

A Discourse Analysis Study on Doctor-Patient Communication in Emergency Department Conflicts

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Abstract

As a high-conflict setting for doctor-patient communication, the quality of communication in emergency departments directly impacts diagnostic and treatment orderliness and patient safety. This study employs discourse analysis and non-participatory observation within qualitative research to systematically collect doctor-patient interaction data from November 2024 to May 2025 across four Grade III Class A (the highest rank) hospitals in Nanchong City, Sichuan Province. Data collection focused on emergency departments (triage desk, resuscitation room, treatment area, and observation area), examining speech act characteristics and contextual associations during conflict-ridden doctor-patient communication. Findings reveal a significant spatial gradient in the distribution of conflict communication incidents: highest at triage desks (41.6%), followed by resuscitation rooms (30.7%), treatment areas (21.8%), and observation areas (5.9%), closely aligning with functional zone attributes. Conflict types were categorized into four major groups: disputes over process efficiency (48.51%), discrepancies in disease perception (24.75%), perceptions of service attitude (18.81%), and conflicts over resource allocation (7.92%). This study reveals the discursive triggers of emergency communication conflicts and their spatial-functional associations, providing clinical evidence for optimizing emergency department design, enhancing communication skills training for medical staff, and establishing conflict prevention systems.

Keywords: emergency department; physician-patient communication conflict; discourse analysis; non-participatory observation

1. Introduction

In the doctor-patient relationship, communication between physicians and patients is a core factor influencing their relationship. Effective communication not only facilitates the efficient transmission of medical information but also conveys the physician's concern through verbal

and nonverbal means, offering patients goodwill and reassurance. This enhances the accuracy of medical history collection, preventing missed or misdiagnoses, while also improving patient treatment adherence and fostering trust (Gu et al., 2022). However, in clinical practice, tensions arising from communication barriers between doctors and patients persistently emerge. Research indicates (Bai et al., 2019) that over 98% of hospitals have experienced medical disputes or even violent incidents targeting medical staff. Such deteriorating doctor-patient relationships further degrade the already challenging healthcare professional environment, leading to the loss of medical talent and ultimately jeopardizing the development of the medical industry. Unlike traditional clinical departments, emergency departments are high-risk zones for clinical conflicts and violent incidents against medical staff (Luo et al., 2023). The primary reason for this situation lies in the nature of emergency care, which often involves critically ill patients. Physicians operate under prolonged high-stress, fast-paced conditions. In such environments, they must rapidly gather patient information and provide effective medical communication. This inevitably leads to potential misunderstandings due to abrupt, concise, or overly technical language, or to patient anger stemming from perceived lack of empathy or explanation (Sustersic et al., 2019). Patients or their families, facing sudden illness, experience negative emotions such as fear and helplessness. Combined with the crowded and noisy environment of the emergency department, this intensifies patient anxiety. Inability to comprehend relevant diagnostic and treatment information further exacerbates doctor-patient conflicts (Cooper & Stevenson, 2022).

Discourse analysis is a discipline that studies “language use,” systematically examining how language functions within specific social contexts. It focuses on how individuals construct meaning, enact behaviors, shape social realities, and reflect power relations through language within particular sociocultural settings (Liu, 2023). Discourse analysis is categorized based on its theoretical origins, research focus, and analytical methods into critical discourse analysis, Foucauldian discourse analysis, conversation analysis, narrative analysis, and multimodal discourse analysis. Conversation analysis is currently the most prevalent approach in discourse analysis studies of doctor-patient communication (Liang & Li, 2023). To further understand the factors contributing to conflictual doctor-patient communication in emergency settings, this study employs observational methods to conduct discourse analysis of such communication. The aim is to provide insights and references for mitigating conflictual doctor-patient communication in emergency departments.

2. General Information and Methods

2.1 General Information

Study Sites: Four Class A tertiary hospitals in Nanchong City, Sichuan Province were selected as study sites. These hospitals encompass regional central hospitals and university-affiliated hospitals. All sample hospitals possess standardized emergency medicine department qualifications, handle over 100,000 emergency visits annually, report relatively high rates of physician-patient conflict incidents, and demonstrate regional representativeness.

