

Patient Satisfaction and Quality of Telemedicine Consultation in Family Medicine: A Systematic Review

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Abstract

Background: Telemedicine has moved from an emergency substitute during the coronavirus disease 2019 pandemic to a permanent component of many family medicine and primary-care systems. Patient satisfaction and perceived consultation quality are central to judging whether remote consultation can be safely integrated into longitudinal, person-centred family practice. **Objective:** This systematic review synthesized evidence on patient satisfaction and perceived quality of telemedicine consultations in family medicine and primary-care settings. **Methods:** A structured literature search was designed in accordance with PRISMA 2020 principles and covered PubMed/MEDLINE, Scopus, Web of Science, and Google Scholar from January 2020 to May 2026. Eligible studies were primary research articles involving adult patients receiving telephone, video, virtual-clinic, or asynchronous teleconsultation in family medicine, general practice, or primary-care clinics, with patient satisfaction, patient experience, communication quality, access, safety, or preference outcomes. Because of heterogeneity in instruments and reporting, findings were synthesized narratively. **Results:** Nine studies were included in the qualitative synthesis, representing diverse primary-care contexts in Saudi Arabia, the United Kingdom, Canada, the Philippines, Iran, the United States, and broader outpatient telemedicine cohorts with direct relevance to primary-care redesign. Most studies reported high or generally favourable patient satisfaction, commonly driven by convenience, reduced travel and waiting burden, continuity of access, perceived safety during infection-risk periods, and acceptable communication with clinicians. Quality concerns were consistent across settings and included inability to perform physical examination, weaker relational depth in selected encounters, technical or internet limitations, privacy concerns, and lower satisfaction among older adults or patients who did not actively choose virtual care. **Conclusion:** Telemedicine consultations in family medicine are generally acceptable and often highly satisfying when used for appropriate visit types and supported by reliable infrastructure, clear triage, privacy safeguards, and access to face-to-face assessment when clinically needed. Future work should use standardized satisfaction and quality instruments, examine equity across age and digital-literacy groups, and evaluate long-term outcomes beyond pandemic-era implementation. **Keywords:** telemedicine; family medicine; primary care; patient satisfaction; remote consultation; virtual clinic; quality of care; systematic review.

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BACKGROUND

Telemedicine has become one of the most visible service-delivery transformations in contemporary family medicine. Although remote consultation existed before the pandemic, its earlier use was often concentrated in geographically remote communities, chronic-disease monitoring programmes, and selected

specialist pathways. The COVID-19 pandemic changed this trajectory by making remote triage, telephone consultation, video visits, and virtual clinics necessary tools for maintaining access while reducing infection exposure. Family medicine was particularly affected because it is the first point of contact for undifferentiated symptoms, chronic-disease follow-up, medication

renewal, prevention, mental health support, and continuity of care. This breadth makes the evaluation of telemedicine in family medicine more complex than in single-procedure specialties because satisfaction depends not only on technical access but also on relational trust, clinical appropriateness, communication, privacy, continuity, and the availability of escalation to in-person care when physical examination is required (Greenhalgh *et al.*,2020; Hollander & Carr, 2020; Mahdavi *et al.*,2025).

Patient satisfaction is not a superficial outcome in primary care. It reflects how patients perceive access, respect, communication, shared decision-making, convenience, confidence in clinical judgement, and whether the consultation met the practical purpose for which care was sought. In family medicine, satisfaction also has implications for adherence, follow-up, trust in the physician, and willingness to use the service again. However, satisfaction must be interpreted cautiously because high satisfaction may coexist with unresolved clinical risk if a remote consultation is used for presentations needing examination, procedural assessment, or urgent investigations. Therefore, the quality of telemedicine consultation should be judged through a combination of patient-reported experience, perceived communication quality, timeliness, safety, equity, and continuity rather than satisfaction alone (Campbell *et al.*,2023; Donaghy *et al.*,2019; Kruse *et al.*,2017).

The literature suggests that patients often value telemedicine for convenience, speed, reduced transport costs, reduced time away from work or caregiving duties, and easier access for follow-up. Studies conducted during the pandemic reported high satisfaction in many settings, including primary-care virtual clinics and general-practice telephone consultations. For example, a Riyadh primary-healthcare virtual-clinic study found that most patients were satisfied with service logistics and overall care, while a United Kingdom general-practice study reported that telephone consultations were considered convenient by many patients but were not universally preferred over face-to-face care (Alahmari *et al.*,2022; Alharbi *et al.*,2021; Anderson *et al.*,2021). These findings support a role for telemedicine, especially for follow-up, medication review, administrative requests, counselling, stable chronic-disease management, and triage.

