International Journal of Health Services Research and Policy
www.dergipark.org.tr/ijhsrp

IJHSRP

e-ISSN: 2602-3482

Review Article

PATIENT ATTITUDES TOWARD TELEHEALTH IN PRIMARY HEALTH CARE: A QUALITATIVE EVIDENCE SYNTHESIS FOR SUSTAINABLE AND QUALITY-ORIENTED DIGITAL TRANSFORMATION[a]

Perihan ŞENEL TEKİN*[1] ***Yonca ÖZATKAN*[2]**

[1,2] Ankara University, Vocational School of Health Services, Department of Medical Services and Techniques, Program of Medical Documentation and Secretarial, Ankara, Türkiye
[*] Corresponding author; ptekin@ankara.edu.tr

Abstract: *Telehealth has become a central component of digital transformation in primary health care. Although its operational benefits are well documented, a clearer understanding of patient attitudes is essential for ensuring patient-centred, equitable, and sustainable service delivery. This study aimed to explore and synthesise adult patients' attitudes toward telehealth in primary health care, with particular attention to perceived benefits, experienced difficulties, and contextual influences on acceptance. This study was designed as a qualitative evidence synthesis and reported in accordance with the ENTREQ statement. Systematic searches were conducted in PubMed/MEDLINE, Scopus, and Web of Science to identify peer-reviewed qualitative studies published in English between 1 January 2025 and 31 December 2025. Eligible studies examined adult patients' experiences, perceptions, or attitudes regarding telehealth in primary care or primary-care-linked services. The study selection process was documented in accordance with the PRISMA framework. Data were synthesised through thematic synthesis, including line-by-line coding, development of descriptive themes, and generation of higher-order analytical interpretations. Seventeen studies were included. The synthesis showed that telehealth was generally perceived as a valuable but conditional mode of care. Patients particularly valued improved access, convenience, reduced travel burden, and support for follow-up and self-management. At the same time, they reported important concerns related to limited physical examination, communication quality, impersonality, technical difficulties, and uneven digital capability. Attitudes were strongly shaped by telehealth modality, consultation purpose, continuity of care, prior patient–clinician relationships, and social and technological conditions. Adult patients' attitudes toward telehealth in primary health care are nuanced and context-dependent rather than uniformly positive or negative. Sustainable integration of telehealth requires more than technological availability; it depends on relational continuity, clear communication, clinical appropriateness, and equitable digital access. Telehealth is most likely to be accepted when implemented as part of a hybrid, patient-centred primary care model.*

Keywords*: Telehealth, primary health care, digital transformation, patient attitudes, qualitative evidence synthesis*

Received:April 29, 2026 *Accepted: June 18, 2026*

a This study was previously presented as an oral presentation at the 3rd Sustainability, Quality and AI Conference in Health Sciences, held on 24–25 April 2026 at International Hellenic University, Thessaloniki, Greece, and received the Best Paper Award. The abstract was published in the conference proceedings.

1. Introduction

The rapid expansion of digital health has reconfigured the delivery of primary care, positioning telehealth as a central modality for improving access, flexibility, and continuity of care. In primary care settings, where services span prevention, first-contact care, chronic disease management, follow-up, and care coordination, telehealth has been increasingly framed as a means of overcoming geographic, temporal, and logistical barriers to healthcare delivery [1, 2]. Its relevance is particularly pronounced in health systems facing rising demand, workforce pressures, and persistent inequities in access to care.

The COVID-19 pandemic accelerated this transformation dramatically. Telehealth moved from a supplementary or selectively used service model to an essential mechanism for maintaining care while minimising infection risk and preserving service continuity [3, 1]. This rapid normalisation of remote care has generated an important shift in the literature. Early debates centred largely on feasibility, policy adaptation, and emergency implementation; more recent work has turned toward the longer-term question of whether telehealth can be meaningfully embedded into routine primary care in ways that are clinically appropriate, operationally sustainable, and acceptable to patients [4, 5].

Available evidence suggests that telehealth offers several important advantages from the patient perspective. Across primary care and family medicine contexts, reported benefits include improved access to care, reduced travel time and cost, greater convenience, enhanced flexibility, and support for continuity in routine and follow-up care [2, 5]. Telehealth may be particularly valuable for patients in rural or underserved areas, for those with mobility limitations, and for individuals requiring ongoing monitoring or chronic disease follow-up [1, 6]. These findings suggest that telehealth can extend the reach of primary care while also reshaping how patients interact with health services, potentially enabling more responsive and individualised patterns of care.

However, the patient experience of telehealth is neither uniform nor unambiguously positive. Existing studies indicate that patient attitudes toward telehealth are strongly contingent on consultation purpose, modality, technological usability, continuity of the patient-clinician relationship, and the perceived adequacy of remote assessment [5, 7]. Telehealth tends to be viewed more favourably for straightforward, routine, or follow-up encounters, but less favourably when health concerns are complex, sensitive, diagnostically uncertain, or require physical examination [3, 5]. Indeed, the inability to perform hands-on examination remains one of the most persistent limitations identified in the literature, raising questions about diagnostic confidence, relational quality, and the clinical boundaries of remote care [3, 2].

In parallel, a growing body of work has shown that the challenges of telehealth are not merely technological, but social, relational, and structural. Patients have reported concerns regarding privacy, confidentiality, communication quality, platform usability, and the potential weakening of interpersonal connection with healthcare professionals [3, 5]. These concerns intersect with broader issues of digital inequity. Telehealth depends not only on service availability, but also on patients' access to devices, internet connectivity, digital skills, confidence, and practical support. As recent work on digital exclusion makes clear, inequalities in access to and benefit from digital healthcare are multidimensional and may disproportionately disadvantage those who are older, socioeconomically vulnerable, geographically isolated, or otherwise marginalized [8]. In this sense, telehealth may simultaneously enhance access for some patients while deepening exclusion for others if contextual barriers are overlooked.

Despite substantial growth in telehealth research, the literature remains fragmented in important ways. Much of the evidence base has emphasized implementation, service models, provider perspectives, utilisation patterns, or system-level outcomes [4, 2]. Even where patient-focused studies exist, they often examine satisfaction or modality preference in isolation rather than offering a fuller

account of how adult patients interpret telehealth, what benefits they perceive, what difficulties they encounter, and which contextual conditions shape these experiences. This is a meaningful gap. Patient perspectives are not reducible to satisfaction metrics; they encompass sense-making, expectations, trust, perceived appropriateness, relational experience, and the everyday practicalities of engaging with care. Without a more integrated understanding of these dimensions, telehealth risks being evaluated primarily in terms of efficiency and uptake rather than in terms of acceptability, equity, and fit with patients' lived realities.

This gap is particularly important in primary care, where the value of care depends not only on technical delivery, but also on continuity, accessibility, interpersonal trust, and responsiveness to diverse patient needs. A nuanced synthesis of adult patients' experiences and perceptions is therefore necessary to clarify where telehealth is experienced as enabling, where it is experienced as burdensome or inadequate, and under what conditions these divergent experiences emerge. Such understanding is essential for informing the design of telehealth models that do not merely expand service capacity but do so in ways that are patient-centred and context-sensitive.

Accordingly, the present study explores and synthesizes how adult patients experience and perceive telehealth services in primary care. Specifically, it examines patients' attitudes toward telehealth, the benefits they perceive, the difficulties they encounter, and the contextual factors that shape these attitudes and experiences. By centring the adult patient perspective, this study aims to advance current understanding of telehealth beyond implementation and utilisation, and to generate evidence relevant to the development of more acceptable, equitable, and sustainable telehealth practices in primary care.

2. Materials and Methods

2.1. Purpose and study design

This review was designed as a qualitative evidence synthesis focused on adult patients' experiences and perceptions of telehealth in primary care. The reporting of the review was guided by the ENTREQ statement to enhance transparency in the synthesis of qualitative research. The study selection process was conducted and documented in accordance with the PRISMA framework, and the methodological quality of the included studies was appraised using the CASP Qualitative Checklist.

Accordingly, the review was guided by the following research questions, focusing on telehealth experiences within primary care settings or services explicitly linked to primary care delivery:

RQ: What are the attitudes of adult patients who have experienced telehealth services in primary care, the benefits they perceive, and the difficulties they encounter?

RQ1: What is the patient experience of telehealth, and how is it interpreted?

RQ2: What are the key benefits of telehealth from the patient perspective?

RQ3: What are the main difficulties encountered when using telehealth?

RQ4: Which contextual factors influence these attitudes and experiences?

Studies were included if they met the following criteria (see Table 1): (1) they were peer-reviewed original research articles published between 1 January 2025 and 31 December 2025; (2) they were published in English; (3) they employed a qualitative design, such as interviews, focus groups, qualitative descriptive approaches, phenomenology, grounded theory, or qualitative content/thematic analysis; (4) they focused on adult patients aged 18 years or older; (5) they examined patients' attitudes, experiences, perceptions, or views regarding telehealth services delivered within primary health care settings; and (6) they provided qualitative findings related to perceived benefits, challenges, acceptability, communication, access, trust, satisfaction, or other aspects of patient experience. Telehealth was defined broadly to include telephone consultations, video consultations, remote clinical

communication, and other forms of technology-mediated health service delivery between patients and primary care providers. Studies on remote monitoring were also eligible if the monitoring process was clearly linked to the delivery of primary health care services. Studies conducted in mental health were included only when the service was delivered within a primary care context.

