

Telemedicine Service Domains in Korea: Delphi Consensus

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Abstract: This study identified clinical domains suitable and unsuitable for telemedicine in Korea and explored safeguards for its phased implementation. A three-round modified Delphi study was conducted from September 8 to November 18, 2022, involving 21 experts nominated by five professional organizations. Panelists evaluated 20 candidate service domains, six exclusion domains, and 16 specialty-specific domains using a four-point Likert scale. Consensus was defined as a convergence index of ≤ 0.5 and a consensus index of ≥ 0.75 . Positive consensus emerged for functions related to chronic disease follow-up and monitoring, infectious disease monitoring, community-based home care, disability-related care, services in medically underserved areas, and clinically stable neurological or neurosurgical populations. Conversely, negative consensus was reached regarding long-term care hospitals, urolithiasis, and ophthalmic consultations. Four exclusion domains achieved consensus: emergencies or urgent conditions, invasive or other face-to-face interventions, new conditions or injuries requiring direct care, and suspected postoperative complications. While most experts preferred to exclude cases requiring computed tomography (CT), magnetic resonance imaging (MRI), or laboratory confirmation, this criterion did not meet the predefined threshold. Therefore, telemedicine should be gradually introduced for low-risk, clinically stable populations as a complement to in-person care, underpinned by clear accountability, digital access, and pathways for in-person assessment.

Keywords: Telemedicine; Delphi Method; Digital Health; Health Policy; Korea

1. Introduction

The COVID-19 pandemic has acted as a global catalyst for the digital transformation of healthcare delivery systems, including in South Korea [1, 2]. This acceleration has shifted policy discourse from emergency-use frameworks toward the institutionalization of telemedicine as a sustainable mode of care. In Korea, temporary telephone consultation and prescription were authorized during the COVID-19 pandemic in 2020, followed by the launch of a pilot project for non-face-to-face treatment in June 2023 [3, 4].

However, telemedicine governance varies significantly across countries, shaped by differences in healthcare system maturity, digital infrastructure, and regulatory capacity. In high-readiness contexts, telemedicine has contributed to measurable improvements in chronic disease management, mental health care, and hypertension control [2], [5]. For example, in the United States, the Centers for Medicare & Medicaid Services (CMS) expanded Medicare reimbursement, prompting a substantial rise in telehealth utilization [6]. Similarly, in the United Kingdom, national-level digital and clinical protocols implemented by the National Health Service (NHS) system enabled over 90% of primary care consultations to be conducted remotely at the pandemic's peak [7].

By contrast, countries such as Iran, India, and parts of China have struggled to maintain consistent care quality due to fragmented systems, legal ambiguity, and underdeveloped digital infrastructure—factors that also eroded stakeholder trust [5]. These cases illustrate that institutional maturity is a key determinant not only of the scale and speed of telemedicine adoption but also of its clinical effectiveness.

Recognizing this, the Organisation for Economic Co-operation and Development (OECD, 2025) emphasizes that telemedicine integration must be context-sensitive, taking into account variations in governance structures, legal frameworks, digital capabilities, and public trust. Schürmann et al. (2025) further support this

view through the Expanded Value Framework (EVF), which identifies stakeholder misalignments in trust, risk perception, and institutional expectations as major barriers to sustainable digital health adoption [8].

Despite the global growth of telehealth, many Asian countries—including South Korea—continue to face context-specific challenges, including legal uncertainty, infrastructure limitations, and lack of stakeholder alignment [5]. In Korea, telemedicine governance remains contested, with ongoing legal ambiguity, unresolved liability concerns, and sustained resistance from physician associations hindering systemic integration [9-14].

While several studies have explored patient perceptions of telemedicine—including issues of trust, risk, and usability—such as Kuen et al. (2023) [15], who highlighted the multidimensionality of risks and trust transfer across different referents from the patient's perspective, there remains a lack of structured, quantitative research examining how these factors are perceived and operationalized by healthcare professionals. This gap is particularly salient given the central role of provider buy-in in sustaining telemedicine beyond crisis-driven adoption.