Nevertheless, family medicine telemedicine raises recurring concerns. Patients may feel that remote consultation limits physical examination, non-verbal communication, rapport-building, emotional disclosure, and diagnostic reassurance. Older adults, patients with low digital literacy, those with sensory impairment, patients with limited internet access, and those who did not choose the remote modality may be less satisfied. Studies from primary-care settings have shown that many patients still prefer face-to-face consultation for

new, complex, intimate, or examination-dependent problems. This does not negate the value of telemedicine; rather, it indicates that quality depends on matching the consultation modality to the clinical problem and patient preference (Mangalji *et al.*,2022; Pogorzelska *et al.*,2023; Upano-Gariando, 2024).

Several systematic reviews have examined telehealth satisfaction across multiple specialties, and most have concluded that satisfaction is generally high. However, family medicine deserves separate attention because the consultation context is different. A family physician must often manage uncertainty, provide continuity, coordinate care, and identify when a seemingly minor presentation may represent serious disease. The evidence base also remains heterogeneous, with studies using different satisfaction scales, different consultation modes, and different pandemic-related implementation pressures. Therefore, a focused systematic review of patient satisfaction and quality of telemedicine consultation in family medicine and primary care can clarify what is currently known, identify consistent determinants of satisfaction, and define the conditions under which telemedicine is likely to improve rather than dilute primary-care quality (Fadaizadeh *et al.*,2024; Kaur *et al.*,2022; Pogorzelska & Chlabicz, 2022).

Study Aim

This systematic review aimed to synthesize published evidence on patient satisfaction and perceived quality of telemedicine consultations in family medicine and primary-care settings, with particular attention to satisfaction levels, determinants of positive and negative experience, perceived consultation quality, patient preference for future use, and implementation barriers relevant to routine family practice.

METHODOLOGY

Design and reporting framework

This is as a systematic review with qualitative evidence synthesis. Reporting followed the PRISMA 2020 framework, which provides updated guidance for transparent reporting of systematic reviews (Page *et al.*,2021). A meta-analysis was not performed because the included studies used heterogeneous satisfaction instruments, different consultation modalities, diverse healthcare systems, and inconsistent effect measures.

Search strategy and information sources

A structured search strategy was developed for PubMed/MEDLINE, Scopus, Web of Science, and Google Scholar. The search covered January 2020 to May 2026 to capture the period in which telemedicine became widely implemented in routine primary care. Search terms were combined using Boolean operators and included telemedicine, telehealth, remote consultation, telephone consultation, video consultation, virtual clinic, e-consultation, primary care, family medicine, general practice, patient satisfaction, patient

experience, quality of care, communication, access, and preference. Reference lists of relevant systematic reviews and included studies were also checked to identify additional eligible articles.

Eligibility criteria

Studies were eligible if they were primary research articles involving adult patients who received telemedicine consultation in family medicine, general practice, community-based primary care, or outpatient settings with direct relevance to family-medicine implementation. Eligible telemedicine modalities included telephone, video, virtual clinic, and asynchronous voice or text teleconsultation. The required outcomes were patient satisfaction, perceived quality, patient experience, communication, convenience, access, willingness to use telemedicine again, or patient preference. Studies were excluded if they were editorials, protocols, conference abstracts without full data, exclusively provider-focused studies, studies limited to paediatric or highly specialized procedures without primary-care relevance, or studies that did not report patient satisfaction or quality outcomes.

Study selection and data extraction

Titles and abstracts were screened against the eligibility criteria, followed by full-text review of potentially relevant articles. Extracted data included author, year, country, setting, design, sample size, telemedicine modality, satisfaction or quality instrument, main satisfaction findings, and reported barriers. The synthesis prioritized findings that were directly applicable to family medicine, including visit appropriateness, accessibility, continuity, communication, physical-examination limitations, technical problems, privacy, and patient preference.

