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Degree in Dentistry

EVALUATION OF LEGAL JUDGEMENTS IN DENTISTRY

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RESUMEN

Introducción: El consentimiento informado (CI) se ha identificado como el principal factor de responsabilidad en cirugía dental, superando al error técnico en España y el Reino Unido.

Objetivos: el objetivo principal es evaluar las implicaciones éticas y legales de la responsabilidad profesional en cirugía dental, analizando el papel del CI y el error técnico en las resoluciones judiciales de ambas jurisdicciones. Los objetivos secundarios incluyeron revisar la legislación vigente, examinar sentencias judiciales seleccionadas y comparar los marcos legales.

Metodología: Revisión documental sistematizada mediante búsqueda en PubMed/MEDLINE, Scopus y ScienceDirect, combinando descriptores MeSH y términos libres, con criterios de inclusión y exclusión explícitos. El proceso de selección se documentó mediante diagrama de flujo PRISMA. **Resultados:** Se incluyeron diez estudios (ocho primarios y dos post-análisis). En España, el CI deficiente fue la causa más frecuente de responsabilidad, superando al error técnico. En el Reino Unido, el estándar Montgomery y los casos Hughes v Rattan y Pawley v Whitecross establecieron un marco de responsabilidad institucional. La lesión neurológica fue la categoría de daño más costosa en ambas jurisdicciones. **Conclusiones:** El CI deficiente constituye el principal motor de responsabilidad en cirugía dental en ambas jurisdicciones. La calidad de la comunicación y la documentación clínica son tan determinantes como la competencia técnica en la resolución judicial de reclamaciones.

PALABRAS CLAVE

Odontología, responsabilidad profesional, mala praxis dental, negligencia dental, consentimiento informado,

ABSTRACT

Introduction: Professional liability in dentistry arises when a practitioner fails to meet the required standard of care, causing harm to a patient. Informed consent (IC) failure has been identified as the primary driver of liability in dental surgery, exceeding technical error in frequency across both Spanish and UK jurisdictions. **Objectives:** The primary objective was to evaluate the ethical and legal implications of professional liability in dental surgery, analysing the role of informed consent failures and technical errors in judicial outcomes in Spain and the United Kingdom. Secondary objectives included reviewing applicable legislation, examining selected judicial decisions and comparing the legal frameworks of both jurisdictions. **Methods:** A systematised documentary review was conducted using PubMed/MEDLINE, Scopus and ScienceDirect, combining MeSH descriptors and free terms. Explicit inclusion and exclusion criteria were applied, and the study selection process was documented using a PRISMA-style flowchart. **Results:** Eight primary studies and two post-analysis studies were included (ten studies in total). In Spain, IC failure was the most frequent basis for professional liability, exceeding technical error. In the United Kingdom, the Montgomery standard and cases Hughes v Rattan and Pawley v Whitecross established a dual framework of individual and institutional accountability. Neurological injury was the most costly category of harm in both jurisdictions. **Conclusions:** Deficient informed consent constitutes the primary driver of professional liability in dental surgery across both Spain and the UK. The quality of clinical communication and documentation is at least as determinative of judicial outcomes as technical competence.

KEYWORDS

Dentistry, Professional liability, dental malpractice, informed consent, negligence

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1. INTRODUCTION

1.1. Definition and background of the subject

1.1.1 What is a legal judgement

Dentistry is a regulated healthcare profession in which clinical competence alone is insufficient to define the boundaries of professional responsibility. Beyond the technical demands of diagnosis and treatment, dental practitioners operate within a framework of legal and ethical obligations that govern the standard of care owed to patients. Understanding these obligations and how they are interpreted when disputes reach the courts or professional regulatory bodies has become an increasingly important aspect of dental practice in both Spain and the United Kingdom.

Professional liability in dentistry arises when a practitioner fails to meet the standard of care that the law or professional regulations require, and that failure causes harm to a patient.

Dentistry is most commonly associated with malpractice claims. Internationally, a study from Italy similarly documented high volumes of dental litigation. Italian courts have been reported to face more than 30,000 malpractice claims per year, with verdicts in favour of the patient in approximately 74% of cases. (1) These figures collectively suggest that dental malpractice litigation is not just a marginal phenomenon but a substantive and growing dimension of professional practice in multiple jurisdictions.

Understanding the different types of consent are a significant attribute that is applied when making a legal judgement. What is particularly notable about the available evidence is that the primary driver of professional liability in dental surgery may not be of clinical error in the conventional sense. Across the findings reviewed in this study, failures in informed consent (IC), defined as the absence or insufficiency of the process through which a patient is adequately informed about the nature, risks, and alternatives of a proposed treatment, appear to arise at least as frequently as technical errors as a basis for liability determinations. (2)

This observation challenges the assumption that professional responsibility is fundamentally about technical competence and suggests instead that the legal and ethical obligations of patient communication carry independent and often decisive weight in how courts and regulatory bodies determine accountability.

Regarding malpractice, surgery was the sector that was mostly involved for legal claims as shown in FIGURE 1.

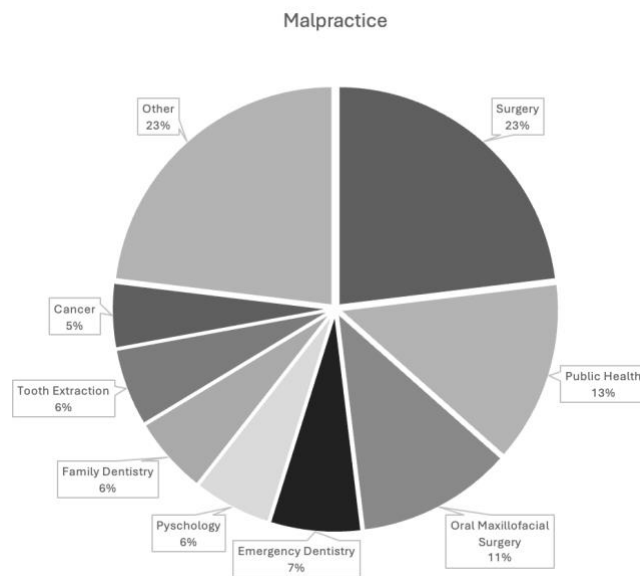


Fig 1 malpractice sectors in dentistry (3)

