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It is two years since the World Health Organization officially declared that the world was in the grip of a coronavirus (COVID-19) pandemic. Since then, social, health and economic systems have struggled to respond to unprecedented demands and challenges. Anthropologists call such an event a ‘liminal moment in which a given order that is considered normal or desired is dissolved, breaks down, and is affected by a decomposition or unbalance that needs to be restored’ (Visacovky 2017, p. 7). Many of these disruptions transformed our everyday lives resulting in a deceleration of everyday life, the shrinkage of social spaces, the collapsing of work and domestic spaces, and the closure of schools and businesses. One welcome outcome of this chaos has been the role digital technologies have and continue to play in mitigating the personal and social uncertainties associated with this crisis. Digital and social media are allowing us to maintain some level of social contact and economic activity (work or school attendance) amid lockdowns and social distancing (Fuchs 2020, p.396). Many commentators have remarked that we are currently living in an age of accelerated digitalization (Caldwell and Krishna 2020, Eurofound 2021). In fact, it has been estimated that human society went through the equivalent of 7 years technological innovation and change in the first 9 months of Covid-19 (LaBerge et al 2020).

For healthcare, this process of accelerated digitalization had several impacts. Prior to the COVID pandemic, many scholars were convinced that technological innovation, especially digital technology, would deliver social transformation and benefits for all. Digital health was assumed to offer a more effective and less expensive healthcare system compared to current forms of healthcare (Urban 2019). Digital health is also deemed to promote and encourage self-responsibility through self-tracking devices (Lupton 2017, p.2). During the pandemic, the prospect of a digitally mediated healthcare was no longer a theoretical argument. Telehealth and health data management systems (e.g. Track and trace, modelling projections) were shown to deliver tangible and increased efficiencies in the administration of healthcare (Hogan et al 2020). In dentistry too, teledentistry offered a vital lifeline for the safe delivery of oral healthcare, for patients and staff alike (e.g. Rahman et al 2020). Normative expectations about the clinical competency of dental students also had to ‘pivot’ to the educational pressure presented by having limited or no access to patients (see Belluigi et al 2020). Dental schools, and their staff had to improvise and adapt pedagogically by either embracing the design principles of online learning or commit to the establishment of a fallow year. (e.g. Cheng et al 2021, Farrokhi et al 2021, British Dental Journal Special Collection on Dentistry and Coronavirus, 18 March 2022).

Running parallel to this self-congratulatory and utopian version of digital dentistry lies a shadow side to digital dentistry. There have been strong voices of dissent and disapproval from patient groups and concerned citizens of how digital technologies reproduced and exacerbated existing inequalities regarding access to oral care (Healthwatch 2020, GDC 2020). These challenges also resulted in a 40 million dental appointment backlog, throwing into sharp focus the uneven distribution of NHS dental services and the barriers of access to dentistry for many groups in UK. (Haynes 2020, Woods 2020, Burn 2022).

A recent Healthwatch report clearly documents how stressful and disingenuous teledentistry can be for patients (Healthwatch 2020).

I lost a filling right at the start of lockdown - phoned my dentist and was told to buy some temporary tooth repair paste. I had a check-up appointment for May which was postponed to December. The dentist re-opened in June but was only dealing with emergencies. I have phoned...
them a few times but still get told they are only dealing with emergencies. Yesterday (9 September) they told me that (a) they are not dealing with anyone on ‘my’ list (i.e. needing treatment but not in pain) and that (b) they will have to cancel my December appointment. I am in despair.” Experience reported to Healthwatch England

The patient was undergoing dental treatment pre-Covid-19 (fillings and root canal) but due to the outbreak the treatment was paused. She then had toothache. The pain was manageable, but the patient felt that the longer she left it her teeth could get worse. The practice has only been seeing emergency patients, but the dentist did prescribe antibiotics. He said that once the pain subsides, she could have an appointment. At the appointment her teeth were x-rayed, and it was confirmed that she needed root canal treatment. The dentist said that he wasn’t going to do it and that she should have this treatment privately at another practice. His reason was that root canals take too long, and he wanted to focus on seeing patients that required fillings, check-ups - basically short appointments.” Healthwatch Birmingham

Some may read these testimonies and their adverse experiences of oral health care as evidence of the human cost associated with the ‘ethics of triage’ (Shaw 2020) and the types of ethical dilemmas created where the competition for and allocation of resources in a time of scarcity allows for such accommodations as the medical reclassification of patients into being ‘deserving’ and ‘undeserving’ of treatment (Kipnis 2003) to the suspension of specialist services(e.g. Aseem et al 2020). However, we know that the ethics of triage are associated with redistributive justice (Kipnis 2003), or the (uneven) distribution of resources in society. Furthermore, as COVID-19 scholarship matures and has further opportunities for ‘reflections-in-action’(Schon 1991), it is finding that issues of equality/inequality are strongly grafted onto the ‘digital transformation debate’(Bellugi et al 2020). It is widely acknowledged that pre-existing social and health inequalities becoming more entrenched and divisive because of COVID-19 and the management (e.g. Public Health England, 2020; Raharja, Tamara and Kolt, 2020; Sze et al., 2020). Teledentistry does not extinguish pre-existing structural disadvantage, but creates additional disadvantages, especially for older populations. A survey conducted by GDC on patient experiences of the pandemic found(Community Research 2020) only 43% of respondents were aware of the existence of urgent dental care centres during the first lockdown, 25% did not know whether some, all or no dental practices were open for patients at the time of the questionnaire. Only 7% of respondents over the age of 65 sought out dental services information online, compared to 18% of 18-34 year olds. Digital dentistry then has the capacity to reproduce and create additional barriers to access, ones that echo the digital divides that already criss-cross society (e.g. Davidson 2018, Holmes and Burgess 2021). Interestingly, reflections on the material inequalities created by teledentistry are often curiously absent from systematic reviews of teledentistry (Bhargarva et al 2021, Deshpande et al 2021).

The ongoing COVID-19 pandemic has given us an opportunity to reflect on how healthcare is organized, and motivate us to make improvements, in the name of public health(see Asimakopoulou et al 2021). Living through this natural experiment of change has demonstrated that digital health delivers technological innovation in the delivery and organization of primary care. However, these ‘efficiencies’ also have social and ethical consequences which exacerbate rather than ameliorate inequalities of access. Advocates of digital dentistry would be well served to always remember that technological innovation have salient social and ethical dimensions, and to plan for these immediate and wider-reaching implications accordingly when designing and implementing digital health projects.
References


