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Legal Analysis of the Protection of Dental Professional Students from the Risk of Malpractice Lawsuits in Teaching Hospitals

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ABSTRACT

Dental students (interns/junior dentists) occupy a unique position in healthcare because they are directly involved in clinical procedures in teaching hospitals but do not yet have independent practice authority as stipulated in Law Number 17 of 2023 concerning Health, Article 263. Unclear regulations concerning their legal status, authority, responsibility, and protection may create legal uncertainty, particularly when clinical incidents result in patient harm. This study aims to analyze the construction of legal responsibility for dental students and the forms of legal protection available against the risk of malpractice claims in teaching hospitals. This normative legal study employs statutory and conceptual approaches. Primary and secondary legal materials were analyzed qualitatively through legal interpretation and legal argumentation to identify normative gaps and examine the relationship between authority, supervision, and legal responsibility. The findings indicate that dental students' legal responsibility is limited and situational. Clinical procedures must be performed under authorized instructions, approval, and supervision of the DPJP. Under mandate-based delegation, responsibility remains with the mandate giver when actions remain within authorized limits and supervision. Students may be personally liable when acting beyond authority, without approval, or contrary to SOPs and professional ethics. Preventive protection includes clear regulations, competency-based authority, supervision, informed consent, and proper documentation, while repressive protection involves dispute-resolution mechanisms.

Keywords: Legal Protection, Dental Professional Students, Malpractice, Teaching Hospitals, Legal Responsibility.

I. Introduction

Healthcare is never without risks. In everyday practice, the potential for medical errors is always present, even when healthcare professionals strive to provide the best possible care (Brauer & Bartols, 2025). Based on the Minister of Health Regulation Number 11 of 2017 related to Patient Safety, patient safety is described as a framework that ensures safer patient care. This framework encompasses risk evaluation, the identification and management of patient-related risks, the reporting and analysis of incidents, the capacity to learn from these incidents and their subsequent actions, as well as the execution of solutions aimed at reducing risks and avoiding harm (Cernega et al., 2026). Although the government has updated regulations



in the health sector through Law Number 17 of 2023 concerning Health, its implementation still faces obstacles, particularly regarding the regulation of the position of professional students in clinical practice (Abomalik et al., 2022). Among healthcare providers, dental students occupy a unique position. Dental students are graduates of a bachelor's degree (S-1) in dentistry who are currently undergoing further education in the form of clinical clerkships. During this stage, students are involved in promotive, preventive, curative, and rehabilitative services in dental hospitals, under the supervision of lecturers or clinical instructors (Yalçın Balçık et al., 2023). They are required to apply clinical knowledge directly to patients as part of the educational process, which requires good manual skills (hand skills) (Alsaeed et al., 2022).

Normatively, dental professional students do not yet have the authority to practice independently because they do not have a Registration Certificate (STR) or Practice Permit (SIP) (Hsu et al., 2025). This aligns with Article 263 of Law Number 17 of 2023 concerning Health, which states that medical and health personnel must possess a permit in the form of a SIP (Student License) to practice their profession. This legal limitation limits the scope of clinical procedures that can be performed, so professional education practices must be carried out with great care (Vadde et al., 2024). In carrying out their duties of providing dental and oral health services, dental professional students are still required to uphold the Indonesian Code of Dental Ethics (KODEKGI), even though formally they are not yet fully included in the subjects bound by KODEKGI. This is reinforced by Law Number 20 of 2013 concerning Medical Education, Article 18 paragraph (2), which states that professional students must still comply with the code of ethics of Doctors or Dentists (Costanza-Gugiu et al., 2025). In clinical practice, they are also required to adhere to the fundamental concepts of bioethics include beneficence, non-maleficence, honoring patient autonomy, justice, and truthfulness (Pătru et al., 2026).

In light of the implementation of Law No. 17 of 2023 related to Health, the reorganization of the medical and healthcare workforce system has impacted both its development and oversight patterns. However, regulations specifically governing the oversight mechanisms and legal protection for dental Students in teaching hospitals have not had clear and complete guidelines created (Sharma et al., 2026). This ambiguity creates legal uncertainty and leads to students' hesitation in undertaking medical procedures, especially when there is potential legal risk due to negligence in providing medical care (Costanza-Gugiu et al., 2025). Although existing research and regulations have provided a basis for the status of professional students, the obligation to provide clinical supervision, and their right to legal protection during their education in teaching hospitals, there remain doctrinal issues that remain unresolved. Established knowledge indicates that professional dental students are not medical or healthcare professionals authorized to practice independently because they lack legal practice credentials. Therefore, their clinical actions must be conducted within the framework of education and supervision. Furthermore, regulations regarding the delegation of medical or dental procedures utilize a mandate structure, which, in principle, maintains responsibility for the person granting the mandate. The problem is that these provisions do not explicitly position professional students as the recipients of the delegation of authority. This situation raises doctrinal issues regarding the legal basis for students to perform clinical procedures, the limits of the authorizations they can grant, and the division of responsibility if such actions result in harm to patients.

Therefore, the research gap in this article lies not solely in the absence of regulations, but in the unclear legal structure linking students' status as learners, clinical action authority, mandate-based delegation, DPJP supervision, and legal accountability within a single normative framework. Previous research has discussed the importance of supervision and limiting student authority, but has not provided a systematic construct that determines when responsibility remains with the DPJP and when students can be held personally accountable. This paper fills this gap by offering a normative interpretation that student involvement in clinical actions cannot be understood as independent practice authority, but rather as limited, competency-based, conditional clinical authorization under the supervision of the DPJP. Consequently, primary responsibility remains with the mandate giver as long as actions are carried out within the limits of authorization and supervision, while personal accountability of students is only relevant when there are actions outside of authorization, without required instructions or approval, or violations of SOPs and codes of ethics. This construct also serves as the basis for formulating the need for implementing regulations that

specifically regulate the authority, supervision, documentation of authorization, and division of responsibility for professional students in teaching hospitals. This article looks at the legal duties that dental students have when they work in teaching hospitals and the legal support they might get if they are accused of making a mistake in their work. This paper is expected to contribute to the growth of health law academically and offer guidance to policymakers and health education organizations.

