

Practice Guidelines for Teledermatology in Australia: 2025 Update.

Title: Practice Guidelines for Teledermatology in Australia: 2025 Update.

Publication year: 2025

Journal: The Australasian journal of dermatology

Authors: Centre for Online Health, The University of Queensland, Brisbane, Queensland, Australia.

Society: European Respiratory Society

Origin country: International (Europe)

Target countries: Europe

DOI: 10.1111/ajd.14599

PMID: 40936368

Source: <https://pubmed.ncbi.nlm.nih.gov/40936368/>

pmc Australas J Dermatol Australas J Dermatol 379 blackwellopen 0135232 AJD The Australasian Journal of Dermatology 0004-8380 1440-0960 pmc-is-collection-domain yes pmc-collection-title Wiley Open Access Collection PMC12687672 PMC12687672.1 12687672 12687672 40936368 10.1111/ajd.14599 AJD14599 9728688 1 Clinical Guidelines Online Only Clinical Guidelines Practice Guidelines for Teledermatology in Australia: 2025 Update Caffery Liam J. <https://orcid.org/0000-0003-1899-7534> 1 2 3 I.caffery@uq.edu.au Taylor Monica L. <https://orcid.org/0000-0001-5333-2955> 1 2 Abbott Lisa M. <https://orcid.org/0000-0002-4005-8421> 4 5 6 Janda Monika <https://orcid.org/0000-0002-1728-8085> 2 Guitera Pascale <https://orcid.org/0000-0001-9519-110X> 7 8 9 Mar Victoria <https://orcid.org/0000-0001-9423-3435> 4 10 11 Bennett Haley <https://orcid.org/0000-0002-3928-531X> 4 Arnold Chris 4 12 13 Shumack Stephen <https://orcid.org/0000-0002-9121-7795> 4 Caccetta Tony <https://orcid.org/0009-0006-7097-3758> 14 Miller Robert 4 Soyer H. Peter <https://orcid.org/0000-0002-4770-561X> 3 1 Centre for Online Health The University of Queensland Brisbane Queensland Australia 2 Centre for Health Services Research The University of Queensland Brisbane Queensland Australia 3 Frazer Institute The University of Queensland, Dermatology Research Centre Brisbane Queensland Australia 4 The Australasian College of Dermatologists Sydney New South Wales Australia 5 The Skin Hospital Sydney New South Wales Australia 6 Medical School University of New South Wales Sydney New South Wales Australia 7 Faculty of Medicine and Health The University of Sydney Sydney New South Wales Australia 8 Sydney Melanoma Diagnostic Centre Royal Prince Alfred Hospital Camperdown New South Wales Australia 9 Melanoma Institute Australia The University of Sydney Sydney New South Wales Australia 10 Victorian Melanoma Service, Alfred Health Melbourne Victoria Australia 11 School of Public Health and Preventive Medicine Monash University Melbourne Victoria Australia 12 Australasian Society of Cosmetic Dermatologists Melbourne Victoria Australia 13 BioGrid Australia Parkville Victoria Australia 14 School of Medicine The University of Western Australia Perth Western Australia Australia * Correspondence: Liam J. Caffery (I.caffery@uq.edu.au) 12 9 2025 12 2025 66 8 502105 10.1111/ajd.v66.8 e553 e564 28 8 2025 02 6 2025 01 9 2025 09 12 2025 10 12 2025 10 12 2025 © 2025 The Author(s). Australasian Journal of Dermatology published by John Wiley & Sons Australia, Ltd on behalf of Australasian College of Dermatologists. <https://creativecommons.org/licenses/by-nc-nd/4.0/> This is an open access article under the terms of the <http://creativecommons.org/licenses/by-nc-nd/4.0/> License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made. **ABSTRACT** In 2020, [the Australasian College of Dermatologists] released its first teledermatology practice guidelines for Australia, with a commitment to regular updates. This article presents the revised guidelines, aimed at educating dermatologists on the benefits and limitations of telehealth, while promoting safer, higher-quality patient care. The updated guidelines harmonise with the Medical Board of Australia's 2023 telehealth guidelines. They address the growing use of telephone consultations—boosted by Medicare subsidies introduced during the COVID-19 pandemic. The latest guidelines provide

recommendations on the appropriate choice of modality (telephone versus video) for teleconsultation. They also include updated guidance on clinical image acquisition. The guidelines are divided into two parts: (1) core recommendations and (2) supporting notes for practical application. Topics covered include teledermatology modalities, patient selection and consent, imaging standards, quality and safety, privacy and security, communication, and documentation, including image retention.