Moreover, negligence is an attributing factor used in legal claims against dentists. These are commonly due to the failure of the dentist. For an action to be deemed as negligent, there are four main aspects that need to be present: first, that the dentist owed a certain standard of care; secondly, that the dentist did not maintain that standard; thirdly, that an injury resulted from the lack of care; and lastly, that there is a causal link between the negligent act and the resultant injury (4). There are many fundamental reasons for dental malpractice. This can entail lack of competence (misdiagnosing) or inexperience when providing the dental treatment (could be referred to a specialist), lack of diligence to prevent mistakes or from a financial point to maximise profit when certain treatments are unnecessary for example, placing an implant when the tooth can be preserved and it is still vital.

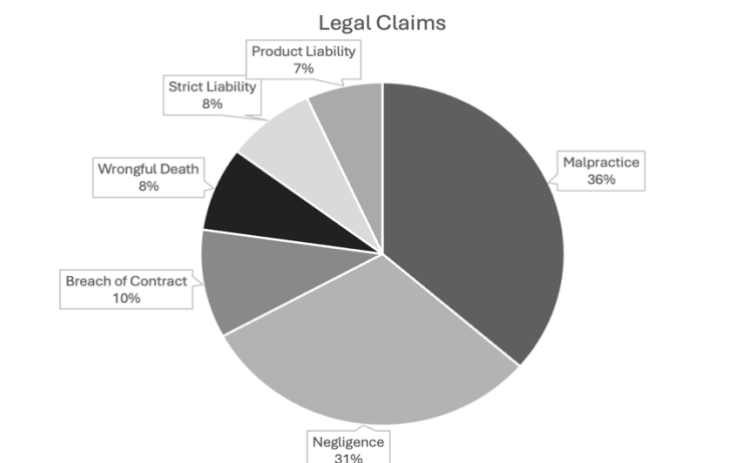


Fig 2 malpractice and other legal claims (3)

1.1.2 Definition of dental surgery

Dental surgery is a specialised field within dentistry that primarily focusses on the diagnosis, prevention and surgical treatment of diseases, injuries and anomalies that affect the dentoalveolar structures and the surrounding anatomical areas. It can range from a simple surgical extraction to a more complex procedure such as corrective jaw surgery. Within dental surgery, as it involves the hard and soft tissue, it can often produce an irreversible alteration (5)

Therefore, it is imperative that these interventions are performed with the correct, detailed anatomical knowledge and technical expertise to assess the inherent risks that are possible to occur. For example, during an extraction, errors in the administration of anaesthesia can cause nerve damage. As well as the treatment itself, there is a high degree of comprehensive treatment planning that consolidates both the aesthetic and patient expected outcome. Research has suggested that a significant proportion of dental malpractice claims could have been avoided through more effective patient communication (3), reinforcing the idea that the practitioner's legal obligations extend well beyond the technical execution of treatment and encompass the entire clinical encounter, from initial consultation through to post-operative review.

1.1.3. Evolution of legal and clinical decision making in dentistry

There has been a significant shift within clinical decision-making in the professional practice of dentistry. Over the past, the practitioner determined the most appropriate treatment, and the patient played a more passive role as the clinician would be viewed as having adequate knowledge and presumed sympathetic intent. However, ethics have played a pivotal role in emphasising morals and righteousness for the patient who can now understand their treatment freely and make the final decision. This evolution incorporates human rights, legal accountability and patient protection in the field of dentistry (6).

Furthermore, dentistry is now regulated within legal and ethical guidelines to acknowledge that the patient is well within their rights to question and challenge anything before the initiation of a treatment and it is the dentist's obligation to convey the information. This evolution has direct implications for how professional liability is understood and adjudicated. In both Spain and the UK, the legal frameworks governing informed consent have developed significantly since the 1990s, and the evidence reviewed in this study suggests that courts in both jurisdictions have

progressively moved towards treating defective informed consent as an independent ground for liability. (7)

IC is described as the “most influential ethical principle in contemporary biomedical practice” (8).

1.2. Theoretical framework

1.2.1 Bioethical principles applied to dental surgery

The ethical backbone of dentistry consists of these four principles: Autonomy, beneficence, non-maleficence and justice. These principles are practical guides to clinical decision-making, and they intersect directly with the legal standards that courts apply when evaluating professional conduct.

Firstly, beneficence is the principle of where the dentist will act for what is the best interest of the patient based on an honest and thorough assessment of their clinical situation. In the context of dental surgery, this means that the practitioner must consider not only whether a procedure is technically achievable but whether it represents the appropriate clinical choice given the patient's individual circumstances.

Non-maleficence is where the dentist has a duty to not harm the patient. This can protect the patient as it keeps the dentist grounded in terms of knowing their own limitations and when it is appropriate to refer them to another professional. In dental surgery, where the potential for permanent and irreversible harm is significant, this principle is of particular importance. It also connects to the obligation to warn patients of foreseeable risks before treatment: a practitioner who performs a procedure without disclosing its known hazards may be seen as having compromised the patient's ability to protect themselves from harm by making an informed choice about whether to proceed.

Autonomy, arguably the most significant, is about respecting the patient's right to make their own conscious decision. This gives the patient the right to refuse or accept a treatment, provided they have been informed with all the necessary information, and the dentist must respect the patient's final decision openly and transparently. Both Spanish and UK law have codified the patient's right to receive adequate information before consenting to treatment.

