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Understanding Predictors of Telemedicine Attitudes in Young Adults in Bangladesh: The Role of Knowledge, Perception, and Demographics

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Abstract

Bangladesh faces persistent access gaps in both rural and rapidly growing urban settings, where high population density strains facilities and workforce capacity. Telemedicine has been promoted nationally as part of the country's digital health agenda to improve timely, affordable care. Understanding what drives young adults' attitudes toward telemedicine is critical because this cohort both consumes and shapes the future supply of digital health services. Telemedicine has emerged as a transformative approach to healthcare delivery, particularly in resource-constrained settings. This study investigates the knowledge, perceptions, and attitudes of young adults in Bangladesh toward telemedicine. A cross-sectional survey of 501 participants aged 18–35 was conducted to assess their understanding and willingness to adopt telemedicine along with key demographic predictors influencing these outcomes. Multiple regression analyses revealed that perception was the strongest predictor of positive attitudes, while knowledge, academic background, gender, and place of residence were not significant. These findings highlight telemedicine's potential to enhance healthcare accessibility in both urban and rural Bangladesh, and emphasize the importance of perception-focused awareness strategies and gender-sensitive education to facilitate broader adoption.

Keywords: Telemedicine, Young Adults, Perception, Knowledge, Attitude, Digital Health.
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1. Introduction

Telemedicine is the delivery of medical services and exchanging information about medical care over distances (Smith & Gray, 2009). It incorporates a wide range of clinical exercises, including diagnosis, treatment, disease prevention, additional training for medical care providers and consumers, and inspection and evaluation (Chuan Wang, 2023). With the aid of more recent technologies like the fast internet bandwidth, artificial intelligence, and devices that enable doctors to measure pulse rate, oxygen saturation, body temperature, and even chest X-rays through the internet, many hospitals, large healthcare systems, health insurance companies, and federal governments are turning to the use of telemedicine to provide healthcare solutions globally (Huang et al., 2014; Zanaboni & Wootton, 2012). The traditional physician consultation involves a patient requesting an appointment and providing basic details about their illness, and the doctor then acknowledges the problem and sets up a time for the visit (Doarn et al., 2016).

Bangladesh encounters considerable obstacles in attaining universal healthcare, particularly for marginalized populations, including persons with poor socio-economic status and those residing in remote areas (Joarder et al., 2019). While telemedicine has been promoted as a solution for rural healthcare disparities, new developments indicate its significance in urban settings, particularly for youth navigating fast-paced lifestyles with digital technology (Ahmed et al., 2014). Due to less complete and further away healthcare facilities and services, as well as higher expenditures as compared to those for urban residents, the situation is getting worse in distant communities (Iqbal, 2018; M. Rahman et al., 2024). According to data published by the World Bank, 59.5% of the people in Bangladesh live in rural areas (World Bank, 2024). Additionally, in 2021, there were only about 70 doctors per 100,00 people in Bangladesh (World Bank, 2025). Telemedicine can, therefore, play a significant role considering the enormous disparity in the availability of healthcare specialists and adequate medical

facilities in the rural area (Ayatollahi et al., 2015). However, young and educated urban residents are becoming important users as well as providers of telemedicine services. The urban areas of Bangladesh are characterized by high population density, such as congestion of hospitals, extensive waiting periods, and poor access to certain forms of health care (World Health Organization, 2021). In urban Bangladesh—especially Dhaka—public hospitals face chronic congestion, long waits, and capacity strain, reflected in a sizable urban population (~41% in 2024) but limited provider capacity (0.67 physicians and 0.8–0.9 beds per 1,000 people, with average bed occupancy ~92%) and reports of Dhaka Medical College Hospital operating at nearly twice its capacity (Nov 2024). It is very common that a patient in need is not promptly provided with a proper consultation or medical remedy since doctors from cities frequently have to drive for long distances (Saha et al., 2021). Also, rapid urbanization in Bangladesh has led to the surge of non-communicable diseases (NCDs) like diabetes, hypertension, and mental health issues among the youth workforce (Riaz et al., 2020). Due to the rapid lifestyles of urban young, telemedicine offers a convenient solution for addressing healthcare requirements, minimizing in-person clinic visits, and facilitating prompt consultations. Telemedicine facilitates early identification, immediate management, and ongoing care for chronic conditions that frequently necessitate consistent monitoring and specialist appointments (Chowdhury et al., 2023). Young adults have the potential to embrace telemedicine and may find it more accessible and cost-effective due to their familiarity with online platforms (H. Rahman et al., 2022). The advantages of telemedicine include increased accessibility to healthcare, lower total healthcare expenditures for the patient, real-time referrals to emergency treatment to prevent complications, and provision of superior quality care (Donelan et al., 2019). Moreover, telemedicine platforms such as Tonic by Grameenphone, Pulse Healthcare, DaktarBhai, and Sebaghar deliver digital health services tailored for urban residents, facilitating immediate access to physicians and preventive health guidance (Al Mamoon & Khan, 2006; Khan et al., 2021).