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Converter:WILEY_ML3GV2_TO_JATSPMC version:6.6.6 mode:remove_FC converted:09.12.2025
Funding: This work was supported by Australasian College of Dermatologists.

These guidelines aim to inform dermatologists practicing in Australia of best practice in teledermatology and provide guidance to standardise and support the appropriate, safe, and effective use of teledermatology in the provision of patient care. They supersede the guidelines originally published in 2020 [1].

The Medical Board of Australia (MBA)'s 'Good Medical Practice: A Code of Conduct for Doctors in Australia' (Good Medical Practice) describes what is expected of all doctors registered to practice medicine in Australia [2]. The application of Good Medical Practice will vary according to individual circumstances, but the principles should not be compromised. These principles are equally valid for technology■based models of medical practice as they are for traditional in■person models.

In addition to the Good Medical Practice, the 'Practice Guidelines for Teledermatology in Australia' complement the MBA's 'Guidelines: Telehealth consultations with patients' [3], the Australian Medical Association's guidelines 'Clinical images and the use of personal mobile devices' [4], and the Australasian College of Dermatologists' Position Statement on the Use of Artificial Intelligence in Dermatology [5]. They are designed to take account of the changing models of care for delivery of dermatological services and work practices of dermatologists, in particular the use of smartphones to capture and transmit clinical information.

The guidelines have been developed by [The University of Queensland's Centre for Online Health] in collaboration with [the Australasian College of Dermatologists]'s Digital Health Committee and have been approved by [the Australasian College of Dermatologists]. To support their development, a review of the literature and relevant national and international guidelines relating to teledermatology was undertaken to reflect current evidence supporting best practice, tailored for the Australian healthcare setting [6].

These guidelines are divided into two sections. Guidelines for dermatologists practising teledermatology.

A series of Notes to support dermatologists in following the Guidelines. These include detailed information on the types of steps dermatologists and referrers can take when feasible and practical to do so.

The Notes cover the following topics: Appropriate technology, environment and practices to ensure quality, confidentiality and privacy

Requisite quality of information—Clinical image acquisition and review

Medical records—Storing clinical images securely

A glossary of terms and abbreviations used in the Guidelines is outlined in Table 1 .

These guidelines are for use by specialist dermatologists practising in Australia.

Teledermatology should only be practised by a dermatologist credentialed to practise traditional in-person dermatology. They should: Be registered with the Australian Health Practitioner Regulation Agency (AHPRA).

Have specialist registration with AHPRA.

Be registered with the Medical Board of Australia.

Be a Fellow of the Australasian College of Dermatologists.

Accredited trainees with the Australasian College of Dermatologists may engage in teledermatology under the supervision of a dermatologist as defined above.

These guidelines may also be a useful resource for primary care practitioners and other medical specialists in understanding the technical, clinical, and medico-legal considerations of best practice teledermatology.

The guidelines cover the use of teledermatology for a consultation with a patient, whether referred by another practitioner or self-referred, providing advice to a clinician managing a patient, including informal advice, and for the purposes of triaging a patient or long-term follow-up of a patient. These guidelines apply to store-and-forward (SAF), real-time videoconsultation (RTVC), real-time telephone consultation (RTTC), and the hybrid use of multiple modalities of teledermatology.

Teledermatology consultations may be provided outside of typical referral from other medical practitioners—for example: When the patient self-refers (often known as direct-to-consumer teledermatology).

When the dermatologist provides long-term follow-up to their patients.

Subject to appropriate assessment of the patient and other relevant circumstances, these guidelines may apply to one or more categories of teledermatology. The categories used in these guidelines are listed in Table 2 .