II. Literature Review and Hypothesis Development

The government ensures that every citizen has the right to live a healthy, happy, and successful life, both body and mind, in order to fulfill the national goal of safeguarding all Indonesians and their heritage, and to improve the well-being of all people as stated in the 1945 Constitution of the Republic of Indonesia. According to Law Number 17 of 2023, Article 1, paragraph (1), health refers to a person's overall condition, including their physical, mental, and social well-being, and it is not just about being free from illness. It means being able to live a productive life. Dental education is part of formal learning, and it has two main parts: academic education and professional education. These are run by universities that have approved programs. The goal is to train qualified graduates who meet the legal requirements. To become a dentist, someone needs to first finish their studies at the Bachelor of Dentistry (S1) level, which usually takes between 3.5 to 4 years. After that, they move on to the next stage of professional training for dentists. These provisions are regulated in Law Number 20 of 2013 concerning Medical Education, specifically Article 7 paragraph (2) and paragraph (6). Students who are currently pursuing this professional stage, after completing their academic education, are generally known as interns or young dentists (Yuce & Kacdioglu Yurt, 2025).

Despite completing their academic education, dental students do not yet have the authority to make independent clinical decisions. All medical procedures, from history taking to treatment, performed by dental students must be approved and supervised by a lecturer or DPJP. According to Law Number 29 of 2004 concerning Medical Practice, a doctor or dentist must have a Registration Certificate (STR) and a Practice Permit (SIP) to be authorised to practice medicine within their competencies. Dental students do not yet possess these documents. This legal limitation ultimately limits the scope of clinical procedures that can be performed. Therefore, dental students may only perform health services after receiving authorisation, instructions, and approval from their lecturer or DPJP (Tom et al., 2024). Based on Indonesian Medical Council Regulation Number 30 of 2014, dental professional education in Indonesia uses a competency-based curriculum that is integrated horizontally and vertically and is oriented towards solving individual, family, and community health problems. This curriculum aims to produce dentists who are competent in providing health services both individually and in the community. The clinical competency of dental students is evaluated based on Miller's taxonomy, which includes four levels: knows, knows how, shows how, and does, which is used to assess clinical readiness in stages (Yu et al., 2024).

Dental students can treat patients according to their skills and competencies only if they receive instructions from a doctor, as stated in Law Number 20 of 2013 concerning Medical Education, Article 18 paragraph (1) and Minister of Health Regulation Number 2052/Menkes/Per/X/2011, Article 24 paragraphs (1) and (2), concerning Practice Permits and Implementation of Medical Practice. Dental students are not permitted to carry out medical procedures without the delegation of authority, instructions and approval from a lecturer/DPJP. The delegation of authority from a lecturer/DPJP to dental students is in the form of a mandate. The authority given by a lecturer/DPJP to dental students aims to provide learning facilities and provide opportunities to be able to work directly in hospitals and is not permanent (Wang et al., 2024). This is necessary because the student is currently studying and has not yet received legal permission to provide health services from the Ministry of Health (Varvara et al., 2026).

Based on its function, RSGM is divided into Educational and Non-Educational RSGM (Article 9 paragraph (1)), where Educational RSGM is required to meet certain criteria such as the availability of educational facilities, service quality, collaboration with the Faculty of Dentistry and the college, and must provide basic to subspecialist dental medical services (paragraphs (2) and (4)). This is in line with Law Number

17 of 2023 concerning Health, Article 187, which emphasises the function of educational hospitals as a place of integrated service and education. Therefore, every university that has a Faculty of Medicine or Dentistry is required to enter into an official cooperation agreement with an educational hospital for the purpose of placing professional students. The existence of this agreement serves as a legal basis that clarifies the status of students as learners, not independent health workers, when carrying out the clinical learning process in hospitals (Amaral & Caldas, 2024). In the context of healthcare, legal protection is important for medical personnel, including dental students, who are involved in clinical practice. Dental students, as part of the educational process, have the right to obtain legal protection during their clinical practice. This is regulated in Law Number 20 of 2013 concerning Medical Education, Article 31 paragraph (1), which states that every student has the right to obtain legal protection in participating in the teaching and learning process, both in medical or dental faculties and in teaching hospitals and medical education facilities. This legal protection includes preventive aspects, such as the provision of clear guidelines and supervision, as well as repressive aspects, such as dispute resolution mechanisms in the event of legal problems (Tănase et al., 2026).

Students are in the clinical education stage and may be involved in patient care as part of the learning process, but they do not have the authority to practice independently. Therefore, student involvement in clinical procedures cannot be understood as a stand-alone exercise of professional authority, but must be situated within the nexus of education, instruction, approval, and supervision by a physician or DPJP. The literature on clinical competency, including the use of Miller's taxonomy, helps explain the stages of student competence from knowledge to the ability to perform actions, but it does not necessarily determine the legal consequences of those actions. Therefore, clinical competency and legal authority are two concepts that must be distinguished when analyzing the status of professional students (Afandy et al., 2026). From an authority perspective, previous research discussing the delegation of authority to professional students places instruction and supervision as essential requirements for the implementation of clinical procedures. This delegation is understood in the form of a mandate, allowing students the opportunity to perform certain actions within the limits granted for educational purposes, while legal responsibility ultimately rests with the mandate giver. This perspective provides a basis for understanding why students cannot be positioned as independent practitioners. However, there is an unresolved doctrinal issue: whether the mandate construction has a sufficient normative basis when the recipients of the action are professional students who are not legally categorized as health workers with the authority to practice. This issue becomes even more important because Article 23 of Minister of Health Regulation No. 2052/Menkes/Per/X/2011 explicitly names nurses, midwives, or certain other health workers as recipients of the delegation, but does not specifically mention professional students (Abang Anton et al., 2024).