To improve the nation's health service quality, efficacy, and safety, the Bangladeshi government has formed a collaboration with corporate groups, non-governmental organizations, and development partners (H. Rahman et al., 2022). The Bangladeshi government has prioritized telemedicine under its "Digital Bangladesh Vision 2021" to incorporate information and communication technology (ICT) into the healthcare system, addressing the needs of both rural and urban people. The government has since formalized this direction in the **B**angladesh Digital Health Strategy 2023–2027, which outlines goals for equitable access, interoperable platforms, and a digitally enabled health workforce (Directorate General of Health Services [DGHS], 2023). Corporate partnerships and government measures, including the construction of telemedicine services in hospitals, have improved access to specialists in Dhaka, helping individuals across various socio-economic strata (Welfare, 2011). However, earlier research has revealed that some major obstacles to adopting telemedicine among healthcare professionals include a lack of knowledge, skills, and training and resistance to change (Zobair et al., 2020). Zobair et al. also described the successful implementation of telemedicine as encountering obstacles such as insufficient awareness, reluctance to change, and inadequate technological resources (Zobair et al., 2020). Only a small portion of people know telemedicine, making it difficult to use it when they need it (Zhao et al., 2010). Since the urban, young adults are more likely to adopt telemedicine with its expansion, this study aims to determine the young adults' knowledge, perception and attitude towards telemedicine among young, primarily urban adults in Bangladesh. Under this broader objective, we evaluated the predicted attitude towards using telemedicine considering knowledge, perception, academic background (majors), living location, and sex as a predictor and their predicted knowledge of telemedicine considering academic background (majors), living location, and sex as predictors. This research can improve policies and programs that promote telemedicine use, enhance healthcare accessibility, and fulfill the needs of the population by addressing gaps in knowledge and perception.

Recent national survey evidence from Bangladesh demonstrates that awareness of telehealth is rising, yet gaps in knowledge and concerns about access persist (Rahman et al., 2020). Motivated by these findings, we examine how knowledge, perception, and demographics predict telemedicine attitudes among young adults.

2. Methodology

2.1 Study Design, Settings, and Population

A cross-sectional survey was conducted between April 10 and June 10, 2022, to assess knowledge, perceptions, and attitudes toward telemedicine among young adults in Bangladesh. Data were collected using a self-administered, structured questionnaire developed through literature review and expert consultation [23,24]. The questionnaire consisted of four sections: (1) demographic characteristics; (2) knowledge of telemedicine (17 items); (3) perception of telemedicine (9 items); and (4) attitude and willingness to use telemedicine (4 items).

Responses were recorded on a trichotomous scale ("Yes," "No," "Don't know") and recoded into binary format for analysis (Yes = 1; others = 0).

The questionnaire was originally developed in Bangla and subsequently translated into English using a forward–backward translation process to ensure semantic and conceptual equivalence. The study was approved by the Institutional Review Board of the authors' university.