Used as a substitute or an adjunct to an in-person consultation.

Patient consents to the use of telehealth.

Patient would attend the consultation if done by RTVC, RTTC or hybrid methods.

Dermatologist must have received a valid referral to be eligible for Medicare rebates (see Australian Medical Association summary of valid referrals [7] for specialist care).

Used to provide advice to a clinician managing a patient without the managing clinician referring the patient.

Communication is typically between the managing clinician and dermatologist and the patient may not attend the consultation.

Clinician managing the patient would ordinarily be responsible for follow up care.

Used to provide dermatology services directly to the patient.

May use any modality of telehealth. However, store and forward of patient acquired images is the most common model of care.

Used to assess the need and urgency of dermatological care.

A referral for dermatological care from a referring clinician is reviewed by a dermatologist prior to seeing the patient.

The dermatologist then makes and communicates a management plan which may include the following options: schedule for in person consultation with appropriate urgency, direct booking for procedure or surgery, management of the patient by the referrer without a need for further dermatologist advice, management of the patient by the referrer and subsequent review by the dermatologist, or discharge without need for follow up.

When the dermatologist recommends the referrer manage the patient, a treatment plan should be included in the response.

Triage teledermatology typically uses store and forward.

Used to provide triage advice to a clinician managing a patient without the managing clinician referring the patient.

Communication is typically between managing clinician and dermatologist.

The clinician managing the patient is responsible for follow up care.

These guidelines support dermatologists practising teledermatology. The medico legal risk mitigation strategies include: Confirming that their indemnity insurance covers telehealth.

Using telehealth only for patients who meet appropriate criteria and have provided informed consent.

Using open disclosure practices as outlined in the Australian Open Disclosure Framework [8].

Keeping accurate and contemporaneous records.

Adhering to all relevant practice guidelines.

Taking into account the limitations of telehealth, such as not being able to perform a physical examination or limitations in the technology, when making the diagnosis or recommending treatment.

Choosing good quality telehealth technology and optimising this technology.

Choosing the appropriate modality for telehealth.

Taking reasonable steps to ensure patient privacy.

In an emergency, it may not be possible to practise according to these guidelines. If an alternative is not available, a teledermatology consultation or investigation should be as thorough as possible and lead to more suitable arrangements for the care and follow-up of the patient.

Dermatologists practicing teledermatology should:

Ensure they have sufficient knowledge and understanding of teledermatology to allow them to appropriately select patients and visits suitable for teledermatology, and sufficient knowledge and understanding of the limitations of teledermatology when making a diagnosis or recommending treatment.

Ensure they have sufficient expertise in image interpretation, especially if using advanced imaging techniques, including dermoscopy, reflectance confocal microscopy, optical coherence tomography, and total body photography.

3 Be compliant with all relevant State and Territory and Commonwealth legislation—for example, the Privacy Act 1988— including taking reasonable steps to help protect the privacy of their patients and the privacy of their patients' health records and reporting of privacy breaches if it is likely to result in serious harm.

Select and optimise use of appropriate and reliable technology, platforms, equipment, data services and physical environment to fulfil their obligations to deliver teledermatology services safely and effectively while protecting patient privacy and confidentiality.

When capturing images using a mobile device, manage these in accordance with the guidelines prescribed by the Australian Medical Association entitled “Clinical images and the use of personal mobile devices” [4].

When conducting RTVC, determine if the technical and socio-technical factors of the videoconference interaction are of sufficient quality to undertake a teledermatology consultation.

When conducting RTTC, ensure that visual information is not needed or that the visual information (e.g., images) is available to the dermatologist via other means.

8 Use their professional judgement to determine on a case-by-case basis whether teledermatology is an appropriate consultation method. The need for a direct physical examination should be considered when determining if teledermatology is appropriate. The choice of modality and patient ability to access the most appropriate modality should also be considered. If suitable for teledermatology, determine whether a blended approach to delivering care is appropriate where a proportion of visits are provided in person and a proportion are provided by teledermatology.