Finally, justice outlines equality. Treating the patient fairly. Ensuring that the patient is treated with the same professional care and quality as any other patient when providing the service. (9,10)

1.2.2 Legal framework governing dental practice in Spain

In Spain, the system is governed through the Ley 41/2002 law, which is the law for informed consent and the right to receive ample clinical information. Consent is voluntary and Spain's professional conduct is structured by the Código deontológico del consejo general de dentistas, which sets out the ethical principles for dental professionals to adhere to when making a legal judgement. The information provided must, at a minimum, include the purpose and nature of each intervention, the associated risks, potential consequences, and available treatment alternatives (11). This places a proactive information-sharing duty on the practitioner rather than a purely reactive one. In the context of dental surgery, this means that before performing procedures such as third molar extractions, dental implant placement, or orthognathic surgery, the dentist is legally obligated to disclose all foreseeable risks particular to the patient's anatomy, clinical condition, and age, not merely generic risks associated with the procedure class. Spanish courts over time have recognised two distinct categories of breach: failure in technique and defective or absent informed consent. Spanish courts have recorded a greater number of professional liability findings grounded in defective informed consent than in technical surgical error, reflecting a significant shift in the predominant source of dental surgical malpractice claims (2). This finding challenges the assumption that technical competence constitutes the primary measure of professional responsibility in dental surgery, revealing that the quality of patient communication and ethical practice are equally, if not more, determinative of legal outcomes.

1.2.3 Legal framework governing dental practice in the United Kingdom

Like Spain, the UK also have their own set of guidelines to follow to ensure the correct procedures are carried out. This is delegated by the general dental council (GDC). These standards address, amongst other things, the requirements for valid informed consent: patients must receive sufficient information in a format they can understand, must have the opportunity to ask questions and to consider their options, and must give their consent voluntarily before treatment begins. The GDC's standards are not legally binding in themselves, but departure from them is treated by courts and tribunals as relevant evidence of whether the professional standard of care has been met.

A key role on informed consent arose from a specific case “Montgomery v Lanarkshire” these doctors were sued for negligence. Essentially, a woman had a high-risk pregnancy as she had diabetes and was of small stature. The baby was expected to be larger than normal and so the doctor recommended a vaginal delivery. However, she was not informed by the doctor that there can be a 10% risk of shoulder dystocia and in the end, the baby had this condition (12). This information was not disclosed when it should have been. This caused an uproar and it highlights how crucial it is to disclose information to the patient of the potential risks involved no matter the circumstance and ensuring clear and concise communication to the patient as when we apply this for dentistry in the UK, everything is open and honest to avoid malicious intent and supports fairly when trying to make an appropriate judgement.

The UK demonstrates the importance of communication and informed consent being one of the main factors. It is more in-depth than just performing the final treatment and relates specifically to the journey from when the patient first enters the clinic. It includes having the substantial documentation, closure of possible risks and complications and important decision making ensures a healthy relationship to practice within legal and ethical standards.

1.3. Current state of the subject

1.3.1 Increase in medico-legal claims in dental surgery

The trend in the rise of medico-legal claims in dental surgeries is down to patients’ awareness of their legal rights or when the clinical decisions deviate from the expected outcome. The most common cases are treatment failures (3). This can be due to the fact that aesthetic dentistry and patients’ expectations are increasing drastically. Further studies also show how as expectations are higher, there is more conflict and issues which can lead to insufficient communication and highlights how detrimental it can be when performing high risk and complicated treatments (13)

Professional liability claims and formal complaints in dental surgery have shown a sustained upward trend in both Spain and the United Kingdom over recent decades. In Spain, claims submitted to professional colleges and civil courts have grown alongside the rapid expansion of the dental workforce in regional datasets from Murcia and Catalonia. (14,15)

Across both jurisdictions, certain clinical procedures carry disproportionate liability exposure. Dental implant surgery, third molar extraction, and other procedures with significant nerve proximity risk consistently appear at the top of compensation rankings in Spanish claims data,

(16) and nerve damage is identified as the costliest single injury category in the UK NHS OMFS dataset (17). These findings are consistent with the clinical reality that oral surgical procedures involving the posterior mandible carry well-established and foreseeable risks of inferior alveolar and lingual nerve injury risks that practitioners are legally obligated to disclose before obtaining consent, and whose non-disclosure may ground a liability finding independently of whether any surgical error occurred.

In the UK, qualitative evidence from Thakrar and Wassif (2021) suggests that newly qualified dentists may be entering practice with insufficient confidence in applying GDC legal and ethical standards, which may contribute to the persistence of IC failures documented in the claim's literature. This parallel evidence from two jurisdictions may suggest that the knowledge gap between legal standard and practitioner understanding is not merely an individual problem but a systemic one with roots in professional education and training. (18)

1.4 Justification of the study

Dental surgery is evolving and becoming more complex, and it will only continue to do so. Patients' expectations are increasing, as well as legal scrutiny and therefore understanding the legal and ethical implications of clinical decision making has become essential for ensuring we practise professionally as well as responsibly. With all this I hope to aim and explore the ethical and legal dimensions of professional responsibility and find the most appropriate way to finalise how we judge when practicing throughout this field.

Dental practitioners in Spain and the United Kingdom operate within demanding regulatory frameworks in which legal accountability extends beyond clinical competence into the domains of patient communication, documentation, and ethical conduct. Despite this, the available evidence suggests that a significant proportion of practitioners do not fully understand or consistently apply the legal standards that govern them. No systematised cross-jurisdictional review has previously compared the legal reasoning applied in Spanish and UK dental surgical liability cases alongside contemporary practitioner knowledge evidence. The existing literature addresses each jurisdiction in isolation, or focuses on single liability categories such as technical error, without examining the relative contribution of informed consent failure as a liability driver across both systems simultaneously. This review addresses that gap by synthesising ten primary studies drawn from both jurisdictions, enabling a structured comparison of the legal, ethical,

and educational dimensions of professional liability in dental surgery. The findings are directly relevant to undergraduate and postgraduate dental education, to clinical governance, and to the development of institutional informed consent frameworks in both countries.