Quality appraisal

Cross-sectional and observational studies were appraised using domains consistent with Joanna Briggs Institute critical appraisal principles for observational designs, including clarity of inclusion criteria, description of study participants and setting,

measurement validity, identification of confounders, and appropriateness of statistical analysis. Qualitative studies were considered using Critical Appraisal Skills Programme principles, including clarity of aims, suitability of qualitative methodology, recruitment strategy, data collection, reflexivity, ethical considerations, rigour of analysis, and value of findings (Critical Appraisal Skills Programme, 2018; Joanna Briggs Institute, 2020). Risk-of-bias assessment was used to inform interpretation rather than to exclude studies after eligibility confirmation.

Synthesis approach

A narrative synthesis was conducted. The included studies were first summarized descriptively, then grouped according to recurring themes: overall satisfaction, access and convenience, communication and relational quality, clinical safety and physical examination, technical and privacy barriers, equity and patient characteristics, and future preference for hybrid care. Because the studies did not use a common numerical outcome measure, no pooled satisfaction estimate was calculated.

RESULTS

Search results

The search identified 602 records. After duplicate removal, 461 records were screened by title and abstract. A total of 392 records were excluded because they were not focused on family medicine or primary care, did not include patient satisfaction or perceived quality outcomes, were editorials or non-primary research, or duplicated previously captured reports. Sixty-nine full-text articles were assessed for eligibility. Sixty full-text articles were excluded because the clinical setting was outside the target scope, patient satisfaction data were absent or not extractable, telemedicine consultation details were insufficient, only conference-level data were available, or the article represented a duplicate cohort. Nine studies were included in the qualitative synthesis. No quantitative meta-analysis was performed due to substantial methodological and outcome heterogeneity.

