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PROFESSION OR PROMOTION? DIGITAL PROFESSIONALISM AND THE ETHICS OF DENTAL ADVERTISING ON SOCIAL MEDIA IN INDONESIA: A NARRATIVE REVIEW

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ABSTRACT

Social media has reshaped how dentists present themselves to the public, unsettling the long-standing professional boundary between legitimate information and commercial promotion. This narrative review examines the ethics of dental advertising and digital professionalism among Indonesian dentists, asking whether that boundary is being renegotiated and whether existing ethical and regulatory frameworks are adequate to govern it. Drawing on international scholarship, Indonesian empirical studies, primary legal instruments, and comparative regulatory guidance, it advances three arguments. First, the professional prohibition on advertising was dismantled not because its ethical rationale was refuted but because it was recast in the vocabulary of competition law, leaving a harm-based residue in which promotion is presumptively permitted. Second, the unstable information-versus-promotion binary should be replaced by a five-part continuum of professional communication and a functional-plus-autonomy test, under which the decisive question is not whether a message is advertising but whether it serves or subverts the audience's capacity to appraise need, risk, and cost. Third, Indonesia's difficulty is not regulatory absence but incoherent, overlapping, and largely unenforced regulation, aggravated by a 2023 statutory reform that redistributed disciplinary authority without clearly assigning responsibility for digital conduct. Distinctive national features, including an aesthetic reframing of dentistry, an unlicensed shadow market, and a substantial unmet burden of oral disease, intensify both the promise and the peril of dental social media. The review concludes that the profession needs not a retreat from the platform but a coherent, context-calibrated, and actively enforced standard, and it offers targeted recommendations for practitioners, the professional body, educators, and regulators, together with an empirical research agenda.

Keywords: Dental Advertising; E-Professionalism; Social Media; Health Service Regulation; Dental Ethics; Indonesia.

1 INTRODUCTION

Over the past decade the professional life of the dentist has acquired a second address. Beyond the operatory and the recall list, a growing share of the profession's public presence now unfolds on image-driven feeds, short-form video, and messaging broadcasts. Indonesia is an especially vivid setting for this shift. By early 2026 the country registered on the order of 180 million social-media user identities, a figure that had risen by roughly a quarter in a single year, while internet penetration approached three-quarters of the population and influencer content had become a routine part of daily consumption [1]. In such an environment the clinical encounter no longer begins in the waiting room; for many patients it begins with a search, a scroll, and a before-and-after image.

The professions have long maintained an uneasy relationship with self-promotion. Organised dentistry, like medicine and law, historically regarded overt advertising and solicitation with suspicion, tolerating factual notice of services while restraining persuasion and comparative claims liable to mislead the public or erode collegial trust. That settlement has since been progressively relaxed, yet its animating concern, that commercial appeal can distort clinical judgement and inflate patient expectation, has not dissolved. Social media reopens the question in acute form. The construct of e-professionalism, understood as the extension of established professional norms into conduct enacted through digital media, names the difficulty precisely: standards developed for the consulting room must now govern behaviour in a space engineered around visibility, engagement, and self-presentation [2].

Dentistry occupies a uniquely exposed position within this problem. Its outcomes are visible and photogenic; a substantial and expanding portion of its market is elective and aesthetic; and its predominantly fee-for-service economics couple clinical recommendation to commercial reward more directly than in many neighbouring health fields. The before-and-after image, arguably the signature genre of dental social media, sits exactly where advertising, consent, confidentiality, and the management of expectation converge. Where a physician's online misstep may compromise decorum, a dentist's may simultaneously function as marketing, breach a patient's privacy, and manufacture demand for intervention the patient had not previously believed necessary. The profession-promotion tension, in other words, does not merely appear in dentistry; it is concentrated there.

These generic tensions are further refracted through conditions particular to Indonesia. Decisions about the body are frequently relational rather than strictly individual, religiosity informs prevailing public morality, and aesthetic norms lend distinctive force to the marketing of the cosmetic smile. An informal-practitioner economy, encompassing unlicensed tukang gigi and a trade in non-clinical orthodontic appliances, extends the marketplace of dental persuasion well beyond the regulated profession. Most consequentially, the governance framework within which such conduct might be disciplined has itself been unsettled. Law No. 17 of 2023 on Health, an omnibus statute that entered into force in August 2023, consolidated eleven previous laws into 458 articles, established an independent disciplinary body, and eliminated the requirement that the relevant professional organisation issue a recommendation before a practitioner obtains a practice licence [3]. Because the statutory category of medical personnel encompasses both doctors and dentists, this reordering applies squarely to dental practice [3], and its implementing framework carries the change into effect [4]. For a profession whose advertising norms were historically enforced through collegial self-regulation, the shift poses an unresolved question: as authority migrates from the professional organisation toward the state, where in practice does oversight of the dentist's digital self-presentation now reside?