Participants were recruited using convenience sampling to ensure accessibility to both urban and non-urban populations. Eligible participants were Bangladeshi residents aged 18 to 35 years. Informed consent was obtained electronically through a detailed participant information statement outlining the study's purpose and voluntary nature. All responses were anonymized, and raw data were stored securely and deleted after digital compilation.

A total of 540 responses were received, of which 501 were complete and included in the final analysis.

2.2 Study Tool

After reviewing relevant literature on telemedicine and consulting with experts in the field, the authors developed the questionnaire. (Gagnon et al., 2004; Kabir et al., 2024). An expert panel assessed the tool's face validity and content validity both during and after development to make sure that the respondents understood the instrument used in the study. The questionnaire consists of four sections: 1) Demographic details of the respondents; 2) Knowledge about telemedicine; 3) Perception about telemedicine; and 4) attitudes towards the utilization of telemedicine.

The first section collects demographic information such as the participant's age, gender, educational qualification, academic department/division, occupation, monthly family income in BDT, and living location(urban/non-urban). It also includes an overview of the research purpose and the participant's consent.

The second and third sections comprise close-ended questions to assess knowledge, perception, and willingness to use telemedicine in Bangladesh. The second section includes seventeen questions evaluating participant's knowledge of telemedicine services. The third section consists of nine questions assessing participant's perception and four questions evaluating their willingness to use telemedicine. The participants were asked to respond to each question "yes," "no," and "I don't know", which means "someone agrees with it," "someone doesn't agree with it," and "someone doesn't know about it," respectively. The questionnaire was originally developed in Bangla (the native language of the participants). Besides the original questionnaire, an English translation was also provided to ensure accurate comprehension of scientific terminologies and maintain conceptual equivalence. To assure the quality and validity of the translated instrument, a strict forward-backward translation procedure was used. The Institutional Review Board of the authors' university approved the study.

2.3 Statistical Analysis

Data were initially collected and organized using Microsoft Excel. Descriptive statistics were computed to summarize participant responses, and results were reported as frequencies and percentages. All statistical analyses were performed using JMP software (SAS Institute Inc.).

For analysis, responses to all items were recoded into binary format: "Yes" = 1, and both "No" and "Don't know" = 0. Composite scores for knowledge, perception, and attitude were calculated by summing individual item responses in each category.

Multiple linear regression analyses were conducted to identify predictors of (1) attitude toward telemedicine and (2) knowledge of telemedicine. Predictor variables included sex, academic background, and place of residence. Multicollinearity was assessed using variance inflation factors (VIF), with values below 5 considered acceptable.

3. Results

The study sample was mostly young and comparatively with a good level of education, with an average age of 27.87 years (SD: 8.1). The male participants were more dominant (65%) than the females. The level of education was very high: 55.92% of the participants had a Bachelor's degree or higher. Most of the people who took part came from science-related backgrounds (63.43%), and more than half of them were students (54.54%). There was a wide range of monthly family incomes: 36.75 percent made between 20,001 and 40,000 BDT, 16.79 percent made between 40,001 and 60,000 BDT, 16.4 percent made less than 10,000 BDT, and only 8.69 percent

made more than 60,000 BDT. Most of the people who took part (77.86%) lived in urban areas, while 22.13% lived in rural or other non-urban places. The detailed demographics of the participants are presented in Table 1.

As shown in **Table 2**, the majority of participants (93.9%) reported awareness of telemedicine services. Awareness was slightly higher among males (95.4%) than females (91.0%), and among urban (94.7%) compared to non-urban participants (91.1%), though these differences were not statistically significant. Participants with a science background had significantly higher knowledge (95.6%) than those from non-science backgrounds (90.8%) ($\chi^2 = 4.756$, $p < .05$).

A significant association was found between academic background and awareness of regulatory issues, particularly regarding whether non-registered medical practitioners can provide telemedicine services ($\chi^2 = 22.793$, $p < 0.001$). Science-background participants also demonstrated significantly greater knowledge about the limitations of medication prescriptions, legal protections, emergency use, and telemedicine platforms such as Shastho Batayan (all $p < 0.01$ or $p < 0.001$).

