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Managing Dental Tourism Complications in Ireland: A Cross-Sectional Survey of Dental Professionals' Attitudes and Practices

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Abstract

***Introduction*:** Dental tourism is a growing global phenomenon with unresolved implications. No guidelines exist in Ireland to assist dental professionals managing patients who present with complications following treatment abroad.

***Aims*:**This study investigated how dental professionals at the Dublin Dental University Hospital (DDUH) manage such patients, and their opinions on medicolegal responsibility, financial accountability, and the need for guidelines. It was hypothesised that higher qualification level would be associated with decreased referral incidences.

***Methods*:** A cross-sectional survey was distributed in January 2026 to 80 DDUH clinical staff and students via QualtricsXM. Quantitative data were analysed using IBM SPSS (v29). Qualitative responses underwent thematic analysis.

***Results*:**Consultants and specialists reported greater confidence managing complications (81.8%) compared to GDPs (32.6%) and students (30.8%; p =0.009) and were more likely to feel legally protected (p <0.001). Students were more likely to manage complex cases from start to finish. 79.7% of participants supported the development of formal guidelines, while 84.4% disagreed that the HSE should financially cover remedial treatment.

***Conclusion*:** Concerns over care for patients following treatment abroad were common. A lack of structured national guidelines to standardise practice and support clinicians managing the complexities of dental tourism was a particular concern.

Key points

- The study compared how confident consultants/specialists, General Dental Practitioners (GDPs) and dental students felt dealing with dental treatment carried out abroad based on four cases.
- Quantitative and qualitative questions also highlighted wide variation in how each group felt about dental treatment carried out abroad.
- A lack of national guidance, and concerns about legal cover for GDPs, were also highlighted.

Introduction

Dental tourism is defined by the American Dental Association (Resolution 28H-2008) as the act of travelling to another country for the purpose of obtaining dental treatment.[1] The development of dental tourism has been driven by increased patient mobility, affordability, and awareness, leading to an estimated 20.9% increase between 2020 and 2025.[2] Treatment costs abroad are reported to be two to eight times lower.[3, 4, 5] Dental tourism has implications for follow-up care and medico-legal issues, prompting calls for guidelines.[6, 7, 8, 9]

Continuity of Care

Although many patients report positive experiences with dental treatment abroad, complications may present after they have returned home.[10] Within the EU, mutual recognition of dental qualification theoretically provides regulatory oversight of care delivered; however, practical arrangements for ongoing follow-up and management of complications are often unclear.[10, 11, 12] This can leave clinicians managing complex cases without knowledge of the original treatment, materials used or intended treatment plan.[10] Negative attitudes towards dental tourism may further deter clinicians from providing care and patients from seeking remedial care, increasing barriers to access and disrupting continuity of care.[13]

Who is responsible?

Dentists are ethically obligated to provide emergency care, yet responsibility for remedial treatment remains unclear.[14, 15] In Ireland, this ambiguity around the responsibility for remedial treatment is particularly relevant. The Health Services Executive (HSE) provides certain free dental services to select and means-tested patients under the medical card scheme, but no clear provision exists for complications arising from treatment received abroad.[16,17] Previous authors have highlighted unresolved questions regarding accountability, responsibility for postoperative complications and financial liability.[8, 18] These uncertainties informed the development of the present survey.

Call for guidelines

Concern regarding the burden of managing complications from dental tourism prompted NHS England to publish guidance in 2024.[10, 15, 19] The issue of dental tourism in Northern Ireland has very recently been raised by the British Dental Association.[20] Cross border travel for healthcare in Ireland represents a particular issue in this regard as the guidance differs for the UK and Ireland. Although the Irish Dental Association provides information for patients considering dental tourism, no guidance currently exists for Irish dental professionals managing these complications.[21]

This study aimed to investigate how dental professionals at the DDUH currently manage patients presenting with dental tourism complications, and to explore their opinions on medicolegal responsibility, HSE financial accountability, and the need for formal guidelines. A cross-sectional survey was distributed to clinical staff and students at the DDUH to address these aims. Significant variation was expected to exist in clinicians' management approaches and opinions based on qualification level and clinical experience, with higher qualification level decreasing referral incidences.

