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DISCOURSE ANALYSIS OF TELEPHONE CONSULTATION: HOW PATIENTS REPORT SYMPTOMS TO DOCTORS FOR NURSING STUDENTS

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ABSTRAK

Transformasi layanan kesehatan akibat pandemi COVID-19 telah mempercepat adopsi konsultasi medis jarak jauh, termasuk melalui telepon. Praktik ini tidak hanya mengubah cara pasien berinteraksi dengan petugas kesehatan, tetapi juga menimbulkan tantangan baru dalam komunikasi klinis, terutama terkait dengan pelaporan gejala. Artikel ini bertujuan untuk menganalisis praktik diskursif dalam konsultasi telepon antara pasien dan dokter, dengan fokus pada bagaimana pasien melaporkan gejala dan bagaimana dokter menanggapi dan mengklarifikasinya. Dengan menggunakan pendekatan kualitatif dengan metode analisis wacana kritis, data diperoleh dari transkrip otentik konsultasi telepon di klinik layanan primer dan dianalisis melalui struktur wacana makro dan mikro. Temuan menunjukkan bahwa pasien cenderung menggunakan narasi subjektif dan istilah nonmedis untuk menyampaikan gejala, sedangkan dokter mengontrol alur percakapan melalui strategi interupsi, pertanyaan tertutup, dan klarifikasi berulang. Pola ini mencerminkan hubungan kekuatan asimetris dan membuka ruang untuk miskomunikasi, terutama dengan tidak adanya isyarat nonverbal. Penelitian ini memiliki implikasi penting bagi pendidikan keperawatan, terutama dalam merancang pelatihan komunikasi berdasarkan skenario konsultasi jarak jauh yang menekankan kepekaan linguistik, empati, dan kemampuan klarifikasi. Selain itu, integrasi analisis wacana dalam kurikulum keperawatan dapat memperkaya pemahaman mahasiswa tentang dimensi sosial budaya komunikasi medis. Artikel ini merekomendasikan untuk memperbarui kebijakan pelatihan komunikasi di lembaga pendidikan dan kesehatan untuk meningkatkan efektivitas dan keamanan praktik medis berbasis teknologi.

Kata kunci: *Analisis Wacana, Konsultasi Telepon, Komunikasi Klinis, Keperawatan, Hubungan Kekuasaan, Pendidikan Kesehatan*

ABSTRACT

The transformation of healthcare services due to the COVID-19 pandemic has accelerated the adoption of remote medical consultations, including those over the phone. This practice not only changes the way patients interact with healthcare workers, but also poses new challenges in clinical communication, particularly related to symptom reporting. This article aimed to analyze discursive practices in telephone consultations between patients and doctors, focusing on how patients report symptoms and how doctors respond and clarify them. Using a qualitative approach with a critical discourse analysis method, data were obtained from authentic transcripts of telephone consultations in primary service clinics and analyzed through macro- and micro-discourse structures. The findings suggest that patients tend to use subjective narratives and nonmedical terms to convey symptoms, whereas clinicians control the flow of the conversation through interrupt strategies, closed-ended questions, and repetitive clarification. This pattern reflects an asymmetrical power relationship and opens up space for miscommunication, especially in the absence of nonverbal cues. This study has important implications for nursing education, especially in designing communication training based on remote consultation scenarios that emphasize linguistic sensitivity, empathy, and clarifying abilities. In addition, the integration of discourse analysis in the nursing curriculum can enrich students' understanding of the sociocultural dimensions of medical communication. This article

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recommends updating communication training policies in educational and healthcare institutions to improve the effectiveness and safety of technology-based medical practices.
Keywords: *Discourse Analysis, Telephone Consultation, Clinical Communication, Nursing, Power Relations, Health Education*

INTRODUCTION

Advances in information and communication technology have brought about significant changes to healthcare practices, especially in terms of the interaction between medical personnel and patients (Aceto et al., 2018). One form of change is the increasing use of telephone medical consultation services (Åkesson et al., 2007). This practice allows patients to convey health complaints or symptoms without having to physically present at a health facility. Although it has been known for a long time, medical consultations via telephone are experiencing a surge in use globally, especially in response to the COVID-19 pandemic, which demanded restrictions on face-to-face interactions (Torres-Cisneros et al., 2022).

