakers display that they are attending to, responding to, and jointly constructing the ongoing interaction. Rather than invoking the full Appraisal Framework, which was designed for dialogicality in continuous text, we treat engagement as the practices that make dialogue possible and that are captured in our resonance categories.

2.2.3. Resonance as a form of verbal engagement in alignment

The concept of alignment emerged in the study of adjacency pairs, particularly in the context of question-answer and information-exchange structures. Stivers (2008, 2011) made a clear distinction between the alignment and its allied concept of affiliation in the mid-telling environment of storytelling. He conceptualized alignment as the recipients’ vocal continuation (e.g., “hum”, “mm”) and abandonment of taking a full turn from the storyteller, providing reference for further study on alignment in responding actions (Lee & Tanaka, 2016). This can support the structural asymmetry of the storytelling activity. However, (a)symmetry is at the heart of doctor-patient interaction studies (Dingwall & Pilnick, 2020). The effect of the power imbalance leads to a negative paternalistic relationship (Beisecker & Beisecker, 1993), and obviously communication turns out to be the means through which individuals can achieve symmetry, at least on an interactional level (Mey, 1987). The asymmetry in medical discourse is partly due to the knowledge gap between the interlocutors, so the aim of alignment is not to eliminate this asymmetry completely, but to narrow the doctor-patient cognitive gap between doctor and patient through an interactional process. This need brings us back to the concept of a working alliance between doctor and patient that emerged in modern medicine (Bordin,

1979). The concept echoes interpersonal studies showing that an indispensable factor in the success of treatment depends on the cooperation of the participants.

Resonance, as the focus of this research, serves as a particular way of embodying the verbal engagement that is one of the many elements in achieving alignment. Although resonance is a distinctive form of alignment (Pickering & Garrod, 2021), existing studies to date stop short of investigating the relationship between resonance and alignment in rural doctor-patient interactions. Given the scenario that such “on record” dialogic engagement occurs when speaker B demonstrates that what A said was relevant to the continuation of the interaction (Tantucci & Lepadat, 2024), and that resonance is based on a constructive approach to dialogue that allows for the quantitative measurement of proactive engagement in interaction on a large scale (Tantucci & Lepadat, 2024), it is necessary to examine the construction of doctor-patient alignment through the verbal engagement of resonance in this under-explored context.

According to Ameka and Terkourafi (2019), it is inappropriate to regard widely accepted Western categorizations as culturally neutral. It is therefore necessary to reframe the aforementioned concepts within Chinese cultural contexts. In response to this imperative, the present study focuses on existing forms of resonance, a phenomenon defined here as the interlocutors’ formal repetitions or pragmatic responses to the prior interlocutors’ utterances within adjacency pairs, through which alignment is achieved. Resonance constitutes a manifestation of verbal engagement at the micro-level and serves as a key element in a previously under-explored pathway to understanding doctor-patient alignment. By demonstrating its presence in the context of China’s rural healthcare, this study investigates the categorization of resonance and how it facilitates the process of achieving such alignment.

3. Data and method

3.1. Research question

In this study, we attempt to probe into the construction of doctor-patient alignment in China’s rural medical consultations through resonance as verbal engagement with the ensuing two major research questions:

1. How are the discursive strategies of resonance employed in China's rural medical consultations?
2. What functions do these strategies play in China's rural medical consultations?

3.2. Data collection

According to the National Bureau of Statistics, the total number of village clinics was 581,964 in 2023, and such rural medical institutions covered more than 94.8% of administrative villages in 2019. The township health centers, at a higher level than the village clinics in China's rural medical system, had a total of 1,309 million person-time consultations and treatments, carrying the majority of medical services for rural residents. Due to the relatively small size of rural medical institutions compared with urban hospitals, most rural doctors are general practitioners. The patient participants were predominantly elderly, with common conditions including hypertension, diabetes, and chronic pain (see example 1, 2, 3, 4). In addition, most patients in such small rural communities would establish long-term doctor-patient relationships with doctors due to limited provider options.