Methods

Study development

Ethical approval

for this study was obtained from the Trinity College Dublin Research Ethics Committee prior to commencement. A cross-sectional online survey comprising both open-ended and closed-ended questions was developed on Qualtrics XM to facilitate anonymous data collections, and non-parametric statistical analysis of quantitative data and thematic analysis of qualitative responses.

Four case scenarios involving implant, periodontal and restorative complications were adapted from the literature.[22, 23, 24] Additional questions were added to explore themes found in the existing literature surrounding clinicians' opinions on medicolegal responsibility, financial accountability, and need for guidelines. The survey development process took six weeks. Questionnaire items were reviewed by all research team members at weekly meetings for their relevance, clarity and appropriateness. Items were revised, removed or refined as required through this iterative process to refine its content validity and alignment with our research aims. A focus group invitation was included in the survey for further discussion surrounding the topics.

Survey Distribution

The survey was reviewed by four experts in the DDUH prior to distribution, a Clinical director, Statistician, and two Dental Public Health Specialists. It was then distributed to all clinical staff at the DDUH, including Junior House Officers, Senior House Officers, Clinical Supervisors, and Consultants. Fifth year Dental Science students were also included. The required sample size was determined using the formula for estimating a single proportion. The population of clinical and teaching staff who were eligible to participate in this study is estimated at 185. With a margin of error of 10%, and a confidence level of 95% (Z = 1.96), a sample size of 64 was calculated. Anticipating missing data and drop-outs, the target sample was set at 80. One week after the initial distribution, a reminder email was circulated to encourage survey completion. The survey remained open for two weeks, after which responses were collected for analysis.

Data analysis

A total of 64 complete responses and 35 incomplete responses were received. Incomplete survey responses were treated as missing data and were included in the analysis where applicable. Quantitative data were analysed using non-parametric statistical methods in IBM SPSS Statistics (version 29). Selected response categories were combined for a clearer statistical analysis, i.e. 'somewhat agree and strongly agree' were combined into one category. Chi-squared tests were performed to determine whether differences in responses were due to levels of experience or demographics.

Qualitative responses to the open-ended survey questions (Questions 5 and 10–18) underwent thematic analysis aligning with Braun and Clarke's six-phase framework.[25] Responses for each question were independently reviewed by four members of the research team. Any disagreements between the reviewers were resolved through discussion and consensus. Recurring patterns were identified then organised into themes and subthemes.

There were no responses for the focus group, therefore it did not take place.

Results

The survey sent out to all DDUH clinical staff and 5th year students received 99 responses. Of these responses, 3 were Consultants, 12 were Dental Specialists, 55 were General Dental Practitioners (GDPs), and 14 were 5th Year Dental Students at the DDUH. 15 responses were unanswered.

It was found that 89.7% of participants had seen patients who had received dental work abroad. 60% of participants did not feel confident when managing complications from dental tourism. 64% of participants believed they were not legally protected when managing complications from dental tourism. 79.7% of participants felt that there should be dental tourism guidelines. 84.4% of participants disagreed with the statement that the HSE should provide financial support for patients (including medical card holders) who require corrective treatment after failed dental tourism treatment.

Case-based scenario results

Table 1 shows responses to the case-based scenario questions regarding chosen treatment options and reasons treatment was not completed.

Table 1
Case treatment options (Question 10–17)

Treatment option	Case 1		Case 2		Case 3		Case 4	
	Count	%	Count	%	Count	%	Count	%
Complete treatment yourself and manage the patient from start to finish	1	1%	7	10%	12	18%	2	3%
Provide emergency treatment to relieve pain and then refer to another clinician	33	47%	29	42%	18	28%	N/A	N/A
Refer this patient immediately onto another clinician within Ireland	13	19%	9	13%	10	15%	19	29%
Tell the patient that they should go back to the original dentist who completed the treatment	11	16%	16	23%	21	32%	38	58%
Other	12	17%	8	12%	4	6%	6	9%
Total	**70**	**100%**	**69**	**100%**	**65**	**100%**	**65**	**100%**
If you choose not to complete the treatment, what is the reason? (Choose all that apply)								
Complexity of the case	45	30%	44	38%	27	32%	24	21%
Resource limitations	22	15%	8	7%	5	6%	33	30%
Liability reasons	31	20%	29	25%	22	26%	23	21%
Insufficient experience or beyond your scope	46	30%	29	25%	23	28%	25	22%
Other	8	5%	6	5%	7	8%	7	6%
Total	**152**	**100%**	**116**	**100%**	**84**	**100%**	**112**	**100%**

Across the scenarios, emergency treatment followed by referral within Ireland or referral back to the original dentist were the predominant management strategies (Table 1). Referral back to the original dentist was most common in the unfamiliar implant scenario (58.5%).