In this review, the term telehealth was used as an umbrella concept referring to synchronous and asynchronous technology-mediated clinical communication and care delivery between patients and healthcare providers. Related terms such as telemedicine, teleconsultation, virtual care, remote monitoring, and digitally supported care were interpreted as modality-specific expressions of telehealth when they involved a clinical interaction, follow-up process, or care-related communication connected to primary care. This conceptual approach was adopted to maintain consistency across studies using different terminology while preserving the review's focus on patient experiences of digitally mediated care.

For the purposes of this review, primary care was interpreted pragmatically to include both services delivered directly within primary health care and telehealth-enabled services clearly embedded in, coordinated with, or functionally linked to primary care pathways. This broader boundary was adopted because contemporary telehealth delivery in primary care increasingly extends beyond conventional face-to-face general practice consultations to include triage, remote monitoring, rehabilitation support, and digitally mediated follow-up models that remain organisationally or clinically connected to primary care. Accordingly, the review synthesises evidence on patient attitudes toward telehealth in primary care and primary-care-linked services, rather than restricting the concept exclusively to routine general practitioner consultations in a narrow sense.

Mixed-methods studies were eligible only if their qualitative findings were reported separately and clearly enough to allow independent extraction and synthesis. Studies addressing patient satisfaction were included only when satisfaction was explored qualitatively through patient narratives, explanations, or lived experiences rather than being reported solely as a numerical score or survey outcome.

Studies were excluded if they were quantitative studies, reviews, systematic reviews, meta-analyses, editorials, commentaries, letters, conference abstracts, theses, reports, or study protocols. Studies were also excluded if they focused exclusively on healthcare professionals, caregivers, administrators, or paediatric populations; if they were conducted outside primary care settings, such as specialist outpatient services, hospital-based care, emergency care, or independent specialist mental health services; or if they addressed digital tools without a clear clinical care interaction in primary care. In addition, studies were excluded when telehealth-related outcomes were limited to operational performance, utilisation rates, technical effectiveness, or satisfaction scores without qualitative exploration of patient perspectives.

Table 1. Inclusion and exclusion criteria for study selection

Domain	Inclusion criteria	Exclusion criteria
Publication characteristics	Peer-reviewed original articles published in English between 1 January 2025 and 31 December 2025	Reviews, systematic reviews, meta-analyses, editorials, commentaries, letters, conference abstracts, theses, reports, protocols, non-English publications, and studies published before 1 January 2025 and after 31 December 2025
Study design	Qualitative studies, including interviews, focus groups, and other qualitative approaches; mixed-methods studies if qualitative findings were separately and clearly reported	Quantitative studies and mixed-methods studies without clearly separable qualitative findings

Table 1 Continued.

Domain	Inclusion criteria	Exclusion criteria
Participants	Adults aged ≥18 years receiving or experiencing telehealth services in primary care	Children or adolescents, caregivers, healthcare professionals, administrators, and studies with mixed samples in which patient data could not be isolated
Phenomenon of interest	Patients' attitudes, experiences, perceptions, views, perceived benefits, and challenges related to telehealth	Studies focusing only on utilisation, technical performance, clinical outcomes, or numerical satisfaction scores without qualitative patient perspectives
Telehealth scope	Telephone consultations, video consultations, remote clinical communication, and other technology-mediated primary care services; remote monitoring if clearly linked to primary care delivery	Administrative or non-clinical digital tools only; remote monitoring without a clear connection to primary care service delivery
Setting	Primary health care settings, including family practice, general practice, community-based primary care, and primary care mental health services	Hospital-based care, specialist outpatient services, emergency care, inpatient settings, and independent specialist mental health services
Outcome reporting	Qualitative findings on access, communication, trust, acceptability, patient-centredness, satisfaction, benefits, and barriers	Studies lacking qualitative exploration of patient experience; satisfaction reported only as a score, scale, or survey result
Availability	Full-text articles available	Full-text articles unavailable

Note. Telehealth was defined broadly to include synchronous or asynchronous technology-mediated clinical communication between patients and primary care providers, including telephone and video consultations. Mixed-methods studies were included only when qualitative findings could be clearly distinguished from quantitative results. Studies on remote monitoring were eligible only if they were explicitly linked to the delivery of primary health care services. Mental health studies were included only when conducted within a primary care context.

2.2. Search and selection strategy

A systematic search strategy was developed based on four core concepts: telehealth, primary health care, patients, and qualitative research. Search terms included controlled vocabulary and free-text keywords related to telehealth modalities, primary care settings, patient perspectives, and qualitative methods. The search strategy was adapted for each database, including PubMed/MEDLINE, Scopus, Web of Science, using database-specific subject headings, field tags, and syntax. Boolean operators ("AND," "OR"), truncation, and phrase searching were used as appropriate. Searches were limited to peer-reviewed articles published in English between 1 January 2025 and 31 December 2025. In addition, the reference lists of included studies and relevant reviews were screened to identify potentially eligible studies not captured through database searching.

The search was conducted using a combination of controlled vocabulary and free-text terms. The main search blocks included terms related to telehealth ("telehealth", "telemedicine", "teleconsultation", "virtual care", "remote consultation", "remote monitoring", "digital health"), primary care ("primary care", "primary health care", "general practice", "family practice", "family medicine", "community health services"), patient perspectives ("patient experience", "patient attitude", "patient perception", "patient view", "acceptability", "satisfaction"), and qualitative research ("qualitative", "interview", "focus group", "thematic analysis", "content analysis", "phenomenology", "grounded theory"). The search strategy was adapted to the indexing structure and syntax of each database. For PubMed/MEDLINE, MeSH terms and title/abstract keywords were combined where appropriate; for

Scopus and Web of Science, title, abstract, and keyword fields were searched using equivalent free-text terms. The searches were restricted to English-language, peer-reviewed original qualitative studies published between 1 January 2025 and 31 December 2025. The full database-specific search strategies are provided in Supplementary Table 1.

The search was limited to PubMed/MEDLINE, Scopus, and Web of Science because these databases provide broad multidisciplinary coverage of medicine, primary care, digital health, and health services research. PubMed/MEDLINE was selected for biomedical and primary care literature; Scopus and Web of Science were included to broaden coverage across health management, digital health, social science, and interdisciplinary research. Although databases such as CINAHL, PsycINFO, Embase, and the Cochrane Library may contain additional relevant studies, they were not included in the present review. This decision is acknowledged as a limitation, particularly because patient experience, nursing, psychology, and allied health studies may be indexed in these databases.

The decision to restrict the search to studies published in 2025 was made deliberately in order to capture the most recent qualitative evidence emerging after the emergency phase of the COVID-19 pandemic, when telehealth had increasingly shifted from a crisis-response mechanism to a more routine component of primary care delivery. This time frame was considered appropriate for the purpose of this review because patient attitudes during this period were more likely to reflect experiences with telehealth as an embedded service model rather than as a temporary or exceptional pandemic-related substitute. Focusing on this recent evidence also allowed the review to address contemporary issues such as hybrid care, digital inclusion, continuity of care, AI-supported tools, remote monitoring, and the organisational sustainability of telehealth in primary care. However, this decision also means that relevant qualitative studies published before 2025 may not have been captured, and this implication is acknowledged as a limitation of the review.

All records identified through database searching were imported into a Microsoft Excel spreadsheet for screening and documentation. The study selection process was conducted by two team members (PŞT and YÖ) and documented according to the PRISMA 2020 framework. A total of 1,051 records were identified from Web of Science, Scopus, and PubMed/MEDLINE. After the removal of 628 records based on duplication, publication type, language, and date restrictions, 423 records were retained for title screening. Titles were screened against the predefined eligibility criteria, and 190 records were excluded at this stage. The remaining 233 records were assessed at abstract level. Each record was classified as include, exclude, or unclear; records considered potentially relevant or insufficiently described in the abstract were advanced to full-text review.

At the abstract screening stage, 179 records were excluded mainly because they did not use a qualitative design or provide separable qualitative findings, did not focus on adult patients, were not focused on telehealth or patient experience of telehealth, or did not have a clear primary care or primary-care-linked context. Subsequently, 54 reports were retrieved and assessed in full text using a standardised eligibility form covering publication characteristics, study design, participants, telehealth scope, primary care setting, reporting of qualitative findings, and minimum methodological adequacy. At the full-text stage, 37 reports were excluded because they lacked an eligible primary care or primary-care-linked context, did not provide separable qualitative adult patient experience data, did not involve a clear telehealth care interaction, were not completed original qualitative studies, were outside the review scope, or had insufficient methodological or contextual fit with the review criteria. Finally, 17 studies were included in the qualitative evidence synthesis. The full study selection process is presented in Figure 1.