While earlier research—such as Choi et al. (2019)—highlighted barriers to telemedicine implementation, including provider resistance rooted in concerns about professional autonomy and systemic readiness, these findings stem from a pre-pandemic context [16]. Given the significant shifts in digital infrastructure and public attitudes post-COVID-19, implementation priorities must be re-evaluated under current conditions.

In this study, telemedicine is conceptualized as technology-mediated healthcare, including remote consultation, remote monitoring, digital communication between patients and providers, and continuity of care supported by digital tools. This framing positions telemedicine at the intersection of clinical care, information and communication technology (ICT), and health policy.

Accordingly, this study aims to identify context-specific priority areas for telemedicine implementation in South Korea through a structured Delphi consensus process involving clinical experts. The goal is to generate actionable insights to inform regulatory and policy frameworks that are both adaptive and institutionally grounded.

2. Materials and Methods

2.1 Study Design

This study employed a modified Delphi methodology to identify priority service domains, clinical conditions, and institutional policy directions for telemedicine implementation in Korea. The Delphi technique was selected for its effectiveness in achieving expert consensus in areas with limited empirical evidence.

2.2 Expert Panel

A multidisciplinary panel of 21 experts was assembled, including representatives recommended by five professional bodies: the Korean Medical Association, Korean Association of Primary Care Physicians, Korean Hospital Association, Korean Society of Medical Informatics, and the Korean Telemedicine Society. The panel included clinicians, policy experts, and digital health specialists.

2.3 Delphi Process

A three-round modified Delphi process was conducted from September 8 to November 18, 2022, to establish expert consensus on telemedicine service domains, exclusion criteria, specialty-specific applications, and institutional policy directions.

Round 1 employed open-ended questions to elicit candidate domains for telemedicine indications and exclusions, as well as institutional and policy considerations. Responses ($n = 11/21$; 52.4% response rate) were qualitatively analyzed and used to structure the Round 2 questionnaire.

Round 2 used a structured questionnaire comprising 20 candidate service domains (Table 1), six exclusion domains (Table 2), and 16 specialty-specific domains (Table 3). Panelists ($n = 15/21$; 71.4% response rate) rated each item on a four-point Likert scale (1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree). A moderated group discussion between Rounds 2 and 3 clarified domains and areas of disagreement.

Round 3 re-evaluated 16 service-domain items, three exclusion-domain items, and 14 specialty-specific items that had not reached consensus in Round 2. Fourteen of the 15 invited panelists responded (93.3%), yielding the final convergence and consensus indices.

Table 1. Expert Consensus on Telemedicine-Appropriate Conditions and Services: Modified Delphi Study

Item	Q1	Q3	IQR	Final Convergence	Final Consensus	Consensus Round	Consensus Direction	Expert Note
Chronic disease follow-up prescription	3	3	0	0	1	3	Positive	In-person follow-up remains the general principle; experts suggested limiting the duration and frequency of remote prescriptions.
Monitoring for specific diseases in infants and young children	2.25	3	0.75	0.38	0.75	3	Positive	In-person care was generally preferred; remote use was considered mainly for monitoring chronic conditions.
Care consultation for patients with intractable diseases	2.25	3	0.75	0.38	0.75	3	Positive	In-person care with caregiver involvement was preferred; remote care may be feasible at the monitoring level.
Community-based home care for chronic diseases	3	3	0	0	1	2	Positive	Link with community-based care; conditional application at the monitoring level with safeguards.
Care coordination for degenerative diseases in older adults	3	3	0	0	1	2	Positive	Conditional application at the monitoring level and integration with community care.
Guidance and home-based care for persons with disabilities	3	3	0	0	1	2	Positive	Integration with community care and conditional application at the monitoring level.
Chronic diseases	3	3	0	0	1	2	Positive	No additional comments.
Remote and medically underserved areas	3	4	1	0.5	0.75	3	Positive	Eligible areas should be legally designated; remote initial visits may be considered in underserved areas.
Infectious diseases requiring monitoring	3	3	0	0	1	3	Positive	No additional comments.
Long-term care hospitals	2	2	0	0	1	3	Negative	Experts noted the absence of overseas precedents and concerns about integration with the care delivery system.
Services supplementing face-to-face care (e.g., patient education and counseling)	2.25	3	0.75	0.38	0.75	3	Positive	Telemedicine should complement face-to-face care; its scope should be clearly defined and standardized.