Figure 1 presents total responses for all cases on reasons why they would not complete treatment. Most participants who chose not to treat cited complexity of the case (140 responses, 30%) and insufficient experience (123 responses, 26%) (Fig. 1). Not being legally protected (105 responses 23%) was the next most common choice followed by resource limitations (68 responses, 14%).

Qualification and treatment opinions

No significant associations were identified between demographic variables and prior exposure to dental tourism cases ($p > 0.05$). Subsequent analyses therefore focused on associations between qualification level and management decisions.

Table 2 presents the association between qualification level and survey responses. Qualification was significantly associated with self-reported confidence in managing complications arising from dental treatment abroad ($p = 0.009$). Consultants and Specialists reported higher confidence compared to both GDPs and students (81.8% vs 32.6% and 30.8%, respectively) (Table 2).

Perceived legal protection also differed significantly by qualification ($p < 0.001$), with Consultants and Specialists more likely to report feeling legally protected compared to GDPs and students (81.8% vs 21.7% and 46.2%, respectively) (Table 2).

No significant association was observed between qualification and treatment choice in Case 1 or Case 4.

In Case 2, treatment choice differed significantly by qualification ($p = 0.016$). Students selected “complete treatment from start to finish” more frequently than GDPs and Consultants/Specialists (25.0% vs 8.7% and 0.0%, respectively) (Table 2).

Similarly, in Case 3, qualification was significantly associated with treatment choice ($p = 0.009$). Students more frequently selected “complete treatment from start to finish” compared to Consultants/Specialists and GDPs (66.7% vs 10.0% and 10.9%, respectively) (Table 2).

Guidelines and HSE coverage of dental tourism

60% of Consultants/Specialists versus 13.3% and 11.1% of GDPs and students said there is no need for guidelines (Table 2).

Table 2
Chi squared significance of qualification and responses

	Qualification			
	Consultant or Specialist	**General dentist**	**5th Yr Dental Student**	**Total**
How confident are you in your ability to manage complications in dental tourism patients?				
Not confident at all OR Not Confident	**2 (18.2%)**	**31 (67.4%)**	**9 (69.2%)**	42 (60.0%)
Somewhat confident OR Very Confident	**9 (81.8%)**	**15 (32.6%)**	**4 (30.8%)**	28 (40.0%)
Total	11 (100.0%)	46 (100.0%)	13 (100.0%)	70 (100.0%)
	$p = 0.009$			
Do you believe that you are legally protected against events that may occur when providing corrective treatment for these patients?				
Yes	**9 (81.8%)**	**10 (21.7%)**	**6 (46.2%)**	25 (35.7%)
No	**2 (18.2%)**	**36 (78.3%)**	**7 (53.8%)**	45 (64.3%)
Total	11 (100.0%)	46 (100.0%)	13 (100.0%)	70 (100.0%)
	$p < 0.001$			
In your opinion, should regulatory bodies set clear guidelines for general dentists regarding dental tourism?				
Yes	**4 (40.0%)**	**39 (86.7%)**	**8 (88.9%)**	51 (79.7%)
No	**6 (60. 0%)**	**6 (13.3%)**	**1 (11.1%)**	13 (20.3%)
Total	10 (100.0%)	45 (100.0%)	9 (100.0%)	64 (100.0%)
	$p = 0.003$			

Qualitative Analysis

Thematic analysis of open-text responses identified five principal themes across all case scenarios.

1. Perceived Responsibility of the Original Dentist

A dominant theme was the perception that responsibility for complications remained with the original treating clinician. Many participants stated that patients should return to the dentist who completed the initial treatment, particularly where warranties or ongoing restorative work were involved. This perspective was most frequently expressed in Cases 3 and 4, where respondents emphasised that adverse outcomes should be managed by the original provider. One Consultant in the DDUH stated they were ‘not willing to take responsibility for adverse consequences.’ Similar sentiments were reflected in statements such as ‘not my responsibility,’ while other respondents stated that responsibility ‘lies with the original dentist.’

