



Orthodontist-Patient Communication: A Cross-Sectional Study among Private Practitioners

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Abstract

Introduction: Communication between the orthodontist and the patient is a cornerstone of therapeutic success, shaping adherence, satisfaction, and cooperation throughout treatment. Emerging tools such as teleorthodontics and social media offer new opportunities for improvement, yet their place in daily practice remains poorly defined. This study aimed to assess orthodontists' communication practices, identify their limitations, and explore avenues for improvement. **Materials and Methods:** A cross-sectional study was conducted among orthodontists in private practice in Casablanca. Of 304 orthodontists identified in the registry of the National Council of the Order of Dentists of Morocco and invited to participate, 102 returned complete, analyzable questionnaires (response rate 33.6%). Data were collected through an anonymous, self-administered questionnaire. **Results:** Most practitioners (77.5%) saw their patients on a monthly basis and favored direct face-to-face communication (88.2%). The first consultation lasted 10 to 20 minutes for 59.8% of respondents, yet visual aids were used systematically by only 43.1% of practitioners. Teleorthodontics remained underused (29.4%), despite being perceived as useful for aligner monitoring and initial consultations. The main areas of patient misunderstanding involved oral hygiene (68.6%), treatment duration (44.1%), and appliance maintenance (42.2%). Overall, 51% of orthodontists perceived their patients as satisfied with the communication provided, and 50% considered treatment adherence satisfactory. Post-treatment follow-up was maintained by 72.5% of practitioners, though with highly variable modalities. Finally, most practitioners expressed a need for more comprehensive visual aids (71.6%) and digital applications (52%) to strengthen communication. **Discus-**

sion: Our findings were compared with results from studies conducted in other countries, and recommendations were proposed to improve communication between orthodontists and patients, both within the practice and remotely. These recommendations offer perspectives for optimizing patient interactions, enhancing remote support, and ultimately improving orthodontic treatment outcomes while ensuring their long-term stability through regular follow-up.

Conclusion: Optimizing orthodontic communication requires clearer structuring of consultations, the systematic use of visual and digital tools, and ongoing practitioner training. Such improvements would strengthen patient cooperation, satisfaction, and treatment durability, positioning orthodontic practice within a modern, ethical, and patient-centered approach.

Subject Areas

Dentistry

Keywords

Orthodontist-Patient Communication, Treatment Compliance, Patient Satisfaction, Teleorthodontics

1. Introduction

Communication originates from the Latin term *Communicare* and signifies Sharing: Making something common or transmitting something, Transmission: The act of expressing one's thoughts or feelings through speech, writing, gesture, and facial expression, with the aim of being understood, Relationship: The act of establishing a relationship with another person.

The concept of communication is broader and more complex than that of information. Information can be defined as that which suppresses or reduces uncertainty without provoking an immediate feedback response. Communication is an exchange and a relationship between two or more people. It is a dynamic process in movement, which evolves the situation [1].

In orthodontic practice, effective and coherent communication between practitioners, patients, and support staff is essential for achieving successful treatment outcomes. Clear, goal-oriented communication helps establish trust and enables patients and their families to understand treatment objectives, follow instructions, and feel confident throughout their care journey. However, misunderstandings, unmet expectations, and inconsistent advice can create obstacles that hinder progress and lead to patient dissatisfaction. A structured communication strategy, beginning from the first consultation and reinforced throughout treatment, has become increasingly crucial for maintaining alignment between the patient and orthodontist [2].

Tele-orthodontics and social media have emerged as innovative solutions to bridge communication gaps, offering increased accessibility and regular contact

points between patients and practitioners. Tele-orthodontic platforms, including video calls and secure messaging applications, allow orthodontists to provide consultations, share treatment progress, and address concerns in real-time or asynchronously. This approach is particularly valuable for patients facing logistical challenges in attending frequent in-office appointments or requiring regular follow-up to maintain compliance. The increased use of telecommunications since the COVID-19 pandemic has demonstrated that virtual interactions can effectively mitigate many difficulties associated with traditional consultations and reduce appointment frequency.