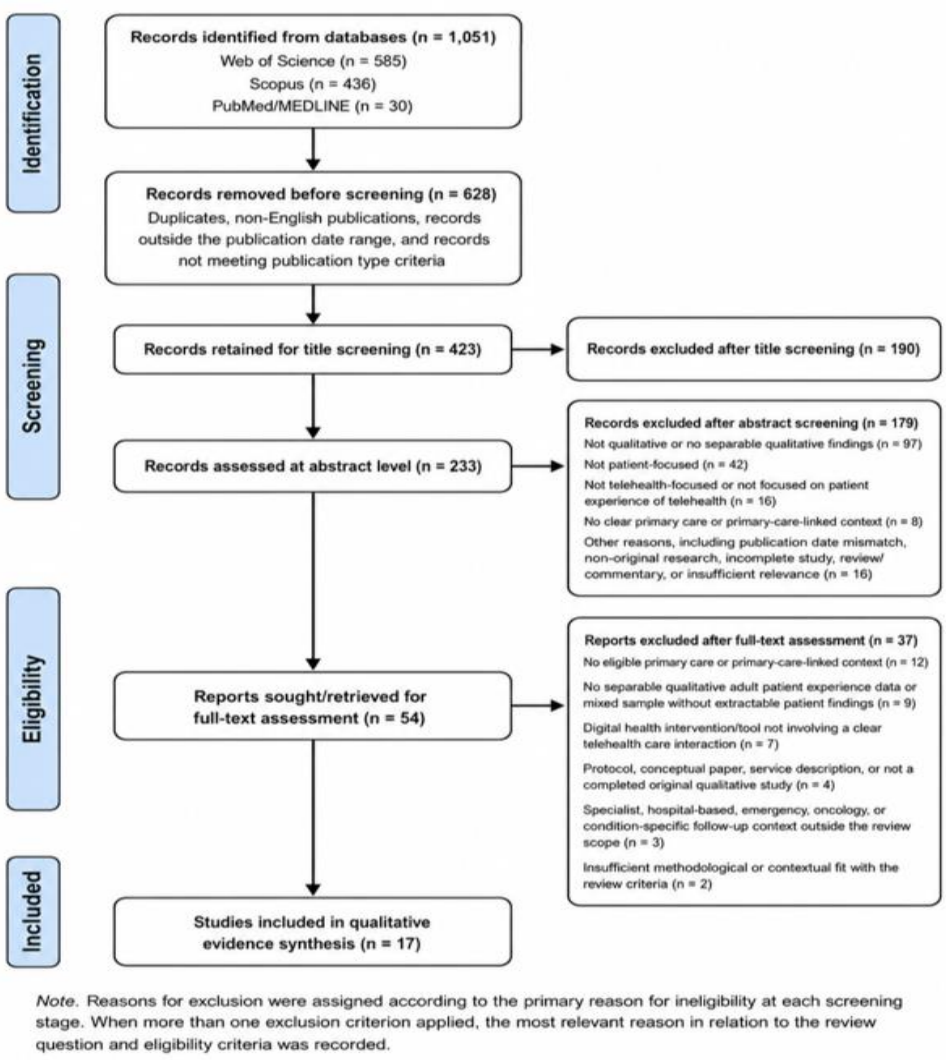


Figure 1. PRISMA 2020 flow diagram of study selection.

2.3. Data extraction

Data were extracted using a standardized form developed for this review. Extracted information included publication details, country, study aim, design, setting, participant characteristics, telehealth modality, data collection and analysis methods, and key qualitative findings related to patient attitudes, perceived benefits, and experienced challenges (see Table 2). Additional fields captured findings related to communication, access, trust, acceptability, and contextual factors shaping patient experiences. Extracted findings were then used to support line-by-line coding and thematic synthesis.

To address the heterogeneity of primary care and primary-care-linked services, additional extraction fields were added to classify each study according to telehealth modality, relationship with primary care, and primary care function. The relationship with primary care was classified as either directly delivered within primary care or linked to primary care through triage, follow-up, chronic disease management, rehabilitation support, language support, remote monitoring, or coordinated care pathways. This classification was used to clarify the extent to which each included study contributed to the review's focus on primary health care.

2.4. Data synthesis

The extracted qualitative findings were synthesised using thematic synthesis. First, the results and participant experience-related findings of the included studies were read repeatedly by both authors to achieve familiarity with the data. Line-by-line coding was then conducted manually using Microsoft Excel. Both authors independently coded the extracted findings from the included studies. Initial codes were compared and discussed, and disagreements were resolved through consensus. Similar codes were grouped into descriptive themes reflecting recurring patterns in patient experiences, perceived benefits, difficulties, and contextual influences. In the final stage, descriptive themes were interpreted across studies to generate higher-order analytical themes. These analytical themes were aligned with the review questions and formed the basis of the four main domains presented in the Results section. No qualitative data analysis software was used; instead, coding, comparison, and theme development were documented through structured Excel matrices.

Table 2. Summary of included studies

Author/ Year	Purpose of study	Sample characteristics and size	Method	Results	Telehealth modality	Relationship with primary care	Primary care function
Eriksson et al. [9]	To explore patient experiences of a chat-based primary care platform in Sweden.	Primary care patients, Sweden; n = 23	Qualitative interviews analysed inductively with sensitivity analysis and UTAUT-informed interpretation.	Patients valued faster access but reported delays, uncertainty, and reduced personal interaction. Findings centred on access, usability, and changing patient–provider dynamics.	Chat-based digital primary care platform	Directly delivered within primary care	Digital access, remote consultation, triage, patient–provider communication
Gray et al. [10]	To examine Veterans' experiences of integrated virtual triage and urgent care.	Veterans, USA; n = 24	In-depth interviews analysed using qualitative description and constant comparison.	Participants reported high satisfaction, especially for timely care and convenience. Some were frustrated by triage routing and limited-service awareness.	Virtual triage and urgent care via call centres	Linked to primary care and urgent care pathways	Triage, urgent care navigation, timely access
Jaranka et al. [11]	To explore patient perceptions of remote monitoring via a central virtual ward in primary care.	Patients with chronic disease, Sweden; n = 22	Semi-structured interviews analysed using qualitative content analysis.	The service was perceived as safe and accessible but also impersonal. Weak coordination with primary care was a major concern.	Remote patient monitoring via centralised virtual ward	Primary-care-linked remote monitoring	Chronic disease monitoring, follow-up, care coordination

Table 2. Continued

Author/ Year	Purpose of study	Sample characteristics and size	Method	Results	Telehealth modality	Relationship with primary care	Primary care function
Karregat et al. [12]	To investigate patient experiences of smartwatch-based ECG monitoring in primary care.	Adults with palpitations, Netherlands; n = 18	Semi-structured interviews after simultaneous smartwatch and Holter use; thematic analysis.	The smartwatch was seen as more practical than the Holter monitor. Challenges included uncertainty, short-episode capture, and anxiety about automated outputs.	Smartwatch-based ECG monitoring	Linked to primary care diagnostics	Diagnostic support, symptom monitoring, clinical interpretation
Leach et al. [13]	To investigate remote consultation experiences among patients with CFS/ME and fibromyalgia.	Adults with CFS/ME and fibromyalgia, UK; n = 13	Semi-structured interviews analysed thematically with Foucauldian interpretation.	Feeling believed by clinicians was central. Positive experiences depended on continuity, trust, and recognition of illness complexity.	Remote consultations by telephone/online formats	Directly linked to general practice/primary care	Remote consultation, continuity of care, management of complex chronic conditions
Leonard et al. [14]	To understand patient experiences of a telehealth diabetes program for rural Veterans.	Rural Veterans, USA; n = 26	Semi-structured interviews analysed using inductive–deductive content analysis.	The program was seen as more frequent, comprehensive, and convenient than prior care. Participants also perceived better diabetes control.	Telehealth diabetes programme	Primary-care-linked chronic disease programme	Diabetes follow-up, chronic disease management, self-management support
Litchfield et al. [15]	To investigate the acceptability of an AI-powered translation tool in primary care access.	Bangladeshi patients, UK; n = 7	Semi-structured interviews analysed using content analysis.	The tool was valued for guidance, access support, and safer discussion of sensitive issues. Translation accuracy was the main concern.	AI-powered translation/triage tool	Linked to primary care access	Language support, appointment navigation, triage, access facilitation
Müller et al. [16]	To explore acceptance of specialist video consultations delivered within primary care.	Older rural men with depression/anxiety, Germany; n = 21	Qualitative interviews analysed using inductive content analysis and TAM.	Attitudes were largely positive, particularly where strong primary care relationships already existed. Lower digital literacy increased the need for support.	Specialist video consultations integrated with primary care	Primary-care-linked specialist consultation	Mental health access, referral support, specialist consultation within primary care pathway
Newhouse et al. [17]	To explore contextual influences and perceived mechanisms of a diabetes text messaging intervention.	Adults with type 2 diabetes, England; n = 43	Semi-structured telephone interviews analysed using inductive thematic analysis.	Messages supported long-term self-management, but their value depended on routines, disruption, and everyday context.	SMS-supported self-management intervention	Linked to primary care chronic disease support	Medication adherence, self-management, diabetes support