Note: This table includes the 11 of 20 candidate service domains that met the predefined criteria in Round 2 or Round 3. Consensus direction was classified using the modal rating: 3 or 4 indicated positive consensus, and 1 or 2 indicated negative consensus. Data are presented as 25th percentile (Q1), 75th percentile (Q3), and interquartile range (IQR, the difference between Q3 and Q1). The consensus round refers to the specific Delphi round (e.g., round 2 or 3) in which consensus was achieved.

Table 2. Final Ratings on Conditions Proposed for Exclusion from Telemedicine: Modified Delphi Study

Item	Q1	Q3	IQR	Final Convergence	Final Consensus	Final Round	Consensus Outcome	Expert Note
Conditions requiring diagnostic confirmation by CT, MRI, or laboratory testing	3	4	1	0.5	0.67	2	No consensus	Ratings favored exclusion, but the item did not meet the predefined consensus threshold. Telemedicine may be used after diagnosis, with transition to in-person care when clinically indicated.
Situations requiring face-to-face clinical intervention, including invasive procedures	4	4	0	0	1	3	Positive	Experts agreed that these situations should be excluded from telemedicine.
Typical emergencies or conditions requiring urgent care (e.g., stroke, acute myocardial infarction, fever $\geq 38.3^{\circ}\text{C}$, uncontrolled vomiting or diarrhea, evident fracture, or severe uncontrolled pain)	4	4	0	0	1	2	Positive	Experts agreed that emergency and urgent-care situations should be excluded from telemedicine.
Patients with chronic or degenerative diseases presenting with new or unrelated diseases or injuries requiring face-to-face care	4	4	0	0	1	3	Positive	Physician judgment should allow transition to face-to-face care when indicated.
Postoperative patients receiving home care with suspected adverse events or complications	3	4	1	0.5	0.75	3	Positive	Face-to-face care was considered preferable when adverse events or complications are suspected.
All patients reporting symptoms considered acute in nature	3	4	1	0.5	0.67	2	No consensus	Some experts emphasized that telemedicine may still serve a triage function and guide transition to face-to-face care.

Note: Four of the six candidate exclusion domains met the predefined criteria. The two remaining items showed ratings favoring exclusion but had a consensus index of 0.67 and therefore did not meet the predefined threshold of 0.75. For these two items ($Q1 = 3$, $Q3 = 4$), the median was 3; the consensus index was therefore calculated as $1 - (4 - 3)/3 = 0.67$.

For acute symptoms, some experts stated that telemedicine may function as a triage tool and that physician judgment should guide transition to face-to-face care.

Data are presented as 25th percentile (Q1), 75th percentile (Q3), and interquartile range (IQR, the difference between Q3 and Q1). The consensus round refers to the specific Delphi round (e.g., round 2 or 3) in which consensus was achieved.

Table 3. Consensus Items on Telemedicine-Appropriate Conditions by Specialty

Specialty	Clinical domain	Q1	Q3	IQR	Final Convergence	Final Consensus	Consensus Round	Consensus Direction	Expert Note
Neurology	Clinically stable patients after stroke	3	3	0	0	1	3	Positive	Some experts recommended limiting implementation to primary care settings.
Neurology	Patients with cerebral palsy	3	3	0	0	1	2	Positive	Integration with community-based care was emphasized.
Neurosurgery	Clinically stable patients after brain surgery (e.g., cerebrovascular disease or traumatic brain injury)	3	3	0	0	1	2	Positive	In-system, face-to-face monitoring should remain available.
Urology	Patients with urolithiasis	2	2	0	0	1	3	Negative	Experts preferred care within the face-to-face healthcare delivery system.
Ophthalmology	Consultation for ophthalmic conditions	2	2	0	0	1	3	Negative	Experts preferred face-to-face assessment and emphasized clarification of legal responsibility.
Other	Patients with diagnosed chronic or degenerative diseases receiving stable maintenance therapy without changes in symptoms	3	3.75	0.75	0.38	0.75	3	Positive	Integration with community-based care was emphasized.