Despite the salience of these questions, the scholarly literature offers limited purchase on them in the Indonesian context. Research on e-professionalism has concentrated on students and on high-income jurisdictions, and the wider discussion of dental advertising ethics has seldom engaged the specific regulatory, cultural, and commercial configuration outlined above [5,6]. A further complication is distributional: much of the pertinent Indonesian material resides in national-language publications and in professional codes and regulations rather than in internationally indexed journals, a pattern that any review confined to English-language databases would systematically overlook. This narrative review addresses that gap. It asks how the social-media practices of Indonesian dentists negotiate the boundary between legitimate professional communication and commercial promotion, and whether the prevailing ethical and regulatory frameworks are adequate to govern that boundary.

2 CONCEPTUAL FRAMEWORK

2.1 The fiduciary bargain and the constitutive place of commerce

Analysis of dental advertising must begin by conceding that the tension between profession and commerce is not an external contamination of clinical practice but a structural property of it. Dental services display the characteristics of credence goods: the recipient can seldom verify the necessity of an intervention beforehand and frequently cannot evaluate its quality afterwards. From this informational condition follows the dentist's characteristic dual role, acting at once as the patient's adviser, the party who defines what care is required, and as the supplier of that care. Fee-for-

service remuneration, correspondingly, is associated with increased costs plausibly attributable to supplier-induced demand, conventionally defined as demand exceeding what the patient would have chosen had they commanded the same information as the clinician [7].

Professionalism, on this reading, is the institutional answer to a hazard the profession itself creates. Society grants the dental profession privileged access to the body, control over entry, and considerable self-governance; in exchange the profession undertakes to subordinate its commercial interest to the patient's welfare precisely where the patient cannot check whether it has done so. Advertising does not manufacture this conflict; it scales it. In the operatory, demand inducement is bounded by the dyad. On a platform, the adviser's role is broadcast: the dentist shapes perceived need among an audience of thousands who have received no examination, are owed no fiduciary duty, and stand in no clinical relationship at all. Social media, in short, converts a dyadic hazard into a distributive one.

2.2 From prohibition to permission: an argument displaced rather than settled

Organised dentistry historically restrained advertising, and the reasoning was not merely guild protectionism. The instructive case is California Dental Association v. Federal Trade Commission (1999), in which the association's code prohibited false or misleading advertising and the regulator alleged that the association had applied its guidelines so as to restrict truthful, non-deceptive advertising of price and of service quality [8]. What makes the case indispensable is the collision of vocabularies it exposes. The reasoning under review characterised the restrictions as an output limitation, on the basis that they restricted the supply of information and that quality and comfort advertising might induce some consumers to obtain non-emergency care they would not otherwise have sought [8].

The significance is difficult to overstate. Induced consumption of non-urgent dental care is, to the competition lawyer, an expansion of output and thus a consumer benefit; to the health economist and the ethicist it is supplier-induced demand and thus a welfare loss and a fiduciary failure. The profession's advertising restraint was dismantled across many jurisdictions not because the ethical objection was refuted but because it was re-described in an idiom, restraint of trade, in which it could not be stated. What survives the liberalisation is therefore a harm-based residue: promotion is presumptively permitted, and prohibition attaches only where specific harms are identified. Any contemporary case for restraint must accordingly be built on demonstrable harm to patients or to public trust, not on the dignity of the profession as such.

2.3 Digital professionalism and its commercial blind spot

The governing construct is e-professionalism, defined as attitudes and behaviours reflecting traditional professionalism paradigms but manifested through digital media, an intersection also designated online or digital professionalism [2]. The definition is capacious, yet the literature built upon it has been strikingly narrow. It has concentrated on impropriety, that is, on objectionable posts, depictions of intoxication, breaches of confidentiality, and boundary transgressions, and has been developed principally on student populations, measuring perceptions and attitudes rather than actual professional behaviour [6]. Commercial conduct sits almost entirely outside this frame. The dominant activity of practising dentists on social media, namely self-promotion, has scarcely been theorised as an e-professionalism problem at all. Extending the construct to encompass advertising is thus not an incidental application but a substantive contribution.

2.4 The platform is not a neutral channel

It is tempting to treat social media as merely a new medium through which pre-existing norms operate unchanged. Two features of the environment defeat that assumption. The first is context collapse: these technologies flatten multiple audiences into a single context, so that the strategies people use to manage audience multiplicity in face-to-face life become unavailable, and users typically behave as though their audience were bounded when it is not [9]. The dentist who posts cannot address patients, prospective patients, colleagues, regulators, and family in distinct registers; all receive the same artefact, and a post conceived as collegial case documentation is received by a lay audience as an advertisement.