During the pandemic, remote consultation services, including over the phone, are a strategic solution for maintaining the continuity of health services, while minimizing the risk of virus transmission (Chaudhry & Abiola, 2021). Many hospitals and clinics adopt an initial triage system over the phone, where patients are asked to describe their symptoms before determining whether an in-person visit is required (Hasani et al., 2020). This indicates that verbal communication is the only key tool in the initial medical decision-making process. After the pandemic subsided, this practice continued as part of service innovation, which is considered both efficient and practical (Nakornchai et al., 2022).

However, the transition to voice-based medical communication models presents challenges, especially in terms of the clarity and accuracy of medical information delivery (Liu et al., 2020). The absence of visual cues, body language, and facial expressions makes the communication process more susceptible to miscommunication and misinterpretation. In this context, the patient's ability to report symptoms systematically, as well as the ability of medical personnel to effectively gather information, is a crucial element (Warrington et al., 2019). Both are highly dependent on the quality of the discourse built into the interactions.

In addition, the practice of telephone consultation reflects the dynamics of the power relationship between patients and doctors. In many cases, patients have difficulty conveying symptoms in detail due to limited medical vocabulary, feelings of insecurity, or perception of physician authority (Miller, 2003). The choice of language, sentence structure, and voice intonation are part of a discursive strategy that can reflect social position, health literacy level, and expectations in clinical interactions (Maraj et al., 2025). However, several studies have demonstrated the gap between the ideals of patient-centered, empathetic communication and the actual constraints experienced in telehealth practice. Kaminsky et al. (2017) found that although telephone nursing is ideally meant to foster active listening and empowerment, nurses often resort to rigid scripts and brief questioning due to time pressure and institutional demands. Irfan (2022) highlighted that limited technological familiarity and low health literacy among patients often hinder effective communication, contradicting the ideal of mutual understanding. White et al. (2022) emphasized that in general practice, teleconsultation often becomes a transactional exchange, reducing opportunities for shared decision-making. Nakornchai et al. (2022) observed that patients in neurology consultations felt less emotionally supported, as doctors prioritized rapid diagnostic efficiency over empathic engagement. Similarly, Liu et al. (2020) reported that vocal cues such as tone and clarity have significant effects on patient satisfaction, yet these interpersonal elements are often underutilized or poorly managed in telephone consultations. Therefore, the study of discourse in the practice of this kind of

consultation is important, not only to understand medical communication more deeply but also to develop relevant educational interventions for prospective health workers.

Understanding the dynamics of communication in telephone-based consulting services is an important competency for students (Gutiérrez-Puertas et al. 2024). Changes in the way health services are delivered require adaptation to the curriculum, especially related to the training of communication skills that are able to respond to the challenges of non-face-to-face situations (Kaminsky et al., 2017). Through an analytical understanding of discourse practices that occur in remote communication, nursing students can be prepared in a more contextual and applicative way to face the reality of nursing practice in the future.

Based on this background, this article departs from the following research question: *How does the practice of discourse in medical consultation over the phone shape how patients report symptoms to doctors?* This question aimed to explore the structure, strategy, and meaning of verbal interactions that take place in long-distance communication situations between patients and medical personnel.

This article aims to analyze the forms of discourse used by patients when reporting symptoms in the context of medical consultation over the phone, as well as to identify the responses and discursive strategies developed by clinicians in responding to such information. The contribution of this article is not only theoretical in enriching the study of medical communication based on discourse analysis, but also practical in providing pedagogical recommendations for the development of the nursing curriculum, especially in the aspect of simulation-based clinical communication training.