Thus, two perspectives need to be synthesized. The first perspective emphasizes that students must gain clinical experience in accordance with their competencies through instruction and supervision as an integral part of professional education. The second perspective emphasizes that the authority to perform clinical actions must have a clear legal basis and cannot be equated with the authority to practice independently. These two perspectives are not contradictory, but they demonstrate the need to distinguish between the competence to perform actions and the legal authority to perform actions. Students may possess certain clinical competencies based on their educational stage, but these competencies do not automatically grant them the authority to practice independently. In this context, student actions must be understood as limited, conditional, and under the supervision of a party with professional authority (Muhammad Nur Aji Basuki & Yuspin, 2023). The next issue relates to legal responsibility. The literature on mandates indicates that the delegation of authority is not always synonymous with the transfer of responsibility. In the construction of a mandate, responsibility remains with the mandate giver as long as the recipient carries out actions within the given boundaries. Therefore, supervision not only has an educational function but also a legal function because it serves as a mechanism to ensure that student actions remain within the boundaries of competence and authorization granted. When students act according to instructions and supervision, the construction of responsibility needs to be distinguished from situations where students act outside of instructions, without the required approval, or beyond their competence. This manuscript uses this distinction as a basis for

establishing the boundary between the responsibilities of the DPJP and the potential personal liability of students (Assaad et al., 2021).

The relationship between supervision and responsibility also demonstrates that legal protection for students cannot be separated from patient protection and the institutional responsibility of teaching hospitals. Active and documented supervision, clear SOPs, informed consent, and complete medical records are not only instruments for patient safety but also evidence that student authority has been granted and exercised within a controlled educational framework. Therefore, preventive legal protection must be placed as part of the clinical risk management system, not simply protection for students when a dispute has already occurred (Afwan Ridha et al., 2026). Based on this synthesis, the conceptual framework of this study is built through the relationship between student status as a learner → clinical competence → clinical action authorization → DPJP supervision → institutional and professional responsibility → legal protection. Student status limits students' authority to practice independently. Clinical competence determines the type of practice. Actions that are educationally permissible, while authorization and instructions determine whether these actions can be performed within the context of clinical services. DPJP supervision serves as a control mechanism to ensure actions remain within the boundaries of competence and authorization. Furthermore, the construction of responsibility is determined based on whether the student's actions are within or beyond these boundaries. Legal protection is then realized through internal regulations, supervision, documentation, informed consent, and dispute resolution mechanisms.

III. Research Method

This research is a legal study that looks at the rules and laws meant to protect dental students from facing lawsuits related to malpractice while they are learning in teaching hospitals. This study looks at whether the rules are suitable, where they are missing, and where they might not work well, to ensure that laws are clear and that patients are safe. The methods used are a statutory method and a conceptual method. The statutory approach is done by looking at the relevant laws and regulations, such as Law Number 17 of 2023 on Health, Law Number 29 of 2004 on Medical Practice, Law Number 20 of 2013 on Medical Education, Government Regulation Number 93 of 2015 on Teaching Hospitals, Minister of Health Regulation Number 2052/Menkes/Per/X/2011 on Practice Permits and Implementation of Medical Practice, Minister of Health Regulation Number 1173/Menkes/Per/X/2004 on Dental and Oral Hospitals, Minister of Health Regulation Number 269/Menkes/Per/III/2008 on Medical Records, and Minister of Research, Technology and Higher Education Regulation Number 18 of 2018 on National Standards for Medical Education.

At the same time, a conceptual method is used to look into the ideas of legal responsibility, carefulness, protecting patients, and the idea of giving authority (like a mandate or delegation) in health care services. The legal materials used include primary, secondary, and tertiary sources that were gathered through research in literature. All materials are studied in a qualitative way using legal interpretation and legal argumentation to create a clearer, more organized, and more reliable legal protection system. Primary law consists of laws and regulations and normative provisions that directly regulate medical education, medical and dental practice, teaching hospitals, clinical authority, delegation of actions, medical records, and legal protection. Secondary legal materials consist of law books, scientific journal articles, previous research results, expert opinions, and academic works discussing authority, mandates, delegation, professional responsibility, clinical supervision, legal protection, and clinical education. Tertiary legal materials are used to a limited extent as supporting material to provide terminological explanations or assist in the search for primary and secondary legal materials.

Legal materials are selected based on four criteria: (1) direct relevance to the research focus; (2) the authority or credibility of the source; (3) relevance to the Indonesian legal context; and (4) the source's ability to explain the relationship between authority, supervision, responsibility, and legal protection. The selected regulations are prioritized based on their position and relevance within the hierarchy of laws and regulations. Secondary literature is selected if it provides conceptual or doctrinal analysis that can be used to explain or

critique primary legal provisions. Sources that provide only general information regarding medical education without any connection to issues of authority and accountability are used only as background and are not used as the primary basis for drawing legal conclusions. The legal materials search was conducted through a literature review by identifying keywords related to dental students, clinical education, clinical authority, delegation of authority, mandate, delegation, supervision, professional responsibility, institutional responsibility, legal protection, and malpractice. The search focused on relevant laws and regulations, scientific publications, law textbooks, and academic sources. All sources found were then selected based on their title, abstract or substance, relevance to the research question, and suitability for the legal context. Sources that were not directly related to the research object or only discussed clinical aspects without legal relevance were not used as the primary source of analysis.