Gender-based differences showed males were more familiar with legal aspects ($\chi^2 = 6.379$, $p < .05$), social media use for telemedicine ($\chi^2 = 9.672$, $p < .01$), and platform familiarity ($\chi^2 = 9.189$, $p < .01$). Urban participants were more likely to be aware of 24-hour services ($\chi^2 = 5.067$, $p < .05$) and emergency care options via telemedicine ($\chi^2 = 5.751$, $p < .05$).

As summarized in **Table 3**, participants generally held positive perceptions of telemedicine. Most believed it reduces costs (89.1%), saves time (89.7%), and improves healthcare access (86.8%). A significant association was observed between residential location and perceived access benefits: 94.6% of non-urban participants agreed that telemedicine improves healthcare access, compared to 84.5% of urban participants ($\chi^2 = 10.99$, $*p < .01$), highlighting the perceived value of telemedicine among underserved populations.

While differences in perception across gender and academic background were generally not significant, science-background students were slightly more likely to view telemedicine as a viable healthcare option (74.1% vs. 68.8%). Additionally, 48.4% of all participants expressed concerns about the risk of unauthorized disclosure of medical information through telemedicine, with no significant variation across demographic groups.

Table 4 presents the multiple regression results predicting attitude towards telemedicine, using knowledge, perception, sex, academic major, and place of residence as predictors. The model demonstrates a moderate positive relationship between the predictors and the outcome ($R = 0.5123$, Adjusted $R^2 = 0.2551$), and the overall regression is statistically significant ($p < 0.0001$). This indicates that approximately 25.5% of the variance in attitude scores can be explained by the included variables. Among these predictors, perception was the only statistically significant factor ($\beta = 0.1965$, $p < 0.0001$), suggesting that individuals who perceive telemedicine more favorably are more likely to have a positive attitude toward its use. In contrast, knowledge, sex, academic background, and residence did not show significant effects ($p > 0.05$), indicating limited individual influence on attitude. Additionally, all VIF values were well below the common threshold of 5, confirming no multicollinearity and supporting the reliability of the model estimates.

Table 5 shows the results of a regression model examining knowledge of telemedicine as the dependent variable, with sex, academic major, and place of residence as predictors. The model reveals a weak but statistically significant relationship ($R = 0.1493$, Adjusted $R^2 = 0.0170$, $p = 0.0089$), suggesting that only a small portion of the variance in knowledge is explained by these variables. Among the predictors, sex was the only statistically significant factor ($\beta = 0.9971$, $p = 0.0080$), with males showing significantly higher knowledge scores than females. Academic major and location were not significant predictors, indicating minimal impact on telemedicine knowledge from those variables. Similar to the previous model, all VIF values were below 5, confirming no multicollinearity among predictors. Although the model's explanatory power is limited, the findings underscore the importance of gender in shaping telemedicine knowledge, suggesting that educational strategies may benefit from being tailored to address such demographic differences.

4. Discussion

This study underscores key socio-demographic patterns in knowledge and attitudes toward telemedicine among educated young adults in Bangladesh. Although the participants generally held a favorable perception of telemedicine and demonstrated high educational attainment—over half possessing a Bachelor's degree or higher—critical gaps remain in their depth of knowledge and influencing factors behind their attitudes.

As reflected in the regression findings, perception was the only significant predictor of a positive attitude toward telemedicine, while knowledge, sex, academic background, and residence showed no statistical significance. This suggests that fostering a favorable perception—perhaps through awareness campaigns or demonstration of telemedicine benefits—could be more impactful in shaping attitudes than simply disseminating technical knowledge. This aligns with prior research emphasizing that individual perceptions, such as perceived usefulness and ease of use, play a dominant role in technology adoption behaviors (Ayatollahi et al., 2015; Gagnon et al., 2004; Kabir et al., 2024). Our result that perception—not knowledge—is the dominant predictor of attitude aligns with Bangladesh-specific survey evidence (Kabir et al., 2024) and with a JMIR Human Factors study of Shastho Batayon users, where perceived service quality and usefulness were associated with intention to reuse (Khatun et al., 2024).