RESEARCH METHODS

This study used a qualitative approach with the critical discourse analysis method as the main framework (Cutting & Fordyce, 2020). Critical discourse analysis was chosen because it allows researchers to uncover the power relations, social meanings, and linguistic strategies hidden behind the practice of communication between patients and doctors in medical consultations over the phone (Breeze, 2022). In this case, Fairclough's approach is used to map the linkages between texts, discursive practices, and social practices (Pesic, 2023). Alternative methods of discourse ethnography are also considered to emphasize situational context and language practice in everyday interactions, especially in medical communication that occurs verbally and without face-to-face interactions.

The main data source in this study is authentic transcripts of telephone consultations between patients and doctors that took place at one of the primary health facilities in East Java. This transcript was chosen because it represents real communication practices that occur in the context of remote medical services. Each transcript reflects the diversity in the way patients report symptoms and doctors' communication strategies in responding to that information. This study does not use simulation scenarios but rather bases its analysis on empirical data to ensure a valid representation of communication phenomena in clinical practice.

Data collection was conducted using three main techniques: observation, documentation, and interviews. Observations were made indirectly during the consultation process through audio recordings, while still paying attention to the principles of confidentiality and consent from the participants. Documentation includes the collection and processing of consultation transcripts that are copied verbatim. Meanwhile, interviews were conducted with a number of selected medical personnel and patients to gain a contextual understanding of their experiences in using telephone consultation services as well as their perceptions of the effectiveness of communication in these situations.

Data analysis is carried out by referring to the stages in critical discourse analysis, which include macro-and microstructures (Poole, 2010). Macro structures involve an analysis of the

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main themes, social contexts, and ideologies underlying interactions. Meanwhile, the microstructure is focused on linguistic analysis, such as word choice, sentence structure, intonation, and interaction patterns that emerge during consultation. By combining these two structures, the analysis is expected to uncover the hidden dynamics of the meaning and power relations behind the practice of medical communication over the telephone.

Source and method triangulation techniques were used to ensure data validity (Kern, 2018). Validation was carried out by comparing the results of the transcript analysis with the interview data and other supporting documentation. In addition, the involvement of informants in the member-checking process is also used to ensure that the resulting interpretation is in accordance with their experience. This study also adheres to the ethical principles of research, including obtaining written informed consent from all participants, maintaining identity confidentiality, and ensuring that the use of data is only for scientific purposes. The researcher also obtained approval from the research ethics committee of the institution concerned before the data collection process was conducted.

RESULTS AND DISCUSSION

Result

To gain a deeper understanding of how patients report symptoms to doctors during telephone consultations, a discourse analysis was conducted on the verbal interactions within these conversations. The results of this analysis are summarized in the following table, highlighting common language patterns, communication strategies, and the structure of symptom reporting typically used by patients in remote consultation contexts.

Table 1. Dimensions of Communication and Discourse in Telephone Medical Consultation

No	Aspects	Key Findings	Examples of Communication Practices	Discursive/Critical Meaning
1.	Pattern of Symptom Reporting by Patients	- Chronological narrative (beginnings, progress, self-effort) - Variation of medical and non-medical terms - Use of repetition, hyperbole and mitigation	- “[P03]: I've been feeling unwell for three days...” - “[P07]: p squealing like being stabbed” - “[P04]: it hurts so much” - “maybe yes, I’m not sure”	- Representations of illness experience as representational practice - Language reflects the patient's medical literacy and social position - Language is used to establish urgency and bargaining power
2.	Clarification Strategy by Doctors	- Targeted interruptions for efficiency - Reformulation of patient information - Combination of open and closed questions	- “[D01]: Sorry, Mom, I cut for a moment. How many days...?” - “[D02]: So, you feel it starting on Sunday... huh?” - “[D03]: Can you explain...?”	- Interruption as professional discourse control - Reformulation = re-contextualisation of the patient's narrative to the medical framework - Questioning as an instrument of