In addition to tele-orthodontics, social media platforms represent a unique medium for continuous engagement and patient education. Social networks enable orthodontists to disseminate educational content, maintain regular contact with patients outside formal appointments, and foster a sense of connection by sharing information asynchronously. This approach not only enhances compliance but also reinforces transparency, potentially reducing misunderstandings regarding treatment objectives and therapeutic progress.

Despite advances in tele-orthodontics and social media utilization within orthodontic practice contexts, empirical research remains limited. Previous investigations have explored factors influencing patient compliance, such as pain tolerance, appointment adherence, and communication with healthcare providers. However, few studies have specifically examined the impact of virtual communication methods on patient adherence to appliance-wear directives, hygiene practices, and treatment instructions.

Therefore, the objective of this study is to characterize, from the perspective of private practitioners in Casablanca, the modalities of orthodontist-patient communication and their perceptions regarding the influence of communication strategies on therapeutic success.

2. Materials and Methods

This was a descriptive cross-sectional observational study conducted among orthodontists working in private practice in Casablanca, Morocco. The aim was to assess the communication methods used between orthodontists and patients, as well as practitioners' perceptions of the impact of communication on treatment adherence and therapeutic success.

The target population consisted of dental practitioners specialized in orthodontics and working in private practices in Casablanca. Orthodontists were included if they were practicing in the private sector in Casablanca, registered with the professional council, and agreed to participate in the survey. Practitioners working outside Casablanca, those working exclusively in the public sector, and incomplete or unusable questionnaires were excluded from the analysis.

The list of orthodontists practicing in Casablanca was obtained from the registry of the National Council of the Order of Dentists of Morocco and comprised 304 practitioners who met the eligibility criteria. All 304 identified orthodontists

were invited to take part in the survey. A total of 102 practitioners returned complete and analyzable questionnaires, corresponding to a response rate of 33.6%.

Data collection was carried out over a six-week period, from January 17 to February 28, 2026.

Data were collected using a structured, self-administered questionnaire developed based on the objectives of the study and available data from the literature. The questionnaire included several sections covering practitioners' professional characteristics, the communication methods used with patients, the use of digital tools, tele-orthodontics and social media, as well as practitioners' perceptions of the impact of communication on treatment adherence, oral hygiene, appliance wear, and treatment success. The questionnaire comprised 31 items organized into six sections: (A) general information on the practitioner (years of experience, type of practice, and consultation frequency); (B) communication practices (channels used for appointments and reminders, time devoted to consultations and treatment visits, content addressed, use of visual aids, tele-orthodontics, perceived patient comprehension, and post-treatment follow-up); (C) communication of clinical information (risks, emergencies, and social-media content); (D) communication challenges; (E) perceived patient satisfaction and treatment adherence; and (F) suggestions for improvement. Items comprised single- and multiple-choice questions, five-point Likert scales (1 = very low to 5 = very high), and frequency scales (from "very often" to "never"), together with a few open-ended questions. No composite score was computed; all responses were summarized as frequencies and percentages. The full questionnaire is provided as Supplementary Material.

Before distribution, the questionnaire was pretested among a small group of orthodontists to assess the clarity, comprehensibility, and relevance of the questions. Feedback obtained during this pretest was used to make the necessary adjustments before final administration.

The orthodontists were contacted by telephone, email, or directly at their private practices. After the study objectives had been explained, the questionnaire was provided in paper and/or electronic format.

Participation was voluntary and anonymous. Practitioners were free to decline participation or withdraw from the study at any time. Returned questionnaires were checked before data entry in order to exclude incomplete or unusable responses.