The analysis process was conducted through several stages. First, an inventory and classification of legal materials based on the issues studied, namely the legal status of students, clinical action authority, delegation in the form of mandates, supervision, legal responsibility, and legal protection. Second, interpretation of primary legal provisions was conducted by comparing formulations between regulations that have a material relationship. Third, these legal provisions are compared with concepts and doctrines derived from secondary legal materials to identify any congruence, discrepancies, gaps, or ambiguities. Fourth, legal argumentation is constructed by linking norms of authority with norms of responsibility and legal protection mechanisms. Fifth, the results of the analysis are used to formulate a normative construct regarding the limits of student authority and the division of responsibilities between students, the DPJP (Public Service Supervisory Agency), educational institutions, and hospitals.

When faced with incomplete, ambiguous, or potentially contradictory provisions, the study employed several legal interpretation techniques. Grammatical interpretation is used to understand the textual meaning of terms and article formulations. Systematic interpretation is used by positioning a provision in relation to other provisions in the same regulation or related regulations, particularly when there are differences in regulations regarding students, medical personnel, health workers, and practice authority. Teleological or sociological interpretation is used to understand the purpose of the regulation, particularly in balancing the interests of clinical education, patient safety, legal certainty, and student protection. Furthermore, conceptual argumentation is used to test whether the constructs regarding mandate, supervision, and responsibility can be consistently applied to students' positions as learners. The validity of the research argument is maintained through consistency between primary legal sources, legal doctrine, the concepts used, and the research questions. Each conclusion regarding the authority and accountability of students is traced back to relevant legal norms and examined for their conformity with the concepts of mandate, supervision, responsibility, and legal protection.

IV. Result and Discussion

4.1. Legal Status and Authority of Dental Professional Students

Dental professional students are part of formal education which consists of two main stages, namely academic education and professional education, which are under the authority of higher education institutions with accredited study programs to produce competent graduates in accordance with statutory provisions.⁴ To become a dentist, a person must first complete academic education at the Bachelor of Dentistry (S1) level, which is then continued with the professional education stage for dentists. These provisions are regulated in Law Number 20 of 2013 concerning Medical Education, specifically Article 7 paragraph (2) and paragraph (6) (Zamani Noudadi et al., 2026). The implementation of the dental professional education program is aligned with learning outcomes that refer to the competency standards established by the Indonesian Medical Council (KKI). Based on Indonesian Medical Council Regulation Number 30 of 2014, dental professional education in Indonesia uses a competency-based curriculum that is integrated horizontally and vertically, and is oriented towards solving individual, family, and community health problems

(Costanza-Gugiu et al., 2025). The clinical competency of dental students is evaluated based on Miller's taxonomy, which includes four levels: knows, knows how, shows how, and does, which are used to assess clinical readiness in stages (Sharma et al., 2026).

Legally, dental students are not allowed to work on their own because they don't have a Registration Certificate (STR) or a Practice Permit (SIP) (Pătru et al., 2026). This follows Article 263 of Law Number 17 of 2023 on Health, which says that medical and health professionals need a permit called SIP (Student License) to do their work. A professional student does not yet have this permit, so all medical procedures, from anamnesis to treatment, performed by a professional student must have the approval and supervision of a lecturer or DPJP (Tom et al., 2024). Dental students can treat patients according to their skills and competencies only if they receive instructions from a doctor, as stated in Law Number 20 of 2013 concerning Medical Education, Article 18 paragraph (1) and Minister of Health Regulation Number 2052/Menkes/Per/X/2011, Article 24 paragraphs (1) and (2) concerning Practice Permits and Implementation of Medical Practice (Yu et al., 2024). Professional students are not permitted to perform medical procedures without the delegation of authority, instruction, and approval of their lecturers/DPJP. The delegation of authority from lecturers/DPJP to professional students is a temporary mandate and aims to provide learning facilities and the opportunity to work directly in hospitals (Wang et al., 2024).

According to Article 23 of the Minister of Health Regulation Number 2052/Menkes/Per/X/2011, medical or dental procedures can be delegated under these conditions: first, the procedure must be something the person receiving the delegation is already trained and skilled to do; second, the person giving the delegation must keep a close watch on how the procedure is carried out; third, the person who gave the delegation is still fully responsible for the procedure as long as it is done as instructed; fourth, the delegated task does not include making clinical decisions on its own; and fifth, the delegated procedure is not something that happens over a long period of time (Varvara et al., 2026). This confirms that the delegation of authority from the DPJP to students is limited, conditional, and remains under strict supervision from the DPJP. However, there is a weakness in the existing regulation because Article 23 paragraph (1) of the Minister of Health Regulation Number 2052/Menkes/Per/X/2011 only mentions "nurses, midwives or certain other health workers" as recipients of the transfer, without explicitly including professional students (Alsaed et al., 2022). This ambiguity is exacerbated by the classification in Law Number 17 of 2023 concerning Health which clearly differentiates between "Medical Personnel", "Health Personnel", and "Students" in the education process.² Article 199 paragraph (1) letter l of Law 17/2023 regulates the existence of "other Health Personnel determined by the Minister", however the phrase "students" in the same Law indicates that professional students, who do not yet have a STR and SIP, are not necessarily included in the category of health workers (Hsu et al., 2025). This situation creates legal uncertainty regarding the position of professional students as recipients of the delegation of authority. Research shows that the delegation of authority from the DPJP to professional dental students often lacks a clear written legal basis, resulting in misinterpretations and inconsistent implementation of the delegation of authority in educational dental and oral hospitals (Varvara et al., 2026).