The data for this study comprise audio recordings of naturally occurring doctor-patient discourse in general practice clinics, internal medicine departments and TCM (Traditional Chinese Medicine) departments from a dataset collected in 2024 from 32 rural medical institutions (township health centers and village clinics) in 11 provinces of the P. R. China (Jiangsu, Shandong, Anhui, Hebei, Jiangxi, Fujian, Shanxi, Gansu, Sichuan, Guizhou, Guangxi), as shown in Table 1.

Province	County	No. of institutions	Category of institutions	Length of transcription (no. of Chinese characters)	No. of encounters
Jiangsu	Funing	1	Township Health Center	2,451	10
Shandong	Pingyuan	1	Village Clinic	2,373	10
Jiangsu	Hai'an	3	Township Health Center & Village Clinic	11,785	31
Jiangsu	Haimen	1	Village Clinic	6,121	45
Guizhou	Xixiu	1	Village Clinic	3,661	11
Gansu	Gangu	3	Village Clinic	3,803	10
Guangxi	Gangbei	2	Village Clinic	4,323	5
Guangxi	Jiangnan	1	Village Clinic	15,887	25
Guizhou	Yuqing	1	Village Clinic	2,310	10
Gansu	Yongchang	1	Township Health Center	6,864	15
Hebei	Huanghua	1	Township Health Center	2,106	17
Sichuan	Xuanhan	2	Township Health Center	4,689	15
Fujian	Quangang	1	Township Health Center	5,319	16
Anhui	Jiujiang	1	Township Health Center	2,645	10
Jiangsu	Xuyi	1	Township Health Center	7,541	15
Jiangsu	Tongzhou	1	Township Health Center	4,614	12
Guizhou	Baiyun	1	Township Health Center	11,302	11
Shanxi	Shiquan	1	Township Health Center	12,262	20
Jiangxi	Nancheng	1	Township Health Center	3,305	11
Jiangsu	Huai'an	1	Township Health Center	1,948	2
Jiangsu	Jiawang	2	Township Health Center	3,304	15
Guizhou	Weng'an	1	Township Health Center	7,085	11
Jiangsu	Yandu	1	Township Health Center	11,246	15
Jiangsu	Danyang	1	Township Health Center	19,098	53
Jiangsu	Taixing	1	Township Health Center	8,928	9

Table 1. Information about Rural Medical Institutions involved.

The dataset for the present study consists of around 55.6 hours of conversation between village doctors and patients in Chinese regional dialects. As for research ethics, we strictly adhered to the three-tiered consent framework designed by the CIOMS guidelines (2016), including pre-interaction disclosure and context-sensitive consent. As the current study is not longitudinal, we excluded the ongoing consent reinforcement. The data were transcribed with 164,970 Chinese characters and translated from Chinese to English in line with the three-line method (Kendrick, 2018), i.e., the first line is Chinese *pinyin*, the second word-for-word translation, and the third idiomatic translation.

3.3. Data analysis

The analysis of the data is based on grounded theory (Glaser & Strauss, 1967), a research process characterized by its fluidity, interactivity, and open-endedness since researchers maintain an innate connection to their topics

(Nouralian, 2024). As a qualitative research strategy, grounded theory entails a meaning-making process that seeks to understand how individuals navigate and co-construct their actions and interactions within a socially constructed phenomenon (Priya, 2016). The fundamental principles of grounded theory encompass the reduction of preconceived ideas about the research problem and data, the simultaneous process of collecting and analyzing data, considering their mutual influence on each other, and the embracing of diverse interpretations of the data (Charmaz, 2008). Such principles decentralize from the existing theories towards a researcher's subjective point of view in qualitative studies. Another crucial feature of the theory is flexibility, and this requires openness to various interpretations of the data (Nouralian, 2024). Charmaz (2000) extended grounded theory, and her constructivist grounded theory focuses on the position of the researcher and the interaction between the researcher, the participants, and the data, while conducting the coding process and developing a theory (Nouralian, 2024).