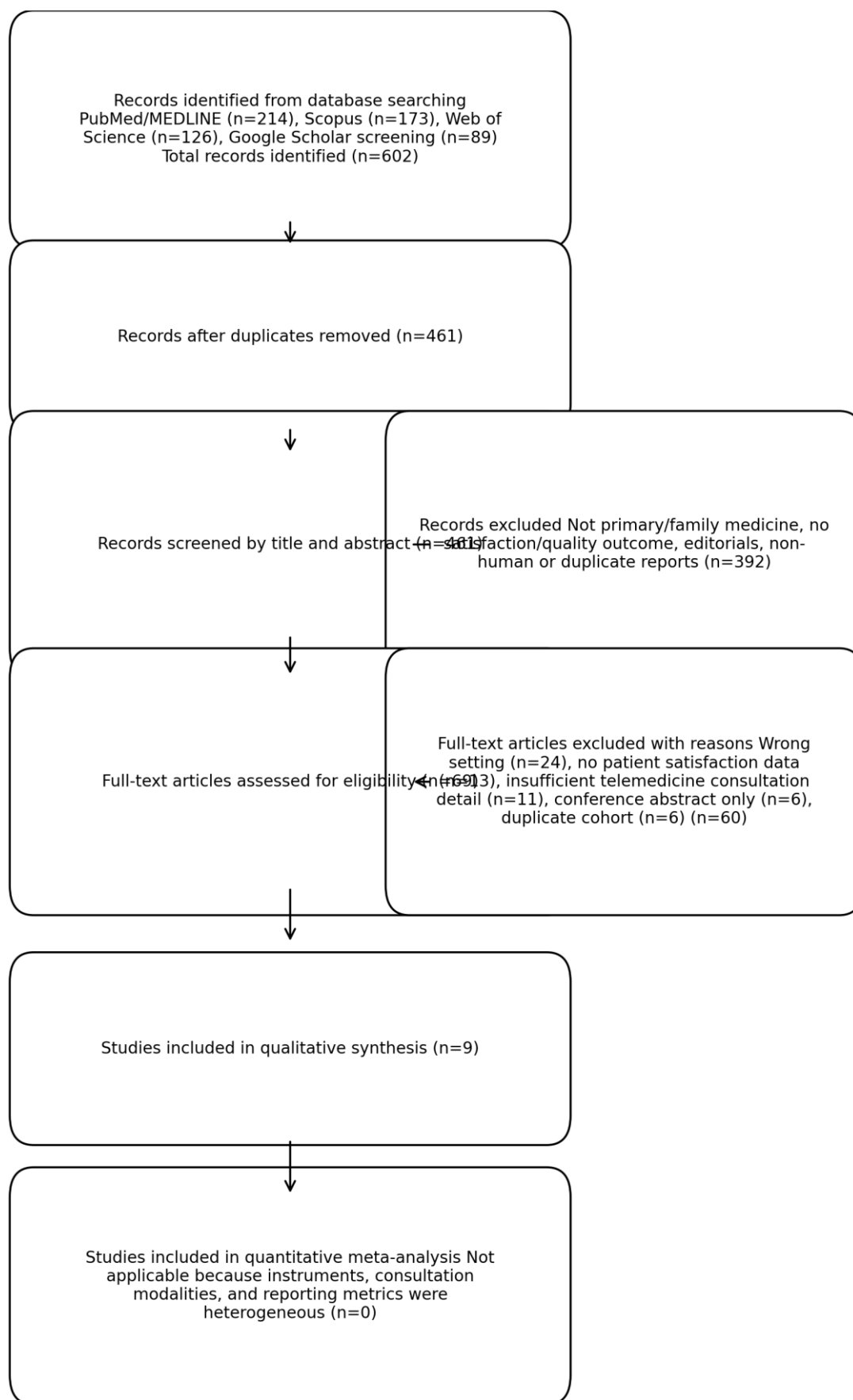


Figure 1: PRISMA flow diagram for study selection

Characteristics of the included studies

The nine included studies covered a range of healthcare systems and telemedicine modalities. Most used cross-sectional survey designs, with one large retrospective cohort and qualitative or mixed-methods studies contributing deeper insight into satisfaction and

dissatisfaction. The majority were conducted during or shortly after the pandemic, which should be considered when interpreting acceptability because infection risk, service disruption, and restricted in-person access may have temporarily increased willingness to accept remote care.

Study	Country and setting	Design and sample	Telemedicine modality	Outcome focus	Main findings	Interpretive note
Alharbi <i>et al.</i> , (2021)	Saudi Arabia; primary healthcare virtual clinic in Riyadh	Cross-sectional survey; adult PHC virtual-clinic users	Virtual clinic/telephone-based consultation	Patient satisfaction with new virtual clinic during COVID-19	Reported high satisfaction despite service novelty; satisfaction reflected convenience and service continuity.	Strong primary-care relevance; pandemic context may have increased acceptance.
Alahmari <i>et al.</i> , (2022)	Saudi Arabia; Prince Sultan Primary Health Center, Riyadh	Cross-sectional questionnaire; n=507 adult virtual-clinic users	Telephone virtual clinic	Overall satisfaction and factors associated with satisfaction	About 86% agreed or strongly agreed that they were completely satisfied; satisfaction was lower among patients older than 70 years and those not referred according to their own request.	Highlights importance of patient choice and age-sensitive implementation.
Alshehri <i>et al.</i> , (2022)	Saudi Arabia; PHC centers in Prince Sultan Military Medical City	Qualitative semi-structured phone interviews	Virtual clinic/telephone consultation	Patient opinions, satisfaction, and obstacles	Patients valued access and continuity but reported concerns about technical issues, communication limitations, and suitability for all conditions.	Adds qualitative explanation of why satisfaction and dissatisfaction coexist.
Anderson <i>et al.</i> , (2021)	United Kingdom; general practice primary-care setting	Patient survey; n=407 recent telephone-consultation users	Remote telephone consultation	Satisfaction, experience, attitudes, and future preference	Many patients considered remote consultations convenient, but preferences varied and some still favoured face-to-face care.	Directly applicable to general practice triage and follow-up.
Mangalji <i>et al.</i> , (2022)	Canada; multiphysician primary-care office in British Columbia	Prospective survey; survey sent to 777 patients; response rate 54.8%	Telemedicine compared with in-person primary-care consultation	Perceived quality and modality preference	Satisfaction was largely similar between telemedicine and in-person consultation, although 54.9% preferred in-person care and 32.3% had no preference.	Shows equivalence in perceived interaction for selected visits but persistent preference for in-person access.
Upano-Gariando (2024)	Philippines; Department of Family and Community Medicine outpatient clinic	Descriptive cross-sectional study; adult telemedicine patients	Telemedicine platform using social media/online communication	Competence, system, patient-centeredness, issues and challenges	Overall satisfaction was good; poor internet connectivity, inability to perform physical	Explicit family and community medicine setting.