The collected data were entered and analyzed using SPSS software. A descriptive analysis was performed. Qualitative variables were expressed as frequencies and percentages. Quantitative variables were described using the mean and standard deviation when normally distributed, or the median and interquartile range otherwise.

The study was conducted in accordance with the principles of anonymity, confidentiality, and voluntary participation. No identifying information was collected from the participants. Participation in the survey was based on the respondents'

free and informed consent.

3. Results

The study sample consisted of 102 practitioners, of whom 89 (87.3%) had a multidisciplinary practice. In terms of professional experience, 37.3% of practitioners surveyed had less than 5 years of practice, while 21.6% had more than 20 years of experience. Regarding the average frequency of consultations per patient, 77.5% of practitioners opted for one session per month.

Regarding how appointment dates were communicated to patients, 88.2% of practitioners communicated them directly face-to-face, while 64.7% did so by phone. For appointment reminders, 80.4% of practitioners used the phone. During the first consultation, regarding time spent communicating with the patient, 59.8% of practitioners spent between 10 and 20 minutes explaining the treatment.

During the first consultation, 90.2% of practitioners discussed the importance of oral hygiene and the methods to adopt with their patients, and 85.3% addressed the duration of treatment. For 45.1% of practitioners, the average time spent on treatment/care appointments was between 10 and 20 minutes. To explain treatment procedures, 43.1% of practitioners reported always using visual aids (photos, X-rays, 3D models).

Among the 102 practitioners surveyed, 29.4% reported using teleorthodontics in their practice. Among the 30 orthodontists who used teleorthodontics, 66.67% used it for initial consultations and 53.3% for monitoring aligner treatments. According to the responses of 102 orthodontists, 52.9% rated patients' understanding of their explanations as satisfactory.

Concerning the frequency of patient questions and the impact of effective communication on their experience, the results are presented in **Table 1**.

According to 38.2% of practitioners, discussing current events with patients could sometimes influence their cooperation. For 44.1% of practitioners, patient expectations very often influenced their treatment plan.

Regarding communication obstacles, patients' non-compliance with care instructions, and the main areas of misunderstanding, the results are summarized in **Table 2**.

Practitioners' perceptions of patient satisfaction, treatment adherence, and the adequacy of information provided were also assessed and are presented in **Table 3**.

Post-treatment follow-up was maintained by 72.5% of practitioners, most commonly every six months (52.6%) or annually (26.3%), and was carried out mainly through face-to-face visits (70.3%) rather than digital channels. When follow-up was not maintained, practitioners most often cited patient disengagement once visible results had been achieved, a problem-driven model of care, and the absence of automated reminder systems.

During follow-up, risk communication focused mainly on caries (89%), relapse (69%), and root resorption (44%), whereas periodontal damage and general treatment-related information were mentioned less frequently.

Communication regarding emergencies concentrated on bracket or wire debonding (92%), aligner fracture (53%), and appliance loss (50%), with less systematic attention to pain or discomfort.

Regarding social media, 52.9% of practitioners reported using it mainly to share before-and-after cases, 36.3% for practical advice, and 14.7% for promotional content, while 30.7% did not use social media at all.

When asked how communication could be improved, practitioners expressed a preference for enhanced visual aids (71.6%), digital tools such as applications or follow-up emails (52%), clearer brochures (33.3%), and communication training (18.6%); a small minority (2%) considered that nothing could replace direct human interaction.

Table 1. Frequency of patient questions and the impact of effective communication on their experience.

VARIABLES	(N)	(%)
Frequency of questions asked by patients at the start of treatment:		
Very often	64	62.7
Often	30	29.4
Sometimes	7	6.9
Rarely	1	1
Never	0	0
Frequency of questions asked by patients during treatment:		
Very often	13	12.9
Often	36	35.3
Sometimes	44	43.1
Rarely	9	8.8
Never	0	0
Impact of effective communication on patient experience:		
Helps reinforce the patient's sense of trust and comfort	84	83.3
Can reduce fears and improve overall patient experience	52	51
Other	2	2
No impact on patient discomfort	1	1

Table 2. Obstacles in communication, non-compliance with care instructions, and areas of misunderstanding.