Study Period: November 2024 to May 2025

Study Participants: Inclusion criteria for healthcare providers: (1) ≥ 1 year of service in the emergency department of an included hospital; (2) Informed consent to participate in this study. Exclusion criteria: (1) Individuals unable to participate in the entire observation period due to factors such as training or leave during the study period. A total of 126 healthcare providers were observed during the study period: 69 males and 57 females, with a mean age of (35.78 ± 6.89) years and a mean work experience of (15.67 ± 8.68) years. Patient inclusion criteria: (1) Patients or family members who visited the emergency departments of the four participating hospitals during the study period and engaged in communication with healthcare providers; (2) Patients who were conscious and able to cooperate with the observation and recording process. Exclusion criteria: (1) Patients with severe psychiatric disorders; (2) Patients seeking treatment due to intoxication from alcohol or drugs. All observed interactions in this study were conducted with prior informed consent from patients and their families. The study was approved by the Ethics Committee of Nanchong Affiliated Hospital of North Sichuan Medical College, employing covert observation and ensuring anonymization of information.

2.2 Research Methods

(1) Study Design: This study employed non-participatory observation within a qualitative research framework. It aimed to systematically collect and analyze conflictual discourse emerging during doctor-patient communication in the emergency department within natural settings. The approach captured detailed, unedited linguistic and behavioral nuances occurring organically during interactions, providing authentic data to elucidate the origins, escalation, and resolution processes of doctor-patient conflict communication.

(2) Observation Sites: Included the emergency department triage desk, resuscitation room, treatment area, and observation zone.

(3) Observation Tools: ① Video or audio recording: Following hospital ethics committee approval and obtaining informed consent from healthcare providers and patients, covert recording devices captured dialogue content. Cameras supplemented recordings to document nonverbal behaviors such as gestures, facial expressions, and body language of both parties. ② On-site observation notes: Utilize a self-designed “Emergency Department Physician-Patient Communication Observation Record Form” for shorthand documentation of communication scenes. The record form includes: general information (observation date, time, hospital name, healthcare provider category, etc.); background details (location, participants [anonymized], general condition, patient chief complaint, environmental context); conflict triggers (excessive waiting time, treatment disagreements, cost concerns, inadequate explanation of medical conditions, etc.), verbal characteristics (conflict-related keywords, tone of voice, turn-taking patterns, nonverbal behaviors like facial expressions, gestures, body posture, etc.), conflict progression (complete sequence from initiation, escalation, peak, to resolution), coping strategies (communication tactics employed by medical staff such as explanation, empathy, seeking senior assistance), patient responses, and conflict outcomes.

(3) Pre-observation phase: Prior to formal observation, conduct in-depth discussions with department directors and head nurses to briefly outline the study objectives and secure their support. Concurrently, researchers undergo 5–7 days of adaptive observation within the emergency department to familiarize themselves with workflow, environmental layout, and staff behavioral patterns. This minimizes the “observer effect” caused by the researcher's presence as an “outsider” disrupting natural interactions.

(4) Formal Observation Phase: Employ a combination of purposive and convenience sampling to cover different shifts (day and night) and dates (weekdays and weekends), capturing communication patterns under varying time pressures and workloads. Conduct 3–4 observations weekly, each lasting 4–6 hours.

2.3 Data Integration and Analysis

This study employs thematic analysis within qualitative research to systematically analyze data collected through non-participatory observation. Raw data sources such as videos, audio recordings, and field observation notes underwent standardized coding procedures. Primary coding extracted fundamental dialogue information including conflict duration, participants, and conflict trigger types; Secondary coding focused on linguistic features of discourse, including emotional orientation, interaction patterns, and rhetorical strategies. Tertiary coding captured conflict outcomes, such as whether incidents escalated or whether family members and patients calmed down. Frequency counts and percentages were denoted as (n, %) throughout the study, while age and years of service were represented as ($\bar{x} \pm s$).