Use teledermatology as a means of delivering dermatology care for a patient who consents to the use of telehealth as an alternative or adjunct to in-person care (or for whom consent is given in accordance with the Guardianship and Administration Act 1985).

Where a referral is for an individual lesion and the dermatologist believes a full skin examination is required, initially manage the individual lesion and make recommendations for a full skin examination where feasible.

Note: Adapted from “Quality Standards for Teledermatology,” by Primary Care Commissioning with input from the Department of Health. UK. 2013. p14 [10].

11 When offering directly to the patient the choice of teledermatology, obtain the patient's informed consent. When the use of teledermatology is recommended by the clinician managing/referring a

patient, it is the responsibility of that clinician to obtain the patient's informed consent to the use of teledermatology, including the provision of the patient's health information to the dermatologist. Informed consent should include an explanation of teledermatology and its risks and limitations.

Where the consultation is directly with the patient using a real-time teleconsultation, adhere to the guidelines for telehealth consultations published by the Medical Board of Australia including making their identity known to the patient, confirming the identity of the patient at each consultation, ensuring all persons attending the real-time teleconsultation or who may be able to hear the consultation are on screen and/or identified; and explaining the process [2]. It should not be routine practice to record and store the teleconsultation. If the teleconsultation is going to be recorded, obtain patient consent.

Informed consent in healthcare means the patient will be given understandable and clear information about their choices so they can make the right decisions about their health and healthcare.

Consent is their agreement for a healthcare professional to provide them with treatment and care, including any tests, medicines, treatments, or procedures they agree to.

Before they give their consent, make sure: The patient is aware of options available.

That any risks, and the likelihood of those risks, are explained.

They understand the purpose of the action they are consenting to.

Informed consent is different for different people. To provide informed consent you may need: An interpreter if English is not their first language and you find it hard to communicate.

A patient's friend, family member, or support person to discuss options.

17 Evaluate whether the quality and completeness of the clinical information and images provided by the referring/managing clinician are sufficient for the modality of teledermatology. If insufficient, additional information should be requested from the referrer, or the patient should be referred for an in-person consultation.

Only use store and forward teledermatology for patients with pigmented lesions if a dermoscopic image taken by a person trained in the use of a dermatoscope is included with the referral.

Where the consultation is directly with the patient, adhere to guidelines for telehealth consultations with patients published by the Medical Board of Australia [3] to communicate with the patient to collect relevant medical and medicines history to make a diagnosis, ensure sufficient clinical justification for the proposed treatment and ensure the proposed treatment is not contraindicated.

20 Keep contemporaneous notes of the consultation and document the clinical consultation in the patient notes in the usual manner with the addition of the following telehealth details: That the service was performed by telehealth.

The modality of the telehealth (i.e., RTVC, RTTC, SAF) and the date and time of consultation.

Responsibilities among the team for each element of the patient's management.

Both the dermatologist and patient-end clinicians should document the clinical consultation. 21 For RTVC and RTTC: Record the names of all attendees and sites that were linked.

Record any technical difficulties that occurred that impacted on the clinician's ability to discharge their duty of care.

Note: Adapted from the "Handbook for the Telehealth online education module," by the Australian College of Rural and Remote Medicine. 2013. Australian Government Department of Health and Ageing. p15–16 [11].

For teledermatology consultations, clinical images form part of the medical record and accordingly should be stored to the patient's file or a secure repository.

It is suggested that when documenting a teledermatology consultation the wording recommended by the American Telemedicine Association be utilised [12], namely: "Based on the images and history provided my impression is as follows."

Ensure that all documentation related to teledermatology, including referral, consultation notes, and images, is retained for the period mandated for medical records by relevant state or territory legislation (typically seven years from date of last contact, or longer for paediatric patients). The retention period for clinical images is the same as for other health records.

25 To support high quality referral images, consider publishing image acquisition guidelines or other aids in a format accessible to referrers—see Note 4 for further information.

Inform the referrer of the outcome of the teledermatology referral. For a SAF consultation, the referring clinician is responsible for informing the patient of the outcome of the teledermatology referral.