2. OBJECTIVE

2.1 Primary objective:

To evaluate the ethical and legal implications of professional responsibility in a dental surgical practice in Spain and the United Kingdom, with particular focus on how informed consent and clinical standards are defined and enforced.

2.2 Secondary objectives:

- To review and interpret Spanish and UK legislation regulating dental practice, specifically Ley 41/2002 and GDC standards, while focusing on informed consent, professional competence, and liability.
- To examine selected judicial decisions and professional liability claim datasets from Spain and the UK, evaluating the legal reasoning applied in determining negligence and the relative weight given to informed consent failure versus technical error in liability outcomes.
- To compare the ethical and legal implications of professional responsibility and patient protection in dental surgery, comparing key aspects between Spain and the UK.

3. MATERIAL AND METHODS

3.1. Focussed question

In a dental surgical practice in Spain and the United Kingdom (P), how do legal judgements evaluate informed consent failures (I) compared to technical errors (C) in determining professional liability outcomes (O)?

3.2. Search strategy

The search was conducted across three electronic databases: PubMed/MEDLINE, Scopus, and ScienceDirect, accessed via the UEM Biblioteca. The search was limited to English and Spanish-language studies with available full texts. Findings were cross-checked against professional guidelines from the General Dental Council (GDC) in the UK and the Consejo General de Dentistas in Spain. The following Boolean search equation was applied across all databases: ("dental malpractice" OR "dental negligence" OR "dental liability") AND ("informed consent" OR "professional liability" OR "standard of care") AND ("Spain" OR "United Kingdom" OR "court" OR "judicial"). A secondary equation targeted practitioner knowledge studies: ("dental negligence" OR "dental law") AND ("legal knowledge" OR "newly qualified" OR "dental education") AND ("Spain" OR "United Kingdom"). Searches were conducted without date restriction to capture the full longitudinal extent of liability data.

3.3 Selection

3.3.1 Inclusion criteria

- Studies, judicial decisions, and case series reporting outcomes of dental malpractice, negligence, or professional liability claims in dentistry, including data on causation, compensation, or legal reasoning
- Appellate court decisions, professional college complaints records, and peer-reviewed empirical studies with publicly available full text, published in English or Spanish
- Studies with a primary focus on dental surgical procedures (including third molar extraction, implant placement, orthognathic surgery, or nerve-risk procedures) or on informed consent as a liability factor in dental practice

- Studies or decisions from Spain or the United Kingdom, selected to enable cross-jurisdictional comparison of legal standards, judicial reasoning, and liability patterns
- Sources providing sufficient information on legal reasoning, standard of care, or the basis for liability findings to permit meaningful analysis and data extraction

3.3.2 Exclusion criteria

- Studies or decisions for which full text was not publicly available or accessible through the UEM Biblioteca, and for which no author contact could resolve the access barrier
- Duplicate records identified across databases, and secondary sources (narrative reviews, editorials, or opinion pieces) that did not report primary empirical or legal data
- Studies exclusively concerning non-dental healthcare professionals where no dental-specific liability data could be extracted, and cases where dental involvement was incidental rather than primary
- Regulatory disciplinary proceedings that did not involve judicial review and from which no legal reasoning applicable to the research question could be derived