The process of data coding in this study consists of three stages, following the coding procedures proposed by Strauss & Corbin (1990). Step 1: Open coding is the process of gradually categorizing the form of resonance. We repeatedly compare the doctor-patient transcripts without any prior assumptions while retaining their original meaning and forming initial labels. By screening 184 cases and 1023 original statements, 20 initial concepts were identified. Step 2: Axial coding further organizes and integrates the concepts formed during open coding. This process intends to identify and establish the internal relationships between different concepts through cluster analysis, thus constructing a more rigorous system. In this study, the 7 initial categories were further condensed until no further features of resonance were identified. Step 3: Selective coding requires the researcher to repeatedly compare, contrast and analyze various categories to identify their intrinsic logical relationships, and thereby construct a more systematic theoretical framework (Nouralian, 2024). We ultimately identified explicit resonance and implicit resonance as the core categories that run through the entire study, based on the degree of formal, surface-level repetition versus deeper, pragmatic and semantic alignment in the conversation. Explicit resonance refers to the overt dialogic imitation in a conversation where an addressee directly reproduces formal linguistic elements towards the prior utterance, which could be identified as obviously concerning the content and structure of adjacency pairs. Implicit resonance is less recognizable, as it denotes an engagement where an addressee pragmatically responds to or semantically

elaborates on the prior utterance without directly repeating its formal features. Selective examples of sub-categories of the two core categories are shown in Table 2.

Core categories	Initial categories	Selective descriptions
Explicit Resonance	Content recurrence (In the form of lexical repetition, propositional recycling, and thematic re-instantiation)	P:这个手要不要这样弄个东西 固定 一下，让它不要动啊？ D:不要 固定 ，你不存在骨头脱位，就是关节上受了伤，就拿药在那里喷喷就好了。 P: Does my arm need fixation to let it not move? D: Fixation is not needed. You don't have a bone dislocation, simply a joint injury, just take the medicine and spray it there.
	Structural replication (In the form of pattern recurrence, frame reiteration, and syntactic parallelism)	P:那这些药全是 我的 吗？ D:对，都是 你的 。 P: Are all these drugs mine? D: Yes, all these are yours.
	Sentence-final Particles (Attach to the end of clauses in the syntactic level, carry distinctive intonation in the prosodic level)	P:我一直要来，烦人 啊 。 D:不是烦 啊 ，医保它不准这样开。 P: I have to come all along. It's annoying. D: It's not matter of annoying. It's not allowed to do this.
Implicit Resonance	Backchanneling Tokens (Minimal responses or listener feedback)	P:我寻思着开多点，我以后不要再来开了。 D: 哎 ，我已经给你开稍微多的了。 P: I would like to have more, so that I won't come again. D: Well, I've already given you a little more. D:那脚呢？ P:脚， 我告诉你啊 ，在这里不是让你打了一针封闭的吗？这样回去之后，疼倒是不疼，就是弯了不好走路，不好走路后，我女儿就想办法叫我跟她到南通附院去。 D: What about your foot? P: Foot, let me tell you, didn't you give an anesthesia needle here? After going back, it was not painful, but it was uneasy to walk, so my daughter tried to ask me to go to the Nantong Affiliated Hospital with her.
	Discourse Markers (Non-propositional and serve certain pragmatic functions)	P:要不血压量量哦？量量哦？ D:可以，量一下，量一下放心。 P: 就是 ，量一下。 P: How about a blood pressure measurement? Is that OK? D: Yeah, have yours checked so as to rest assured.
	Relevance Acknowledgment (Validating the speaker's contribution and signaling that the listener is tracking the conversation's flow)	P: You are definitely right about that, let's do it.

Table 2. Main categories of resonance formed by selective coding.

4. Findings

The research results demonstrate the extent to which Speaker B actively employs explicit resonance in the sub-strategies of content recurrence, structural replication, and sentence-final particles, and implicit resonance in the sub-strategies of backchanneling tokens, discourse markers and relevance acknowledgment to dialogically engage with and build alignment with Speaker A's original utterance. The results are based on the total of 1023 doctor-patient resonances identified in the data, as shown in Table 3.