Interestingly, although males were overrepresented in the sample (65%) and found to have significantly higher knowledge scores than females, this difference did not translate into a statistically significant impact on attitudes. This indicates a knowledge-attitude gap, reiterating the insight from behavioral science models like the Health Belief Model, which posits that knowledge alone is insufficient to drive behavioral change. Cues to action and perceived benefits or risks are equally crucial.

The participants predominantly came from urban areas and science-related academic majors, yet residence and academic background did not significantly influence either knowledge or attitude. This suggests that urban exposure and scientific training may not necessarily translate into better telemedicine literacy—underscoring the need for targeted public education initiatives rather than relying solely on formal education or geographic access.

A modest yet statistically significant relationship was found between sex and knowledge, highlighting that men had greater telemedicine knowledge than women. This is consistent with existing studies suggesting gender disparities in digital health literacy (Kabir et al., 2024). Tailoring outreach and educational efforts to address this gap, particularly for female populations, may enhance overall adoption and trust in telemedicine platforms.

Despite the limited explanatory power of the regression models—especially the knowledge model (Adjusted $R^2 = 0.0170$)—the findings still point to important directions for future intervention. Increasing public engagement, especially among females and non-science backgrounds, and addressing perceptual barriers rather than solely technical knowledge, could improve attitudes toward telemedicine.

Given the growing reliance on digital health services in Bangladesh—accelerated by the COVID-19 pandemic and infrastructural challenges in rural healthcare delivery—the implications of this study are timely. As previous studies have also emphasized, sustainable integration of telemedicine requires coordinated public education, policy standardization, and equitable access initiatives (Joarder et al., 2019; Khan et al., 2021; H. Rahman et al., 2022).

5. Conclusion

This study highlights notable gaps in telemedicine knowledge and the socio-demographic factors influencing attitudes among university-educated adults in Bangladesh. Although participants had relatively high education levels and favorable perceptions of telemedicine, only perception significantly influenced attitude formation, while knowledge and background factors such as sex, academic major, and residence did not have a strong impact.

However, males were found to have significantly higher knowledge scores than females, underscoring gender-based disparities in digital health literacy. These findings reinforce the need for tailored educational and awareness programs, particularly focused on perception enhancement and female inclusion. Digital platforms, especially social media, could serve as effective tools for such outreach among younger populations.

Given the modest predictive power of the regression models, future research should explore additional factors such as digital accessibility, health system trust, and individual health experiences. By addressing these gaps, Bangladesh can enhance telemedicine adoption and ensure its role in achieving universal health coverage.

6. Future Research

Future studies could incorporate variables related to digital literacy, prior experience with telemedicine, and perceived barriers to better explain attitude formation. Longitudinal research designs would further help in understanding how sustained educational and technological interventions can influence behavior over time.

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Table 1: Socio-demographic characteristics of the participants.

Characteristics	Frequency (n)/Mean	Percent (%)/SD
Age	27.87	8.1
Sex		
Male	329	65
Female	177	35
Educational Qualification		
Bachelor/ Honours	283	55.92
High school- College level	75	14.82
Masters or above	138	27.27
Primary school education	10	1.97
Academic Department		
Non Science	185	36.56
Science	321	63.43
Occupation		
Other	230	45.45
Student	276	54.54
Monthly family income in BDT		
10001-20000	108	21.34
20001-40000	186	36.75
40001-60000	85	16.79
Above 60000	44	8.69
Less than 10000	83	16.4
Living location		
Urban/ City	394	77.86
Village/Non-urban	112	22.13

Table 2: Demographic distribution of the knowledge of participants on telemedicine in Bangladesh.