2. Concerns Regarding Medico-Legal Liability

Participants frequently raised concerns regarding legal accountability when managing corrective treatment. A respondent stated, ‘generally the last person to treat the patient gets the blame.’ Another said, ‘I would not touch complex cases completed abroad due to risk of being liable for any further issues that arise in trying to correct issues.’ Some indicated they would seek legal advice or ensure detailed consent documentation prior to intervention. Perceived lack of legal protection was repeatedly cited as a factor influencing referral decisions.

3. Scope-of-Practice and Clinical Complexity

Many participants identified case complexity and scope-of-practice limitations as reasons for not completing treatment. This was particularly evident in implant-related scenarios and cases involving advanced restorative or periodontal disease. Limited familiarity with implant systems and concerns regarding technical feasibility were also reported. In response to Case 4, an unfamiliar failed implant, a respondent wrote it ‘may not be financially viable to [restore because the] system is one I don’t routinely use.’ Another respondent stated, ‘The patients generally don't know the name of practice and dentist that they saw, and the systems/materials used.’

4. Reliance on Informal Professional Guidance

When managing complex cases completed abroad, respondents reported relying primarily on personal clinical judgement and informal consultation with colleagues. Some participants referenced professional documents, including the Irish Dental Council Code of Practice and dental indemnity organisations; however, no formalised protocols specific to dental tourism were identified.

5. Stigmatisation of dental tourists

A small number of participants referenced patient ‘red flags’ suggesting that individuals who had sought treatment abroad may present additional expectation-management challenges due to preformed

negative attitudes towards Irish dental clinicians.

Discussion

Dental Qualification and Its Impact on Management of Patients Treated Abroad

Differences in treatment decisions were observed between demographic groups. Consultants and Specialists tended to limit management to emergency treatment before advising patients to go back to their original dentist, despite reporting greater confidence in their clinical abilities and stronger perceived legal protection. In contrast, GDPs and students reported lower confidence and greater concern regarding legal protection, yet students were more likely to say they would complete treatment from start to finish. This contrasts with the study hypothesis that higher qualification level and greater clinical experience would decrease referral incidences. Instead, the findings suggest that more experienced clinicians may adopt a more cautious approach. One possible explanation is that clinicians with less experience may underestimate the risks associated with managing complex cases beyond their competence. However, this interpretation remains speculative and would benefit from further qualitative investigation.

Previous findings by Doughty et al. suggested that clinicians may avoid treating patients who have received dentistry abroad due to fear of liability.[13] In contrast, the present findings suggest that uncertainty regarding legal protection may sometimes result in clinicians undertaking more treatment rather than referring. It is possible that improving clinicians' understanding of scope-of-practice and legal protection may support appropriate referral decisions.

Unclear Responsibility for Ongoing Care

A strong theme emerging from the qualitative analysis was the perception that complications after treatment completed abroad were 'not my responsibility' and that responsibility instead 'lies with the original dentist.' This reflects reluctance among participants to assume legal or clinical ownership of treatment received elsewhere.

Under EU cross-border healthcare legislation, the foreign state in which treatment is provided is required to ensure appropriate complaint mechanisms and regulatory oversight.[26] However, responsibility for follow-up care generally lies with the patient's home state.[26]

Previous literature has suggested that dentists often feel professionally obligated to manage complications arising from treatment abroad.[14] This was not reflected in the present qualitative findings. Instead, many participants explicitly stated that they did not consider themselves responsible for such cases and that the responsibility lies with the original clinician.

These findings could reveal a disconnect between legislation and clinician sentiment surrounding medico-legal issues. Greater clarification of legal responsibilities, consent procedures, and professional

guidance may support clinicians in providing care within their competence or making timely and suitable referrals within Ireland.

Financial Responsibility of the HSE and overall perception of dental tourism

Most clinicians opposed HSE funding of remedial treatment, despite existing policy indicating that complications ordinarily covered in Ireland should remain publicly funded.[16, 26] Clinicians perceiving this as unfair is not new. Significant documentation of this sentiment has been found in the literature, and this study adds to it.[14, 15] Clinician reluctance to cover costs may also reflect an emotional dimension. Asai et al. suggest that clinicians may feel professionally offended when patients seek care abroad.[14] This is seen in the current findings that some clinicians reported a tendency to avoid patients returning from dental tourism.