Note: This table includes the six of 16 specialty-specific domains that met the predefined criteria in Round 2 or Round 3. Consensus direction was classified using the modal rating: 3 or 4 indicated positive consensus, and 1 or 2 indicated negative consensus. Data are presented as 25th percentile (Q1), 75th percentile (Q3), and interquartile range (IQR, the difference between Q3 and Q1). The consensus round refers to the specific Delphi round (e.g., round 2 or 3) in which consensus was achieved.

2.4 Consensus Criteria and Data Quality

Consensus was predefined as a convergence index ≤ 0.5 and a consensus index ≥ 0.75 . Q1 and Q3 denote the 25th and 75th percentiles of the ratings, and the interquartile range (IQR) is the difference between them. The convergence and consensus indices were calculated as shown in (1) and (2). Consensus direction was classified as positive when the modal rating was 3 or 4 and negative when it was 1 or 2. All responses underwent validity screening for inattentive or erroneous entries, followed by data cleaning (punching, coding, and editing).

$$\text{Convergence index} = (Q3 - Q1) / 2 \quad (1)$$

$$\text{Consensus index} = 1 - (Q3 - Q1) / \text{median} \quad (2)$$

This study was approved with waived informed consent by the Institutional Review Board (IRB) of the National Evidence-Based Healthcare Collaborating Agency (IRB No. NECA IRB 22-014).

3. Results

3.1 Expert Consensus Outcomes on Telemedicine-Appropriate Domains

The panel evaluated 20 candidate service domains (Table 1; Appendix Table 1). Four domains reached full positive consensus in Round 2: care coordination for degenerative diseases in older adults, chronic diseases, guidance and home-based care for persons with disabilities, and community-based home care for chronic diseases (convergence = 0; consensus = 1). In Round 3, positive consensus was reached for chronic disease follow-up prescriptions, monitoring for specific diseases in infants and young children, care consultation for patients with intractable diseases, remote and medically underserved areas, infectious diseases requiring monitoring, and services supplementing face-to-face care. Long-term care hospitals also met the statistical criteria, but the direction was negative (Q1 = 2, Q3 = 2, convergence = 0; consensus = 1). Overall, 10 domains reached positive consensus, one reached negative consensus, and nine did not meet the predefined criteria.

3.2 Expert Consensus on Telemedicine Exclusion Criteria

Six candidate exclusion domains were evaluated (Table 2). Four met the predefined consensus criteria: situations requiring face-to-face intervention, including invasive procedures; typical emergencies or conditions requiring urgent care; new or unrelated conditions or injuries requiring face-to-face care in patients with chronic or degenerative diseases; and suspected postoperative adverse events or complications. The first three reached full consensus (convergence = 0; consensus = 1), whereas suspected postoperative complications reached the threshold (convergence = 0.5; consensus = 0.75). Conditions requiring diagnostic confirmation by computed tomography (CT), magnetic resonance imaging (MRI), or laboratory testing and the blanket exclusion of all patients reporting acute symptoms each showed ratings favoring exclusion (convergence = 0.5; consensus = 0.67) but did not meet the predefined threshold. Some experts emphasized a potential triage role for telemedicine in acute symptoms, with physician-directed transition to face-to-face care.

3.3 Consensus Items on Telemedicine-Appropriate Conditions by Specialty

Six of the 16 specialty-specific domains met the predefined consensus criteria (Table 3). Positive consensus was reached for clinically stable patients after stroke, patients with cerebral palsy, clinically stable patients after brain surgery, and patients with diagnosed chronic or degenerative diseases receiving stable maintenance therapy without changes in symptoms. Negative consensus was reached for patients with urolithiasis and for ophthalmic consultations (Q1 = 2, Q3 = 2, convergence = 0; consensus = 1 for both).