Based on the provisions analyzed, the position of dental students needs to be carefully understood because they face two concurrent legal interests: clinical education and patient protection. On the one hand, students are learners acquiring clinical competency and therefore cannot yet be positioned as medical professionals with independent practice authority. On the other hand, students are actually involved in patient care, so their activities still have legal consequences. This dual position indicates that the student's authority is not independent authority, but rather authority derived from the instructions and supervision of authorized medical professionals. However, this construction does not mean that every student's actions automatically become the responsibility of the Dental Professionals (DPJP). There are legal interpretations that need to be differentiated. The first interpretation positions the student as the person carrying out the action within a mandated relationship, so primary responsibility remains with the person giving the mandate as long as the action is carried out in accordance with instructions, limits of competence, and supervision. The second interpretation emphasizes that the student's status as a learner does not eliminate personal responsibility if the student knowingly engages in actions beyond their authority or deviates from the instructions given.

Therefore, the student's position cannot be understood as absolute, as always free from responsibility, nor as fully responsible for their clinical actions.

This issue becomes even more significant because Article 23 of Minister of Health Regulation No. 2052/Menkes/Per/X/2011 does not explicitly mention professional students as parties who can receive the delegation of medical or dental procedures. This situation differs from the construction of clinical education, which in practice allows students to perform certain actions based on instructions and supervision. Thus, there is a gap between the operational needs of clinical education and the normative formulation regarding the recipients of delegated authority. This finding reinforces previous research showing that unclear boundaries of student authority can lead to differing interpretations in clinical practice. However, this study expands on these findings by showing that the issue is not merely a technical issue of supervision, but also a matter of constructing the legal relationship between students, the DPJP, the educational institution, and the hospital. Thus, the findings in this section essentially confirm the concept that clinical authority must be related to competence and supervision, but also demonstrate the limitations of this theory when applied to professional students, who are not legally independent medical personnel. The main issue is not merely whether students are allowed to perform clinical actions, but on what legal basis these actions are carried out, who gives the authority, to what extent the authority is given, and who is responsible when these actions cause harm.

4.2. Construction of Legal Responsibility of Dental Professional Students

In a legal context, the term responsibility is generally used in the realm of criminal law, while in civil law it is known as liability. Conceptually, responsibility refers to the legal consequences arising from a person's free actions, which are linked to ethical and moral considerations in carrying out an act (Tănase et al., 2026). In dental professional education, this responsibility becomes crucial when students are involved in medical services, as any action they take can have legal implications, whether criminal, civil, ethical, or administrative. The legal relationship between a dentist and a patient is known as a therapeutic transaction, a professional relationship that creates rights and obligations for both parties in the patient's healing process. A therapeutic agreement falls under the category of *inspanningverbinten*, or agreement of effort, because in a doctor-patient relationship, there can be no promise of an outcome, such as healing. What the doctor promises is maximum effort through professional and standard medical procedures, as a form of endeavour to achieve the patient's recovery (Yu et al., 2024).

The legal responsibility of professional students depends a lot on how well supervision, the passing of authority, and the carrying out of medical actions are done according to the right rules and laws. In the context of giving authority, students are in a legal situation that is required by law. This means that authority is given without also giving them the legal responsibility that comes with it. This is highlighted in Article 1 paragraph (24) of Law Number 30 of 2014 about Government Administration. It says that when someone gives authority through a mandate, the responsibility stays with the person who gave the mandate (Brauer & Bartols, 2025). Therefore, every medical action carried out by professional students is essentially under the legal responsibility of the DPJP, as long as the action is carried out with the permission and under the direct supervision of the DPJP (Amaral & Caldas, 2024).

This rule is supported by Article 1367 of the Civil Code, which says that a person is not only responsible for losses from their own actions, but also for losses from the actions of people they are responsible for, or from goods they are in charge of (Wang et al., 2024). Thus, DPJP is responsible for the actions of students under its guidance and supervision. However, students can still be held accountable if they act beyond their authority, without the approval of the DPJP, or if they disregard SOPs and codes of ethics. In such circumstances, legal responsibility can be transferred to the students themselves based on the concept of personal liability, which is the responsibility inherent in individuals based on their actions. The legal basis for this personal liability is Article 1365 of the Civil Code concerning unlawful acts (*onrechtmatige daad*) (Wang et al., 2024). The absence of clear regulations regarding the limits of authority and legal protection for dental students in teaching hospitals indicates a lack of norms that have the potential to harm all parties involved

(Yu et al., 2024). This rule is supported by Article 1367 of the Civil Code, which says that a person is not only responsible for losses from their own actions, but also for losses from the actions of people they are responsible for, or from goods they are in charge of (Tănase et al., 2026).