Resonance Strategies	Frequency	%
Content recurrence	535	52.30%
Structural replication	267	26.10%
Sentence-final particles	57	5.57%
Backchanneling tokens	52	5.08%
Discourse markers	7	0.68%
Relevance acknowledgment	105	10.26%

Table 3. Explicit and implicit resonance strategies in China’s rural medical consultations.

Example (1) below is a case of explicit resonance by using content recurrence in our data occurring from the doctor to the patient.

(1) Content recurrence

A患者: 老人欵, 老了就死了拉倒了, 烦死了。

Patient A: It’s so annoying to be an old man, I wish I was dead.

A医生: 死了你愿意啊?

Doctor A: Don’t tell me you would rather die.

A患者: 我怎么不愿意啊? 我情愿死。

Patient A: Why not? I would rather die.

A医生: 这个大话不要说。

Doctor A: Don’t say such big words.

A患者: 什么大话不要说, 我疼了够了, 我这个腿子一跑一疙瘩一跑一疙瘩, 像断了一样, 一跑一疙瘩, 多远就听得到了, 疼死了。

Patient A: Not big words, I’ve had enough pain. My leg’s creaking and creaking, like it’s broken, creaking when I’m walking, heard from far away, and it hurts so much.

Re-using (parts of the) utterances and constructions of their interlocutors is thought to be the outcome of the creative recombination of form and meaning across turns (Tantucci & Lepadat, 2024). We found that content recurrence is a tactic in our data where specific lexical items, phrases or thematic elements are deliberately repeated across adjacency pairs to reinforce engagement in the ongoing conversation.

Example (1), which occurred in one of the township health centers, is part of a discussion on the patient’s long-term leg problem. After the patient-

initiated complaint, the doctor reuses the key word of [死了 'to die'] to form a rhetorical question to doubt the willingness of the patient, responding to the elderly patient's negative attitude. In the following turn, the patient reaffirms his attitude with [愿意啊 'willing to'], followed by another use and reuse of [大话不要说 'do not say big words'] by the doctor and the patient. In such a typical content recurrence, resonance as a verbal engagement enables the interlocutors to effectively exchange opinions on the relevant theme, so that agreement and disagreement are clear for the subsequent part of the consultation.

Example (2) below is a case of explicit resonance by using structural replication in our data occurring from the patient to the doctor.

(2) Structural replication

B医生: 老哥哥, 你这血压高的厉害了, 180/110呢, 你是不是喝酒了?

Doctor B: Brother, your blood pressure is very high, 180/110, you been drinking?

B患者: 就是喝了啤酒了。

Patient B: Just drank beer.

B医生: 我给你说噢你绝对喝了酒了, 这血压高的很。

Doctor B: I say that you definitely drank alcohol, the blood pressure's so high.

Different from content recurrence, structural replication is non-lexical repetition but is deliberately reproduced in similar syntactic, morphological patterns to a prior utterance in subsequent communication. Example (2), which occurred after taking blood pressure in a township clinic, is about the inquiry about the patient's symptom and cause of hypertension. The resonance occurs from the original structure [喝酒了 'have drunk'] in an interrogative sentence where the doctor asks whether the patient has been drinking. The patient gives an affirmative answer by slightly adapting the structure to similar variants of [喝了啤酒了 'drank beer'], followed by the doctor's reaffirmation of [喝了酒了 'drank alcohol'] in the next turn as a judgment based on the drinking behavior that may lead to the symptom of high blood pressure.

Example (3) below is a case of explicit resonance using sentence-final particles in our data occurring from the patient to the doctor.

(3) Sentence-final Particles

C医生: 叔, 今天过来是怎么了呀?

Doctor C: Uncle, what's wrong with you today?