4. RESULTS

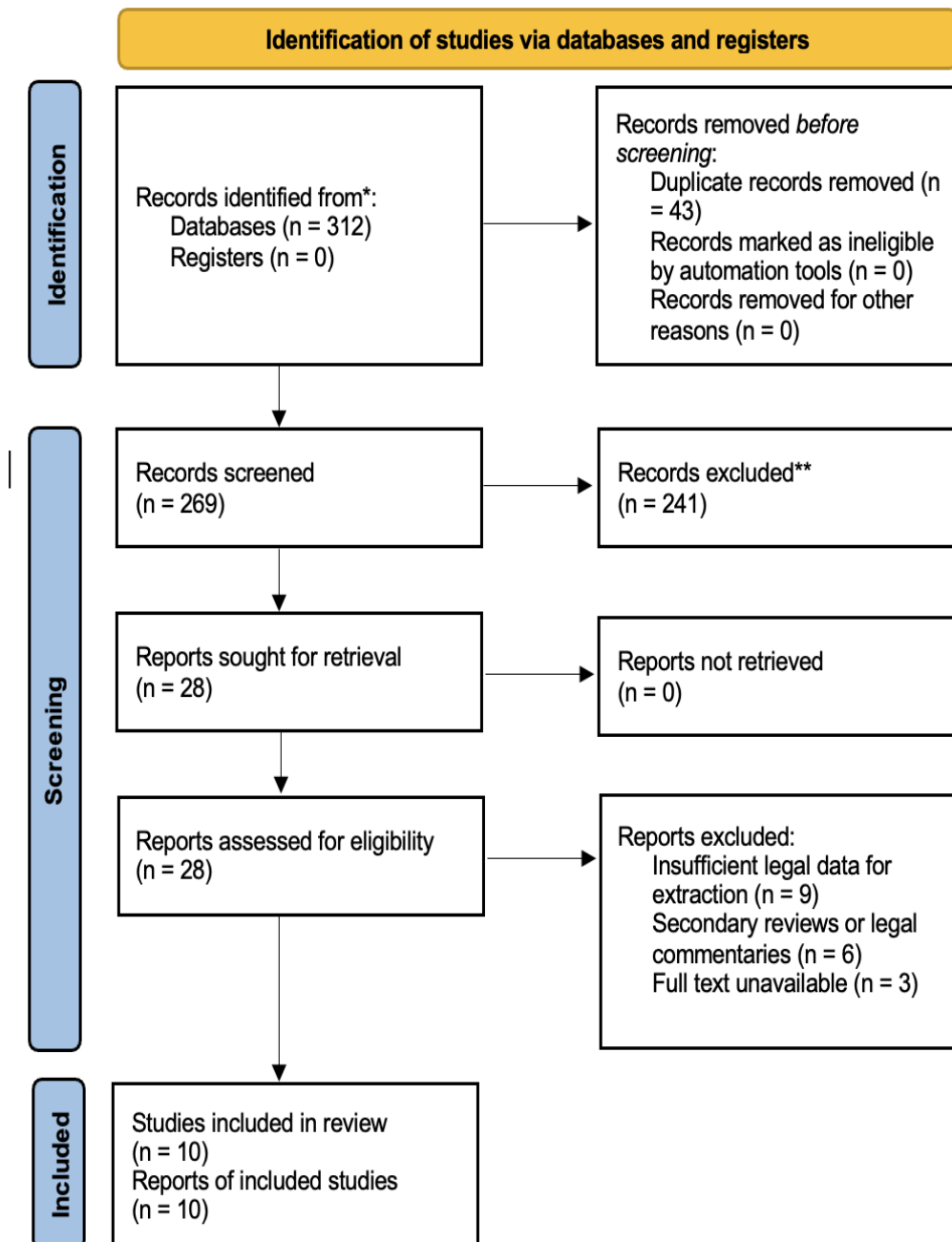


Figure 3 PRISMA 2020 flow diagram for search strategy (19)

The electronic database search identified a combined total of 312 records across PubMed/MEDLINE (n = 147), Scopus (n = 108), and ScienceDirect (n = 57). Following the removal of 43 duplicate records, 269 unique records were screened by title and abstract. Of these, 241 were excluded as they did not meet the inclusion criteria. The remaining 28 full-text articles

were assessed for eligibility. A further 18 were excluded: 9 lacked sufficient legal data for extraction, 6 were secondary reviews or legal commentaries, and 3 were not available in full text. Ten studies were included in the final review, comprising eight primary empirical studies and two post-analysis practitioner studies (Figure 3).

The included studies are heterogeneous in design, ranging from large retrospective cohort analyses of national claims databases to expert witness case series, legal jurisprudential reviews, and appellate court rulings. The UK studies predominantly draw on NHS Resolution Freedom of Information data and appellate case law, whilst the Spanish studies rely on professional college complaints databases, regional liability claim registries, and court sentence analyses. Two post-analysis studies, a cross-sectional MCQ survey of practising Spanish dentists, Sánchez Gisbert et al. 2022 (20) and a qualitative interview study of newly qualified UK dentists, Thakrar & Wassif, 2021 (18) were included to provide contemporary evidence on practitioner legal knowledge as context for the liability patterns observed. The data extraction table below (Table 1) summarises the design, sample, and principal outcomes of all ten included studies.

Table 1 Dental malpractice and negligence results in UK and Spain

Authors (years)	Country	Study design and sample (n)	Outcomes
Ahmed, McGoldrick & Elledge (2021) (17)	UK	Retrospective cohort study (RCS) N=1,122 NHS OMFS claims	Total damages: £32.6 million. Most frequent injury categories: unnecessary operations (27.9%), pain (13.9%), nerve damage (12.4%), dental damage (11.2%). Nerve damage was the costliest single category (£8 million). Total financial liability rose substantially across the decade despite broadly stable claim numbers.
Blanchard et al. (2022) (16)	UK	RCS N= 492 hospital claims	Estimated total cost: £14 million. Most frequent cause: failure/delay in treatment (n=175; £3.9M). Failure to warn/obtain informed consent: n=37 (£1.5M). Most frequent injuries: dental damage (n=197; £4.3M), nerve damage (n=52; £2.4M),

		unnecessary pain (n=125; £2.3M). Wrong site surgery cited in 33 claims.	
Causey & UK Marley (2023) (21)	Retrospective qualitative study N= 30 negligent cases	Five recurring contributory themes identified: task-related factors, patient-related factors, communication failures, organisational factors and dentist-related factors. Communication and documentation failures were consistently present across the majority of cases. Risk-reduction strategies were mapped to each theme.	
Hughes v UK Rattan (2022) (22)	Court case N= single case	Court of Appeal confirmed that an NHS dental practice owner owes a non-delegable duty of care to patients treated by self-employed associate dentists (Woodland test applied). The associates were independent contractors. Practice owners are directly liable for associate negligence via non-delegable duty in NHS dentistry regardless of associate self-employment status.	
Pawley v UK Whitecross Dental Care Ltd (2021) (23)	Court case N= single case	Claimant cannot be compelled to sue defendants she has not chosen to pursue. The dental practice could not force individual treating dentists into proceedings as co-defendants. Patient autonomy extends to litigation strategy.	
Perea-Pérez et al. (2011) (24)	RCS N= 63 court sentences	Nerve damage and post-operative complications were the most frequent events generating liability. IC deficiencies consistently identified alongside technical failures. 89% of criminal proceedings ended in acquittal. Civil liability was the predominant route. Increasing trend in sentences observed across the study period.	

Bordonaba-Leiva et al. (2019) (15)	Spain	RCS N= 315 OMS claims	Compensation rate: 33.8%. Highest-risk procedures: dental implant surgery and third molar surgery. Most compensated: lack of implant osseointegration, neurological injury to inferior alveolar/lingual nerves, poor aesthetic results. Poorly documented IC was statistically and significantly associated with a liability outcome and identified as an independent predictor of claim compensation.
López-Nicolás et al. (2007) (14)	Spain	Retrospective descriptive study N=52 malpractice claims	Adequate professional behaviour in 14 cases; malpractice in 38 cases. Of 38 malpractice cases: 29 technically correct but with information failure; 9 had technical errors. Written IC absent in 40 cases. Where written IC present (n=12), all deemed unsuitable. 20 complaints did not progress beyond the College; 12 went to civil court; 8 to arbitration. Parallel rise in claims and dentist numbers observed across study period.
Sanchez Gisbert et al (2022) (20)	Spain	Cross-sectional descriptive study	33 MCQ covering legal dentistry, forensic science, and health regulations. Only 63% of questions answered correctly, indicating a moderate/deficient level of legal knowledge. Neither training level nor years of experience correlated significantly with legal knowledge score. University-based dentists scored higher than clinically based colleagues. Self-employed and salaried dentists scored below average.
Thakrar and Wassif (2021) (18)	UK	Qualitative study N= 9 newly qualified dentists	Participants consistently reported fear and uncertainty when applying GDC legal and ethical standards in everyday clinical practice. A perceived gap was identified between university training and real-world regulatory demands. Participants felt inadequately prepared to translate GDC Standards for the dental team into

confident clinical decision-making. Study concluded that targeted legal and ethical education is needed at undergraduate and early postgraduate levels.