The analysis shows that the construction of professional student responsibility cannot be determined solely based on their status as students. Responsibility must be analyzed based on the relationship between the source of authority, the form of delegation, the limits of action, supervision, and deviations committed by each party. In the mandate construction, the mandate giver remains responsible for the authority granted as long as the mandate recipient carries out the actions in accordance with the mandate. Therefore, when a student carries out actions ordered and within the scope of the DPJP's supervision, there is a normative basis for placing primary responsibility on the mandate giver. However, this construction does not preclude the possibility of personal responsibility for the student. If the student acts outside of instructions, makes clinical decisions beyond their authority, acts without approval, or deliberately disregards SOPs, the basis for accountability changes. In such circumstances, the student's actions can no longer be viewed solely as carrying out the mandate. This demonstrates that responsibility in clinical education is conditional and must be determined based on the facts and the authority relationship at the time the action is taken. Therefore, there are potential legal interpretations of the relationship between mandate and responsibility. The first approach holds that because the mandate does not transfer responsibility, the DPJP remains responsible for the student's actions. The second approach holds that the principle of personal liability remains applicable if a student's actions independently deviate from the authority granted. These two approaches are not necessarily mutually exclusive, as they can be applied based on the factual circumstances of each case. Therefore, determining the responsible party should not be based solely on the status of the student or the DPJP, but rather through an examination of the form of authority, instructions, level of supervision, and concrete actions taken.

These findings can also be compared with previous research on clinical supervision, malpractice, and medico-legal risk. Previous research generally positions supervision as a crucial instrument for maintaining patient safety and limiting student actions. The findings of this study align with this view but provide analytical development that supervision serves not only educational and patient safety functions but also has consequences for the construction of legal accountability. The clearer the instructions, limits of authority, and documentation of supervision, the easier it is to determine the relationship between student actions and the DPJP's responsibility. Conversely, unclear supervision can create problems in determining whether an action constitutes the implementation of a mandate or a personal act of the student. From the perspective of vicarious liability, institutional responsibility, and personal liability, the relationship cannot be simplified as a two-party relationship between students and the DPJP. Teaching hospitals and educational institutions have a role in creating supervision systems, establishing SOPs, determining competency limits, and providing oversight mechanisms. Therefore, the theory of individual responsibility needs to be read in conjunction with the theory of institutional responsibility. The findings of this study, therefore, do not completely reject existing theories of responsibility, but rather demonstrate that their application in clinical education requires a synthesis of personal responsibility, mandate, supervision, and institutional responsibility.

4.3. Forms of Legal Protection for Dental Professional Students

Legal protection for dental students can be divided into two forms, namely preventive protection and repressive protection. Preventive protection aims to prevent violations from occurring by providing legal subjects with the opportunity to submit objections or opinions before the decision is implemented (Wang et al., 2024). In the context of clinical practice for dental students, preventive protection is realised through: First, strengthening internal regulations in teaching hospitals. Preventive legal protection for dental students can be achieved through the provision of professional guidebooks (modules) containing regulations on permitted student actions, Dental Hospital Bylaws, medical committees, and Standard Operating Procedures (SOPs) for

each procedure (Beni Satria, 2024). Research shows that teaching hospitals with comprehensive internal regulatory frameworks tend to provide better legal protection for students and clinical educators (Di Lorenzo et al., 2024). Second, active and documented supervision by the DPJP. Student clinical supervision is very important for keeping patients safe. Systematic reviews show that good clinical supervision helps make healthcare safer, lowers the risk of problems, and makes medical care better overall (Varvara et al., 2026). DPJP is responsible for ensuring that professional students carry out their duties in accordance with the provisions and limits of their competence, preventing students from carrying out procedures beyond their authority, and reducing the potential for malpractice. In providing guidance, teaching physicians must uphold the principles of non-maleficence, fairness, and maintaining a professional attitude (Zamani Noudadi et al., 2026). Third, the granting of informed consent. According to the manual guideline for medical consent by the Indonesian Dental Association (KKI) for educational purposes, dental students must still seek patient consent in their educational activities, which refers to Article 45 of Law Number 29 of 2004 concerning Medical Practice (Herningtyas et al., 2025). This rule is supported by Article 293, paragraph (1) of Law Number 17 of 2023 on Health. This law says that any medical action done by medical staff or health workers must get permission from the patient or their family. Before that, the patient or their family must be given full and clear information about the medical action that will be carried out (Brauer & Bartols, 2025).

Research on patient autonomy in dental education clinics shows that treatment practices in educational institutions often do not respect patient autonomy, with paternalistic doctor-patient relationships contributing to violations of patient rights. Therefore, it is important to ensure that the informed consent process is carried out properly, including an explanation of student involvement in medical procedures. Fourth, accurate and complete medical record documentation. The obligation to create medical records is stipulated in Law Number 29 of 2004 concerning Medical Practice Article 46, Minister of Health Regulation Number 269/MENKES/PER/III/2008 concerning Medical Records Article 2, and Minister of Health Regulation Number 24 of 2022 concerning Medical Records Articles 3 and 16.27, 28, 29. Students must create complete medical records, including requesting the signature of the DPJP as proof of approval before performing medical procedures, and retain all documentation as a form of legal accountability in the event of a dispute in the future (Yuce & Kacdioglu Yurt, 2025). Repressive protection aims to resolve disputes or violations that have occurred through judicial mechanisms (Yalçın Balçık et al., 2023). In the context of clinical practice for dental students, repressive protection includes internal dispute resolution mechanisms within the hospital and through formal legal channels in the event of ethical violations or negligence that has legal consequences. Because the delegation of authority is mandated, primary responsibility remains with the DPJP. This is relevant to the provisions of Article 1367 of the Civil Code. However, students can still be held accountable if they take actions beyond their assigned authority, without DPJP approval, or if they disregard SOPs and the code of ethics (Wang et al., 2024). In such circumstances, legal responsibility can be shifted to the student himself.