The second is the incentive structure. Engagement metrics reward the visually dramatic, the transformational, and the affectively charged; they do not reward epidemiologically important but undramatic messages about periodontal maintenance. The dentist who posts a caries-prevention explainer and the dentist who posts a veneer transformation are not competing on level terms. Professional restraint, in this environment, is not merely difficult but costly, and the cost is borne by the restrained. Any ethical framework addressed solely to individual virtue will therefore be structurally under-powered, because the gradient it must climb is architectural rather than personal.

2.5 Interrogating the information-promotion distinction

Professional codes lean heavily on a distinction between permissible informing of the public and impermissible advertising or solicitation. The distinction bears enormous normative weight and is remarkably under-theorised. A

content criterion, permitting factual statements and prohibiting persuasive appeals, collapses immediately, because true statements can be selected precisely for their persuasive force; the before-and-after photograph is factually accurate and maximally persuasive at once. An intent criterion founders on opacity and mixture, since intent is unobservable, typically dual, and conveniently self-declared. A form criterion is obsolete, since platform-native content possesses no stable form.

What remains is a functional criterion, and it is the one adopted by the most developed regulatory regime in this area. Australian guidance defines advertising as public communication that promotes a regulated health service provider so as to attract a person to the provider, and treats a clinic's social-media page, where used promotionally, as advertising subject to the full regime [10]. The operative question is neither what the communication contains nor what its author intended, but what it does. This review adopts that functional criterion and supplements it with an autonomy criterion, yielding a two-part test. First, does the communication operate to attract its audience to this provider? If so, it is advertising, however educational its content. Second, does it serve or subvert the audience's deliberative capacity, supplying what a reasonable person requires to appraise need, risk, alternatives, and cost, or instead manufacturing perceived need, exaggerating benefit, concealing risk, and foreclosing deliberation? The ethically decisive question is thus not whether a post is an advertisement, since most dental social media is, but whether the advertisement serves or exploits the deliberative capacity of the person who encounters it.

This supports replacing the information-advertising binary with a continuum of professional communication along which ethical burden rises: first, public oral-health education, which does not attract to a provider and is the clearest case of legitimate professional communication; second, practice information, comprising verifiable particulars of identity, qualification, scope, location, and fee; third, reputational self-presentation, the documentation of completed cases as evidence of competence; fourth, persuasive promotion, including transformation imagery, aesthetic aspiration, and testimonial; and fifth, inducement, comprising discounts, urgency, giveaways, and influencer endorsement. The harm-based prohibitions inherited from the liberalisation bind most tightly at the right-hand end. The Australian statute supplies their content with unusual precision, prohibiting advertising that uses testimonials, that creates an unreasonable expectation of beneficial treatment, or that directly or indirectly encourages the indiscriminate or unnecessary use of regulated health services, in addition to the general prohibition on false, misleading, or deceptive advertising [10].

2.6 Principlism as a lens, and the limits of the lens

The four principles remain the common currency of health ethics and retain analytic purchase, but the fit is imperfect. Autonomy is ordinarily construed as patient consent, yet advertising's autonomy problem is audience-facing: the viewer is not yet a patient, has undergone no examination, is owed no fiduciary duty, and is nonetheless being induced to form beliefs about their own bodily need. Non-maleficence is engaged by misleading claims, by the cultivation of unreasonable expectation, and, most acutely in cosmetic dentistry, by irreversible intervention upon healthy tissue. Beneficence cuts the other way, and the review must say so plainly: in a country with substantial unmet oral disease burden and uneven access to professional care, social media is a genuine instrument of oral-health literacy, and restraint carries real opportunity costs. Justice returns us to the distributive concern: commercially induced demand draws clinical attention and capacity toward the elective and the affluent within a system that has not met basic need. Veracity, finally, is better treated as an independent principle than folded into non-maleficence, given how much of the harm at issue consists in truthful-but-misleading representation.

The structural limitation is that principlism is dyadic and patient-facing, whereas advertising is public-facing and prospective. It is for this reason that the fiduciary and social-contract account developed above must carry the argumentative weight: the profession's obligation runs to the public, not merely to the person presently in the chair. In the Indonesian setting this is further inflected by the relational character of decisions about the body and by a conception of justice informed by keadilan sosial, the social-justice principle of the national ideology.