C患者: C大夫呀, 我昨晚喝了些酒, 现在右边的眼睛有些红肿, 过来请你给我看一下怎么回事儿。

Patient C: Dr. C, I drank some liquor last night, and now my right eye is a little red and swollen, so I'd like you to take a look at what's going on.

As one of the subcategories of explicit resonance, sentence-final particles as resonance refers to the strategic use of utterance-ending particles (e.g., *ah* [啊], *ma* [嘛], *ne* [呢], *ya* [呀] in Chinese) to offer an affective echo, epistemic synchronization, and turn-taking cues. Example (3), which occurred at the beginning of a medical consultation in a village clinic, is composed of greetings and a simple description of illness between a doctor and his regular elderly patient. The identical sentence-final particles [呀 *ya*] in an adjacency pair represent an affective echo in tone at the beginning of a medical consultation. The first [呀 *ya*] by the doctor contains the exclamatory tone of seeing a familiar face, as the doctor uses the fictive kinship term [叔 'uncle'] rather than a normal term "patient". At the same time, the interrogative tone inquires about the purpose of his visit. In the subsequent turn, the patient uses [呀 *ya*] not only as part of the greeting in an exclamatory greeting, but also to give the answer to the proposed question.

Example (4) below is a case of implicit resonance by using backchanneling tokens in our data occurring between the doctor and the patient.

(4) Backchanneling Tokens

D医生: 今天几号了, 是不是快过年了?

Doctor D: What date is it today? Isn't it approaching the Spring Festival?

D患者: 对呀。哎, 现在的年也没什么好过的, 就是老了一岁。

Patient D: Yes, ay, it's nothing fun but one years older.

D医生: 咳, 过年嘛, 多吃点肉、多去逛逛街, 等正月了看看社火, 就这么过呗。

Doctor D: Oh, just eat more meat, hang out more frequently, and watch shehuo performance during the first moon. That's how we celebrate the Chinese New Year.

Different from previously mentioned explicit resonances which are almost all speaker-led repetitions, backchanneling tokens, as listener-driven coordination, are one of the three implicit resonance strategies that particularly refers to minimal verbal or nonverbal responses (e.g., “mhm”, “yeah”, head nods) produced by a hearer to signal alignment with a speaker's ongoing discourse. Example (4), which occurred during injection therapy in a village clinic, contains treatment during the process of consultation which was completed by the same doctor. The small talk, on the topic of celebrating the traditional Chinese Spring Festival involves [哎 ‘ay’] and [咳 ‘oh’], which are backchanneling tokens that do not contain an actual meaning but imply an attitude in response to a previous speaker. [哎 ‘ay’] in the patient's turn is related to the negative reaction to the information given by the doctor about the approaching Chinese New Year, while [咳 ‘oh’] uttered by the doctor in the subsequent turn mitigates the tone of the disagreement to the boredom of celebrating the festival.

Example (5) below is a case of implicit resonance by using discourse markers in our data occurring between the doctor and the patient.

(5) Discourse Markers

E医生: 那脚呢?

Doctor E: What about your foot?

E病人: 脚, 我告诉你啊, 是在这里不是让你打了一针封闭的吗? 这样回去之后, 疼倒是不疼, 就是弯了不好走路。

Patient E: Foot, I'm telling you, remember giving an injection here? After going back this way, it doesn't feel the pain, yet it's uneasy to walk bowing like this.

Use of discourse markers as resonance in our data refers to the strategic use of connective or interactive expressions to create coherence, align stances, or mirror prior discourse patterns. Example (5) occurred in a township health center in the situation of re-examination. [我告诉你啊 'I'm telling you'] signals a shift to high-engagement talk, preempting shared knowledge by responding to the doctor's question.

Example (6) below is a case of implicit resonance by using relevance acknowledgment in our data, occurring between the doctor and the patient.

(6) Relevance Acknowledgment

F医生: 最近工作怎么样?

Doctor F: How's work lately?

F患者: 忙得很, 不过总算有时间来看病了。

Patient F: Busy as hell, but finally I have time to see the doctor.