Appendix Table 2 presents the 10 specialty-specific domains that did not meet the predefined criteria, including chronic conditions in internal medicine, psychiatric care, pregnancy and perinatal care, parenting counseling in pediatrics, postoperative wound assessment, smoking cessation and obesity counseling, postoperative orthopedic wound care, rehabilitation for patients with mobility limitations, and other counseling services. Expert comments emphasized monitoring-based counseling and education, caregiver involvement when indicated, integration with community care, continued access to face-to-face care, and clarification of legal responsibility.

4. Discussion

4.1 Summary and Interpretation of Consensus

This study aimed to assess the feasibility of institutionalizing telemedicine in Korea in the post-COVID-19 context by achieving expert consensus on disease-specific applicability and the necessary institutional and clinical prerequisites. Using a Delphi approach, the study identified potential domains and limitations for telemedicine adoption, as well as key structural conditions for implementation.

The panel supported telemedicine for selected follow-up, monitoring, counseling, and care-coordination functions, particularly for chronic disease management, infectious disease monitoring, disability-related and community-based care, medically underserved areas, and clinically stable neurological populations. However, positive consensus did not extend to entire specialties such as internal medicine or pediatrics. For example, monitoring for specific diseases in infants and young children reached consensus as a service domain, whereas parenting counseling in pediatrics did not meet the specialty-level consensus threshold.

Further, this study's disease-specific conditional application model is consistent with the global review by Ndwabe et al. (2024), which found that telehealth has been used primarily for monitoring and counseling in specific areas—mental illness, cancer, pediatrics, and perioperative care—under highly controlled conditions. Their review emphasized that countries with underdeveloped legal and regulatory frameworks faced more limitations in implementation [17]. These findings parallel our panel's recommendations, which emphasized restricted use for psychiatric or high-risk patients based on clinical criteria, caregiver involvement, and the current lack of legal standards [9-14].

The unanimous negative consensus regarding telemedicine in long-term care hospitals should not be interpreted as indicating that digital tools have no role in this setting. Rather, the finding reflects concerns about the clinical vulnerability of residents, the need for direct assessment, the lack of comparable overseas precedents identified by the panel, and the need to integrate long-term care hospitals with community-based delivery systems. Technology-mediated care may still have a complementary role in specialist consultation, care coordination, discharge planning, and continuity between institutional and community care, but these applications require defined clinical and organizational safeguards.

Consensus supported four specific exclusion domains: emergencies or urgent-care situations, face-to-face interventions including invasive procedures, new diseases or injuries requiring direct care, and suspected postoperative adverse events or complications. Although most experts also favored excluding cases requiring

CT, MRI, or laboratory-based diagnostic confirmation, this item did not reach the predefined threshold. The same was true for the blanket exclusion of all acute symptoms; expert comments indicated that telemedicine could sometimes serve a triage function. These distinctions argue against treating exclusion criteria as an exhaustive list or as immunity for non-listed situations.

Concurrently, expert consensus was not reached for several specific items. These include the use of primary care for minor ailments, discretionary application of telemedicine by physicians, management of dialysis patients, and postoperative outpatient monitoring. The lack of agreement appears to stem from unclear legal responsibilities and vague clinical standards. This highlights the need for more detailed guidelines concerning eligibility criteria, patient selection, and the scope of physician accountability prior to system implementation.

Furthermore, clinical domains such as mental health, rehabilitation medicine, and surgical specialties pose significant challenges in balancing technological adoption with clinical safety. Contributing factors include the necessity of physical examination, patients' communicative capacity, and caregiver presence. For these areas, the development of clinical guidelines—including legal and ethical safeguards—is essential [9-14]. Future research should prioritize field-based evaluations to assess real-world feasibility and ensure patient safety.

4.2 Policy Implications and Recommendations

Previous studies have emphasized the central role of trust in telemedicine adoption. For example, Schürmann et al. (2025) highlighted dimensions such as technological reliability, therapeutic confidence, and operational transparency as key to physician acceptance. These findings align with the need for institutional mechanisms that promote provider confidence and system-level accountability.

To date, telemedicine policy discourse in Korea has primarily focused on dichotomies such as initial vs. follow-up consultations or primary care-centered implementation, often framed in adversarial, politically contentious terms. However, this and prior studies have consistently highlighted foundational concerns raised by the medical community—namely, patient safety, legal clarity, and the absence of institutional infrastructure.