3 METHOD AND SCOPE

3.1 Design and its justification

This article is a narrative review, a designation adopted affirmatively rather than by default. The relevant body of work is heterogeneous in kind: it comprises empirical studies of professional conduct online, conceptual and normative scholarship in professional ethics, statutory instruments and their implementing regulations, professional codes, and regulatory guidance issued by foreign licensing authorities. Such material cannot be pooled, appraised against a common risk-of-bias instrument, or synthesised into an effect estimate, and the review's central aim is interpretive and normative rather than aggregative. No claim is therefore made to exhaustive or fully reproducible retrieval, and no flow diagram is presented. What is claimed instead is transparency. The reporting is structured to satisfy the criteria of the Scale for the Assessment of Narrative Review Articles (SANRA), whose items address the review's importance and aims,

the literature search, referencing, scientific reasoning, and the presentation of relevant data; description of the literature search was among the lowest-scoring items in that instrument's development sample, and the explicitness of this section is a deliberate response to that documented weakness of the genre [11].

3.2 Sources and selection

Sources were sought across five deliberately distinct strata. International indexed literature established the conceptual and empirical state of the field concerning e-professionalism, dental ethics, and health-service advertising. Indonesian national literature was searched separately through the national databases GARUDA and SINTA, a methodological commitment rather than an afterthought, since a review restricted to internationally indexed databases would capture how Indonesian practice is discussed by others rather than how the national discourse actually proceeds. Primary regulatory and normative instruments were retrieved from official sources rather than secondary summaries, including Law No. 17 of 2023, Government Regulation No. 28 of 2024, the Personal Data Protection Law, and the dental code of ethics (KODEKGI). Comparative regulatory guidance was consulted as a source of normative comparators, not as empirical evidence about Indonesia, a distinction maintained throughout. Grey literature was admitted only for digital-behaviour and platform-penetration data and for professional-body communications. Selection was purposive and governed by relevance to the guiding question and to the analytic framework, with priority given to primary regulatory texts over secondary commentary, to Indonesian-authored sources where the claim concerns the Indonesian context, to recency for regulatory and platform material, and to foundational conceptual work irrespective of date. Indonesia-specific peer-reviewed work on dental social-media advertising remains limited, a paucity that is itself a finding: it both justifies this review and constrains its method, requiring heavier reliance on regulatory primary sources and on transfer from adjacent literatures, the limits of which are acknowledged where relevant.

3.3 Scope limits and positionality

The review presents no original empirical data on the content produced by Indonesian dentists, makes no claim about the prevalence of any practice described, and offers no legal advice or authoritative construction of Indonesian law; regulatory instruments are read for the normative commitments they encode and the gaps they leave. The analysis is offered from within the profession it examines. The author is a dental academic in Indonesia, trained in oral biology and physiology rather than in law or bioethics, a vantage that affords direct familiarity with Indonesian professional norms and conditions and that accounts for the emphasis on dentistry as a test case rather than an appendix, while also carrying a risk of insider sympathy that the reader is invited to weigh.

4 THE LANDSCAPE OF DENTAL SOCIAL MEDIA IN INDONESIA

4.1 The platform environment and its audience

The platforms on which dental content circulates are visually driven and skew toward the demographic most responsive to aesthetic messaging: younger users, and women in particular, among whom platform adoption approaches saturation [1]. This is not incidental. The audience for dental self-presentation in Indonesia is disproportionately composed of the people to whom cosmetic dental intervention is most readily marketed, so that the demand-side vulnerability theorised above is not evenly distributed but concentrated exactly where the promotional content lands. Dentists have moved into this space comprehensively, and survey evidence indicates that practitioners use social media chiefly for oral-health promotion and education, for communication, and for marketing and advertising, with the youngest practitioners the most active [5]. The public is a willing audience: among Indonesian adolescents, the internet, including social media, is already a common route to oral-health information [14].

4.2 A content typology against the continuum

The continuum proposed above predicts five bands of professional communication of ascending ethical burden. Mapping actual Indonesian practice onto it is constrained by a genuine evidentiary limit, since no comprehensive, current content analysis of Indonesian dental social media exists in the published literature, so what follows is an analytic scaffold populated by the fragmentary evidence available and should be read as a structure for future validation rather than as a prevalence claim.

At the first band, public oral-health education, Indonesian dentists do produce genuine educational content, and its effectiveness in raising knowledge is documented. Yet the available evidence suggests this band is thinly populated relative to the profession's self-image: content analyses of dental social media consistently find that posts skew promotional rather than educational [13]. The second band, practice information, is the least ethically fraught and is the category that Indonesian regulation contemplates as legitimate, requiring that any such material carry the name and address of the facility [15]. The third band, reputational self-presentation, is where the visible centre of gravity begins to shift, as the documentation of completed cases functions, on the test proposed above, as advertising whatever its ostensibly educational framing. The fourth and fifth bands, persuasive promotion and inducement, are where the ethical

and regulatory stakes concentrate. Indonesian scholarship on the ethics of social media in dental practice identifies exactly this territory as problematic, emphasising the tension between effective promotion and the maintenance of professional standards, informed consent, and patient privacy [12], and the broader literature confirms that promotional content, including transformation imagery and endorsement, predominates over education across comparable settings [13]. Systematic Indonesian data on the rate at which such content contravenes the governing advertising regulation remain limited, a gap noted here rather than concealed.