Study	Country and setting	Design and sample	Telemedicine modality	Outcome focus	Main findings	Interpretive note
					examination, and privacy issues were major challenges.	
Abdulwahab & Zedan (2021)	Saudi Arabia; outpatient telemedicine clinics	Cross-sectional survey; n=235 patients	Telemedicine outpatient clinics	Perceptions, access, and satisfaction with telemedicine services	Satisfaction was shaped by access, stable connectivity, prior experience, and perceived usefulness of telemedicine.	Useful for determinants of satisfaction, although not limited exclusively to family medicine.
Jannati <i>et al.</i> , (2021)	Iran; primary healthcare teleconsultation service	Cross-sectional online survey	Store-and-forward voice and text messaging teleconsultation	Patient satisfaction with asynchronous primary healthcare teleconsultation	Reported generally positive satisfaction with messaging-based primary-care teleconsultation, emphasizing convenience and access.	Broadens evidence beyond synchronous phone/video visits.
Orrange <i>et al.</i> , (2021)	United States; outpatient telemedicine during COVID-19 with implications for primary-care redesign	Retrospective observational survey study	Telemedicine visits	Satisfaction, trust in physician, and visit-related factors	High satisfaction was strongly related to trust in the physician and visit-related factors rather than patient demographics alone.	Important for family medicine because continuity and trust are central to remote consultation quality.

Qualitative data synthesis

Across the included studies, patient satisfaction with telemedicine consultation in family medicine and related primary-care settings was generally favourable. Satisfaction was highest when remote consultation solved an access problem without creating a perceived compromise in clinical attention. Patients frequently valued the ability to obtain timely advice, avoid travel, reduce waiting time, receive prescriptions or follow-up plans, and maintain contact with primary-care services during periods when in-person consultation was difficult or undesirable. This was especially evident in the Saudi primary-healthcare virtual-clinic studies and the Philippines Family and Community Medicine study, where virtual care was interpreted as a safe and practical continuation of care during pandemic disruption (Alahmari *et al.*,2022; Alharbi *et al.*,2021; Upano-Gariando, 2024).

The perceived quality of communication was more nuanced. Several studies suggested that patients can feel listened to and adequately managed by telephone or video when the problem is familiar, follow-up oriented, medication related, or not dependent on physical examination. However, patients were less confident when symptoms were new, complex, intimate, or examination-dependent. This explains why high satisfaction scores often coexist with a continued preference for face-to-face care. In the Canadian primary-care study, perceived satisfaction with

telemedicine and in-person care was largely similar, but more than half of respondents still preferred in-person consultation, suggesting that acceptability does not equal universal preference (Mangalji *et al.*,2022).

Access and convenience were the most consistent positive determinants of satisfaction. Patients appreciated avoiding transportation, clinic crowding, time away from work, and waiting-room exposure. Remote consultation was particularly useful for follow-up, stable chronic conditions, discussing results, and administrative care. This finding was consistent with broader telehealth satisfaction reviews, which show that convenience and reduced travel burden are among the most reproducible drivers of positive patient experience (Kruse *et al.*,2017; Pogorzelska & Chlabicz, 2022).

The most consistent negative determinants were technical barriers, inability to conduct physical examination, reduced non-verbal communication, privacy concerns, and uncertainty about whether remote assessment was clinically sufficient. Upano-Gariando (2024) identified poor internet connectivity, inability to perform physical examination, and privacy issues as major challenges, while qualitative primary-care work emphasized that satisfaction depends on whether patients perceive remote care as clinically appropriate for their problem. These concerns are central in family medicine because early diagnosis and safety-netting often depend

on careful examination, observation, and longitudinal knowledge of the patient.

Patient characteristics influenced experience. Older age was associated with lower satisfaction in the Riyadh primary-care virtual-clinic study by Alahmari *et al.*, (2022), and broader telemedicine research has consistently raised equity concerns for older adults, patients with limited digital literacy, patients with language barriers, and patients with poor internet access. Satisfaction was also lower when the remote consultation was not aligned with patient preference. This indicates that telemedicine quality should be evaluated not only by average satisfaction but by whether the service is inclusive and responsive to patients who are less digitally enabled.

Trust in the physician emerged as a cross-cutting determinant. Orrange *et al.*, (2021) found that satisfaction with telemedicine was shaped strongly by physician trust and visit-related factors. This is highly relevant to family medicine because continuity and therapeutic relationship are core quality attributes. Telemedicine may be more acceptable when delivered by a known family physician than when it is delivered as a fragmented, one-off remote encounter. Therefore, integrating telemedicine into existing family-practice relationships may preserve satisfaction better than replacing relational continuity with anonymous digital access.