Sanctions for professional students who commit violations can include academic sanctions, such as repeated rotations, re-evaluations, and even grade cancellation if the student is found to have violated the established code of ethics or clinical procedures. Meanwhile, sanctions for DPJPs can include administrative actions such as verbal warnings, written warnings, and even revocation of recommendations to practice for a specified period (Tănase et al., 2026). In the event of a medical dispute, resolution can be pursued through professional organizations such as the Indonesian Medical Association (PDGI), the Indonesian Medical Association (MKDKI), or through the district court (Afwan Ridha et al., 2026). According to the 1982 Supreme Court Circular (SEMA), any alleged disciplinary violation by a healthcare worker must first be reviewed by the MKDKI before being prosecuted. The MKDKI's decision serves as initial evidence in the law enforcement process.

The analysis shows that legal protection for professional students cannot be separated from patient protection. Overly broad student protection without regard for patient safety has the potential to reduce accountability for services, while patient protection that focuses solely on individual student accountability can ignore the reality that students work within a clinical education system under the supervision of the

institution and the DPJP. These findings reinforce previous research on the importance of supervision, informed consent, and medical record documentation in clinical education. Previous research on supervision indicates that effective supervision is associated with improved patient safety, while research on patient autonomy demonstrates the importance of transparency regarding student involvement in services. In this study, both findings have a broader relationship with legal protection because supervision and informed consent not only serve as ethical instruments but also serve as important evidence in determining whether clinical actions have been carried out according to authority.

There is also a relationship between preventive and repressive protection. Preventive protection through SOPs, supervision, informed consent, and medical records essentially serves to reduce the likelihood of disputes and provide evidence regarding the service process if disputes do arise. Meanwhile, repressive protection serves to provide a resolution mechanism when alleged violations occur. Thus, these two forms of protection are not stand-alone mechanisms, but rather a series of interrelated legal safeguards. The findings regarding informed consent also demonstrate that student protection should not be understood as an attempt to conceal or minimize student involvement in the presence of patients. Instead, student involvement in clinical procedures needs to be transparently communicated to patients as part of respecting patient autonomy. Therefore, student legal protection can be strengthened through transparency regarding student status, the procedures to be performed, available supervision, and patient consent. In the context of documentation, medical records have a dual function. Medical records not only document patient care but also provide evidence of who gave the instructions, what actions were performed, who supervised them, and whether those actions were in accordance with the authorized authority. Therefore, complete documentation can clarify the construction of responsibility in the event of a dispute. Thus, the findings of this study confirm the theory of preventive and repressive legal protection, while also expanding its application in the context of clinical education. Preventive protection is not sufficient merely through the existence of regulations; it must be realized through operational mechanisms that can demonstrate the relationship between authority, competence, supervision, patient consent, and documentation. On the other hand, repressive protection needs to consider whether the alleged error stems from the student's personal actions, the failure of DPJP supervision, or weaknesses in the institutional system.

4.4. Reconstruction of Legal Supervision and Protection

Based on the above analysis, a reconstruction of legal oversight and protection for dental students is needed, encompassing several key aspects. First, acknowledging that students' clinical authority is limited because of their level of training and experience. This is important because without clear rules about how much clinical responsibility students should have, there's a greater chance they might do things they're not ready for, which could harm patients. Research in different clinical teaching settings has found that when students aren't given clear limits on what they can do, and these limits aren't written in the standard operating procedures or academic rules, there can be medical dangers if they act on their own without being closely watched (Sharma et al., 2026). Second, Improving the rules for active and written oversight by qualified healthcare workers. Clinical supervision of students should be seen not just as a routine administrative task, but as an important part of protecting patients legally and as a way for hospitals to manage risks effectively. The precautionary principle, the principle of responsibility, and the idea of vicarious liability are important for understanding how authority and responsibility relate between different parties (Costanza-Gugiu et al., 2025).

Third, the establishment of implementing regulations for Law Number 17 of 2023 concerning Health, specifically governing student practice in teaching hospitals, including dental students. These regulations need to explicitly stipulate the delegation of authority, supervision standards, limits of authority, and the construction of legal accountability. Ideally, the delegation of authority from the DPJP to dental students should be implemented through a clinical delegation letter as the legal basis for providing medical services, even if the student does not yet have full competence and formal authority (Hsu et al., 2025). Fourth, strengthening preventive protection by improving students' understanding of health ethics and law. Research

shows that dental students still neglect aspects of health ethics and law, such as seeking patients with the help of agents or others, promoting themselves on social media without following regulations, and being unprepared to master material that could ultimately impact patients (Varvara et al., 2026). Therefore, education in health ethics and law needs to be enhanced in the dental professional education curriculum.

This method helps make the law clearer, which in turn helps keep patients safe, ensures students learn well, and reminds hospitals of their duty to take care of patients (Wang et al., 2024). The theory of institutional responsibility highlights the connection between clinical supervision and the duties of an institution, requiring hospitals to provide a safe supervision program that follows professional standards (Costanza-Gugiu et al., 2025). Based on the legal inconsistencies identified in the previous section, the reconstruction of legal supervision and protection needs to be directed not merely at adding regulations, but at establishing a clearer relationship of authority and accountability. The lack of clarity regarding the position of students as recipients of transfers, the limits of clinical authority, and responsibility in the event of deviations are the primary reasons why more specific regulations are needed.

First, the limits of student authority need to be established based on their level of competency and educational stage. This recommendation is directly derived from the finding that students do not have the authority to practice independently and that their clinical actions must be under the instruction and supervision of authorized medical personnel. Therefore, the limitations of authority should not only be stated generally but also outlined in a clinical authority matrix that distinguishes between actions that students can perform directly, actions that require direct supervision, and actions that students are not permitted to perform. Second, supervision needs to be active, proportional, and documented. This recommendation is based on the finding that supervision is a determining factor in the relationship between student actions and the responsibilities of the DPJP. Supervision is not merely evidenced by the appointment of a supervisor; it requires documentation of instructions, approval, implementation of actions, evaluation, and DPJP intervention, if necessary. Thus, supervision serves as both a patient protection mechanism and a tool to provide legal certainty to students and the DPJP.