5. DISCUSSION

The evidence reviewed across both jurisdictions may suggest that professional liability in dental surgery is determined at least as much by the quality of communication before treatment as by the quality of the clinical work itself. This observation is given particular weight by its consistency: informed consent (IC) failure appears as a recurring explanatory factor not in one dataset or one legal system, but across ten independent studies spanning two countries and more than three decades. What the evidence may therefore be describing is not a series of isolated failures but a structural and persistent gap between the legal standard of patient communication and what actually occurs in clinical practice. Understanding why that gap exists, why it persists despite increasingly demanding legal frameworks in both countries, and what its ethical implications are, is the central task of this discussion.

5.1 Informed consent as a key determinant of professional liability

The most consistent finding across all four Spanish studies is the primacy of IC failure as a ground for professional liability. It is not merely as a contributing factor alongside technical error, but frequently as the independent and decisive basis for a liability finding. López-Nicolás et al. (2007) found that 29 of 38 malpractice determinations involved technically correct treatment: the procedure itself was not deficient, yet a malpractice finding was still made (14). This is a significant observation because it directly challenges the assumption that professional liability in dentistry is fundamentally about clinical competence. The data also revealed that written IC was absent in the vast majority of cases, and that where written documents did exist, they were uniformly considered unsuitable. This pattern suggests that what may need to change is the communicative and ethical dimension of practice. Rather, it is the process by which the patient is informed, involved, and protected before treatment begins.

Otero et al. (2022) confirmed that this pattern extends into the contemporary jurisprudential context, finding that more dental malpractice convictions in Spain have arisen from defective IC than from clinical negligence. The research outlines something that if the official IC documents used in Spanish dental practice score in the 'somewhat difficult' range on the INFLESZ scale, they may be satisfying the formal legal requirement of a signed consent document however they would be failing the substantive ethical requirement of genuinely informing the patient (2). A document that a patient signs without fully understanding does not, in any meaningful ethical sense, represent informed consent. It shows it represents more of a formal compliance in the absence of real communication. Spanish courts appear to have recognised this distinction,

treating the absence of comprehensible documentation as evidence that adequate communication did not occur, regardless of whether a form was technically present.

Bordonaba-Leiva et al. (2019) provides that in a dataset of 315 claims over 24 years, poor IC documentation was not merely associated with liability outcomes but identified as a statistically independent predictor of claim compensation (15). This means that, controlling for other variables, inadequate IC documentation alone was sufficient to predict whether a claim would be compensated. This is independent of the nature of the injury or the quality of the clinical work. The implication is substantial as courts are treating documentation not as a formality, but as substantive evidence of what communication occurred. In the absence of adequate documentation, the court may have no reliable basis on which to accept the practitioner's account of what was said, and liability on IC grounds becomes more likely as a result. This creates a practical incentive that extends beyond ethical compliance, as comprehensive documentation constitutes not only appropriate professional conduct but also critical evidentiary support for practitioners in the event of legal scrutiny.

The Montgomery standard requires consideration of whether the particular patient was informed of risks that a reasonable person in the same circumstances would wish to know, thereby establishing a patient-centred and inherently individualised threshold. The Blanchard et al. (2022) found that failure to warn or obtain IC accounted for 37 claims and approximately £1.5 million across a five-year NHS hospital dentistry dataset may already reflect the practical consequences of this more demanding standard operating in practice (12,16). The Montgomery standard emphasises that informed consent should arise from a genuine and individualised dialogue rather than the mere use of a generic consent form. A practitioner who relies on identical printed documentation for all patients is unlikely to persuade a court that reasonable care was taken to ensure that the patient understood the risks associated with their specific circumstances. This evidential logic is similarly reinforced in Spain: documentation of an individualised communicative encounter carries more weight than the presence of a standard form.

5.2 Technical error and nerve damage

Whilst IC failure dominates the Spanish liability picture, technical error and adverse clinical outcomes remain significant liability contributors in both jurisdictions. Perea-Pérez et al. (2011) identified nerve damage and post-operative complications as the most frequent sequelae generating liability in Spanish oral surgery sentences (24). This finding is closely mirrored by

Ahmed et al. (2021), who reported that nerve damage was the costliest injury category in NHS OMFS claims at approximately £8 million, and Blanchard et al. (2022) identified nerve damage as generating approximately £2.4 million across hospital dentistry claims (16,17). The convergence across independent datasets in two countries may indicate that procedures carrying neurological risk, particularly third molar extraction and implant placement in proximity to the inferior alveolar nerve, which represent the highest-risk medicolegal domain of dental surgery in both Spain and the UK.

Neurological injury to the inferior alveolar or lingual nerve is not an unforeseeable complication. It is a well-documented, quantifiable, and procedure-specific risk. Thus, meaning that its legal status in a liability claim may depend critically on whether the patient was warned before consenting to treatment. On a technicality, a flawless procedure that results in nerve damage to the patient that was never warned about may generate a claim not because anything went wrong clinically, but because the patient's opportunity to make an informed choice about accepting that risk was removed. The Bordonaba-Leiva et al. (2019) demonstrates a statistical association between poor IC documentation and neurological injury. This suggests that claims relating to nerve injury may partly stem from prior shortcomings in the informed consent process, rather than being exclusively the consequence of operative complications (15).