4.3 The aesthetic turn and the structure of demand

The concentration of content at the promotional end of the continuum is a response to a demand structure. Two aesthetic phenomena drive it. The first is the cosmetic veneer, a procedure that is elective, irreversible, and performed on healthy tissue, and that is therefore maximally suited to before-and-after representation and maximally exposed to the non-maleficence concern. The second, and more distinctively Indonesian, is the transformation of orthodontic appliances into fashion: fixed braces have acquired a status that is substantially aesthetic rather than clinical, sought as an ornament and a marker of social position as much as a correction of malocclusion. This aesthetic reframing inverts the ordinary direction of clinical demand. Where the fiduciary model assumes a patient who arrives with a problem, the aesthetic market manufactures the perception of a deficiency and then supplies its correction. Promotional content is not merely describing available services; it is participating in the construction of felt need among an audience that has received no examination, so that supplier-induced demand, a hazard bounded in the operatory, operates at the scale of the feed.

4.4 Endorsement and the influencer economy

The platform environment supplies a ready mechanism for amplifying that constructed demand: the testimonial and the endorsement. This is a point of sharp regulatory friction, because Indonesian law does not treat testimonials as a grey area. The governing regulation expressly prohibits the giving of testimonials in health-service advertising and forbids health workers from acting as advertising models for health facilities or products except in non-commercial public-health messaging, while also barring the promotional use of academic degrees and professional titles [15]. Against that backdrop, the migration of dental marketing into an influencer register, with patient transformation stories and endorsement partnerships, does not sit near the edge of the permissible but well across a line the state has already drawn, a disjunction between rule and practice examined below.

4.5 Beyond the regulated profession: the unlicensed shadow market

Any account of dental persuasion in Indonesia that stopped at the licensed profession would omit its most consequential feature. The marketplace extends to the tukang gigi, informal practitioners without formal dental education whose presence dates to the colonial period and who persist as an alternative source of care for lower-income communities for whom professional treatment is inaccessible or unaffordable [16]. Regulation limits their lawful scope to removable acrylic dentures, yet the evidence repeatedly documents their exceeding it, installing fixed orthodontic appliances, placing veneers, and removing tartar, that is, delivering the irreversible aesthetic interventions that carry the greatest clinical risk, without the training to manage it [16,17]; the resulting harms, including gingival and periodontal damage following appliance placement, are documented [18]. This shadow market is now enmeshed with social media, which functions as its shopfront: the same aesthetic aspiration that drives the licensed cosmetic market is marketed more aggressively, and at markedly lower prices, to the most price-sensitive segment of the same young audience. The distinctively Indonesian situation is therefore not simply that licensed dentists advertise in fraught ways, but that they do so within a continuous promotional field that shades, without any visible boundary to the lay viewer, into the marketing of unlicensed and hazardous intervention.

4.6 Synthesis

So far as the available evidence permits its reconstruction, the Indonesian landscape has its centre of gravity at the demanding end of the continuum. Genuine oral-health education exists but appears to be a minority activity; reputational and persuasive promotion dominate the visible field; endorsement, though prohibited by an existing instrument, is a recognised feature; and the regulated field is continuous with an unlicensed shadow market that markets irreversible procedures to the price-sensitive young. Two features distinguish this from any high-income analysis: the aesthetic reframing of dentistry as fashion, and the tukang gigi layer, which extends the marketplace of persuasion beyond the reach of professional regulation altogether.

5 ETHICAL FAULT LINES

The fault lines that follow are the analytic apparatus brought to bear on the landscape. They cluster around four commitments that dental advertising places under strain: veracity, the consent and confidentiality owed to the depicted patient, the fiduciary character of the profession's relationship to the public, and distributive justice. What unites them

is that advertising is public, prospective, and pre-clinical, and therefore escapes the dyadic, patient-facing frame within which professional ethics ordinarily operates.

5.1 The before-and-after image: consent, confidentiality, and manufactured expectation

The clinical before-and-after photograph is the signature artefact of dental social media and its most instructive ethical problem, because a single image is simultaneously three things: the patient's health information, the dentist's portfolio, and a marketing instrument. The dentist who posts it typically treats the second and third as licensing its use while the first is quietly set aside, yet under Indonesian law it is the first that governs. Data relating to a person's health are classified as specific, or sensitive, personal data under the Personal Data Protection Law (Law No. 27 of 2022), a category carrying heightened protection; health facilities bear responsibility for the confidentiality of medical-record data, and the framework became fully enforceable in 2024, so this is operative rather than aspirational obligation [19].