Third, a written mechanism is needed regarding the delegation or granting of clinical authority to students. Given the ambiguity surrounding students' position within the provisions regarding the delegation of authority, a written document can be used as an internal instrument to clarify who grants authority, what actions are permitted, the limits of student competence, the form of supervision, and the conditions under which the DPJP must take over. This reconstruction is not intended to grant students independent practice authority, but rather to provide certainty regarding clinical educational actions that are permitted within the educational system. Fourth, implementing regulations need to clarify the relationship between teaching hospitals, educational institutions, DPJPs, clinical lecturers, students, and patients. This is important because research findings indicate that liability issues are not solely related to individual actions. Failure to establish SOPs, inadequate supervision, or unclear consent mechanisms can constitute institutional issues. Therefore, institutional responsibility needs to be considered alongside mandates and personal liability.

Fifth, strengthening legal and ethical education for students needs to be positioned as part of legal risk prevention. This recommendation stems from findings regarding persistent issues with student compliance with ethical and legal aspects. Students need to understand not only how to perform clinical procedures, but also the limits of their authority, the consequences of performing procedures without instruction, the importance of informed consent, documentation requirements, and the procedures to follow when faced with clinical situations beyond their competence. Comparatively, this reconstruction demonstrates that legal protection cannot rely solely on the concept of mandate. The mandate concept clarifies the position of responsibility of the person granting the authorization, but does not fully address the issue of institutional responsibility and personal liability in the event of deviations. Therefore, a more comprehensive protection model requires integrating four elements: the limits of student authority, DPJP supervision, institutional responsibility, and personal responsibility based on deviant actions. Therefore, the primary contribution of this research lies in its effort to connect the concepts of mandate, supervision, vicarious responsibility, institutional responsibility, and personal responsibility within a single legal

framework. The proposed reconstruction is not merely an administrative recommendation, but rather a logical consequence of the discrepancy between the needs of clinical education practice and the authority regulations that do not explicitly accommodate the position of dental students. The framework is expected to create a balance between legal certainty for students, accountability of DPJP and institutions, and protection of patient safety and autonomy.

V. Conclusion

Based on the analysis, it seems that the way dental students practice in teaching hospitals has many complicated legal issues. Although the students aren't allowed to practice on their own yet because they don't have a Certificate of Injury (STR) or a License (SIP), they are still involved in healthcare services. This puts them in a legal situation that involves the DPJP (Indonesian Dental Association), their school, and the hospital, which provides the service. The legal liability of dental students is limited and situational. When delegated authority in the form of a mandate, primary responsibility rests with the DPJP as long as the action is carried out with their permission and under their direct supervision. However, students can be held personally liable if they are proven to have acted outside their authority, without the DPJP's approval, or if they have disregarded SOPs and the code of ethics. The passing of Law Number 17 of 2023 about health has improved the overall system for developing and managing healthcare workers, but it has not yet included specific rules to protect dental students who are training in teaching hospitals. This difference in rules could lead to confusion in the law, especially when it comes to how much power students have and how responsibility is handled if there is a problem with patient safety.

Based on the results of the normative legal analysis, this study indicates that the position of dental students in clinical practice at teaching hospitals has a special legal character because they play a role in patient care but do not yet have the authority to practice independently. Therefore, students' clinical actions must be placed within the framework of instructions, delegation of authority, competence, and supervision from authorized medical personnel. The lack of clarity regarding the position of students as recipients of delegated authority is a key issue that can create uncertainty in determining the relationship between student actions, the responsibilities of the DPJP, and the responsibilities of the institution. The construction of responsibility identified in this study is conditional, not automatically inherent in either the student or the DPJP. In a mandated relationship, the responsibility of the mandator remains relevant as long as the student carries out actions in accordance with the authority, instructions, competence, and supervision granted. Conversely, students' personal responsibility may arise if actions are taken beyond the limits of their authority, without the necessary approval or instructions, or in disregard of standard operating procedures (SOPs) and professional obligations. Thus, the analytical contribution of this research is to clarify that determining responsibility in clinical education needs to be done through the relationship between mandates, limits of authority, supervision, personal liability, and institutional responsibility, not solely based on the student's status as a learner.

This research's scientific contribution lies in the development of a legal construct that connects the position of dental students with three layers of responsibility: the individual responsibility of the student, the responsibility of the DPJP as mandate issuer and supervisor, and the institutional responsibility of hospitals and educational institutions. This framework provides an extension of previous discussions that tended to view student protection issues primarily from the perspective of supervision and limits of authority. This research demonstrates that legal certainty requires an integration of the source of authority, level of competence, form of supervision, informed consent, medical record documentation, and accountability mechanisms in the event of deviations. This research also found a misalignment between the needs of clinical education practice and regulations regarding the delegation of authority, which do not explicitly accommodate dental students. Therefore, the proposed reconstruction of legal protection is directed at affirming the limits of action based on the level of competence, active and documented supervision, written mechanisms for granting clinical authority, strengthening informed consent and documentation, and

establishing implementing regulations that more specifically govern the relationship between students, DPJPs, hospitals, educational institutions, and patients. Several agendas can be developed for further research. First, a doctrinal comparison can be conducted by comparing the construction of responsibilities for dental students in Indonesia with other countries that have more detailed regulations regarding clinical delegation, supervision, and liability in clinical education. This comparison can be used to identify regulatory models relevant to the development of Indonesian health law.

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