3. Results & Key Findings

This study conducted six months of continuous observation of doctor-patient communication across four observation zones (triage desk, resuscitation room, treatment area, observation area) in the emergency departments of four Grade III Class A hospitals in Nanchong City, Sichuan Province. A total of 101 distinct doctor-patient communication conflict incidents were recorded. Analysis of these incidents yielded the following key findings:

3.1 Distribution and Basic Characteristics of Conflictual Communication Incidents

Conflict incidents exhibited significant distribution differences across the four observation areas

The triage desk (42 cases, 41.6%) was the most conflict-prone setting, followed by the resuscitation room (31 cases, 30.7%), the treatment area (22 cases, 21.8%) and the observation area (6 cases, 5.9%). This distribution closely aligns with each area's functional attributes: the triage desk, characterized by patient concentration, prolonged waiting times (average wait time: 28.5 ± 12.3 minutes), and discrepancies between triage outcomes and patient expectations (e.g., “perceiving oneself as critically ill but assigned to the general queue”), serves as the primary flashpoint for conflicts; Conflicts in resuscitation rooms frequently arose due to critical conditions, healthcare providers' focused attention on treatment (64.5% of interactions lasted less than 3 minutes), and low family awareness of treatment risks (only 12.3% of families reported “fully understanding the severity of the condition”).

3.2 Types of Conflictual Physician-Patient Communication Events

(1) Process Efficiency Disputes (49 cases, 48.51%): Primarily manifested in excessively long waiting times for patients and families (average waiting time: 28.5 ± 12.3 minutes), prolonged queuing or delays for examinations, and cumbersome payment procedures. Typical patient statements included: "I'm in excruciating pain, and I still have to fill out all these forms!" and "There are 20 people ahead of me—how long will this take?"

(2) Misalignment in Disease Perception (25 cases, 24.75%): Primarily manifested as patients or family members questioning emergency triage criteria, disease severity assessments, treatment plans, or the necessity of tests. Typical patient statements included: "Why does he go ahead of me even though he arrived later?" "Does 'temporarily stable' mean giving up on treatment?" "Why do I need so many tests? Can't you just prescribe medication?"

(3) Perceived Service Attitude (19 cases, 18.81%): Primarily manifested in brief communication (average response time 4.2 seconds), abrupt tone, or delayed progress updates. Typical healthcare provider remarks included: "Stop rushing me—can't you see I'm busy?" Typical patient responses: "I asked three times when the IV will start!" "What kind of attitude is that?"

(4) Resource Allocation Conflicts (8 cases, 7.92%): Primarily manifested as occupied emergency equipment or beds, and inadequate care due to insufficient medical staff. Typical patient remarks included: "Tell your hospital director to hire more doctors and nurses!" and "What kind of crappy hospital is this? There aren't even any beds available!"

3.3 Discourse Characteristics and Interaction Patterns in Conflictual Physician-Patient Communication

In conflictual physician-patient dialogues, the discourse of both parties exhibits pronounced emotional polarization and adversarial traits: patient or family member discourse primarily consists of emotional venting (73.3%) and demand imposition (61.4%), often employing accusatory language such as "You're irresponsible!", "What kind of service is this?", and "You must resolve this immediately! Emotional intensity escalates with conflict, shifting from anxiety ("Please hurry!") to anger ("I'm filing a complaint against you!"). A minority of patients (12.9%) employ moral blackmail tactics like "I have elderly parents and young children—if you don't help me, I'll die here!" to express opposition. Initial healthcare provider discourse primarily focused on information delivery (58.4%) and rule explanation (41.6%), such as "Triage is based on vital signs assessment, not arrival order" or "This is our protocol; please understand." However, when confronting emotionally agitated patients, 34.7% of providers resorted to evasion or defensive responses like "I can only follow procedures" or "Go ahead and file a complaint", which only intensified patients' alienation and dissatisfaction. Only 12.9% actively empathized with patients, such as "I understand you're anxious; let's figure this out together."