VARIABLES	(N)	(%)
Main obstacles:		
Complexity of medical terms	42	41.2
Lack of patient interest	38	37.3
Lack of time	32	31.4
Patient stress or anxiety	32	31.4
Language barrier	12	11.8
Other	1	1
Patients' non-compliance with care instructions:		
Very often	27	26.5
Often	44	43.1
Sometimes	29	28.4
Rarely	1	1
Never	1	1
Areas of misunderstanding:		
Hygiene methods	70	68.6
Estimated treatment duration	45	44.1
Appliance maintenance	43	42.2
Pain or possible discomfort	29	28.4
Cost	26	25.5
Care/treatment	25	24.5
Payment terms	15	14.7
Other	0	0

Table 3. Practitioners' perceived assessment of patient satisfaction, treatment adherence, and information adequacy.

VARIABLES	(N)	(%)
Overall assessment of patient satisfaction with information communication:		
Very low	2	2
Low	3	2.9
Average	29	28.4
Satisfactory	52	51
Very satisfactory	16	15.7

Continued

Overall assessment of patient adherence to treatment after communication:		
Very low	0	0
Low	2	2
Average	41	40.2
Satisfactory	51	50
Very satisfactory	8	7.8
Estimation of adequate patient information regarding the course of their treatment:		
Yes, completely	33	32.4
Rather yes	66	64.7
Rather no	3	2.9
No, not at all	0	0

4. Discussion

Most practitioners in our sample (77.5%) scheduled one session per patient per month, communicated appointment dates mainly face-to-face (88.2%) or by phone (64.7%), and relied on the telephone for reminders (80.4%). In a randomized controlled trial conducted in Jordan, Al-Abdallah *et al.* (2021) found no statistically significant difference between traditional and digital channels for conveying appointment and treatment information, suggesting that the consistency of the message matters more than the medium itself [3].

The first consultation emerged as a pivotal moment for communication. Most practitioners (59.8%) devoted 10 - 20 minutes to the first consultation, during which 90.2% addressed oral hygiene and 85.3% discussed treatment duration. Mehra *et al.* (1998) showed that educating patients on the consequences of poor cooperation, expected outcomes, and the value of a strong interpersonal bond improves long-term adherence, while parental involvement is particularly important for younger patients [4]. Hiemstra *et al.* (2009) similarly emphasized that communication should be adapted to the patient's age rather than directed at parents alone, while still clarifying expectations and providing detailed guidance on anticipated discomfort [5]. Visual aids—used systematically by 43.1% of our respondents—play a comparable role: Chiang *et al.* described a 3D simulation system that improves comprehension and aligns expectations with realistic outcomes [6]. Thomson *et al.* (2001) recommended reinforcing verbal explanations with written or visual material, particularly regarding hygiene, daily-life impact, and retention [7], while Ackerman and Proffit (1995) stressed the importance of shared decision-making, clarity, and reassurance in informed consent [8]. More recent work by Perry *et al.* (2021), based on a Delphi survey of UK orthodontists, identified ten risks that should systematically be disclosed, including deminerali-

zation, relapse, and root resorption [9]; Karkazi *et al.* (2024) added that risk prioritization varies culturally, with Greek and Slovak orthodontists emphasizing different concerns [10].