This interaction between technical outcome and prior disclosure has an important ethical dimension. Non-maleficence is not breached only on the operating table; however, it may also be breached at the point where a practitioner withholds information about a foreseeable risk, because doing so removes the patient's capacity to protect themselves by making an autonomous decision about whether to proceed. A patient who understands that a procedure carries a risk of permanent altered sensation may choose to seek a second opinion, to delay treatment, or to accept the risk with full awareness. A patient who is never informed, cannot make any of those choices. The legal finding of liability in these cases may therefore be understood as the law's recognition that the ethical failure occurred before the patient commenced the actual treatment and occurred at the consultation stage, where the disclosure obligation was not met.

5.3 Legal reasoning in Spanish courts

Evidence from Spain provides insight into how courts evaluate professional fault when adverse outcomes occur. The findings reported by Perea-Pérez et al. (2011), which indicate that 89% of criminal proceedings in dental surgery cases resulted in acquittal and that civil liability

represents the primary mechanism for redress, may reflect a deliberate and principled calibration by the courts rather than a deficiency in the legal system's protection of patients . In Spain, criminal liability requires proof that a practitioner's conduct went beyond the ordinary range of professional error and involved gross negligence, recklessness, or intentional wrongdoing. This high rate may therefore suggest that courts generally recognise that many adverse outcomes in dental surgery, including nerve injury and procedural complications, fall within the inherent uncertainties of surgical practice rather than warranting criminal sanction (2,24)

Civil liability, which operates under a lower evidentiary threshold, performs a distinct yet complementary role. It addresses failures in informed consent that may occur even when the technical aspects of treatment are adequate cases that, according to the available evidence, account for most dental liability findings in Spain. In this context, civil liability does not function primarily as a form of punishment but rather as a corrective mechanism, acknowledging that the patient's rights were not fully respected and providing an avenue for redress without attributing to the practitioner the level of culpability required for criminal liability. The gradual decline in patient confidence in the professional college system identified by López-Nicolás et al. (2007), reflected in an increasing number of cases being pursued through civil courts, may indicate a growing perception among patients that civil proceedings offer a more effective route to accountability than internal professional regulation. This shift may, in turn, have encouraged more rigorous documentation practices among practitioners, who increasingly recognise that complaints are more likely to be resolved through judicial processes rather than through professional college mechanisms (14,24).

5.4 Institutional liability and the UK legal framework

Pawley v Whitecross introduces a complementary dimension by demonstrating that patient autonomy extends beyond the clinical context into the procedural domain: patients retain control over how they pursue legal accountability, and dental practices cannot rely on internal liability structures to override those choices. The court's refusal to allow the practice to compel the patient to join individual dentists as defendants may be read as an affirmation that the institutional accountability framework established in *Hughes v Rattan* does not come at the cost of the patient's ability to determine how and against whom they pursue redress. Together, the two decisions may suggest that UK courts are engaged in a sustained project of holding dental practice structures accountable in ways that treat the institution and not only the individual clinician as the relevant unit of professional responsibility (22,23).

5.5 The knowledge gap: why liability patterns may persist

Individual carelessness or deliberate disregard for patient rights cannot plausibly account for a failure that recurs consistently across two independent legal systems over 30 years. What the post-analysis studies may suggest instead is a systemic explanation: practitioners are not consistently meeting the IC standard, at least in part, because they have not been adequately equipped to do so.

Sánchez Gisbert et al. (2022) found that only 63% of legal knowledge questions were answered correctly by practising dentists and stomatologists in the Valencian Community a result the authors characterised as indicating a moderate to deficient level of legal knowledge (20). The most significant aspect of this finding may not be the 63% figure itself, but what did not predict improvement in that score: neither years of professional experience nor additional training qualifications correlated significantly with legal knowledge. This implies that the problem is not one that time in practice resolves organically, and that the acquisition of further qualifications does not reliably address it either. A practitioner who enters clinical work with insufficient legal literacy about IC obligations may carry that deficit throughout their career unless it is specifically and deliberately addressed. In a legal environment where IC deficiencies have been found to generate more convictions than clinical errors, a substantial proportion of practitioners answering roughly one in three legal knowledge questions incorrectly represents an ongoing source of professional risk for the patients who are inadequately informed and for the practitioners who may not realise they are generating liability exposure.

Thakrar and Wassif (2021) approached the same question through a qualitative lens and found that the problem is not simply one of insufficient knowledge but of insufficient confidence in applying that knowledge under the pressures of real clinical practice. Newly qualified UK dentists described fear and uncertainty when applying GDC legal and ethical standards in daily practice not an absence of awareness that standards existed, but a felt inability to translate those standards reliably into clinical behaviour. The depth and consistency of this uncertainty, articulated across interviews of approximately one hour and twenty minutes each, may suggest that it is not a superficial deficit addressable by a brief update session. What participants seemed to be describing was a gap between the theoretical understanding of consent they acquired during training and the practical skills needed to conduct a legally adequate consent conversation with a real patient under time pressure in a real clinic. These are different competencies, and the evidence may suggest that dental education has not reliably developed the second even when it has communicated the first (18).

5.6 Comparison between Spain and the United Kingdom

When the findings from the two jurisdictions are considered together, the most striking feature may be the degree of convergence rather than divergence. Both countries show sustained volumes of dental surgical liability claims over time. Both consistently identify IC failure and documentation deficiency as recurring contributors to liability outcomes. Both generate disproportionate liability in procedures carrying nerve damage risk. And both, through the post-analysis studies, show evidence that practitioner legal knowledge may be insufficient to meet the demands their respective legal frameworks place upon them. This convergence across two independent legal traditions may suggest that the problem of IC failure in dental surgery is not the product of any regulatory environment but reflects something more fundamental a gap between what the law requires and what clinical practice delivers that transcends jurisdictional difference.