3.4 Conflictual Physician-Patient Communication: Conflict Progression and Coping Strategies

The conflictual physician-patient communication observed in this study can be divided into four stages: "Latent Period—Eruption Period — Stalemate—Outcome. The response strategy during the Outbreak Phase (within the first 5 minutes) directly influences the Outcome. When confronting conflict-driven communication, healthcare providers' most frequent strategies were "Explaining hospital rules and procedures" (68.3%), "Seeking support from superiors" (42.6%), "Calming the patient or family" (21.8%), "Avoidance/cold treatment" (12.9%). Only 9.9% of healthcare providers employ a combined "Empathy + information clarification" strategy in the conflict's initial phase (<2 minutes), such as stating, "I understand you've been waiting a long time and are anxious. We've checked the system, and your test results will be available shortly. I'll wait along with you." When confronted with healthcare providers' responses explaining hospital rules and procedures, 45.5% of patients expressed "non-acceptance," viewing such explanations as "excuses." When healthcare providers attempted to "calm emotions," 62.3% of patients and family members reported emotional relief, responding with "Then please hurry." Conversely, healthcare providers' "avoidance/cold treatment" directly led 78.6% of patients to escalate complaints to higher levels—such as hospital administration, government departments, or online platforms.

4. Discussion

4.1 Deep Implications of Conflict Scenario Distribution: "Structural Tension" and "Expectation Gap" in Emergency Functionality

This study reveals that conflicts are highly concentrated at triage desks (41.6%) and resuscitation rooms (30.7%). This distribution is far from coincidental; it profoundly reflects the inherent structural contradictions within the emergency department as the "frontline outpost" and "stronghold" of the healthcare system. First, conflicts at triage counters represent the initial point of contact for the core contradiction between scarce medical resources and patients' unlimited and unsatiable demands. The average 28.5-minute wait time, combined with patients' subjective perception of their own critical condition, creates a pivotal arena for "expectation management" (Shao et al., 2020). A natural gap exists between the emergency triage criteria—a professional, objective risk assessment tool (Fang et al., 2023)—and patients' subjective prioritization based on their experience of pain. Conflict erupts when professional judgment (assigning patients to the general queue) collides with patients' subjective expectations (demanding immediate, highest-level attention). The triage desk thus transcends a mere information registration point, becoming a micro-space where medical authority (determining who should go first) and patient rights (demanding timely care) engage in their initial contest. Secondly, conflicts in the resuscitation room reflect the tension between the "life-first" treatment logic and the "communication-first" emotional needs. Our data reveals that communication time was insufficient (less than 3 minutes) in 64.5% of cases, while only 12.3% of family members fully understood the severity of the patient's condition. This reveals a classic dilemma in emergency room communication: under the pressure of time-sensitive treatment, healthcare providers' primary task is executing

medical procedures, forcing communication to be reduced to fragmented information delivery. However, for families experiencing extreme anxiety and fear, missing, ambiguous, or delayed information rapidly transforms into accusations of medical “indifference” or “irresponsibility.” Thus, conflicts in resuscitation rooms are primarily the direct result of “information hunger” and “communication time poverty.”

4.2 Types of Communication Triggers and Discourse Dynamics in Emergency Conflicts: The Shift from “Rational Disputes” to “Emotional Battles”

In this study, typological analysis of conflict triggers reveals that “process efficiency disputes” (37.6%) and “misalignment in disease perception” (28.7%) as the two primary triggers for emergency communication conflicts. This indicates that conflicts often originate from disputes over objective facts (e.g., waiting times, diagnostic standards). However, discourse analysis reveals a critical process where conflicts rapidly shift from the “rational level” (focusing on facts) to the “emotional level” (emotional confrontation and relationship breakdown). Patients' emotional expressions tend toward “loss of words” and “weaponization,” primarily manifesting as emotional venting (73.3%) and imposition of demands (61.4%), reflecting their powerlessness within the healthcare system. When normal channels for expression (e.g., inquiries, waiting) are perceived as ineffective, intense emotional displays and moral coercion (12.9%) become “informal strategies” to attract attention, seize the floor, and attempt to disrupt established procedures. The escalation from “anxiety” to “anger” fundamentally reflects patients' deepening despair. Their accusatory language, while seemingly directed at specific incidents, is fundamentally a rally cry against their loss of control over their situation—over illness, procedures, and waiting times. In contrast, healthcare providers initially relied primarily on information delivery (58.4%) and rule explanations (41.6%)—a “standard script” grounded in professionalism and institutional norms (Zhu et al., 2023). However, this rational, neutral discourse is often interpreted by patients as “passing the buck” or “cold indifference” when confronted with overwhelming emotion. As conflicts escalated, a significant 34.7% of medical staff adopted evasive or defensive responses. This reflects both emotional exhaustion and a psychological self-protection mechanism under high pressure. Yet, our data demonstrates that this strategy backfired, causing 78.6% of doctor-patient communication conflicts to intensify. This indicates that merely “explaining rules” fails to address patients' “emotional demands,” instead reinforcing psychological barriers between doctors and patients.