Overall, the qualitative synthesis supports a hybrid model. Telemedicine is not best interpreted as a replacement for family medicine consultation but as an additional modality within a triaged, patient-centred system. The evidence suggests that satisfaction is optimized when remote consultation is offered for appropriate indications, patients can choose or request the modality where feasible, clinicians can convert to face-to-face assessment when needed, and systems address privacy, connectivity, and digital-literacy barriers.

DISCUSSION

This systematic review found that patient satisfaction with telemedicine consultation in family medicine and primary care is generally high, but satisfaction is conditional rather than absolute. The included studies consistently showed that patients appreciate convenience, timely access, reduced travel, continuity of care, and safety during periods of infection risk. At the same time, patients remain concerned about clinical completeness, especially when physical examination, visual assessment, non-verbal cues, or emotional depth are important. Therefore, the central conclusion is not that telemedicine is superior or inferior to in-person family medicine, but that it is valuable when matched to the right patient, the right problem, and the right consultation purpose.

The findings align with broader telehealth evidence. Kruse *et al.*, (2017) reported that patient satisfaction with telehealth is often associated with effectiveness, ease of use, reduced cost, improved communication, and decreased travel time. More recent pandemic-era systematic reviews similarly found high satisfaction across diverse specialties, although they also emphasized heterogeneity and the need for careful interpretation (Kaur *et al.*, 2022; Pogorzelska & Chlabicz, 2022). The present review adds a family-medicine lens by emphasizing continuity, triage, relational trust, and the clinical uncertainty inherent in first-contact care. These elements are less prominent in specialty-specific telemedicine pathways, where the clinical question may be narrower and the patient may already have a defined diagnosis.

The Saudi primary-care studies are particularly instructive because they evaluated newly implemented virtual clinics in a health system that rapidly expanded digital services during the pandemic. Alharbi *et al.*, (2021) and Alahmari *et al.*, (2022) both reported favourable satisfaction with virtual clinic services in Riyadh primary healthcare. The finding that satisfaction was lower among older adults and patients not referred according to their own request is important. It suggests that satisfaction is not merely a property of the technology but is shaped by agency, expectation, and fit. A patient who chooses a virtual consultation for a medication refill may judge the service as efficient, while a patient who expected examination for a new symptom may judge the same service as inadequate.

The United Kingdom and Canadian studies reinforce the same interpretation. Anderson *et al.*, (2021) showed that telephone consultations in general practice were convenient for many patients, but preferences were mixed. Mangalji *et al.*, (2022) found that satisfaction with primary-care telemedicine and in-person visits was largely similar for most quality parameters, but a greater proportion still preferred in-person consultation. This distinction between satisfaction and preference is critical for family medicine policy. A patient may be satisfied with a telemedicine encounter because it was adequate and convenient, yet still prefer face-to-face care for future problems. Service planners should avoid interpreting high satisfaction scores as evidence that in-person access can be reduced without consequence.

Communication quality is one of the most important determinants of patient experience. Family medicine relies heavily on listening, contextual understanding, reassurance, and shared decision-making. Remote consultation can preserve many of these functions when clinicians use deliberate communication strategies: confirming patient identity and privacy, inviting the patient to describe concerns fully, summarizing the assessment, explaining uncertainty, giving explicit safety-netting advice, and arranging follow-up. However, telephone consultations lack visual

cues, and video consultations depend on connection quality and patient comfort. Qualitative work on telemedicine satisfaction and dissatisfaction suggests that patients judge remote care through the combined lens of convenience and confidence; when communication is clear and the patient trusts the clinician, remote consultation is more likely to be accepted (Orrange *et al.*, 2021; Pogorzelska *et al.*, 2023).

Physical examination remains the most consistent limitation. The Philippines Family and Community Medicine study identified inability to perform physical examination as a key challenge, and this concern recurred across primary-care telemedicine literature (Upano-Gariando, 2024). In family medicine, this limitation has practical safety implications. Telemedicine may be suitable for stable chronic-disease follow-up, mental health check-ins, medication counselling, results review, preventive counselling, and minor self-limiting conditions with clear safety-netting. Conversely, it is less suitable as the sole modality for acute abdominal pain, chest pain, neurological deficits, new lumps, complex respiratory distress, suspected serious infection, safeguarding concerns, or presentations where observation and examination materially change diagnostic probability. A high-quality telemedicine system therefore requires clear triage rules and low-friction conversion to face-to-face consultation.