Notably, Schürmann et al. (2025) found that trust is the single most important determinant of telemedicine acceptance among German physicians. Their analysis indicated that trust comprises three key dimensions: technological reliability (43%), therapeutic confidence (64%), and transparency—rooted in clearly defined operational systems (71%) and expert-based feedback mechanisms (79%). These findings underscore the need for inclusive, transparent institutional design with the active participation of front-line providers from the outset.

In addition to structural and professional readiness, patient-level barriers must be considered in policy design. According to Weißenfeld et al. (2021), common obstacles include limited digital literacy, mistrust in diagnostic accuracy, and lack of technical support. These must be addressed through patient education, equitable access to digital technologies, and robust support systems to ensure socially inclusive and effective telehealth implementation [18].

Although Monaghesh and Hajizadeh (2020) offered valuable insights into pandemic-era telehealth adoption, they did not fully explore the structural conditions needed for long-term institutionalization. In contrast, our findings, when compared with the pre-pandemic Korean study by Choi et al. [16], confirm that the structural challenges identified—legal, infrastructural, and delivery-related—are enduring, independent of the pandemic context.

In conclusion, this study moves beyond descriptive accounts of pandemic-era telemedicine by identifying specific technology-mediated service domains, boundaries, and implementation conditions. The relevant digital functions include remote consultation, remote monitoring, patient-provider communication, education, and digitally supported continuity of care. These findings support phased implementation beginning with low-risk, clinically stable populations while maintaining clear pathways to face-to-face care.

4.3 Study Limitations

This study has several inherent limitations.

First, the panel was composed primarily of experts nominated by physician, hospital, medical informatics, and telemedicine organizations. Patients, nurses, legal and ethical experts, and other stakeholders were not directly represented. This provider-centered composition may have placed greater emphasis on safety and professional liability. Future studies should incorporate a broader range of stakeholders to improve the balance and generalizability of the findings.

Second, while the study emphasizes the importance of trust and acceptability in telemedicine policy, the perspectives of patients or the general public were not directly incorporated, potentially limiting consumer-centered relevance.

Third, although the study recommends a phased implementation strategy, it does not provide detailed operational criteria such as disease classification, risk-based eligibility, or legal safeguards required for institutionalization. Developing a concrete policy framework remains an essential task for future research.

Fourth, consensus was not reached in several clinical areas, including psychiatric care, parenting counseling in pediatrics, internal medicine chronic disease care as a specialty domain, and rehabilitation medicine. The study did not conduct an in-depth analysis of the reasons for these disagreements. Future studies should examine these domains using both quantitative and qualitative methods.

Fifth, this study identified ICT-enabled healthcare service domains but did not evaluate a specific telemedicine platform, system architecture, cybersecurity model, interoperability standard, or user-interface performance. The findings should therefore be interpreted as service- and policy-level guidance rather than validation of a particular information system.

5. Conclusions

This modified Delphi study found positive consensus for selected telemedicine functions in chronic disease follow-up and monitoring, infectious disease monitoring, community-based home care, disability-related care, medically underserved areas, and clinically stable neurological and neurosurgical populations. Negative consensus was reached for long-term care hospitals, urolithiasis, and ophthalmic consultations. Consensus supported excluding emergencies, invasive or other face-to-face interventions, new conditions or injuries requiring direct care, and suspected postoperative complications. Telemedicine should therefore be applied selectively as a complement to, rather than a replacement for, face-to-face care.

By highlighting disease-specific appropriateness and institutional prerequisites, this study provides actionable guidance for phased national telemedicine implementation. Prioritizing low-risk, clinically stable populations and embedding trust-based governance can facilitate sustainable digital health policy development in Korea, with relevance to other health systems facing similar challenges.

