
Editorial

The practice of teleorthodontics

Digital and information technology has radically changed the way society functions and is increasingly governing how humans interact with each other. Like it or not, there is a distinct lack of personal encounter as the public becomes adept in adopting developing technologies and incorporating them into daily life. The advent of telemedicine, defined as the incorporation of technologies and activities that offer new ways to deliver health care, is changing the way health services and information are supplied to patients. It provides opportunities for patients who are homebound, who live at distances from services or are otherwise impeded from seeking care. However, while digital innovation provides significant positive benefits, many of which are administrative, there are concerns regarding the ethics involved.

Chaet et al.,¹ in a review paper that focussed on telemedicine and telehealth, raised issues related to privacy and confidentiality, transparency and informed consent, clinical competence, the continuity of care and the patient/provider relationship. These are significant concerns particularly if the viewer is making treatment decisions solely based on images on a screen. At the very least, the images should be accompanied by a case history and additional information to facilitate a considered opinion.

The Australian Society of Orthodontics has recently released a statement indicating concerns about the practice of teledentistry. A current example of teleorthodontics is the remote supervision of a case under active treatment by the submission to the practitioner of images of the teeth in their current state. The tracking of treatment is assessed to decide whether an appointment is necessary or whether the patient can continue along their current course. The touted benefit to the patient is that time is saved and personal appointment costs are much reduced if surgery attendance is not required. This is all predicated on the ability to adequately assess and diagnose the

state of treatment and make an informed decision. Although there are devices to render image capture consistent, significant variability in image quality and orientation exist that make a positive decision problematic. Who then bears the responsibility if an appliance malfunction occurs or a problem is missed?

Simplistic though it might be, undergraduate students are taught that an orthodontic diagnosis is not possible upon the analysis of a set of study models alone. A full problem-based diagnosis comes from a complete examination of the patient in a clinical, functional and radiographic sense. Is that what happens in teleorthodontics? To ascertain a need for treatment, prospective patients are encouraged to take 'selfies' for submission to a provider who assesses the need for treatment. This need is invariably based on the aesthetics of the case rather than functional concerns, and simply considers the alignment of the teeth with unlikely regard to treatment stability or long-term outcome.

This raises questions regarding competence and fidelity. An assessing practitioner still has an obligation to provide competent care that is accurate and objective. Appropriate clinical qualifications and experience are mandatory, along with proficiency in the use of technology in communicating with patients. Fidelity involves the obligation to place the interests of patients first and requires the clinician to minimise conflicts of interest and bias. Financial and other interests may influence decisions related to commercial websites and should be avoided. The major aims of telehealth and teleorthodontics are to support and promote long-distance health care, increase patient and professional health-related education and improve public health administration. This patient/clinician interaction still demands a level of direct and indirect accountability.

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1. Chaet D, Clearfield R, Sabin JE, Skimming K. Ethical practice in Telehealth and Telemedicine. *J Gen Intern Med* 2017;32:1136-40.