Limitations

This study was confined to the DDUH, which limits the generalisability of findings to other clinical environments or healthcare systems. The survey was not formally validated for this population, and findings should be interpreted with caution. Furthermore, survey methodology alone cannot fully capture the complexity of clinical decision-making in dental tourism. A focus group would have facilitated real-time observation and in-depth qualitative results that would likely yield richer understanding.

Future research

The present study's finding may represent a valuable opportunity for senior clinicians to serve as key informants in the development of practical guidance to support decision-making in primary care settings. Such guidelines might explore areas including consent procedures and responsibility for patients who have received treatment abroad, both of which emerged as areas of uncertainty in this study. A focus group incorporating Consultants, Specialists, and medicolegal experts could be a productive first step towards developing structured, evidence-informed recommendations for Irish dental professionals.

Conclusion

The continued rise of dental tourism globally has implications for both private dental practices and HSE dental services. This study found that most clinicians at DDUH were willing to manage emergencies arising from treatment abroad; however, ongoing care was frequently referred either to a specialist within Ireland or back to the original treating dentist. Uncertainty surrounding medico-legal responsibility emerged as a significant concern. Notably, lower levels of confidence and understanding of legal protection were associated with greater case retention, suggesting a lack of clear professional consensus and raising scope-of-practice concerns. There was strong agreement among participants

that formal guidelines would assist in standardising practice and reducing uncertainty. Future development of such guidance should incorporate input from Dental Consultants, Specialists, and medico-legal experts to ensure clarity regarding scope-of-practice, liability, and financial responsibility in the management of complications arising from dental tourism.

Declarations

Competing interest

The authors have no competing interests to declare.

Author contributions

All authors (CS, MVH, AA, NA, EJ, SL, CN, BYZ and JL) contributed to the conception and design of the study. CS, AA, NA, EJ, SL, CN and BYZ contributed to data acquisition and analysis. CS drafted the manuscript. All authors critically revised the manuscript for important intellectual content, approved the final version to be published, and agreed to be accountable for all aspects of the work

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Data availability

The anonymised data that support the findings of this study are available from the corresponding author upon reasonable request.

References

1. American Dental Association. Statement of the ADA Council on Ethics, Bylaws and Judicial Affairs on Dental Tourism - Ethical Obligations of Dentists [Internet]. 2009. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/about/principles/cebja-statements-and-white-papers/statement_ethics_dental_tourism_2009.pdf?rev=c5f6724515354a8195c29937c05aca69&hash=C1BC64711A058FC7AAADB32D90F902B4
2. Swenson M, Bansal A. Medical, Dental, and Wellness Tourism A Post-Pandemic Perspective. 1st ed. Apple Academic Preess; 2023. 308 p.