Table 2. Continued

Author/ Year	Purpose of study	Sample characteristics and size	Method	Results	Telehealth modality	Relationship with primary care	Primary care function
Nyqvist et al. [18]	To compare video and in-person initial physiotherapy consultations in primary care.	Adults with knee symptoms, Sweden; n = 15	Semi-structured interviews analysed using content analysis and comparative thematic synthesis.	Video consultations were seen as efficient and convenient, but more dependent on technical competence, communication, and trust in assessment.	Video-based physiotherapy consultation	Primary-care-linked rehabilitation/allied health care	Initial assessment, rehabilitation support, musculoskeletal consultation
Østerbø et al. [19]	To explore patient experiences of video-supported emergency outpost consultations.	Patients with complex needs, Norway; n = 7	Semi-structured interviews analysed using systematic text condensation.	Patients valued shorter travel and rapid GP access, but some were dissatisfied with the absence of a physically present GP and with technical problems.	Video-supported emergency outpost consultation	Linked to municipal primary care/emergency primary care	Urgent assessment, GP access, triage, care coordination
Sexton et al. [20]	To explore experiences of one-step and two-step urgent care telephone triage.	Patients and carers, UK; n = 25	Semi-structured interviews analysed thematically with conceptual interpretation.	Two-step triage was often viewed as more complex and frustrating. Communication with clinicians was perceived as more natural and reassuring.	Telephone triage	Linked to primary/urgent care access	Triage, routing, first-contact care, clinical prioritisation
Söderhielm et al. [21]	To investigate stroke survivors' experiences of the F@ce 2.0 rehabilitation intervention.	Stroke survivors, Sweden; n = 12	Interviews at two time points analysed using reflexive thematic analysis.	Trust, person-centred goal setting, and team collaboration were central. SMS support was useful, though some needed help with technology.	Digitally supported rehabilitation with SMS support	Primary-care-linked rehabilitation pathway	Rehabilitation support, goal setting, follow-up, self-management
Wong et al. [22]	To explore stroke survivors' experiences of a nurse-led teleconsultation program.	Stroke survivors, Hong Kong; n = 21	Focus groups analysed thematically.	Teleconsultation was seen as supportive and suitable for stable follow-up, but long-term viability depended on resolving clinical and technical limitations.	Nurse-led teleconsultation	Primary-care-linked follow-up care	Stable follow-up, care advice, post-stroke support
Woodall et al. [23]	To investigate perceptions of telehealth and requirements for culturally safe care.	Aboriginal and Torres Strait Islander Australians; n = 17	Questionnaire and semi-structured interviews analysed thematically and by content analysis.	Telehealth reduced access barriers but also created communication and usability challenges. Cultural safety depended on communication, relationships, and local knowledge.	General practice telehealth	Directly delivered within general practice/primary care	Access to general practice, culturally safe care, remote consultation

Table 2. Continued

Author/ Year	Purpose of study	Sample characteristics and size	Method	Results	Telehealth modality	Relationship with primary care	Primary care function
Wu et al. [24]	To examine how virtual care has affected therapeutic relationships and compassion.	Patients, Canada; n = 36	Semi-structured interviews analysed using inductive thematic analysis.	Virtual care changed communication patterns and had mixed effects on relationships. Participants identified core elements of compassion in virtual care.	Virtual care in primary care interactions	Directly linked to primary care	Remote consultation, therapeutic relationship, compassion in care
Zhao et al. [25]	To explore how digital health technologies enable both empowerment and exclusion among blind young adults.	Educated young adults with blindness, China; n = 12	Semi-structured interviews analysed using inductive thematic analysis.	Findings reflected an "empowered but excluded" dynamic, in which digital benefits were constrained by systemic inaccessibility.	Digital health technologies	Linked to healthcare access and digital care pathways	Access facilitation, digital inclusion, patient empowerment and exclusion

2.5. Quality appraisal

Methodological quality was appraised using the Critical Appraisal Skills Programme (CASP) Qualitative Checklist. The appraisal addressed clarity of aims, appropriateness of qualitative methodology and research design, recruitment strategy and data collection, reflexivity, rigour of analysis, clarity of findings, and overall research value (Table 3). At the full-text stage, articles were first assessed for eligibility and minimum methodological adequacy. The CASP appraisal was then applied to the final included studies and was used to support interpretation of the synthesis rather than as a numerical scoring tool or as the sole basis for exclusion. Overall, the methodological quality of the included studies was considered sufficient to support qualitative synthesis. The most common limitation concerned limited reporting of researcher reflexivity, while a small number of studies provided less detail on recruitment or data collection procedures.

Table 3. CASP quality appraisal summary of included studies

Author/Year	Clear aims	Appropriate qualitative methodology	Recruitment/data collection	Reflexivity	Rigour of analysis	Clear findings	Overall appraisal
Eriksson et al. [9]	Adequate	Adequate	Adequate	Partial	Adequate	Adequate	Strong
Gray et al. [10]	Adequate	Adequate	Adequate	Partial	Adequate	Adequate	Strong
Jaranka et al. [11]	Adequate	Adequate	Adequate	Partial	Adequate	Adequate	Strong
Karregat et al. [12]	Adequate	Adequate	Adequate	Partial	Adequate	Adequate	Strong
Leach et al. [13]	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate	Strong
Leonard et al. [14]	Adequate	Adequate	Adequate	Partial	Adequate	Adequate	Strong
Litchfield et al. [15]	Adequate	Adequate	Partial	Partial	Adequate	Adequate	Moderate
Müller et al. [16]	Adequate	Adequate	Adequate	Partial	Adequate	Adequate	Strong

Table 3 Continued.

Author/Year	Clear aims	Appropriate qualitative methodology	Recruitment/data collection	Reflexivity	Rigour of analysis	Clear findings	Overall appraisal
Newhouse et al. [17]	Adequate	Adequate	Adequate	Partial	Adequate	Adequate	Strong
Nyqvist et al. [18]	Adequate	Adequate	Adequate	Partial	Adequate	Adequate	Strong
Østerbø et al. [19]	Adequate	Adequate	Partial	Partial	Adequate	Adequate	Moderate
Sexton et al. [20]	Adequate	Adequate	Adequate	Partial	Adequate	Adequate	Strong
Söderhielm et al. [21]	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate	Strong
Wong et al. [22]	Adequate	Adequate	Adequate	Partial	Adequate	Adequate	Strong
Woodall et al. [23]	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate	Strong
Wu et al. [24]	Adequate	Adequate	Adequate	Partial	Adequate	Adequate	Strong
Zhao et al. [25]	Adequate	Adequate	Adequate	Partial	Adequate	Adequate	Strong

Note. The CASP appraisal was used to support interpretation of the synthesis rather than to generate a numerical quality score. "Adequate" indicates that the criterion was clearly addressed in the published report; "Partial" indicates that the criterion was addressed but with limited detail; and "Limited" would indicate substantial lack of reporting or methodological clarity. No included study was rated as methodologically unsuitable after full-text assessment. Studies with partial reporting in recruitment, data collection, or reflexivity were retained because they provided relevant and sufficiently clear qualitative findings for synthesis.

3. Results

The study selection process is presented in the PRISMA 2020 flow diagram. A total of 1,051 records were identified. After removing 628 records before screening, 423 records were screened at title level; 233 records were assessed at abstract level; 54 reports were retrieved for full-text assessment; and 17 studies were included. The main reasons for exclusion were lack of qualitative focus, insufficient patient focus, or inadequate contextual fit with the review criteria.

All 17 included studies were published in 2025, reflecting the review's intentionally recent post-pandemic focus. Collectively, the studies represented a wide range of healthcare systems and contexts, including Sweden, the United Kingdom, Germany, Norway, the Netherlands, Australia, Canada, China, Hong Kong, and the United States [9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25].

The included evidence covered synchronous telephone and video consultations, asynchronous digital platforms and chat-based services, remote patient monitoring, SMS-supported self-management interventions, AI-enabled triage and translation tools, and digitally supported rehabilitation. Across studies, participants were adult primary care users or adults receiving primary-care-linked services, including rural patients, older adults, people with chronic conditions, stroke survivors, Indigenous patients, and people with disability. Sample sizes ranged from 7 to 43 participants across the qualitative studies reported in the included corpus, and the synthesis captured a broad range of patient experiences across routine, urgent, chronic, rehabilitative, and supportive care contexts.

The included studies covered a heterogeneous range of telehealth modalities, and patient attitudes varied according to the type of technology used, the clinical purpose of the encounter, and the degree to which the modality preserved access, communication, continuity, and trust. Across telephone and video

consultations, patients generally valued rapid access, reduced travel burden, and convenience, particularly for triage, follow-up, stable chronic conditions, and routine care [10, 16, 18, 19, 20, 22]. However, these modalities were viewed as less suitable when patients needed physical examination, reassurance through embodied assessment, or more complex relational communication. Telephone-based triage was sometimes experienced as efficient but also potentially scripted or frustrating when patients were routed through multiple steps, whereas video consultations were often perceived as more personal than telephone contact but more dependent on digital confidence, technical quality, and clear clinician communication.

Chat-based digital platforms and AI-supported tools were valued mainly for easier entry into care, practical guidance, and support in navigating services, especially where language, access, or embarrassment-related barriers existed [9, 15]. Nevertheless, these tools also raised concerns about algorithmic accuracy, translation reliability, uncertainty about appropriate use, and reduced personal interaction. Remote patient monitoring, smartwatch-based monitoring, SMS-supported self-management, and digitally supported rehabilitation were more positively received when they supported ongoing care, self-management, motivation, and follow-up. These modalities were particularly useful for chronic disease management and rehabilitation contexts, but their acceptability depended on integration with primary care, professional interpretation of data, technical support, and the extent to which patients felt that remote monitoring was connected to real clinical care rather than functioning as an isolated digital tool.