F医生: 看得出来, 别太拼了, 健康第一。

Doctor F: I can see that, don't work too hard, health first.

Relevance Acknowledgment is another listener-driven implicit type of resonance in which the listener demonstrates that what the other interlocutor said was relevant for the continuation of the interaction, thereby sustaining dialogic alignment. Unlike backchannels (e.g., “mhm”), it involves content-sensitive responses that directly engage with the speaker's proposition or stance. Usually, such implicit resonance comes at the beginning of a response, via comment or recognition of the relevance of the previous turn. For example, [看得出来 ‘I can see that’] in Example (6), which occurred in a township health center, is the evaluative expression through which the doctor treats what the patient has said as important supplementary evidence for his judgment of the living state.

5. Discussion

The present study contributes to two aspects of resonance research by exploring the explicit and implicit strategies in China's rural medical consultations. Terminologically, the current study contributes to further distinguishing resonance from the perspectives of speaker-led and listener-driven and finding their discursive practices. In terms of data type, it is the first attempt to study resonance in authentic China's rural medical consultations. The discussion here intends to incorporate the Chinese culture to analyze how the culturally loaded rural medical consultations involve resonance as verbal engagement to establish alignment between doctors and patients.

Our findings show that resonance strategies, whether explicit or implicit, help narrow the cognitive gap between rural doctors and patients, who are mostly elderly. Consequently, the long-term mutual trust in rural settings is likely to be fostered and sustained. According to previous studies, patients' trust in rural China is strongly associated with doctors' abilities to make accurate diagnoses, provide appropriate treatment, and consider patients' concerns regarding overprescription and unnecessary tests (Cai et al., 2021). The cognitive alignment between doctors and elderly patients, who have frequent contact with doctors and are highly dependent on them, requires explicit and straightforward resonance to emphasize the professional image of doctors and their concern for patients' health and economic interests, as age is a crucial predictor of patient's trust in primary care institutions in China (Li et al., 2022). In Example (2), the resonance occurs from the original structure [喝酒了 'have drunk'] in an interrogative sentence where the doctor analyzes and seeks confirmation on the cause of patient's hypertension symptom. The subsequent patient-initiated and doctor-initiated structural replication demonstrates the establishment of patient's trust and further care from the doctor. According to our data analysis, the explicit resonance of such functions falls mainly on content recurrence and structural replication. When individuals engage with the lexical items, phrases and thematic elements of the previous speaker, or at the syntactic and morphological level to fully or partially represent a prior utterance, such recurrence serves as a cognitive engagement that guides their stance and theme in alignment with the previous speaker and shapes their responses to such a medical tailored inquiry (Gallotti et al., 2016). It should be noted that explicit resonance frequently occurs in the initial stages of the medical consultation. Since the initial stage requires interaction on a number of details about symptoms and other personal situations, the cognitive function by using explicit resonance is consistent with what Fusaroli et al. (2012) found, namely that the degree to which dyads align their linguistic practices and converge on shared task-relevant vocabularies through repeated trials significantly correlates with their task performance. In terms of implicit resonance, we argue that the frequent use of relevance acknowledgments such as [看得出来 'I can see that'] in example (6) creates echo chambers that amplify the following cognitive resonance, which is conducive to the construction of doctor-patient cognitive alignment by conveying the professional image of the doctor's authoritative identity. In addition, the relatively rarely used discourse markers such as [我告诉你啊 'I'm telling

you'] in example (5) tailor content to the listener by preempting the cognitive-related content in the following dialogue. More importantly, such discursive strategies appear to ignore the point that the physician in effect competes with the patient from a knowledge-based but opposite position (Keller et al., 2023), while emphasizing, on the cognitive level, the jointness (Schmid, 2014) and shared goal on a common enemy: diseases. The absence of patient-initiated implicit resonance strategies as cognitive alignment in our dataset may be attributed to two interrelated sociocognitive constraints: (1) patients' limited pragmatic competence in constructing cognitive-level relevance within adjacency pairs, and (2) a systemic incapacity to procedurally initiate alignment through implicit interactional resources. This aligns with Bernstein's (1996) restricted code theory, wherein institutional power asymmetries restrict marginalized speakers' access to contextually nuanced communicative repertoires.