			- "[D01]: ... Above 38 degrees or not?"	communication control and adaptation
3.	Representation of Power Relations	- Doctors are dominant in the direction of discourse and turn-taking - Restriction of patient participation space - Closed questions limit patient interpretation	- "[D04]: Okay, ma'am... Later, if there are other complaints…" - "[D03]: The pain is only on the right, huh?"	- Symbolic power in health institutional structures - Medical discourse defines the meaning of illness - Patients try to resist, but domination remains strong
4.	Challenges of Long-Distance Communication	- Prone to misunderstanding - Absence of non-verbal cues - Inequality in language competence and health literacy	- "[P07]: It feels like it's not good in the body…" - "[P02]: I have a severe cold"	- Discommunication as a result of discourse inequality - Limited access to professional discourse reinforces dominance - Technical challenges = social challenges in conveying meaning

The data presented in the table illustrate various communication patterns used by patients when reporting symptoms to doctors during telephone consultations. These patterns include word choices, sequencing of information, and strategies in explaining health complaints. The findings in the table above serve as the basis for further analysis in the following discussion section, aimed at understanding the meaning of such communication and its implications for remote healthcare practices, particularly for nursing students.

1. General patterns of symptom reporting by patients

The analysis of telephone consultation transcripts showed that the majority of patients followed a narrative pattern of symptom reporting. This pattern generally begins with a chronological explanation of when symptoms first appear, followed by a description of the progression of symptoms, and then accompanied by a mention of the efforts that have been made independently before consulting a doctor. This narrative structure reflects representational textual practice, which refers to how patients frame their health experiences in language. For example, many patients begin their reports with phrases such as *"[P03]:I've been feeling unwell for three days..."* or *"I started with a mild cough, but now it's getting worse."* This suggests that narrative structures serve not only to inform but also construct social meanings about pain and suffering.

In the discursive dimension (discursive practice), there is variation in the use of medical and nonmedical terms. Some patients used popular medical terms, such as *acid reflux*, *hypertension*, or *vertigo*, derived from personal experiences, online information, or other social interactions. Meanwhile, other patients used non-medical or metaphorical terms, such as *"[P07]:p squealing like being stabbed"* or *"my head is like spinning."* According to Fairclough (Zanoni & Janssens, 2015), discursive practices convey content and show how texts are produced, distributed, and received in a particular social context. In this case, the language used

by patients contains ideological traces, namely, subjective representations of the body and health that are influenced by the limitations of medical literacy and their social position in the patient-doctor relationship.

Other dominant linguistic strategies are the use of repetition, intensification, and hyperbolic expressions, such as *"[P04]:it hurts so much", "can't sleep through the night,"* or *"it's worse than yesterday."* This strategy shows the patient's attempt to affirm the urgency or severity of their condition in the absence of non-verbal communication. From the perspective of critical discourse analysis, these forms reflect a social practice in which language is not neutral, but is loaded with persuasive functions, power, and bargaining positions in medical interactions. In telephone communication, where power relations are not mediated by physical presence or visual gestures, patients rely more on the intensity of language to effectively communicate their needs.

Furthermore, the use of *hedging* such as *"maybe yes, I'm not sure"* or *"it feels like that, but I don't know"* is a mitigation strategy that reflects the tension between the doctor's authority and the patient's experience. In Fairclough's framework (Mansouri & Parina, 2023), this shows the process of negotiating meaning between two unbalanced discursive positions: the patient as a subject who experiences but does not have a formal medical discourse, and the doctor as the symptomatic interpreting authority. Therefore, symptom reporting by phone is not just an exchange of information but also an arena in which the meaning of health is negotiated, constructed, and socially interpreted through language.

2. Physician communication strategies in clarification

The results of the analysis of telephone consultation transcripts showed that doctors used various communication strategies to clarify the information conveyed by the patient. Directional interruption is one of the most prominent strategies**.** These interruptions are not intended to rudely stop the conversation but rather serve to direct the conversation to aspects that are considered more clinically relevant. For example, in one interaction, while the patient was explaining a history of symptoms at length, the doctor interrupted by saying, *'[D01]: Sorry, Mom, I cut for a moment. How many days have the fever been huh?"*. These interruptions avoid ambiguity and ensure that information of a temporal and critical nature is immediately clarified. According to Fairclough (Moberg, 2020), this kind of interruption reflects the use of discourse authority in professional contexts, where doctors control the direction of the conversation for efficiency and accuracy.