Overall, modality-specific findings suggest that patients did not evaluate telehealth as a single uniform service model. Instead, they assessed each modality according to its clinical appropriateness, ease of use, relational quality, and capacity to support timely and coordinated care. Telehealth modalities that extended existing care relationships, reduced practical burden, and supported follow-up or self-management were more likely to be accepted. In contrast, modalities that weakened communication, created uncertainty, lacked integration with primary care, or attempted to replace clinically necessary face-to-face assessment were more likely to be viewed as limited or inadequate.

Following this modality-specific overview, the thematic synthesis is presented under four domains aligned with the review questions: (1) how adult patients experienced and interpreted telehealth in primary care, (2) the key benefits perceived by patients, (3) the main difficulties encountered, and (4) the contextual factors shaping these attitudes and experiences.

3.1. Patient experience of telehealth and how telehealth was interpreted

Across the 17 studies, patients rarely positioned telehealth as either wholly satisfactory or inherently inferior. Rather, telehealth was typically interpreted as a useful but conditional mode of care, valued in some clinical situations and viewed as inadequate in others. This conditionality was one of the most consistent findings across the synthesis.

This pattern was reproduced in several primary studies. Patients using a Swedish chat-based primary care platform expected faster access and appreciated digital entry into care yet often reported that this initial gain was offset by downstream delays, uncertainty regarding appropriate use, and a desire for more personalised interaction [9]. Patients enrolled in centralized remote patient monitoring described care as secure and accessible, but also impersonal and poorly coordinated with their ordinary primary care providers [11]. Stroke survivors in nurse-led teleconsultation similarly described teleconsultation as supportive and convenient, but not a full substitute for in-person care when clinical complexity increased [22]. Aboriginal and Torres Strait Islander participants likewise viewed telehealth as helpful in reducing barriers to general practice access, while emphasizing that it should function as an addition to, rather than a replacement for, face-to-face care [23].

A second cross-cutting finding was that patient experience was not determined by the digital modality alone, but by whether the interaction still conveyed attentiveness, responsiveness, and professional care. Patients repeatedly emphasized the importance of feeling listened to, believed, taken seriously, and known as a person. This was particularly pronounced among participants with complex or contested conditions. In Leach et al. [13], patients living with chronic fatigue syndrome/myalgic encephalomyelitis and fibromyalgia described an overarching need to feel believed, with communication quality, clinician choice, and continuity of care emerging as central to remote consulting experiences.

Similarly, Wu et al. [24] found that patients perceived five key elements as central to compassion in virtual care and reported that virtual care altered communication patterns in ways that could either support or constrain the therapeutic relationship. In video-based physiotherapy, patients in both digital and in-person formats highlighted the importance of trust, communication, and partnership-building, although video consultations placed greater demands on the patient and relied more heavily on clear instructions and perceived professional competence [18]. In digitally supported stroke rehabilitation, patients valued SMS-based support yet also stressed that meaningful goal setting and rehabilitation planning depended on trusting relationships and collaboration with the team [21].

Taken together, these findings suggest that patients did not interpret telehealth merely as a technical channel for information exchange. Rather, they evaluated it relationally, that is, in terms of whether care remained attentive, individualised, and credible in a remote format.

3.2. Key benefits of telehealth from the patient perspective

The most consistent benefit identified across the synthesis was improved access. Patients valued telehealth for reducing geographical and logistical barriers, particularly in rural, remote, mobility-limited, or otherwise underserved settings.

This benefit was echoed across primary studies. Rural Veterans enrolled in a telehealth diabetes programme described telehealth care as more frequent, more comprehensive, and more accessible than their previous diabetes care, particularly by reducing the burden of specialist access in rural areas [14]. Veterans using integrated nurse triage and virtual urgent care described high satisfaction with the timeliness and organization of care and valued being able to resolve health issues quickly from home [10]. Stroke survivors emphasized that teleconsultation reduced transportation burdens and made follow-up more manageable, while patients in municipal emergency outpost satellites valued shorter travel distances and rapid access to a general practitioner via video link [22, 19]. Aboriginal and Torres Strait Islander participants also framed telehealth as reducing practical barriers to care, including doctor availability and convenience of consultation timing [23].

Convenience constituted a second dominant benefit. Patients frequently described telehealth as easier to fit around daily life, work, caregiving responsibilities, fatigue, disability, or rehabilitation needs. This was particularly evident in studies involving rural patients, stroke survivors, patients requiring urgent access, and individuals receiving chronic disease or rehabilitation-related support [10, 14, 19, 21, 22, 23]. The same logic appeared in chronic and rehabilitative care. In digital support for type 2 diabetes medication adherence, participants reported broad and sometimes unexpected benefits over time, and the perceived value of the messaging system varied according to contextual need and disruption to routines [17]. Patients using smartwatch-based rhythm monitoring found the wearable more user-friendly and feasible than the conventional Holter monitor, indicating that telehealth-related tools may also reduce procedural burden in primary care diagnostics [12]. Video-based physiotherapy and digitally supported rehabilitation were also valued when they reduced practical burden while maintaining communication, trust, and follow-up support [18, 21].

A third perceived benefit was telehealth's capacity to support longitudinal engagement with health conditions. Patients in several studies described telehealth as strengthening monitoring, motivation, and day-to-day disease management. In the tele diabetes study, participants perceived their diabetes control as better in the telehealth program than in usual primary care, and they described the telehealth service as both thorough and supportive [14]. In the SMS-based diabetes self-management intervention, participants reported that brief messages helped sustain health-related cognitions and behaviours over time, with benefits extending beyond medication reminders into broader self-management support [17]. In digitally supported stroke rehabilitation, SMS reminders were perceived as increasing motivation and awareness, while in remote patient monitoring for chronic disease, patients associated telehealth with security, access, and enhanced self-care [11, 21].

For some groups, telehealth also created a more comfortable or emotionally safer environment. Litchfield et al. [15] found that an AI-enabled translation tool was positively viewed for appointment booking, next-step guidance, and providing a safe, anonymous way to discuss sensitive concerns among Bangladeshi communities. Stroke survivors in nurse-led teleconsultation valued the comfort of follow-up from home and the emotionally supportive nature of the interaction. In some asynchronous settings, digital communication also reduced embarrassment associated with discussing certain problems [22].

3.3. Main difficulties encountered when using telehealth

One of the most frequently reported limitations across the included studies was the inability to conduct physical examination or perform sufficient hands-on assessment. This limitation was particularly visible in studies involving video-based physiotherapy, nurse-led teleconsultation, smartwatch-based ECG monitoring, and emergency outpost video consultations [12, 18, 19, 22]. Patients in video-based physiotherapy pointed to the need for more thorough assessment and indicated that trust in the consultation could be harder to establish remotely when physical examination was constrained [18]. Stroke survivors highlighted the inability of teleconsultation to respond adequately to emergencies or fully address complex care needs [22]. In smartwatch-based rhythm monitoring, patients were uncertain about when to trigger recordings and needed clinician support to interpret findings, underscoring that digital tools alone could not resolve diagnostic ambiguity [12]. In video-supported emergency outpost consultations, some patients also expressed dissatisfaction with the absence of a physically present general practitioner and with technical problems that affected confidence in the consultation [19].

The second major difficulty concerned communication quality. Several studies suggested that telehealth could reduce conversational richness, impair nonverbal communication, and weaken relational depth. Patients with chronic fatigue syndrome/myalgic encephalomyelitis and fibromyalgia reported difficulties with telephone and online consulting because of the lack of physical communication and emphasized the importance of ongoing relationships and continuity [13]. In one-step and two-step telephone triage, communication with non-clinicians was often experienced as scripted and inflexible, whereas clinicians were perceived as more natural and empathetic [20]. Wu et al. [24] likewise found that virtual care shifted communication patterns and that these shifts had uncertain implications for the therapeutic relationship.

This relational concern also surfaced in rehabilitative and culturally specific contexts. In video-based physiotherapy, limited nonverbal communication could make trust-building more difficult [18]. Aboriginal and Torres Strait Islander patients described communication quality as central to a culturally safe telehealth experience, and some participants reported that poor communication reduced the perceived adequacy of care [23].

Technical problems and usability issues formed a third major theme. Across studies, these included poor internet connectivity, platform complexity, limited digital literacy, inadequate integration

of systems, uncertainty about how to use tools, and algorithmic inaccuracies. In Eriksson et al. [9], the automated symptom checker was often seen as too broad or too narrow and as insufficiently able to interpret patient input in context. In Litchfield et al. [15], the most frequently raised concern regarding the AmarDoctor tool was the possibility of translation inaccuracies and associated clinical risk. In Østerbø et al. [19], some patients felt unsafe using municipal emergency outpost satellites because of technical issues and communication difficulties.

Patients also described telehealth as insufficiently personalised when continuity and coordination were weak. Jaranka et al. [11] captured this most clearly in the overarching theme "sense of security and accessibility, but impersonal and uncoordinated," reflecting a simultaneous appreciation of access and dissatisfaction with fragmented communication between the centralized virtual ward and ordinary primary care. Eriksson et al. [9] similarly found that patients, especially returning users, wanted more personalised interactions and were concerned about tensions between digital access and relational continuity. In urgent virtual care, some Veterans were frustrated when routed to nurse triage rather than directly to their primary care clinicians, indicating that system efficiency did not always align with patient expectations about relational continuity [10].