Comprehension followed a similar pattern: 52.9% of practitioners rated patient understanding as satisfactory, and patients asked questions far more often at the start of treatment (62.7% “very often”) than during it (35.3% “often”), reinforcing the importance of the initial visit while underscoring the need for sustained communication thereafter. Maestre *et al.* (2016) linked comprehension directly to treatment acceptance and realistic expectations [2], and Sinha *et al.* (1996) showed that active listening and detailed explanation strongly predict patient participation [11]. Yet time pressure remains a concern: while 45.1% spent 10 - 20 minutes per treatment visit, 38.2% reported time sufficient only for the technical procedure itself, despite 83.3% of practitioners believing communication strengthens trust and comfort and 51% believing it reduces fear—revealing a gap between stated conviction and actual practice time. This gap is not trivial, as Klages *et al.* (1992) showed that the orthodontist’s verbal behavior during routine orthodontic visits is directly associated with patients’ communicative cooperation [12].

Teleorthodontics, which expanded considerably during the COVID-19 pandemic, was used by only 29.4% of practitioners, mainly for initial consultations (66.7%) and aligner follow-up (53.3%). These figures align closely with international data: Kayalar and Küçük Kurt (2023) and Park *et al.* (2021) both described pandemic-driven growth concentrated on remote monitoring and initial assessment, tempered by technical and legal constraints [13] [14], while Abu Arqub *et al.* (2024) found that many AAO members recognize its value yet remain hesitant to adopt it routinely [15]. Saccomanno *et al.* (2020) and Homsy *et al.* (2023) noted growing post-pandemic interest limited by traditional clinical preferences and insufficient training [16] [17], whereas Lo Giudice *et al.* (2022) viewed teleorthodontics more favorably, as a complementary tool that enables early complication detection, reduces unnecessary visits, and strengthens patient engagement and organizational efficiency [18].

Non-clinical exchange also shaped cooperation: 38.2% of practitioners felt conversation about everyday topics sometimes improved it, consistent with Maestre’s (2016) emphasis on the human relationship as foundational to care [2]. Patient expectations very often influenced treatment plans for 44.1% of respondents, echoing McKeta *et al.* (2021), who called for balancing clinical rigor with growing attention to patient-centered goals [19].

Post-treatment, 72.5% of practitioners maintained regular contact, most commonly every six months (52.6%) or annually (26.3%), largely through face-to-face visits (70.3%) rather than digital channels—reflecting both the clinical need for visual assessment of retention and limited adoption of orthodontic-specific apps, as documented by Prithiviraj (2023) and Nelson (2015), and a generally promotional rather than therapeutic use of platforms like Instagram (Yavan, 2024) [20]-[22]. Where follow-up was absent, practitioners most often cited patient disen-

agement once visible results were achieved, a largely reactive model of care limited to problem-driven visits, and a lack of automated reminder systems. During follow-up, risk communication centered on caries (89%), relapse (69%), and root resorption (44%), while broader risk categories—periodontal damage, general treatment information—were rarely mentioned, despite Perry’s (2021) call for systematic, standardized disclosure of at least five core risks [9] and Karkazi’s (2024) emphasis on culturally adapted communication [10]. Emergency-related communication followed a similar pattern, concentrated on bracket or wire debonding (92%), aligner fracture (53%), and appliance loss (50%), with less systematic attention to pain or discomfort—despite Baidas (2020) showing that unanticipated discomfort can undermine engagement and even lead to treatment abandonment [23].

Digital communication strategies varied widely: 52.9% of practitioners used social media mainly to share before/after cases, 36.3% for practical advice, and 14.7% for promotional content, while 30.7% did not use social media at all—patterns broadly consistent with Yavan (2024) and Prithiviraj (2023), who described social platforms as serving both image-building and patient education functions, albeit inconsistently applied [20] [22]. The main barriers to effective communication identified by practitioners were the complexity of medical terminology (41.2%), lack of patient interest (37.3%), time pressure and patient anxiety (31.4%), and language barriers (11.8%)—only 6% reported no communication difficulties at all. These findings mirror Chiang *et al.* (2023), who advocated visual and interactive tools to simplify technical language [6], and Mehra (1998), who linked patient motivation directly to comprehension [4].