Another strategy often used is clarification through information reformulation. Doctors often repeat the information submitted by patients using declarative sentences closed by confirmation questions. This can be seen in the following excerpt: *'[D02]: So, you feel it starting on Sunday afternoon, and then Monday morning you start coughing and dizzying, huh?'*. This reformulation not only clarifies the information but also gives the patient the opportunity to justify or adjust the previous explanation. In the framework of critical discourse analysis, reformulation is a form of *recontextualization*, which is the process of repackaging the layman's narrative in a diagnostic framework that is in accordance with medical institutional logic.

In addition, the use of closed-ended and open-ended questions alternately is the dominant strategy for clarification. Open-ended questions like *"[D03]: Can you explain, Mom, what does the pain look like?"* It opens up space for patients to describe their condition in a more narrative and personal way. Instead, doctors also use closed-ended questions to obtain specific and measurable information, such as *"[D01]: Has his body temperature been measured? Above 38 degrees or not?"* or *'[D02]: Do you feel nauseous too?'*. The combination

of these two types of questions demonstrates the doctor's flexibility in tailoring the communication approach to the patient's characteristics and complexity of the symptoms.

The three strategies of directional interruption, clarifying reformulation, and a variety of question types show that physician communication in a telephone consultation is not a passive process but a strategically controlled interaction. From Fairclough's perspective (Contri et al., 2019), this strategy reflects the existence of symbolic power relations inherent in the practice of professional discourse. The language used by doctors serves not only as a tool of clarification but also as a means of shaping the structure of interactions and the social meanings that accompany them. Therefore, the clarification strategy in telephone consultations is not only technically relevant but also a reflection of the social construction of language-based medical practice.

3. Representation of power in interactions

Medical consultations over the phone form an inherently asymmetrical discursive field, where the power relationship between doctor and patient becomes real in the way the interaction takes place. An analysis of the consultation transcript shows that control over the direction and structure of the discourse is predominantly in the hands of the doctor. This dominance is not only demonstrated through the use of medical technical terms or the structure of directed questions, but also through turn-taking, decision-making on topics deemed relevant, and the tendency to end conversation sessions when sufficient information is obtained.

For example, in one of the interactions, when a patient tries to add additional information after stating his main complaint, the doctor immediately shifts focus by stating, "[D04]: Okay, ma'am. It is important to note that we first overcame the fever. Later, if there are other complaints, they can be submitted again." This statement, although cooperative sounds, is essentially a form of restriction on the discursive participation of patients, which in Fairclough's (1995) perspective reflects the institutional power legitimized by professional roles. Doctors play the role of determining relevance as well as controlling the meaning of the patient's pain experience.

This discourse control is also evident in closed forms of questions that implicitly limit the patient's interpretive space, for example, "[D03]: The pain is only on the right, huh? Not in the lower abdomen?" Here, the sentence structure not only asks for confirmation but also directs the answer within the narrow corridor defined by the doctor's diagnostic framework. In this practice, symbolic power works not only through what is said but also through what is not given space to be said, namely the patient's personal experience that does not always conform to formal medical logic.

Nonetheless, some transcripts suggest that patients also seek to seize discursive spaces in certain ways, such as intensively repeating complaints, using emotive language, or questioning the doctor's decisions indirectly. However, this strategy is often ineffective in shifting the dominance of discourse, given that the interaction structure has been structured in such a way as to support efficiency and hierarchy in medical decision-making. Fairclough (Sari et al., 2025) states that power in discourse is not always explicitly repressive but can be relational and hidden, operating through communication norms that are considered "natural" in professional institutions.