3. Dhama K, Patthi B, Singla A, Gupta R, Niraj LK, Ali I, et al. Global Tourist Guide to Oral Care - A Systematic Review. J Clin Diagn Res JCDR. 2016;10(9):ZE01–4. doi:10.7860/JCDR/2016/19438.8408 PubMed PMID: 27790595; PubMed Central PMCID: PMC5072095.
4. Garg A, Guez G. Dental tourism. Dent Implantol Update. 2011;22(6):45–7. PubMed PMID: 21735971.
5. Vequist DG 4th, Stackpole I. Dental tourism: an opportunity for public health. Interview by Lois K Cohen. Compend Contin Educ Dent Jamesburg NJ 1995. 2012;33(2):90, 92–3. PubMed PMID: 22545426.
6. Adams K, Snyder J, Crooks VA. The Perfect Storm: What's Pushing Canadians Abroad for Dental Care? J Can Dent Assoc. 2017;83:h10. PubMed PMID: 29513212.
7. Brescia V, Cavarra F, Campra M, Boffano P, Rocchetti V. Bibliometric analysis and trends related to dental tourism: Qualitative, social, economic and ethical implications. Health Serv Manage Res. 2025;9514848251314111. doi: 10. 1177/09514848251314111 PubMed PMID: 39819055.
8. Iqbal J, Shah S, Ashley M. International rescue? Managing the dental tourist. Dent Update. 2014;41(1):40–3. doi:10.12968/denu.2014.41.1.40 PubMed PMID: 24640476.
9. Jaapar M, Musa G, Moghavvemi S, Saub R. Dental tourism: Examining tourist profiles, motivation and satisfaction. Tour Manag. 2017;61:538–52. doi:https://doi.org/10.1016/j.tourman.2017.02.023
10. Tomić RA, Milojica V, Roblek V. Economic Benefits and Ethical Questions of Dental and Aesthetic Tourism in Europe: Thematic and Semantic Analyses of Articles. Tourism. 2025;73(4):682–99. Located at: Scopus. doi:10.37741/t.73.4.6
11. European Parliament and Council of the European Union. Directive 2013/55/EU of the European Parliament [EU Directive] [Internet]. Official Journal of the European Union, L 354, pp. 132–170: Publications Office of the European Union; 2013. Available from: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A32005L0036
12. Department of Further and Higher Education, Research, Innovation and Science. Recognition of Professional Qualifications [Government publication] [Internet]. Dublin: Government of Ireland; 2020. Available from: https://www.gov.ie/en/department-of-further-and-higher-education-research-innovation-and-science/publications/recognition-of-professional-qualifications/#have-your-qualifications-recognised
13. Doughty J, Moore D, Ellis M, Jago J, Ananth P, Montasem A, et al. Contemporary dental tourism: a review of reporting in the UK news media. Br Dent J. 2025;238(4):230–7. doi:10.1038/s41415-025-8330-2 PubMed PMID: 40021870; PubMed Central PMCID: PMC11870843.
14. Asai RG, Jones KDJ. Am I obligated to treat a patient whose need for emergency care stems from dental tourism? J Am Dent Assoc 1939. 2007;138(7):1018–9. doi:10.14219/jada.archive.2007.0301 PubMed PMID: 17606503.

15. BDA. UK dentists picking up the pieces from dental tourism boom. British Dental Association [Internet]. 2022 Jul 14. Available from: https://www.bda.org/media-centre/uk-dentists-picking-up-the-pieces-from-dental-tourism-boom/?utm_source=chatgpt.com
16. Citizens Information. Dental Services [Internet]. Citizens Information Board; 2025. Available from: https://www.citizensinformation.ie/en/health/health-services/dental-aural-and-optical-services/dental-services/
17. Citizens Information, Medical cards [Internet]. Citizens Information Board; 2026. Available from: https://www.citizensinformation.ie/en/health/medical-cards-and-gp-visit-cards/medical-card/
18. Ashiti S, Moshkun C. Dental tourists: treat, re-treat or do not treat? Br Dent J. 2021;230(2):73–6. doi:10.1038/s41415-020-2591-6 PubMed PMID: 33483660.
19. NHS England. Avoidance of doubt: Clinical policy for self-funded dental treatment requiring NHS intervention [Internet]. 2024. Available from: https://www.england.nhs.uk/long-read/avoidance-of-doubt-clinical-policy-for-self-funded-dental-treatment-requiring-nhs-intervention/
20. Kelso T. A novel approach to tackling dental tourism. BDJ Pract. 2026;39(7):212–3. doi:10.1038/s41404-026-3604-1
21. IDA. Dental Tourism [Internet]. Irish Dental Association. Available from: https://www.dentist.ie/your-oral-health/dental-tourism.6558.html
22. Vasant M. The Pitfalls of Dental Tourism. 2016;57–9.
23. Milosevic A. Dental tourism-a global issue? J Esthet Restor Dent Off Publ Am Acad Esthet Dent Al. 2009;21(5):289–91. doi:10.1111/j.1708-8240.2009.00277.x PubMed PMID: 19796293.
24. Barrowman RA, Grubor D, Chandu A. Dental implant tourism. Aust Dent J. 2010;55(4):441–5. doi:10.1111/j.1834-7819.2010.01267.x PubMed PMID: 21133945.
25. Ahmed SK, Mohammed RA, Nashwan AJ, Ibrahim RH, Abdalla AQ, Ameen BMM, et al. Using thematic analysis in qualitative research. J Med Surg Public Health. 2025;6:100198. doi:https://doi.org/10.1016/j.glmedi.2025.100198
26. van den Bossche AM, Ploscar P. Rights of dental patients in the EU - A legal assessment. J Forensic Odontostomatol. 2012;30(SUPPL.1):5–11. Located at: Scopus