3.4. Contextual factors influencing attitudes and experiences

One of the clearest contextual influences was the presence of an existing relationship with a clinician. This finding was echoed across primary studies. Leach et al. [13] showed that patients with CFS/ME and fibromyalgia benefited when there was a good relationship with a clinician and continuity of care. Woodall et al. [23] identified a pre-existing doctor-patient relationship as one of the essential elements of culturally safe telehealth. Müller et al. [16] reported that acceptance of specialist mental health video consultations increased when patients had strong relationships with primary care and prior care experience. Across the synthesis, therefore, continuity was not a peripheral factor; it was central to whether telehealth was experienced as credible, safe, and person-centred.

A second major contextual factor was the purpose of the consultation. Patients were consistently more favourable toward telehealth when used for follow-up, routine management, triage, self-management support, or stable chronic care. By contrast, telehealth was regarded as less appropriate for new, complex, uncertain, or physically demanding clinical situations. This pattern was reflected in studies of nurse-led teleconsultation, telephone triage, video-supported emergency outpost consultations, and general practice telehealth, where telehealth was more acceptable when used for follow-up, triage, stable care, or access support rather than as a replacement for complex in-person assessment [19, 20, 22, 23].

Digital capability emerged as a third key contextual determinant. Patients who were familiar with digital tools, had access to support, or used technologies already embedded in their daily routines generally reported smoother experiences. Conversely, low technological familiarity, lack of support, or inaccessible system design constrained use and acceptance. Müller et al. [16] found that some patients readily adapted to mental health video consultation, especially when they had prior videoconferencing experience, whereas those with lower technology literacy relied on technical support provided within primary care. Litchfield et al. [15] found that acceptability of an AI-enabled translation tool was partly linked to ease of use among those with limited digital literacy. Zhao et al. [25], however, demonstrated that even educated and digitally literate young adults with blindness experienced an "empowered but excluded" dynamic because systemic inaccessibility, inaccessible online systems, and provider assumptions undermined the potential benefits of digital health.

Finally, telehealth experience was shaped by broader social and equity conditions. This broader equity lens was strongly supported by the primary studies. Aboriginal and Torres Strait Islander participants emphasized cultural safety, local knowledge, and communication style as core requirements

for acceptable telehealth [23]. Bangladeshi communities highlighted language accessibility and dialect sensitivity as crucial to the acceptability of AI-supported tools [15]. Educated young adults with blindness showed that digital empowerment did not remove structural exclusion but instead coexisted with it [25].

Taken together, the 17 included studies indicate that adult patients in primary care generally viewed telehealth as a valuable but bounded mode of care. Its strongest advantages were improved access, convenience, reduced logistical burden, and support for continuity and self-management, particularly in follow-up and chronic care contexts. However, these benefits were contingent on consultation purpose, technological usability, relational continuity, and broader equity conditions. Telehealth became less acceptable when physical examination was needed, when communication felt scripted or impersonal, when digital systems were difficult to use, or when care was experienced as fragmented. Overall, the evidence supports a hybrid understanding of telehealth: patients did not reject it, but neither did they position it as an unconditional substitute for in-person primary care. Rather, they favored telehealth when it was relationally grounded, clinically appropriate, technically workable, and responsive to the needs of diverse patient groups [9, 11, 22, 23, 25].

4. Discussion

This review synthesised qualitative evidence from 17 studies to examine how adult patients experience and perceive telehealth in primary care. Across the included studies, telehealth was not experienced as either uniformly beneficial or inherently inferior to in-person care. Instead, patients tended to regard it as a valuable but conditional mode of care: one that was highly useful in some situations but clearly limited in others. Overall, patient evaluations appeared to be shaped less by the presence of technology itself than by the fit between modality, clinical purpose, communication quality, relational continuity, and local context [9, 11, 5].

A central contribution of this review is that it shifts the interpretation of telehealth away from a simple acceptance-versus-rejection framework. Patients did not typically ask whether telehealth was good or bad in the abstract; rather, they judged whether it was appropriate for the problem at hand, whether the interaction still felt personal and credible, and whether it enabled meaningful care rather than merely remote contact. This interpretation is consistent with wider primary care telehealth literature showing that teleconsultation is most acceptable when used for follow-up, routine management, prescription-related care, and stable chronic disease support, but is less acceptable when clinical uncertainty is high or physical examination is central to decision-making [2, 5]. Schlegel [26] similarly argues that a telemedicine-first model may be promising in primary care because many common primary care concerns are suitable for remote management, provided that continuity and comprehensiveness are preserved rather than sacrificed.

Improved access emerged as the strongest and most consistent advantage across the synthesis. Patients valued telehealth because it reduced travel, saved time, lowered the physical burden of attendance, and enabled easier contact with care, especially in rural, remote, or mobility-limited circumstances [10, 14, 22]. These findings support the wider argument that telehealth can substantially reduce friction in primary care access. Schlegel's [26] combined telemedicine-first and direct primary care model is especially relevant because it frames telemedicine not merely as a convenience tool, but as a mechanism for delivering comprehensive and continuous care more efficiently when remote care is clinically appropriate.

At the same time, the findings of this review indicate that access alone is not enough. What patients valued was not simply the ability to enter the system remotely, but the ability to obtain care that was timely, understandable, coordinated, and responsive. Several studies in the synthesis showed that digital entry points could feel efficient at first but become frustrating if they led to downstream delays,

unclear next steps, weak coordination, or depersonalised care [9, 11]. This interpretation is reinforced by literature on digital communication and coordination across care levels, which shows that digital systems may accelerate information flow and referral processes, but only when interoperability, communication standards, and role clarity are adequately developed [27, 28].

One of the strongest themes in the present synthesis was the enduring importance of the therapeutic relationship. Patients repeatedly described telehealth as acceptable when they felt listened to, believed, taken seriously, and known by the clinician. Conversely, telehealth became less acceptable when communication felt rushed, scripted, impersonal, or emotionally thin [13, 20, 24]. This is especially important because it challenges the assumption that telehealth limitations are mainly technical. In reality, the most consequential limitations often concern the relational quality of care. This interpretation is strongly supported by Omidi and Pati [29], who argue that telehealth communication is shaped not only by spoken interaction but by the wider communication environment, including technological disruptions, nonverbal losses, and the physical environments on both sides of the encounter. Their framework helps explain why patients in the present review were sensitive not only to what clinicians said, but to whether the virtual encounter still conveyed attentiveness, reassurance, and interpersonal presence.

The review also confirms that the inability to perform physical examination remains the clearest clinical boundary of telehealth from the patient perspective. Patients were most hesitant about telehealth when symptoms were new, complex, unstable, or diagnostically uncertain, and when reassurance depended on embodied assessment rather than history-taking alone [12, 18, 22]. This does not mean that telehealth lacks clinical value; rather, it suggests that patients distinguish clearly between encounters that can be managed primarily through communication and those that require embodied assessment. That distinction aligns with more recent implementation and model-building literature, which tends to position telehealth within hybrid systems rather than as a universal replacement for in-person care [2, 26].

Continuity of care emerged as another major determinant of positive telehealth experiences. Patients were generally more comfortable with remote care when they already had a relationship with the clinician or when telehealth was clearly embedded within an ongoing care pathway [13, 16, 23]. This is a critical finding for primary care because continuity is one of its defining attributes. The evidence in this review suggests that telehealth is most acceptable when it extends an existing relationship rather than replacing it with a purely transactional interaction. This reading also converges with Schlegel's [26] argument that telemedicine-first delivery becomes more compelling when paired with a continuity-oriented primary care model rather than fragmented episodic care.

A further contribution of this review is its demonstration that telehealth experiences are deeply structured by digital, social, and equity conditions. Across the included studies, barriers such as poor connectivity, low digital confidence, inaccessible interfaces, language barriers, cultural unsafety, and disability-related inaccessibility shaped whether telehealth was experienced as enabling or exclusionary [15, 23, 25]. The additional literature broadens this point substantially. Rural populations may show high smartphone ownership yet still have limited prior experience with digital health interventions, indicating that access to devices does not automatically translate into meaningful digital participation [30]. In parallel, work on health-related social need screening shows that virtual care access problems can sit alongside wider forms of social vulnerability, suggesting that digital access should be understood within the broader landscape of social need rather than as a stand-alone technical matter [31].

This broader equity perspective has direct implications for primary care telehealth. The populations most likely to benefit from reduced travel and lower transaction costs may also be those most vulnerable to digital exclusion if services are poorly designed. The present synthesis showed this pattern among older adults, rural patients, Indigenous communities, culturally and linguistically diverse

groups, and people with disabilities. Supporting evidence comes from condition-specific work as well. In patients with COPD, remote consultation may be acceptable for stable care, but older and more severely affected patients often prefer face-to-face care because of access barriers, technology use difficulties, and reduced reassurance under conditions of clinical uncertainty [32].