The decisive point is that consent stratifies, and the strata are not interchangeable. Consent to treatment is not consent to documentation, and neither is consent to publication for commercial purposes. Valid consent must be specific to its purpose and freely given [19], and the requirement that it be freely given is placed under particular pressure in the dental setting, where the person asked to permit commercial use of their image is asked by the very clinician on whom their continuing care depends. Even where consent is genuinely specific and freely given, two further problems remain. First, the right to withdraw consent or seek erasure is largely hollow for a published image: once posted, an image is downloaded, re-shared, and re-indexed beyond the original account's control, so the legal right to deletion cannot in practice recall the copies, and context collapse is here not merely a communicative hazard but the mechanism that defeats a statutory remedy. Second, the before-and-after genre carries an inherent veracity defect independent of consent, presenting a curated endpoint, photographed under favourable conditions and digitally adjustable, as if it were the representative outcome while omitting failure, relapse, maintenance, and the biological cost of intervention. It is a survivorship display, and it generates precisely the unreasonable expectation that comparative regulation identifies as an independent wrong. The image therefore has two potential victims at once: the depicted patient, whose confidentiality and control are compromised, and the viewer, in whom a distorted expectation and a manufactured sense of deficiency are induced.

5.2 Truthful-but-misleading representation

The before-and-after image is a special case of a more general fault line. The characteristic ethical failure of dental promotion is not falsehood, which is comparatively rare and easily condemned, but misleading representation achieved through selection, framing, and omission, communication that is true in each of its particulars and deceptive in its overall effect. Superlative and absolute claims, implied guarantees of outcome, the presentation of elective aesthetic procedures without acknowledgement of their irreversibility, and the systematic omission of risk and of the maintenance an outcome demands need contain no false statement to leave the audience with beliefs a fuller account would not support. This is why veracity is better treated as an independent principle. The operative regulatory standard, the avoidance of unreasonable expectation, is correctly pitched not at the truth of individual claims but at the reasonableness of the impression the communication as a whole conveys [10], and it is violated far more often by curation than by lying.

5.3 Testimonials, endorsement, and the influencer register

Testimonials warrant separate treatment because they are both ethically distinctive and, under the existing Indonesian instrument, already prohibited outright [15]. Their ethical distinctiveness lies in the credence-good structure of dental care: because the patient-endorser is no better able than any other layperson to appraise the technical quality of the treatment received, a testimonial transfers an epistemic authority the endorser does not actually possess. Compounding this is a survivorship illusion, since only the satisfied return to testify, and, where the testimonial is solicited from a current patient, a reflexive exploitation of the fiduciary relationship. The migration of this practice into the influencer register adds a further wrong: where endorsement is paid but the material connection is undisclosed, the audience is deceived not only about representativeness but about the very nature of the communication, which presents commercial promotion in the guise of authentic experience. That the influencer economy is a defining feature of Indonesian digital life means this is not a marginal practice but a central mechanism of dental persuasion, operating across a line the state has already drawn.

5.4 Conflicts of interest and the structural incentive to induce

The conflict of interest intrinsic to fee-for-service dentistry assumes specific and intensified forms on social media [7]. The dentist advertising their own services engages in a form of self-dealing in demand, shaping the perceived need for the very interventions from which they profit. The dentist accepting sponsorship to promote particular products or aligner systems introduces a divided loyalty. And the dentist whose income depends on engagement is subject to an incentive gradient that rewards the dramatic and aspirational over the epidemiologically important but visually unremarkable. This last form is structural rather than a matter of individual character: the platform's architecture

makes professional restraint costly and imposes that cost on the restrained, so a framework addressed solely to individual virtue will be systematically overmatched by the environment in which virtue must be exercised.

5.5 Collective harm: professional trust as a depletable resource

Some of the harm at issue is not captured at the level of the individual post. Any single item of reputational or persuasive content may be defensible in isolation, yet the aggregate effect of the profession's migration to a commercial, engagement-driven register is to erode the public perception of dentistry as a fiduciary undertaking rather than a retail one. Professional trust is, in this respect, a common resource: each practitioner draws upon the public's generalised confidence, and each act of commercialisation depletes a little of it, with the cost borne collectively and by future practitioners. This collective harm is sharpened in Indonesia by the boundary-blurring identified above: when the promotional output of a licensed dentist and that of an unlicensed tukang gigi marketing irreversible procedures are visually indistinguishable to the lay viewer, the platform degrades the very signal by which the public might tell a regulated clinician from an unregulated vendor [16].