If a diagnosis of possible skin malignancy or other urgent diagnosis is made, ensure communication directly to the referring clinician is appropriately rapid, so that the patient can be informed and appropriate action taken.

Ensure all communication with the referrer regarding ongoing management within primary care includes: An agreed process for implementing the management plan, including any responsibility for prescribing and follow-up.

Guidance as to when and in what circumstances further dermatologist's advice may be needed.

Where appropriate and available, any educational materials that may support the referrer and patient.

When feasible, ensure the patient is informed of the agreed processes for implementing the management plan if this has not already been done during the teleconsultation.

For SAF consultations, respond to the referrer with the following information: A management plan and differential diagnosis.

If appropriate, arrangements for an in-person visit.

If appropriate, arrangements for the onward referral to another specialist.

If no diagnosis or management plan can be given after a SAF teledermatology referral, inform the referring clinician that they will need to consider alternative options to obtain dermatological advice.

Provide feedback to the referrer on the quality and completeness of referral information and imaging as part of continuous quality improvement. In scenarios where a diagnosis or management

plan cannot be given, the dermatologist should provide feedback as to why the referral was unsuitable (e.g., poor quality image, or patient unsuitable for teledermatology).

Note: Adapted from “Quality Standards for Teledermatology,” by Primary Care Commissioning with input from the Department of Health. UK. 2013. p32–34 [10].

The following notes are provided for dermatologists when selecting an appropriate device, application, messaging/mail service, display, data network, and physical environment for teledermatology (Table 3).

Technical information for dermatologists planning to use teledermatology.

Encrypt all data (e.g., images, referral and response) transmitted over a data network. Be aware this precludes using unencrypted email that is transmitted across public networks for teledermatology.

Avoid using smartphone text messages, multi-media messaging, and consumer messaging services. Instead use purpose-built secure teledermatology, medical photography or electronic medical record applications.

Ensure device is password protected and secure from unauthorised access

Ensure images do not auto-upload to any social media networks or backup sites.

Delete the image from any personal device once it is saved to the patient record.

Note: Adapted from “Clinical images and the use of personal mobile devices: A guide for medical students and doctors” by the Australian Medical Association and Medical Indemnity Industry Association of Australia 2014 [4].

Allows encryption of authentication, video and audio traffic using encryption protocols that are non-proprietary, standards-based in order to foster interoperability, inspectability and trust.

Supports a minimum frame rate of 25 frames per second (to avoid poor video quality).

Supports a minimum of 16 kilobits per second audio channel (to avoid poor audio intelligibility).

Supports content sharing (additional video channel for sharing screen).

Dermatologist's display (screen) should support a minimum resolution of 1280 × 720 pixels.

Size of the display should be appropriate for the viewing distance (rule of thumb that may be employed is that minimum display size = viewing distance / 2.5).

To avoid poor performance, round-trip latency should be lower than 300 ms.

To avoid connection issues, the dermatologist may install a network connection dedicated to videoconferencing.

Take measures to ensure auditory privacy i.e., that the content of the consultation is not overheard from outside of the room. This may include using headphones, or acoustic insulation (including acoustic panels, acoustic tiles, carpet, and curtains).

Test the video and audio prior to connecting to the videoconsultation.

Use a headset if typing (e.g., consultation notes) during the consultation to eliminate keyboard noise being transmitted. If not using a headset, place the microphone/speaker close.

If there is more than one participant at either end, they should be seated adjacent to each other and seated approximately two metres from the camera.

Frame all participants in camera view so their head and shoulders occupy the majority of the frame (newsreader view) and their faces are clearly visible.

At the beginning of the videoconsultation, dermatologists should: ■ Introduce themselves and state their credentials.

Verify all participants at each end can be seen and heard.

Give instructions to patient ■ end on what will occur if there is a disruption in the videoconference connection (contingency plan).

Document all persons in attendance during the videoconsultation in the patient notes.

It should not be routine practice to record and store RTVC. If the teledermatology consultation is going to be recorded, then patient consent should be taken.