Emotional bonding is a necessary component in the doctor-patient relationship, which lies in their working alliance (Bordin, 1979). The construction of affective alignment through resonance in China's rural medical consultations exhibits distinctive pragmatic characteristics that fundamentally differentiate it from both online consultations and typical urban medical institutional discourse. Though China's urbanization rate surpassed 50% in 2011 and reached 66.16% in 2024 (National Bureau of Statistics of China, 2024), the rural area still retains the traits of an "acquaintance society" as familiarity arises from long-term communal living and labor (He, 2000), compared with the "slight acquaintance society" found in urban contexts (Chen & Xu, 2025). In terms of implicit resonance, backchanneling tokens such as [哎 'ay'] and [咳 'oh'] in example (4), in the context of small talk on the topic of a non-medical cultural tradition in the community during the interaction, benefit the confirmation and intensification of affective alignment. The implicit resonance on the sentence-final particles [呀 *ya*] in example (3) also demonstrates how affective alignment is constructed through a combinative tone of mutual respect, familiarity, and cooperation after the fictive use of kinship terms [叔 'uncle']. It is worth noting that the pragmatic function of resonance in China's rural medical consultations is not only to show affiliation but also to express a certain stern expression of showing resonance, because on occasions professional authority was exercised for the long-term benefit of the patient despite causing short-term discomfort, as shown in example (1).

The primary distinction between cognitive and affective alignment is manifested in their different preferred initiators, with the former being predominantly doctor-driven and the latter being found in both patient and doctor discourse regardless of sub-strategies. In contrast, cognitive alignment exhibits a doctor-dominated trajectory due to the inherent epistemic asymmetry between doctors and rural patients (compare Many et al., 2024). Nevertheless, both patient and doctor participate in such alignment, as mutual understanding of the content is significant to the cooperation game of dialogue of dialogue (Lewis, 1969).

As the content recurrence and structural replication constitute most (78.4%) of the resonance that occurred in this dataset, we can identify the underlying principle of imitative behavior as what connects the functions of cognitive alignment and affective alignment in doctor-patient resonance (Cook et al., 2012). Scholars have closely examined the multiple functions of imitation, ranging from improving understanding (Adank et al., 2010) to increasing affiliation and empathy between interaction partners (LaFrance, 1979). This is where cognitive and affective alignment (which function by explicit resonance) find their common genesis.

6. Conclusion

This study focuses on doctor-patient alignment in China's rural medical consultations, regarding resonance as strategies of verbal engagement. The paper explores the discursive strategies and functions of resonance, analyzing selected cases from naturally occurring conversations from 32 rural medical institutions in 11 provinces of P. R. China.

Under the division of explicit and implicit categorization, resonance was classified into six sub-categories. We discussed their roles in establishing cognitive alignment and affective alignment between doctors and patients. Understanding this two-way alignment in rural China requires an appreciation of two foundational elements: the long-term, mutually trusting relationship between doctors and patients, and the fundamental role of rural medical institutions within a tiered medical service system. The alignment is built on resonance, revealed by resonance, reinforced by resonance, but the cultural background of the rural society and the sense of belonging to a small community, compared to cities, implicitly influences the construction of alignment.

The implications of the current study are twofold. First, this study fills the existing void by connecting discursive resonance with the process of constructing doctor-patient alignment, analyzing the strategies with the support of naturally occurring data from China's rural medical consultations. Second, we highlight the two-way contribution of doctor and patient to the cognitive and affective discursive function of resonance in the cultural context of rural China.

Future studies should further explore the strategies of resonance as verbal engagement in different contexts, so as to improve the existing categorization of strategies and their functions. In addition, the discourse of China's rural medical consultations could be the key to disclosing a unique form of benign in-clinic communication, which provides an exemplary reference for doctor's professional training and communicative competence.

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