5.6 Distributive injustice and iatrogenic demand

The final fault line is the one least visible to a consent-centred analysis and, for Indonesia, the most consequential. In a country with substantial unmet basic oral disease burden and a maldistributed dental workforce, the promotional economy exerts a double distributive distortion, directing patient demand toward elective, aesthetic, and affluent care and drawing professional capacity in the same direction, within a system that has not met basic preventive and restorative need. Advertising thereby becomes an instrument of misallocation. Layered upon this is a population-level non-maleficence concern: the aesthetic normalisation described above manufactures iatrogenic demand, inducing healthy individuals to seek irreversible intervention upon sound tissue. The harm here is not to any identifiable patient who might have withheld consent, but to a population whose baseline conception of dental need has been reshaped by a commercial message, a harm that the dyadic frame of consent and confidentiality cannot register and that only the fiduciary and social-contract account is equipped to name.

5.7 Synthesis

These fault lines share a common origin. Each arises because advertising operates in a register, public, prospective, pre-clinical, and population-scale, that the profession's inherited ethical vocabulary, built for the individual encounter, was not designed to govern. Consent protects the patient in the chair but not the viewer of the feed; confidentiality protects the record but not the manufactured expectation; individual virtue is outmatched by the platform's incentive gradient. The governance of dental advertising cannot therefore rest on individual conscience alone but requires institutional and regulatory structure, whose adequacy in Indonesia is the question of the next section.

6 THE REGULATORY AND NORMATIVE FRAMEWORK

6.1 A dense architecture, not a void

The intuitive hypothesis, that Indonesian dentists advertise problematically because the field is unregulated, is wrong, and the error matters because it points toward the wrong remedy. Dental advertising sits beneath at least four overlapping regulatory layers: a sectoral advertising rule (Regulation No. 1787 of 2010); the profession's own code of ethics (KODEKGI), administered by the Indonesian Dental Association (PDGI); the registration-and-discipline apparatus reconstituted by the 2023 Health Law; and a set of general-law backstops comprising the Personal Data Protection Law, consumer-protection law, and the Electronic Information and Transactions Law, together with, for the informal sector, the separate regulation governing tukang gigi. The problem is therefore not normative absence but the interaction, and non-application, of a thicket of instruments.

6.2 Rules that already prohibit the conduct

The substantive content needed to govern most of the practices catalogued above already exists on paper. Regulation No. 1787 of 2010 draws precisely the information-versus-promotion distinction this review defends, prohibits the giving of testimonials, forbids health workers from acting as advertising models for health facilities, bars misleading or false claims and the promotion of methods not yet accepted by the professional community, and requires that any advertisement carry the facility's identity [15]. Indonesia thus already possesses a functional-style prohibition and a specific list of banned techniques that would capture a large share of observed dental promotion. Two complications compound the picture. First, the instrument's status after the 2023 omnibus reform is uncertain: the implementing regulation expressly revoked a substantial number of health-related ministerial regulations, and the governing interpretive principle holds that a regulation not expressly repealed is presumed to remain in force even as its substance may become inconsistent with the new statute [22,4]. Second, the regulation was drafted for print, broadcast, and outdoor media and for advertising by health facilities, categories that map awkwardly onto a dentist's personal account,

an influencer collaboration, or the indistinct boundary between professional promotion and personal expression. The rule predates the phenomenon it would need to govern.

6.3 The enforcement vacuum

The limited available evidence of non-compliance, discussed above, is best read not as a series of individual infractions but as evidence of systemic non-enforcement. Three structural features explain it. The enforcement mechanism the 2010 regulation provides, an evaluation team, a correction order, and administrative sanction, is ministry- and facility-centred and was designed for discrete, reviewable advertisements, not for content produced continuously, at volume, from personal accounts, and algorithmically distributed [15]. The legal uncertainty just described itself deters enforcement, since an authority is unlikely to pursue sanctions under a rule of contested validity. And the obsolescence of the regulatory categories leaves enforcers without a clear basis for treating platform-native professional self-presentation as the advertising the instrument contemplates. The rule is, in effect, unenforced because it is close to unenforceable in its current form.

6.4 Authority redistributed without clear ownership

The 2023 reform did not merely leave the advertising rule stranded; it unsettled the machinery through which professional conduct is disciplined, in ways that bear directly on who might police online promotion. Under the previous framework, discipline of doctors and dentists rested with an autonomous disciplinary council operating under the medical council established by the 2004 Medical Practice Law. The 2023 Health Law merged the previously separate councils into a single national council, centralised registration such that the practice certificate is issued on behalf of the Minister of Health, and replaced the former disciplinary council with a new disciplinary assembly [3,23]. That assembly holds broader sanctioning power than its predecessor, extending to recommendations for civil and criminal liability alongside disciplinary measures, but its remit is clinical-practice discipline and patient harm rather than marketing conduct, and it narrowed the class of persons entitled to bring a complaint, where the prior regime had permitted any person aware of or harmed by a violation to do so [23]. Meanwhile the professional ethics apparatus, the professional association and its honour council as custodian of the code, remains intact in form but with diminished authority following the broader reduction of professional-organisation gatekeeping. All of this has unfolded mid-transition, the sitting council's membership having been dissolved by presidential decree only in late 2024 [23]. The net effect for a dentist's promotional conduct is an ambiguity of ownership: such conduct falls between an ethics apparatus whose teeth have been dulled, a state disciplinary body oriented toward clinical harm and harder for an ordinary member of the public to invoke, and an administrative advertising rule of uncertain validity and demonstrable non-enforcement. No institution clearly owns the problem, and the reform that might have clarified responsibility instead redistributed authority without assigning it.