It is preferable to use video over telephone in the following circumstances: When a visual assessment is needed

When non-■ verbal, visual cues can assist with diagnosis and management

When patient engagement and retention in a service, program, or course of therapy is important for effective treatment

When verbal communication with a patient is impaired (e.g., a patient with hearing loss)

Note: Adapted from “Telephone versus video consultations: A systematic review of comparative effectiveness studies and guidance for choosing the most appropriate modality” by Caffery et al., 2024 [13].

When practicing teledermatology, a dermatologist must comply with all relevant State and Territory and Commonwealth legislation—for example, the Privacy Act 1988 . This includes taking reasonable steps to help protect the privacy of their patients and their health records and reporting privacy breaches if it is likely to result in serious harm.

Selection of technology is important to ensuring the quality of the consultation and privacy of patients and their health records. The physical environment and etiquette are important to ensuring patient privacy and confidentiality.

Dermatologists should use good quality telehealth technology and optimise this technology. The technical information provided below aims to assist dermatologists and can be applied when relevant, feasible, and practical to do so.

This Guidance Note provides information on the types of factors that dermatologists should consider when making case-■by-■case decisions on the suitability of teledermatology for the patient and for individual visits within an episode of care.

The decision to provide telehealth should be informed by the following criteria: The dermatologist's ability to make a definitive diagnosis.

The provider's comfort and expertise with teledermatology.

Whether the referrer will accompany the patient during a teleconsultation, and whether the referrer can adequately undertake a physical examination.

Whether the patient has been previously seen via real-time direct consultation.

Whether there is a need to perform a full skin examination.

Clinical factors such as the presenting condition, complexity of consultation, type of consultation (e.g., new versus review), and location of skin condition (e.g., hair bearing skin, mucosa).

Whether the health care organisation where the dermatologist is employed has a set of criteria about which patients are suitable for telehealth.

Coordination factors such as continuity of care, shared care, and existing doctor-patient relationships.

Practical factors such as the availability of specialists, local clinical staff, and technology.

Patient factors such as the ability of the patient to travel, the willingness of the patient to travel, and the patient's family, work, and cultural situation.

Note: Adapted from the "Handbook for the Telehealth online education module," by the Australian College of Rural and Remote Medicine. 2013. Australian Government Department of Health and Ageing. p15–16 [9].

Note: Adapted from "Quality Standards for Teledermatology," by Primary Care Commissioning with input from the Department of Health. UK. 2013. p14 [10].

Note: These factors are not of equal value or importance. That will depend on the circumstances of the individual's case.

Note: The Medical Board of Australia has stated that "Prescribing or providing healthcare for a patient without a real-time direct consultation, whether in-person, via video or telephone, is not good practice and is not supported by the Board" [3].

This Guidance Note provides further information for both dermatologists and referrers/managing clinicians on: The types of circumstances in which a dermatologist should obtain patient informed consent and when it is a referrer or managing clinician's responsibility to do so.

What to do in circumstances where the patient is unable to provide informed consent or is a minor.

Ways to support referrers to obtain appropriate informed consent.

There are a number of entry points to teledermatology and these determine who is responsible for obtaining the patient's informed consent (see Table 4).

Determining responsibility for obtaining a patient's informed consent.

Referrer obtains consent to share information and for teledermatology.

Dermatologist does not need to obtain further informed consent to participate in telehealth consultation.

Informed consent may be written or verbal. The consent information provided to a teledermatology patient should include: What the teledermatology process involves (this will vary between services) and why it may be helpful for their care.

Medical opinion can only be based on the images and information provided.

That there may be a difference in diagnostic accuracy between teledermatology and an in-person consultation.

The issues referred to above are about the risks and limitations of teledermatology.

What technology and connectivity are required and what to do if the technology fails.

They may still need to have an in-person consultation.

They may bring a family member or companion or, if appropriate, a chaperone to the teledermatology session.

They should be aware of their surroundings and who may be able to hear audio or view the consultation.

What the billing arrangements are e.g., if they can access Medicare rebate, gap payments, etc. (financial consent).