The implementation literature also strengthens an important systems-level implication of this review: telehealth success depends on more than patient willingness or clinician enthusiasm. Sustainable digital care requires workflow integration, implementation support, training, governance, and change management. OntarioMD's implementation framework for AI-enabled tools in primary care highlights the importance of structured implementation, stakeholder collaboration, and education in achieving sustainable adoption. Notably, early AI scribe pilots were associated with reduced documentation burden and improved engagement and rapport, which underscores a broader lesson for telehealth: digital innovations are more likely to be accepted when they reduce friction and protect the relational core of care [33].

Taken together, these findings support a more mature interpretation of telehealth in primary care. The findings suggest that telehealth is no longer best understood merely as an emergency substitute or a convenience add-on. Rather, the review supports understanding telehealth as a relational, organisational, and infrastructural reconfiguration of primary care. From the patient perspective, its legitimacy depends not only on whether care can be delivered remotely, but on whether care remains clinically appropriate, communicatively credible, personally meaningful, and equitably accessible. This is precisely why hybrid, continuity-preserving models appear more promising than technology-led substitution models. In this respect, the present review and the wider literature converge: the next phase of telehealth development in primary care should focus less on scale alone and more on fit, coordination, communication, and justice in digital care delivery [2, 5, 29, 26].

4.1. Strengths, limitations, and future research

This review makes a timely contribution by centring adult patients' perspectives on telehealth in primary health care, an area still underdeveloped relative to the dominant focus on implementation, professional views, and system performance. Its main strength lies in the synthesis of recent qualitative evidence across multiple countries, care contexts, and telehealth modalities, allowing a more analytically robust understanding of how access, communication, trust, continuity, and digital capability jointly shape patient attitudes. Several limitations, however, warrant consideration. The search was restricted to peer-reviewed qualitative studies published in English during 2025, which sharpened the review's focus on the most recent post-pandemic evidence but may have excluded relevant studies from other time periods, languages, and grey literature sources. The restriction to English-language publications may have introduced language bias, and the use of three databases may have limited retrieval of relevant studies indexed in nursing, psychology, allied health, or broader biomedical databases such as CINAHL, PsycINFO, Embase, or the Cochrane Library. The included studies were also heterogeneous in modality, clinical purpose, and service configuration; although this breadth strengthened conceptual insight, it limits straightforward generalisation across all forms of telehealth in primary care. In addition, the studies were conducted in diverse healthcare systems and sociocultural settings, meaning that the findings are context-sensitive and should be transferred cautiously. Some included studies also examined primary-care-linked services rather than routine general practice narrowly defined, reflecting the evolving boundaries of digitally mediated primary care. Finally, as with all qualitative evidence syntheses, the analytical themes are interpretive and should be understood as a theoretically grounded account rather than an exhaustive taxonomy of patient perspectives. Future research should extend this evidence base across wider time frames, languages, and health system settings, while examining more precisely how attitudes vary by telehealth modality, consultation purpose, and patient group. Greater

attention is especially needed to underrepresented populations and to the mechanisms through which continuity of care, digital literacy, communication quality, and organisational design shape the long-term acceptability, equity, and sustainability of telehealth in primary care.

4.2. Managerial implications

From a health management perspective, the findings indicate that telehealth should be planned not only as a digital access channel but also as an organisational service model requiring clear governance, resource allocation, workforce preparation, and performance monitoring [2, 26, 33]. The potential cost-related benefits of telehealth, such as reduced travel burden for patients, lower indirect costs, fewer unnecessary face-to-face visits, and more efficient follow-up pathways, should be evaluated together with the investments required for digital infrastructure, technical support, staff training, system integration, and data security. Therefore, managers should avoid assuming that telehealth is automatically cost saving; instead, its value should be assessed in relation to clinical appropriateness, patient outcomes, equity, continuity of care, and service sustainability.

Telehealth implementation also requires meaningful performance indicators. Beyond utilisation rates or number of remote consultations, health organisations should monitor patient experience, access equity, waiting times, continuity of care, resolution of clinical problems, referral patterns, digital exclusion risks, and safety-related outcomes [8, 29]. The findings of this review suggest that performance measurement should capture whether telehealth expands access without weakening communication, fragmenting care, or excluding patients with limited digital capacity. In this respect, telehealth quality indicators should include both operational metrics and patient-centred measures.

The workforce implications are equally important. Telehealth changes clinical workflows, communication practices, role boundaries, documentation requirements, and coordination between professionals [27, 28, 33]. Health managers should therefore support clinicians and administrative staff through training in virtual communication, digital triage, culturally safe communication, technical troubleshooting, and appropriate selection of consultation modality. Implementation mechanisms should include clear protocols for deciding when telehealth is suitable, escalation pathways for face-to-face assessment, integration with electronic health records, technical assistance for patients, and continuous feedback loops [2, 26, 27, 28]. These mechanisms are essential to ensure that telehealth strengthens primary care capacity without increasing staff burden, reducing relational quality, or producing new forms of inequity.

4.3. Implications for practice

The findings have several implications for primary care practice and service design. First, telehealth should be implemented as part of a hybrid care model rather than as a universal replacement for in-person care. Consultation type should be matched to clinical purpose, complexity, and patient preference [2, 5]. Second, continuity of care should be prioritised. Telehealth is more likely to be acceptable when patients interact with clinicians they already know or when remote encounters are clearly integrated into an ongoing care pathway [13, 23]. Third, communication quality should be treated as a design priority. Clinicians need support not only in using digital platforms but also in sustaining empathy, trust, clarity, and reassurance in remote interactions [29]. Fourth, digital inclusion should be built into implementation from the outset. Accessible interfaces, technical assistance, translation support, culturally safe approaches, and disability-inclusive design are essential if telehealth is to function equitably [15, 25]. Finally, organisational interoperability and information-sharing mechanisms should be strengthened so that telehealth expands care without introducing new coordination failures [27, 28].

5. Conclusion

This qualitative evidence synthesis suggests that adult patients generally perceive telehealth in primary care as valuable, but not universally appropriate. Patients most strongly value telehealth when it improves access, reduces burden, supports follow-up and self-management, and operates within an established care relationship. At the same time, telehealth becomes less acceptable when physical examination is needed, when communication feels impersonal, when care is fragmented, or when digital barriers limit meaningful participation. Overall, the findings support a hybrid interpretation of telehealth: patients do not reject it, but neither do they view it as an unconditional substitute for face-to-face care. Instead, they favour telehealth when it is selectively used, relationally grounded, clinically matched to need, and embedded within coordinated primary care [5, 26].

Ethical statement:

This study does not involve human participants, patient data, animal subjects, or any intervention. Therefore, ethical approval was not required. The manuscript represents original work, is not under consideration by any other journal, and has been approved by all authors for submission.

Funding:

No financial support was received for the research, authorship, and/or publication of this article.

Conflict of interest:

The authors declare that they have no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Authors' contributions:

All authors contributed equally to the conception, design, preparation, writing, and revision of the manuscript.

Generative AI statement:

The authors declare that no Gen AI was used in the creation of this manuscript. Artificial intelligence tools were used only for language editing and translation support during manuscript preparation. They were not used for database searching, study selection, quality appraisal, data extraction, coding, thematic synthesis, interpretation of findings, or reference selection. The intellectual content, methodological decisions, analysis, interpretation, and final responsibility for the manuscript remain entirely with the authors.

References

[1] A. Kichloo, M. Albosta, K. Dettloff, F. Wani, Z. El-Amir, J. Singh, M. Aljadah, R. C. Chakinala, A. K. Kanugula, S. Solanki, and S. Chugh, "Telemedicine, the current COVID-19 pandemic and the future: A narrative review and perspectives moving forward in the USA," *Fam. Med. Community Health*, vol. 8, Art. no. e000530, 2020, doi: 10.1136/fmch-2020-000530.

[2] S. Mahdavi, M. Fekri, S. Mohammadi-Sarab, M. Mehmandoost, and E. Zarei, "The use of telemedicine in family medicine: A scoping review," *BMC Health Serv. Res.*, vol. 25, Art. no. 376, 2025, doi: 10.1186/s12913-025-12449-7.

[3] R. Ftouni, B. AlJardali, M. Hamdanieh, L. Ftouni, and N. Salem, "Challenges of telemedicine during the COVID-19 pandemic: A systematic review," *BMC Med. Inform. Decis. Mak.*, vol. 22, Art. no. 207, 2022, doi: 10.1186/s12911-022-01952-0.

[4] C. Leighton, N. Joseph-Williams, A. Porter, A. Edwards, and A. Cooper, "A theory-based analysis of the implementation of online asynchronous telemedicine platforms into primary care

practices using Normalisation Process Theory," *BMC Prim. Care*, vol. 26, Art. no. 27, 2025, doi: 10.1186/s12875-025-02717-0.

[5] G. F. Morillon, M. Guillon, M. Laberge, A. Sowanou, and T. G. Poder, "Patients' perspective about synchronous teleconsultation with a general practitioner: A mixed-method systematic literature review," *BMC Prim. Care*, vol. 26, Art. no. 259, 2025, doi: 10.1186/s12875-025-02931-w.

[6] M. Peyroteo, I. A. Ferreira, L. B. Elvas, J. C. Ferreira, and L. V. Lapão, "Remote monitoring systems for patients with chronic diseases in primary health care: Systematic review," *JMIR mHealth uHealth*, vol. 9, no. 12, Art. no. e28285, 2021, doi: 10.2196/28285.