		Gender			Living Area			Academic Background		
Question	**Total Yes n (%)**	**Male Yes n (%)**	**Female Yes n (%)**	**Chi square**	**Urban Yes n (%)**	**Non Urban Yes n (%)**	**Chi square**	**Science Yes n (%)**	**Non science Yes n (%)**	**Chi square**
Do you know what Telemedicine service is?	475 (93.9)	314 (95.4)	161 (91)	4.017	373 (94.7)	102 (91.1)	1.964	307 (95.6)	168 (90.8)	4.756
Do you agree that telemedicine provides proper health knowledge on remote area?	345 (68.2)	229 (69.6)	116 (65.5)	4.300	265 (67.3)	80 (71.4)	0.700	215 (67.0)	130 (70)	1.815
Is patient consent mandatory for telemedicine consultation?	326 (64.4)	208 (63.2)	118 (66.7)	2.321	253 (64.2)	73 (65.2)	0.141	214 (66.7)	112 (60.5)	2.835
Do you agree that non-registered medical doctor can provide telemedicine service?	102 (20.2)	71 (21.6)	31 (17.5)	1.412	78 (19.8)	24 (21.4)	6.791*	68 (21.2)	34 (18.4)	22.793***
Do you agree that telemedicine effectively protects both doctors and patient's legal rights?	282 (55.7)	190 (57.8)	92 (52)	6.379*	214 (54.3)	68 (60.7)	2.417	195 (60.7)	87 (47.0)	16.919***
Is prescribing medicines limited via telemedicine consultation?	231 (45.7)	163 (49.5)	68 (38.4)	5.803	183 (46.4)	48 (42.9)	9.143*	163 (50.8)	68 (36.8)	22.486***
Is it allowed to prescribe any narcotic medicines through telemedicine consultations?	99 (19.)	72 (21.9)	27 (15.3)	7.469*	73 (18.5)	26 (23.2)	2.960	67 (20.9)	32 (17.3)	18.659***
Is it possible to prescribe any psychotropic medicines(that used to treat mental health disorders) through	169 (33.4)	108 (32.8)	61 (34.5)	0.319	114 (34)	35 (31.3)	0.890	121 (37.7)	48 (25.9)	18.020***

telemedicine consultations?										
Is telemedicine service encouraged for emergency care?	362 (71.5)	240 (72.9)	122 (68.9)	0.957	275 (69.8)	87 (77.7)	5.751	234 (72.9)	128 (69.2)	9.445**
Have you ever participated in conferences and webinars related to telemedicine?	147 (29.1)	110 (33.4)	37 (20.9)	9.383**	109 (27.7)	38 (33.9)	2.462	91 (28.3)	56 (30.3)	19.549***
Are you familiar with the following telemedicine platforms- Shastho Batayan, Praava Health, SeekMed etc?	263 (52.0)	187 (56.8)	76 (42.9)	9.189*	212 (53.8)	51 (45.5)	4.601	170 (53%)	93 (50.3)	11.559**
Is it possible to receive health advice from a specialist/ consultant through "Shastho Batayan"?	314 (62.1)	219 (66.6)	95 (53.7)	9.445**	240 (60.9)	74 (66.1)	1.200	209 (65.1)	105 (56.8)	4.990
Do you agree that "Shastho Batayan" provides 24 hours online healthcare service?	253 (50.0)	175 (53.2)	78 (44.1)	9.673**	191 (48.5)	62 (55.4)	5.067	155 (48.3)	98 (53%)	4.831
Do you agree that "Shastho Batayan" gives information on Doctors, Hospital and Ambulance service in your area?	254 (50.2)	180 (54.7)	74 (29.1)	13.481**	192 (48.7)	62 (55.4)	1.620	154 (48)	100 (54.1)	2.486
Do you believe that "Praava Health" is an effective platform for telemedicine service?	218 (43.1)	143 (43.5)	75 (42.4)	6.612*	164 (41.6)	54 (48.2)	4.315	143 (44.5)	75 (40.5)	0.778

Can you use social media (eg, Facebook, Messenger/ Viber/WhatsApp for telemedicine service?	322 (63.6)	221 (67.2)	101 (57.1)	9.672**	250 (63.5)	72 (64.)	0.194	203 (63.2)	119 (64.3)	0.091
Can we use telemedicine service for follow-up consultation/ follow-up treatment?	384 (75.9)	253 (76.9)	131 (74%)	7.133*	294 (74.6)	90 (80.4)	3.205	250 (77.9)	134 (72.4)	3.182

*p<05; **p<0.01; ***p<0.0001

Table 3: Demographic distribution of the perception of participants on telemedicine in Bangladesh.