Permission to inform the patient's usual general practitioner or other relevant practitioners of outcomes of the consultation.

Consent if the consultation is digitally recorded or information uploaded into digital health infrastructure such as My Health Record.

If an adult is temporarily unable to consent and treatment is required, permission (consent) to refer and/or manage the patient via teledermatology should be obtained from the person highest on the list of the order of persons from which consent can be obtained relevant to Commonwealth, State or Territory legislation. In the case of an emergency where the patient is not competent to consent, teledermatology services can lawfully be provided without consent, although treatment cannot be administered if the patient had, prior to becoming incompetent, expressed a wish not to receive the treatment contemplated (in some States or Territories).

Even if a patient is a minor, if the minor is mature enough to understand the nature and effect of the service proposed, consent could be obtained from the minor. Generally speaking, most adolescents aged 16 and over are capable of providing informed consent. Those aged 13 and under are generally not. It depends whether they can understand the issues involved. If in doubt, obtain legal advice.

Note: Adapted from "Medico-legal aspects of telehealth services for Victorian Public Health Services," by the Department of Health and Human Services. 2015. State Government of Victoria, Australia. p28–30 [9].

The quality of images is critical to being able to deliver teledermatology services. This Guidance Note aims to assist both dermatologists and referrers by providing further information on: Collection, use, and disclosure of clinical images

This Note should be followed when relevant, feasible, and practical to do so.

To support high quality referral images, dermatologists could consider making available image acquisition guidelines and/or the CLOSE■UP mnemonic [14], accessible to referrers.

Images acquired on a mobile device should be acquired and managed in accordance with the guidelines prescribed by the Australian Medical Association entitled “Clinical images and the use of personal mobile devices” [4]. These provide important information on the decision■making process for collecting, using and storing clinical images for the purposes of clinical care to ensure privacy and confidentiality obligations are met.

To optimise image quality, it is recommended that images acquired for teledermatology have the following camera settings: Minimum resolution of 2000 × 1500 pixels or 3 megapixels.

White balance should be set to automatic.

Cameras set to capture maximum quality JPEG files.

Consistent camera settings should be used from one visit to the next to aid comparability of imaging.

It is recommended that the following technique be employed when imaging for teledermatology assessment: Patients must consent to imaging.

To avoid the risk of misidentification, each individual patient session should begin and end with a photograph to identify the patient. Take one photograph of something to identify the images as belonging to an individual patient, e.g., unique identification number. Repeat at the end of the individual patient session.

If possible, remove jewellery and clothing.

Acquire images with the camera perpendicular to the skin surface.

Acquire images in cephalic orientation i.e., with the patient's head toward the superior of the frame.

Acquire one or more overview image/s of relevant areas of the body (e.g., back, legs, arms) to demonstrate the distribution of skin lesions or pathology.

Acquire one or more mid■close up image/s to include some anatomical marker (e.g., joint, navel) establishing the location, laterality and providing some general context for the lesion or pathology. Lesions should be identified. Identification markers should be placed adjacent to the lesion without covering any portion of it. Lesions can be identified using adhesive labels, surgical tape, or washable markers.

Acquire at least two macro (close■up) images of the lesion or pathology using either macro mode or optical zoom. The camera should be approximately 20 cm from the skin surface. Acquire using electronic flash and acquire two images at two different angles to help ensure specular reflection does not obscure any of the skin surface.

If possible, use a solid, neutral colour with a non-reflective surface (e.g., a towel) as a background to the image.

For skin lesions, acquire a further macro image with a centimetre scale.

For skin lesions, the lesion should be in the centre of the frame with equal areas of surrounding skin on the periphery.

Referrers should review images, ensure they are focussed, of sufficient quality, and clinically relevant.

The dermatologist should consider whether both polarised and non-polarised dermoscopy images are indicated. If only one dermoscopic image is obtained, it should use polarised light.

Dermoscopic images should be captured using the same orientation as the corresponding close-up.

The level of magnification should allow the visualisation of dots and regression structures (if present).

The image should include a method to define the size of the lesion.

Sequential imaging should employ a consistent imaging protocol and techniques to aid the comparability of images over time.