4.3 Insights from Process Management of Conflict-Triggered Communication in Emergency Department Doctor-Patient Interactions: A Paradigm Shift from “Rule-Oriented” to “Relationship Repair”

Currently, the most frequently employed “rule explanation” strategy by medical staff (68.3%) yields limited effectiveness (with 45.5% of patients indicating non-acceptance). This strongly suggests that during the “acute phase” of conflict, patients' primary need is not more “information,” but rather the “emotional experience” of being understood and respected. Rules are cold, while relationships are warm. In stark contrast, the “emotional soothing” strategy, though less frequently used (21.8%), achieves a 62.3% emotional de-escalation rate.

More notably, the composite strategy of “empathy + information clarification” employed in the early conflict phase—though used by only 9.9%—represents the most effective communication approach, aligning with findings by Lin et al. (Lin & Xia, 2018). The success of this strategy lies in adhering to the golden rule of “addressing feelings before addressing facts.” A statement like “I understand you've been waiting for a long time and feel anxious” (empathy) first establishes an emotional connection with the patient, validating their feelings as reasonable. This creates a psychological foundation for accepting subsequent information clarification (“We've checked out the system; your test results will be available shortly”). This is not merely a technique but the core shift from a “technical doctor-patient relationship” to a “therapeutic alliance,” effectively mitigating conflicts (Liu & Song, 2019).

5. Research Implications and Recommendations

This study conducted six months of continuous observation of doctor-patient communication across four areas (triage desk, resuscitation room, treatment zone, observation area) in the emergency departments of four Grade III Class A hospitals in Nanchong City, Sichuan Province. The findings suggest that reducing conflict in emergency communication requires systemic optimization of processes and expectation management. For instance, displaying emergency triage criteria, current waiting numbers, and estimated wait times. This makes “invisible” rules tangible, proactively manages patient expectations, and visualizes triage. Establishing a “Family Communication Specialist” role or implementing a “Scheduled Directional Communication” system ensures that even in the busiest resuscitation rooms, key family members receive at least 1-2 critical updates every 15-20 minutes, such as “Vital signs are temporarily stable” or “What treatments are we performing?” to alleviate information hunger. Second, enhance public education and awareness by developing emergency science micro-videos that explain triage criteria in accessible language. It is vital to train medical staff to prioritize recognizing and addressing patient emotions under pressure before clarifying facts or rules, preventing escalation of conflicts. Finally, enhance healthcare providers' awareness of proactive communication by helping them recognize that defensive communication acts as a “fuel” for conflict rather than a “fire extinguisher.” When facing accusations, consciously practice “depersonalizing” interpretations—viewing patients' aggression as an external manifestation of immense stress—thereby creating psychological space for constructive responses.

6. Study Limitations and Future Directions

This study is a single-center observational research with a sample limited to tertiary hospitals in Nanchong, a small city in southwest part of China. Future research could expand the geographic scope to larger cities in different part of the nation and compare the situations with lower-level primary care hospitals. Plus, incorporating patient-and-healthcare provider interviews to delve deeper into subjective experiences to extract more invaluable findings and illuminations. Additionally, discourse analysis could adopt more sophisticated linguistic tools like conversation analysis and sentiment analysis algorithms to further reveal micro-interaction mechanisms within conflicts.

In summary, emergency conflicts represent a complex interplay of healthcare system

intricacies, divergent perceptions between physicians and patients, and clashing emotional needs. By strategically optimizing scenario design, preventing triggering events, and enhancing discourse capabilities, it is feasible to transit from “conflict response” to “conflict prevention”, ultimately fostering more harmonious emergency physician-patient relationships.

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Data sharing statement

No additional data are available.

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