Non-compliance with care instructions, particularly around hygiene, was frequently reported (43.1% “often”), with hygiene methods identified as the leading source of patient misunderstanding (68.6%). Le Foulter *et al.* (2021) showed that active, kinesthetic instruction improves adolescent compliance more than passive methods [24], while Al-Abdallah *et al.* (2021), in a randomized controlled trial, found that adding weekly digital messages to traditional communication produced only a slight, statistically non-significant improvement in compliance, indicating that message consistency matters more than the channel used [3]. Sinha (1996) further linked relationship quality—listening, clarity, availability—to both satisfaction and compliance [11]. Consistent with this, practitioner-perceived patient satisfaction and treatment adherence were both rated “satisfactory” by roughly half of respondents (51% and 50%, respectively), though only a minority reported very high satisfaction (15.7%) or very good adherence (7.8%), in line with Wong (2018) and Sinha (1996), who linked communication quality directly to satisfaction and engagement [11] [25].

Despite this generally positive self-assessment—64.7% of practitioners believed their patients were well informed about treatment progress—McKeta (2012) cautioned that practitioners often overestimate patient comprehension relative to what patients actually report, since the volume of information delivered matters

less than how well it is retained and understood [19]. This gap underscores the value of practitioners critically reassessing their own communication practices.

Finally, when asked how communication could be improved, practitioners expressed a clear preference for enhanced visual aids (71.6%), digital tools such as apps or follow-up emails (52%), clearer brochures (33.3%), and communication training (18.6%), with a small minority (2%) insisting that nothing replaces direct human interaction. These priorities align with Chiang (2023), Al-Abdallah (2021), and Maestre (2016), all of whom emphasized that visual, digital, and team-consistent communication strategies improve comprehension, adherence, and overall patient experience [2] [3] [6].

Strengths and Limitations of the Study

This descriptive, exploratory study offers a current overview of communication practices among orthodontists in Casablanca. The questionnaire was grounded in established scientific references and pre-tested for clarity, supporting both content validity and consistency with the international literature.

Several limitations should nonetheless be considered. The descriptive design precludes causal inference, allowing only the identification of trends and associations. Although participants were randomly selected, the sample remains limited to private-sector practitioners in a single region, restricting generalization to the wider orthodontic population. The response rate was relatively low—102 of 304 practitioners contacted (about 33%)—raising the possibility of selection bias, as respondents may have had a particular interest in communication. The self-reported nature of the questionnaire also exposes the data to recall and social desirability bias. Finally, the study reflects only the practitioner's perspective, without capturing the patient's point of view, which limits the objectivity of conclusions regarding satisfaction and communication effectiveness.

Despite these limitations, this study provides a meaningful contribution to understanding orthodontic communication practices in Morocco and offers a foundation for future comparative or longitudinal research incorporating the patient perspective alongside objective evaluation tools.

5. Conclusions

This study highlights the central role of communication in the success of orthodontic treatment among private practitioners in Casablanca. Beyond technical skill, treatment outcomes depend on a structured, personalized, and continuous patient-practitioner relationship that shapes adherence, satisfaction, and clinical results. While most orthodontists recognize the value of effective communication, disparities persist in the methods used, time allocated, and consistency of information delivered—particularly during the first consultation, appointment reminders, risk disclosure, and post-treatment follow-up. Teleorthodontics and digital tools, despite their recognized potential, remain underused, and social media, while valuable for patient education and professional image, requires ethical and

targeted use.

These findings call for a shift toward a more humanized, pedagogical, and technologically adapted orthodontic practice—one that integrates visual aids, strengthens follow-up protocols, tailors communication to individual patient profiles, and trains teams in clinical and intercultural communication. Ultimately, successful orthodontic treatment relies not only on clinical competence but, just as importantly, on the quality of the therapeutic alliance built through clear, empathetic, and sustained communication. The orthodontist of tomorrow must be as much an educator and communicator as a clinician.

Conflicts of Interest

The authors declare no conflicts of interest.

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