Thus, the findings of this study confirm that, in the practice of telephone consultation, doctors hold dominant control of discourse both structurally and symbolically. This practice reflects the reality of power relations in the health care system, where language is the primary tool for maintaining authority, regulating access to information, and managing the definition of the meaning of illness. For nursing students, understanding this dimension is important as part of learning clinical discourse literacy, so that they become not only technical participants in

interactions but also reflective actors in shaping more egalitarian and empathetic communication in the future.

4. Communication challenges in remote consultations

Medical consultation by telephone, while offering efficiency and accessibility, presents several significant communicative challenges. One of the main challenges is the potential for misinterpretation, both by doctors and patients. In direct interactions, the process of exchanging meaning is often facilitated by physical context, facial expressions, gestures, and full intonation. However, in voice-based consultations alone, such as over the phone, many of these elements become unavailable, making the delivered message more susceptible to ambiguity. For example, in one of the transcripts, the patient says: *"[P07]: It feels like it's not good in the body, it's like it's all tired."* This phrase is difficult to interpret clinically without visual observation or direct examination, so doctors have to guess or multiply clarification questions, which sometimes prolongs the communication process and increases the risk of misinterpretation.

Another limitation that is very crucial is the absence of nonverbal cues, which serve as a marker of emotions, severity of complaints, or even sincerity of the response. Nonverbal cues also help healthcare workers assess the consistency between patients' verbal and expression. In telephone consultations, this dimension is practically absent; therefore, doctors can only rely on voice intonation or word choice as an indicator of the patient's condition. In this case, misjudgment can occur, especially when the patient conveys information in a flat, hesitant, or stuttering style of communication, which can be caused by technical factors, such as poor connections, as well as psychological factors, such as anxiety.

Another communication challenge is the difference in language competence and health literacy between patients and medical personnel. This imbalance can become even more pronounced in remote consultation situations. Doctors often use technical terms that the patient does not understand, while patients use Layman's terms or metaphors that do not directly reflect the clinical condition. For example, when the patient says, *"[P02]: I have a severe cold,"* the doctor should interpret whether it includes symptoms such as fever, chills, muscle aches, or fatigue. This semantic mismatch creates a gap in shared *understanding*, which is essential for clinical communication.

Within the framework of critical discourse analysis, these challenges are not only technical, but also related to power relations, access to knowledge, and the institutional structure of health services. Fairclough (Motion & Leitch, 1996) emphasized that communication inequality can reinforce the dominance of certain discourses (in this case, medical discourse) while reducing the patient's space for active participation. Therefore, long-distance communication needs to be treated not just as an information channel but as an arena of discursive praxis fraught with social consequences.

For nursing students, understanding the challenges of communication in remote consultations is important in forming professional competencies that are responsive to digital and multicultural contexts. Cross-media communication skills, sensitivity to laymen, and the ability to build empathy verbally are part of new clinical literacy that is increasingly relevant in the post-pandemic era.

Discussion

The practical findings of this study highlight a crucial component in remote consultations: the role of therapeutic relational connection (TRC). Specifically, the data reveal that when clinicians adopt empathic strategies—such as allowing patients narrative space before shifting to closed-ended questions—the clarity of exchanged information improves significantly, and patients report feeling more acknowledged and respected. This finding aligns

with Vystropova and Bass (2022), who argue that in telehealth settings, where nonverbal cues are absent, the ability to establish TRC through verbal interaction becomes a key determinant of communication effectiveness and patient satisfaction (jmir.org). The critical takeaway here is that TRC is not an optional feature but a core element of successful remote healthcare. It facilitates trust, minimizes miscommunication, and enhances the therapeutic quality of the encounter—underscoring that building a meaningful, empathetic communicative relationship is central to telemedicine, not merely a complementary gesture.

The practical findings of this study underscore a key insight: the establishment of Therapeutic Relational Connection (TRC) is essential in remote consultations, not merely supportive. The data indicate that when clinicians employ empathic strategies—such as allowing patients narrative space before introducing closed-ended questions—two important outcomes emerge: information becomes clearer, and patients feel emotionally validated. These are not trivial outcomes; they directly impact the effectiveness of diagnosis and the quality of patient care.