Figures

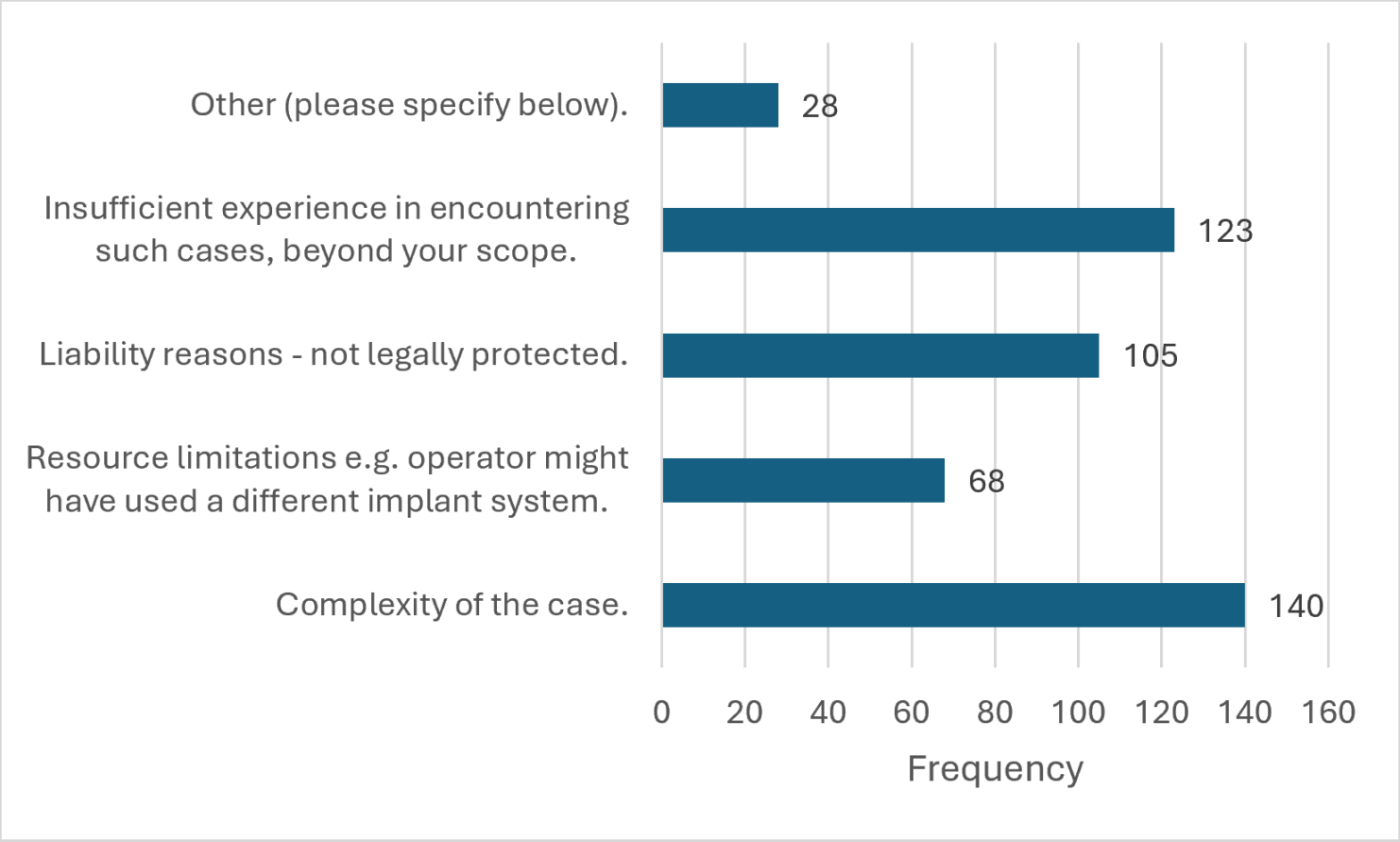


Figure 1

Reasons not to treat