[7] D. Senyel, E. Boutros, M. Frith, F. Savira, L. Tong, B. K. Y. Asiamah-Asare, R. Norman, S. Robinson, and J. H. Boyd, "The (dis-)advantages of telehealth consultation for allied health services: A scoping review," *BMC Health Serv. Res.*, early access, 2026, doi: 10.1186/s12913-026-14504-3.

[8] Z. Xue, N. Zhou, Y. Wu, and H. Qi, "Digital exclusion in healthcare services: A scoping review," *Int. J. Equity Health*, vol. 25, Art. no. 37, 2026, doi: 10.1186/s12939-025-02755-1.

[9] P. Eriksson, F. Gabrielsson-Järhult, H. Thorold Nylin, and E. Nilsson, "Patients' experiences with using a digital platform for chat-based consultation in primary health care in Sweden: Qualitative study," *J. Med. Internet Res.*, vol. 27, Art. no. e77478, 2025, doi: 10.2196/77478.

[10] C. Gray, A. Engstrom Buggaveeti, T. Urech, and A. Vashi, "Veteran experiences and satisfaction with Veterans Affairs call centers' tele-triage and virtual urgent care appointments: Qualitative evaluation," *J. Med. Internet Res.*, vol. 27, Art. no. e80656, 2025, doi: 10.2196/80656.

[11] A. Jaranka, G. H. Nilsson, T. Stenfors, M. Hägglund, P. Papachristou, and M. Taloyan, "Patient's perceptions of a centralized virtual ward for remote patient monitoring in primary care: Qualitative study," *JMIR Hum. Factors*, vol. 12, Art. no. e78780, 2025, doi: 10.2196/78780.

[12] E. P. M. Karregat, P. Vooijs, E. Wierda, R. Harskamp, W. Lucassen, J. C. L. Himmelreich, and E. P. Moll van Charante, "Patient experiences with a smartwatch 1L-ECG versus traditional Holter monitoring for ambulatory cardiac rhythm monitoring: A qualitative study," *BMJ Open*, vol. 15, Art. no. e101557, 2025, doi: 10.1136/bmjopen-2025-101557.

[13] H. Leach, A. Eccles, C. A. Chew-Graham, and H. Atherton, "Patient experiences of remote consulting with chronic fatigue syndrome/myalgic encephalomyelitis and fibromyalgia: A qualitative study," *BJGP Open*, vol. 9, no. 1, 2025, doi: 10.3399/BJGPO.2024.0079.

[14] C. Leonard, R. R. Kenney, A. Syed, E. Hess, C. Wilson, A. Smith, C. Schihl, J. Lai, P. Reaven, and G. Behari, "Patient perceptions of rural telehealth diabetes control program in Department of Veteran's Affairs," *J. Rural Health*, vol. 41, no. 2, Art. no. e70027, 2025, doi: 10.1111/jrh.70027.

[15] I. Litchfield, G. Delanerolle, L. Harper, and S. Dunning, "Understanding acceptability of AI triage tools amongst underserved populations: Lessons from the early phases of co-production with Bangladeshi communities in Birmingham, UK," *Health Expect.*, vol. 28, no. 6, Art. no. e70523, 2025, doi: 10.1111/hex.70523.

[16] S. Müller, A. Ritter-von Kramer, J. Tönnies, A. Wildenauer, M. Wensing, H. C. Friederich, and M. W. Haun, "Engaging underrepresented patient groups in specialised treatment: Qualitative results from the PROVIDE-C randomised trial on integrated mental health video consultations for

depression and anxiety," *BMC Public Health*, vol. 25, Art. no. 3817, 2025, doi: 10.1186/s12889-025-25235-1.

[17] N. Newhouse, Y. K. Bartlett, S. C. Simao, L. Miles, R. Cholerton, C. Kenning, L. Locock, V. Williams, D. P. French, R. Rea, and A. Farmer, "Experiences of using a digital text messaging intervention to support oral medication adherence for people living with type 2 diabetes: Qualitative process evaluation," *J. Med. Internet Res.*, vol. 27, Art. no. e70203, 2025, doi: 10.2196/70203.

[18] M. Nyqvist, E. Lithner, J. Hall, T. Ekman, and E. Lange, "Experiences of video-based and in-person initial consultations in individuals presenting with knee-related symptoms: A qualitative comparison," *Physiother. Theory Pract.*, early access, 2025, doi: 10.1080/09593985.2025.2597387.

[19] T. Østerbø, G. Hovland, S. Ytrehus, D. Kyrkjebø, E. Zakariassen, and O. T. Kleiven, "Experiences of patients with complex needs at municipal emergency outpost satellites," *Scand. J. Prim. Health Care*, vol. 43, no. 4, pp. 733–744, 2025, doi: 10.1080/02813432.2025.2502095.

[20] V. Sexton, J. Dale, C. Bryce, and H. Atherton, "Exploring two-step and one-step urgent care telephone triage: A UK-based semi-structured interview study," *BJGP Open*, vol. 9, no. 4, 2025, doi: 10.3399/BJGPO.2024.0270.

[21] K. Söderhielm, M. Tistad, C. Ytterberg, and S. Guidetti, "Experiences of F@ce 2.0: A person-centred intervention for home-based rehabilitation after stroke supported by digital technology—A qualitative study," *BMJ Open*, vol. 15, Art. no. e089147, 2025, doi: 10.1136/bmjopen-2024-089147.

[22] A. K. C. Wong, X. Lu, J. X. Wang, R. S. Y. Lin, J. J. Su, R. M. Wang, and V. W. Y. Kwok, "Navigating the boundaries of teleconsultation: Capabilities, limitations, and pathways for improvement: Qualitative study of the experiences of patients with stroke," *J. Med. Internet Res.*, vol. 27, Art. no. e75841, 2025, doi: 10.2196/75841.

[23] H. Woodall, R. Evans, L. McArthur, T. Sen Gupta, R. Ward, and K. Brumpton, "Can culturally safe general practice telehealth overcome barriers to care for Aboriginal and Torres Strait Islander Australians? A qualitative study," *BMJ Open*, vol. 15, Art. no. e089436, 2025, doi: 10.1136/bmjopen-2024-089436.

[24] K. Wu, M. Dang Nguyen, G. Rouleau, R. Azavedo, D. Srinivasan, and L. Desveaux, "Understanding how virtual care has shifted primary care interactions and patient experience: A qualitative analysis," *J. Telemed. Telecare*, vol. 31, no. 1, pp. 73–81, 2025, doi: 10.1177/1357633X231167905.

[25] J. Zhao, C. Su, X. Zhu, C. Cai, W. Liu, and X. Ma, "Health care experiences of educated young adults with blindness in the digital age: Qualitative study," *J. Med. Internet Res.*, vol. 27, Art. no. e79587, 2025, doi: 10.2196/79587.

[26] D. Schlegel, "Combined telemedicine-first and direct primary care as a promising model of healthcare delivery," *J. Telemed. Telecare*, vol. 31, no. 10, pp. 1493–1499, 2025, doi: 10.1177/1357633X241300725.

[27] T. N.-B. Lam, Y. Shahab, and P. Lau, "General practitioners' experiences in managing patients in clinical trials conducted by non-GP specialists: An exploratory qualitative study," *J. Clin. Transl. Sci.*, vol. 9, Art. no. e287, 2025, doi: 10.1017/cts.2025.10217.

[28] S. Vokksepp, K. Lubi, and M.-L. Elland, "Oncological follow-up care in digital era: Communication complexities between primary and speciality care physicians," *J. Commun. Healthc.*, early access, 2025, doi: 10.1080/17538068.2025.2609033.

[29] F. Omidi and D. Pati, "What shapes telehealth? The role of environment and technology in communication quality," *Health Environ. Res. Des. J.*, vol. 19, no. 2, pp. 68–82, 2026, doi: 10.1177/19375867251396068.

[30] L. M. König, C. Betz, M. Al Masri, and T. Bartelmeß, "Health behaviours and mobile intervention use in patients recruited from general practitioners' practices in rural Bavaria," *Health Psychol. Behav. Med.*, vol. 13, no. 1, Art. no. 2444244, 2025, doi: 10.1080/21642850.2024.2444244.

[31] P. D. Rollins, S. King, A. Majcher, B. D. Hughes, E. A. Newman, and E. E. Perone, "The first step is knowing: Quantifying social need through screening in a pediatric surgery clinic," *J. Surg. Res.*, vol. 317, pp. 493–499, 2026, doi: 10.1016/j.jss.2025.11.055.

[32] A. Aljahan, R. E. Jordan, and J. Hodgkinson, "COVID-19 and its impact on healthcare services provided to patients with COPD: A qualitative study," *BMJ Open Respir. Res.*, vol. 12, Art. no. e003196, 2025, doi: 10.1136/bmjresp-2025-003196.

[33] S. Ling and A. Zavar, "Empowering health: Model for sustainable AI implementation," in *From Insights to Action: Empowering Health*, G. Strudwick et al., Eds. Amsterdam, The Netherlands: IOS Press, 2025, pp. 47–51, doi: 10.3233/SHTI250012.