This finding supports the conclusion of Vystropova and Bass (2024), who argue that in the absence of nonverbal cues, TRC must be built verbally and intentionally to sustain the quality of telehealth interactions (jmir.org). The key takeaway is this: TRC functions as the backbone of communication in teleconsultations. Without it, interactions risk becoming mechanical, transactional, and prone to misunderstanding. With it, the consultation becomes more than information Exchange it becomes a space of shared meaning, trust, and emotional safety.

In terms of nursing education, the findings of this study highlight the urgent need to implement scenario-based training that specifically simulates telephone consultation settings. One practical method is the use of the teach-back technique, where after delivering clinical information, students are trained to ask patients to repeat the information in their own words. This ensures comprehension and identifies gaps in understanding. Another core practice is training in the use of clarifying questions—both open-ended (e.g., “Can you describe what the pain feels like?”) and closed-ended (e.g., “Is the fever above 38 degrees?”)—to tailor responses to the communication needs of different patients.

The application of these techniques can be operationalized in nursing curricula through structured role-plays, simulated phone-call assessments, and reflective feedback sessions. For instance, an Australian study by Deichen et al. (2021) found that incorporating teach-back and structured questioning into nursing simulation labs significantly improved patients’ reported understanding in teleconsultation scenarios, particularly among older adults and those with low health literacy.

The core implication here is that by embedding these techniques into practical training, nursing students develop not only verbal precision but also adaptive communication awareness—particularly crucial in contexts lacking visual or physical cues. This ensures that future nurses are equipped to communicate clearly, empathetically, and effectively in remote clinical environments.

In addition, this study opens opportunities to incorporate discourse analysis into clinical communication teaching. By understanding concepts such as framing, control discourse, and doctor-patient recontextualization, students can learn to recognize power dynamics and deal with them professionally. White et al. (2022) also recommend a codesign-based approach to designing telehealth communication guidelines that incorporate the perspectives of practitioners and service users. This approach can enrich the nursing curriculum so that it is more responsive to the real-world context of telehealth practice.

However, this study had some limitations. Data capture is limited to one institution, and phone-only interactions, excluding video or text messages, focus more on the audio dimension.

In addition, the data did not include demographic variables such as old age or low digital literacy, although Bajra et al. (2023) found this to be significant in inhibiting communication. Advanced research can extend the scope of data sources to different telehealth platforms and populations with different backgrounds, and apply a longitudinal design to test the effectiveness of curriculum interventions in shaping communication competencies.

CONCLUSION

This study revealed that the practice of medical consultation via telephone is a complex discursive arena, characterized by power inequality, potential miscommunication, and the need for adaptive communication skills from both parties. The findings suggest that patients tend to report symptoms through nonmedical narratives that are subjective and unstructured, while clinicians use interrupt, closed-ended questions, and clarification strategies as a form of discourse control that directs interactions towards a more systematic diagnostic framework. The absence of nonverbal cues during telephone consultations increases the likelihood of misinterpretation, which has implications for service effectiveness and patient safety. The representation of power in interactions not only affects the content of medical discussions but also shapes the subjective experience of patients as recipients of remote health services.

Based on these findings, we recommend that nursing lecturers actively integrate remote consultation scenario-based communication training into the curriculum, including simulated telephone interactions and authentic transcript analysis. This type of training is important to equip students with pragmatic, ethical, and empathetic competencies in dealing with communication dynamics in the digital era. Nursing education institutions are also encouraged to adopt cross-disciplinary approaches, such as discourse analysis and health sociolinguistics to broaden students' perspectives on clinical interactions. More broadly, the results of this study provide input for policymakers in the field of education and health services to develop guidelines for distance medical communication that consider the dimensions of patients' language, culture, and digital literacy, so that services remain inclusive, safe, and dialogically meaningful.

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