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Appendix

Table 1. Non-consensus Items among the 20 Candidate Service Domains

Item	Q1	Q3	IQR	Final Convergence	Final Consensus	Final Round	Expert Note
All conditions except those restricted by the Ministry of Health and Welfare	2	3	1	0.5	0.67	3	Temporary restrictions may be necessary during early implementation to prevent misuse.
Telemedicine at the physician's discretion when clinically appropriate	2	3.75	1.75	0.88	0.30	3	Experts preferred legal specification over relying solely on individual physician discretion.
Clinical domains excluding initial visits and other specified restricted situations	2	3	1	0.5	0.60	3	Some experts opposed excluding all initial visits and supported exceptions for mild cases in vulnerable or underserved populations.
High-severity cases requiring frequent consultation rather than in-person visits	2	3	1	0.5	0.50	3	Views differed on whether such cases could be managed within the delivery system and when mobility limitations should take precedence over severity.
Monitoring clinically stable patients who do not require additional in-person care	2	3	1	0.5	0.60	3	The boundaries among consultation, monitoring, and diagnosis remained unclear.
Preoperative risk assessment for scheduled surgery	2	3	1	0.5	0.67	3	Experts emphasized that preoperative patients should be assessed in person within healthcare facilities.
Minor illnesses manageable in primary care clinics	1.25	3	1.75	0.88	0.42	3	Clinical definitions of minor illness and associated safety standards were considered insufficiently clear.
Postoperative acute care for conditions requiring secondary or tertiary hospital management	2	3	1	0.5	0.50	3	Postoperative complications may require in-person care, and classification of postoperative conditions was considered ambiguous.
Guidance and monitoring for dialysis patients	2	3	1	0.5	0.67	3	In-person care should remain the default, although monitoring-level remote care may be feasible.

Note: These nine items did not meet the predefined consensus criteria in either Round 2 or Round 3.

Data are presented as 25th percentile (Q1), 75th percentile (Q3), and interquartile range (IQR, the difference between Q3 and Q1).

The final round is the last Delphi round in which the item was assessed.

Table 2. Non-consensus Specialty-Specific Domains

Specialty	Clinical domain	Q1	Q3	IQR	Final Convergence	Final Consensus	Final Round	Expert Note
Internal Medicine	Patients with chronic conditions (e.g., hypertension, diabetes, or dyslipidemia)	3	4	1	0.5	0.67	3	Experts emphasized monitoring-based counseling and education rather than prescription-focused telemedicine.
Psychiatry	Patients with depression or schizophrenia who avoid in-person care	2	3.5	1.5	0.75	0.50	2	Caregiver involvement and clarification of legal responsibility were emphasized.
Psychiatry	Patients with psychiatric disorders, with caregiver presence considered for intellectual disability or autism	2.25	3.75	1.5	0.75	0.50	3	Face-to-face care remained the preferred approach; caregiver presence may be necessary.
Obstetrics and Gynecology	Patients requiring pregnancy and perinatal care	2	3	1	0.5	0.67	3	Clarification of legal responsibility was emphasized.
Pediatrics	Parenting counseling	3	4	1	0.5	0.67	3	Clarification of legal responsibility was emphasized.
General Surgery	Postoperative wound assessment	2	3	1	0.5	0.60	3	Monitoring guidance may be feasible, but face-to-face care was preferred within the delivery system.
Family Medicine	Smoking cessation and obesity counseling	3	4	1	0.5	0.67	3	Clarification of legal responsibility was emphasized.
Orthopedic Surgery	Postoperative wound care	2	3	1	0.5	0.67	3	Patient monitoring and education were noted, alongside the need to clarify legal responsibility.
Rehabilitation Medicine	Patients with mobility limitations (e.g., lower-limb disability)	3	4	1	0.5	0.67	3	Symptom consultation and linkage with community care were noted.
Other	Counseling (e.g., contraception, psychological support, headache, back pain, rehabilitation, or eyewear use)	3	4	1	0.5	0.67	3	Clarification of legal responsibility was emphasized.

Note: These 10 of 16 specialty-specific domains did not meet the predefined consensus criteria in either Round 2 or Round 3.

Data are presented as 25th percentile (Q1), 75th percentile (Q3), and interquartile range (IQR, the difference between Q3 and Q1).

The final round is the last Delphi round in which the item was assessed.



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