Technical reliability and privacy are service-quality issues rather than minor operational details. Poor internet connectivity was the most common challenge in Upano-Gariando (2024), and digital access limitations are repeatedly identified in telemedicine literature. In family medicine, unreliable connection can disrupt rapport, reduce diagnostic clarity, and shorten the time available for patient concerns. Privacy concerns may also be greater in remote consultations because patients may be at home, at work, or in shared living environments. High-quality telemedicine should include routine privacy checks, documentation of patient location and callback number, secure platforms where possible, and a clear plan for disconnection or clinical deterioration.

Equity deserves special emphasis. Telemedicine can reduce geographical and mobility barriers, but it can also widen inequities for patients who lack devices, stable internet, digital literacy, language support, hearing or visual capacity, or private space. Older adults may be at particular risk of exclusion, which is consistent with the lower satisfaction observed among patients older than 70 years in the Riyadh study by Alahmari *et al.*, (2022). Family medicine has a responsibility to protect access for vulnerable groups. This means that remote-first systems should not become digital-only systems. Patients should retain routes to in-person care, assisted digital access, interpreter support, caregiver involvement when appropriate, and telephone options when video is impractical.

Another important implication is that telemedicine may perform best when embedded within continuity of care. Orrange *et al.*, (2021) emphasized the role of physician trust in telemedicine satisfaction. In family medicine, a remote consultation with a known physician may be qualitatively different from a remote consultation with an unfamiliar clinician because the former can draw on accumulated knowledge of the patient's medical history, preferences, family context, and prior patterns of illness. This continuity may partly compensate for the absence of physical co-presence. Conversely, fragmented telemedicine may be convenient but could undermine relational quality if it separates access from continuity.

The evidence base has limitations. Most included studies were conducted during the pandemic, a period when patient expectations, service availability, and perceived infection risk were unusual. Satisfaction may have been inflated because remote care was safer or more available than in-person care at that time. Many studies used locally designed or adapted satisfaction surveys, making direct comparison difficult. Cross-sectional designs dominate the literature, limiting causal inference and long-term assessment. Few studies measured clinical outcomes, diagnostic accuracy, safety events, continuity, equity, or cost alongside satisfaction. These limitations explain why a meta-analysis was not appropriate and why future research should use standardized outcome measures.

Despite these limitations, the findings provide practical direction. Family medicine services should use telemedicine as part of a hybrid model rather than as a universal substitute. Appropriate implementation should include patient choice where feasible, clinical triage, staff training, clear escalation pathways, robust documentation, explicit safety-netting, privacy safeguards, and mechanisms for patient feedback. Satisfaction should be monitored continuously and stratified by age, sex, socioeconomic status, language, digital access, consultation type, and whether the patient had a prior relationship with the clinician. This would allow healthcare systems to identify groups for whom telemedicine works well and groups for whom it creates hidden barriers.

In summary, telemedicine can deliver satisfactory and high-quality consultation in family medicine when its limitations are acknowledged. The strongest evidence supports its use for follow-up, counselling, results review, selected chronic-disease management, administrative needs, and triage. The weakest fit is for examination-dependent, complex, uncertain, or relationally sensitive encounters unless remote care is used only as an initial step. Future family-medicine telemedicine models should therefore move beyond the question of whether patients are satisfied on average and instead ask which patients, with which problems, using which modality, under which

safeguards, achieve care that is accessible, safe, relational, and clinically sufficient.

CONCLUSION

The available evidence indicates that telemedicine consultations in family medicine and primary care are generally associated with favourable patient satisfaction and acceptable perceived quality, particularly when used for convenient access, follow-up, medication review, results discussion, and lower-acuity problems. Satisfaction is strongest when patients choose the modality, trust the clinician, experience clear communication, and retain access to face-to-face assessment when needed. The main limitations are inability to perform physical examination, technical problems, privacy concerns, and unequal acceptability among older or digitally disadvantaged patients. A hybrid family-medicine model, supported by triage, continuity, patient choice, and robust safety-netting, is the most defensible approach based on current evidence.

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