The more meaningful divergences lie not in clinical pattern but in legal mechanism and institutional structure. Spain's professional liability system channels accountability primarily through civil courts and professional colleges, with IC failure operating as an independent statutory ground for liability under Ley 41/2002. The Spanish framework focuses accountability on the individual practitioner and places significant evidential weight on the documentation they produce. The UK's common law system, shaped by the Montgomery standard and now extended by the institutional accountability framework in *Hughes v Rattan*, is developing a dual structure: the individual practitioner bears responsibility for the quality of the consent conversation they conduct, whilst the practice bears institutional responsibility for ensuring that the conditions exist in which adequate consent processes can be delivered (11,12,22). These different structures may point towards different optimal responses to the shared underlying problem. In Spain, the evidence may most directly support educational and cultural interventions at the practitioner level, building legal literacy and consent competence into dental training and continuing professional development. In the UK, institutional-level governance reforms practice-wide IC protocols, training requirements, documentation standards, and audit mechanisms may complement practitioner-level improvement and address the structural dimension that individual education alone cannot reach.

Taken together, the two jurisdictions may offer complementary lessons. Spain's long-running empirical record of IC failure as the primary liability driver provides a compelling demonstration of what inadequate IC governance costs patients and practitioners alike over time. The UK's developing institutional accountability framework may point towards a structural response that addresses that cost not solely through individual practitioner education but through the

governance of the practices within which those practitioners work. Neither approach, on the available evidence, has yet closed the gap between legal standard and clinical practice. But the comparison between the two systems may suggest that a comprehensive response requires both dimensions: practitioners who are educated to understand and apply the IC standard, and institutional structures that support, monitor, and enforce its consistent application.

5.7 Limitations

The claims and sentences data reviewed are subject to significant underreporting. They capture only those adverse events that resulted in formal legal action, a small and potentially unrepresentative fraction of the total number of adverse outcomes occurring in dental surgical practice. The true volume of IC failures, technical errors, and adverse outcomes in both jurisdictions is likely substantially larger than the liability data suggest, meaning that the liability figures reviewed here may understate rather than overstate the scale of the underlying problem.

The post-analysis studies carry their own limitations. Sánchez Gisbert et al.'s regional scope limits the generalisability of its findings to Spanish dentists nationally, and its knowledge-based assessment instrument measures awareness of legal standards rather than the applied competence required to deliver legally adequate IC in practice. This demonstrates that the deficit identified, may be greater in clinical reality than the scores indicate. Thakrar and Wassif's small purposive sample limits statistical representativeness; its findings on newly qualified dentists' uncertainty should be read as indicative of possible themes rather than generalisable data, though the consistency with the Sánchez Gisbert quantitative findings strengthens the overall interpretive picture (18,20)

6. CONCLUSION

1. Professional responsibility in dental surgery carries ethical implications that extend beyond technical competence. Across the evidence reviewed, informed consent failure emerges as the primary driver of liability findings in both Spain and the United Kingdom, demonstrating that the legal and ethical obligation to adequately inform the patient before treatment is at least as determinative of professional accountability as the quality of the clinical work itself.

2. Both Spanish and UK legislation establish proactive, patient-centred frameworks for informed consent. Spain's Ley 41/2002 and the Código Deontológico place a duty of comprehensive information-sharing on the practitioner, whilst the Montgomery standard in the UK demands an individualised approach to disclosure. Despite structural differences, both frameworks treat defective informed consent as an independent ground for liability, reflecting a shared shift in how professional responsibility is legally defined and adjudicated. (11,12)

3. Analysis of UK appellate court decisions and Spanish professional liability claim datasets and retrospective sentence analyses consistently identifies deficient or absent informed consent, rather than technical error, as the predominant basis for liability determinations. In the UK, *Hughes v Rattan* and *Pawley v Whitecross* established individual and institutional accountability frameworks. Across the Spanish datasets, documentation quality emerged as a critical evidentiary factor, with inadequate records identified as an independent predictor of claim compensation, indicating that courts treat documentation as substantive evidence of whether adequate communication occurred. (14,15,22-24)

4. Spain and the United Kingdom share a convergent pattern of liability in which IC failure, documentation deficiency, and neurological injury risk are recurring contributors. The principal divergence lies in institutional structure: Spain holds the individual practitioner accountable, whilst the UK is developing a dual framework in which the dental practice itself bears direct institutional responsibility. Both jurisdictions show evidence of a persistent knowledge gap between legal standards and practitioner understanding, suggesting that targeted reform of legal and ethical education across undergraduate and continuing professional development is necessary to reduce the liability patterns the evidence documents. (12,15)

7. SUSTAINABILITY

From a social perspective, improving informed consent processes directly supports patient autonomy, dignity, and equitable access to quality healthcare, aligning with SDG 3 (Good Health and Well-being) and SDG 10 (Reduced Inequalities). IC failures disproportionately affect patients who receive inadequate pre-treatment information. Targeted strategies include embedding IC communication training in undergraduate dental curricula and implementing practice-level documentation audits.

From an economic perspective, inadequate IC documentation is an independent predictor of compensation claims, with dental litigation costs reaching tens of millions of pounds in the UK alone. Strengthening IC practices and legal literacy constitutes a cost-reducing strategy for healthcare systems. Proposed strategies include standardised institutional IC protocols, continuing professional development in legal and ethical competence, and practice-level risk management audits, aligning with SDG 16 (Peace, Justice and Strong Institutions).

From an environmental perspective, adopting practice-wide digital consent management systems would reduce paper-based administrative processes and improve documentation quality and retrieval, simultaneously addressing the evidentiary deficiencies identified in this review and supporting SDG 3.

Collectively, these dimensions highlight that improving professional communication and legal education in dentistry is not only an ethical imperative but a sustainable one. (SDG 3, SDG 10, SDG 16) (25)

8. REFERENCES

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9. ANNEXES