The dermatologist should review teledermatology images: On a display that is less than five years old to mitigate luminance decay.

Using review software that allows rotation, panning and zooming.

On a display not affected by reflection. This can be achieved by high-brightness display or by reducing the ambient room lighting.

Dermatologists should ensure images, as with other medical records, are transmitted and archived securely to protect them from theft, damage, or alteration. They should also ensure they are retained for the period of time mandated by legislation.

This Note provides information on the physical and technical considerations and steps dermatologists can take to store images securely (Table 5).

Considerations for storing images securely.

Store laptop or portable storage device in a locked physical location.

Alternatively, employ full disk encryption when the laptop or portable is not physically secured.

Take care not to (re)apply the Joint Photographic Experts Group (JPEG) compression to images as can happen when saving images to storage media.

Save any images manipulated in any software program as a copy. Do not save them over the original file.

Archive images on a hardware device that has fault tolerance – for example, redundant array of independent disks (RAID). Alternatively, images should be backed up and the backup copy stored in a separate geographical location to the original image.

Store images in architecture that employs disaster recovery procedures.

Control access to images so that access is limited only to those persons directly involved in the patient's care or responsible for managing the image archive.

Limit access to read only to prevent accidental image loss.

Keep an audit trail of persons viewing images.

Store images in Digital Imaging and Communications in Medicine (DICOM) format as this: ■
Permits portability of both the image and metadata.

Ensures there is no separation of the images and the metadata.

If DICOM is not used, use a standards■based consumer image file format such Joint Photographic Experts Group (JPEG), Portable Network Graphic (PNG), Tagged Image File Format (TIFF) or RAW.

A health care organisation's Picture Archiving and Communication System (PACS) or Vendor Neutral Archive (VNA).

A managed network drive, storage server or a cloud storage provider (See Cloud computing storage below). When using these storage devices, images should be stored using a file structure that at root level identifies the patient and subdirectories based on date to identify the imaging study. The image file name shall include a patient identifier to help prevent misidentification.

Only store images in a repository where there exists functionality to export the images and associated metadata in a standards■based format to facilitate portability and avoid vendor lock in.

Do not archive images on a local hard drive of computers, removable storage devices (e.g., portable hard■disk drives, thumb drives) or a non■validated cloud provider (See Cloud computing storage below).

Do not archive images on an imaging modality before verifying that the modality meets the requirements for images to be archived securely and for the period of time mandated by relevant legislation.

A dermatologist may outsource the storage of images to a cloud service provider. Imaging repositories (e.g., PACSs, VNAs), electronic medical records, network drives and storage servers may use cloud computing storage.

If using a cloud storage provider, apply the recommendations of the Australian Cyber Security Centre [16], namely: Use a locally owned vendor or a foreign owned vendor that is located in Australia and stores data only within Australia.

Perform a risk assessment before using a cloud service provider for the storage of images.

Use the risk assessment [17] prescribed by the Australian Signals Directorate.

Consider the sensitivity of the images that will be stored and the choice of cloud provider should reflect these sensitivities. Highly sensitive images such as nude photographs should be stored using well-known cloud providers with strong security protocols.

Declaration Regarding the Use of AI : The authors affirm that no AI or AI-assisted tools were used in the development of this manuscript.

H.P.S. is a shareholder of MoleMap NZ Limited and eDerm consult GmbH and undertakes regular teledermatological reporting for both companies. H.P.S. is a Medical Consultant for Canfield Scientific Inc. and a Medical Advisor for First Derm. V.M.'s institution has received clinical trial funding from MoleMap. H.P.S., S.S., and P.F.P. are current AJD Editorial Board Members. P.G. received honouraria from Metaoptima PTY and travel support from L'Oréal.

We acknowledge the assistance of the Australasian College of Dermatologists in coordination of the study and reviewing the manuscript. Open access publishing facilitated by The University of Queensland, as part of the Wiley – The University of Queensland agreement via the Council of Australian University Librarians.

Data sharing is not applicable to this article as no new data were created or analysed in this study.