		Gender			Living Area			Academic Background		
Question	**Total Yes n (%)**	**Male Yes n (%)**	**Female Yes n (%)**	**Chi square (p-value)**	**Urban Yes n (%)**	**Non Urban Yes n (%)**	**Chi square (p-value)**	**Science Yes n (%)**	**Non science Yes n (%)**	**Chi square (p-value)**
Do you think telemedicine will help in reducing cost of service?	451 (89.1)	293 (89.1)	158 (89.3)	0.125	346 (87.8)	105 (93.8)	3.801	283 (88.2)	168 (90.8)	1.908
Do you think telemedicine is a viable approach for providing comprehensive healthcare to the patient?	358 (70.8)	235 (71.4)	123 (69.)	2.368	272 (69)	86 (76.8)	3.831	221 (68.8)	137 (74.1)	5.665
Do you think telemedicine saves time?	454 (89.7)	293 (89.1)	161 (91)	0.790	349 (88.6)	105 (93.8)	2.641	288 (89.7)	166 (89.7)	4.063
Do you think telemedicine reduces efforts (routine check-up or continues monitoring etc)?	274 (54.2)	211 (64.1)	123 (69.5)	1.637	268 (68)	66 (58.9)	5.366	218 (67.9)	116 (62.7)	4.423
Do you think that telemedicine is important medical care for the remote and underserved	428 (84.6)	284 (86.3)	132 (74.6)	2.349	292 (74.1)	87 (77.7)	0.618	244 (76)	135 (73)	3.684

area?

Do you think providing telemedicine service can lead to disclosing medical information to people who aren't authorized to do so?	245 (48.4)	153 (46.5)	92 (52)	1.921	185 (47)	60 (53.6)	2.736	161 (50.2)	84 (45.4)	1.345
Do you think telemedicine will improve access to healthcare facilities?	439 (86.8)	283 (86)	156 (88.1)	1.891	333 (84.5)	106 (94.6)	10.99**	280 (87.2)	159 (85.9)	0.177
Do you think telemedicine service is going to be the major change in near-future clinical practice?	431 (85.2)	275 (83.6)	156 (88.1)	1.917	333 (84.5)	98 (8705)	1.971	272 (84.7)	159 (85.9)	0.904

**p<0.01

Table 4. Multiple Regression of Factors Associated with Attitude Towards Telemedicine Use

Model	R	Adj R square	F	Sig.	Coeff.	Std. error	t	Sig.	95% CI for the coeff.	VIF
(Constant)					2.3665	0.1460	16.21	<.0001*	(2.0797, 2.6533)	.
Knowledge					0.0103	0.0094	1.10	0.2721	(-0.0081, 0.0288)	1.3607
Perception	0.5123	0.2551	35.5894	<.0001*	0.1965	0.0181	10.83	<.0001*	(0.1609, 0.2321)	1.3396
Sex					-0.0773	0.0694	-1.11	0.2658	(-0.2137, 0.0590)	1.0597
Majors					-0.0559	0.0679	-0.82	0.4110	(-0.1894, 0.0776)	1.0355
Location					-0.0420	0.0786	-0.53	0.5937	(-0.1964, 0.1127)	1.0299

Table 5: Multiple Regression of Factors Associated with Knowledge of Telemedicine Use

Model	R	Adj R square	F	Sig.	Coeff.	Std. error	t	Sig.	95% CI for the coeff.	VIF
(Constant)					8.3038	0.4917	16.89	<.0001*	(7.3377, 9.2694)	.
Sex					0.9971	0.3747	2.66	0.0080*	(0.2611, 1.7336)	1.0315
Majors	0.1493	0.0170	3.9095	0.0089*	0.5442	0.3709	1.47	0.1430	(-0.1846, 1.2731)	1.0311
Location					-0.4024	0.4289	-0.94	0.3468	(-1.2440, 0.4401)	1.0238