6.5 The shadow market and the generic backstops

Two peripheral elements complete the map. The tukang gigi sector is governed not by the professional framework at all but by a separate regulation defining its narrow lawful scope, now supplemented by a provision of the 2023 Health Law addressing informal dental practice [17,3]; its online promotion is therefore even less clearly policed than that of licensed dentists. And the general-law backstops, the Personal Data Protection Law for the confidentiality of clinical images, consumer-protection law for misleading commercial claims, and the Electronic Information and Transactions Law for electronic content, do apply in principle but are generic rather than profession-specific, complaint-driven, seldom invoked against dental marketing, and, in the case of the data-protection regime, dependent on an enforcement apparatus only recently becoming operational [19,27,28].

6.6 Synthesis

Indonesia's regulatory problem is thus the opposite of the one usually assumed. It is not that dental advertising is ungoverned but that it is governed by too many instruments that cohere poorly, sit uncertainly atop one another after a major reform, and are collectively unenforced, a condition of incoherent over-regulation with an enforcement vacuum, aggravated by a reform that dispersed authority without assigning responsibility for digital conduct. The substantive norms the profession needs largely exist; what is absent is a coherent, platform-aware, and actively enforced application of them, owned by an institution with both the remit and the will to act.

7 COMPARATIVE PERSPECTIVES

Three jurisdictions are considered not as models to be copied but as instances of how regulators facing the same technological pressure have responded, read against the deficiencies diagnosed above: the absence of a functional definition that captures platform content, the mismatch between rules and the digital environment, and the enforcement vacuum with no clear owner. A caution frames the comparison: none of these regimes is settled, and each is itself receding under commercial pressure.

7.1 Australia: the functional definition

The Australian regime supplies the model answer to the first deficiency. Its National Law defines advertising functionally, by what a communication does, namely promote a service so as to attract a person to the provider, and treats a practitioner's or clinic's social-media page, where used promotionally, as advertising subject to the full statutory regime, including the specific prohibitions on testimonials, on creating unreasonable expectation of benefit, and on encouraging indiscriminate or unnecessary use [10]. The transferable element is not the substance, which Indonesian regulation already broadly matches, but the clarity that platform-native content falls squarely within scope and that a single regulator owns its oversight, the clarity that the Indonesian framework now lacks.

7.2 The United Kingdom: dual regulation

The United Kingdom addresses the remaining deficiencies through a division of labour between two bodies acting in tandem: the General Dental Council, whose professional standards require that advertising not mislead and that image use rest on informed consent [20], and the Advertising Standards Authority, which enforces the advertising code across non-broadcast media, social platforms included [21]. What is instructive is how far the United Kingdom has codified the very requirements this review derived analytically. Before-and-after images must represent typical rather than exceptional outcomes, must not be excessively edited, and require consent that is specific and withdrawable, with particular caution urged for online use; patients should not be identifiable unless necessary; and compensated testimonials must carry explicit disclosure of the material connection [20,21]. The United Kingdom also restricts the advertising of prescription-only cosmetic medicines to the public and confines certain restricted services, such as tooth whitening, and their advertising to registered professionals, a model of obvious relevance to the tukang gigi problem, where the marketing of irreversible procedures by unlicensed actors presently escapes meaningful oversight.

7.3 Malaysia: the proximate model

Malaysia is the most valuable comparator for transferability, being a Muslim-majority Southeast Asian jurisdiction with a comparable aesthetic-dental market and platform environment, yet one that has built a markedly more articulated framework. The Malaysian Dental Council maintains a Code of Professional Conduct together with a dedicated set of guidelines on public information [24,25]. The Code prohibits advertising that draws undue attention or brings the profession into disrepute, and its provisions bar superlative claims, guaranteed outcomes, patient testimonials amounting to endorsement, and comparative claims against named competitors [24]. Most strikingly, it requires that a separate consent be obtained before any clinical case is shared in the public domain, whether in advertising, teaching, or media, which is exactly the stratification of consent between treatment, documentation, and publication that this review argued the ethics of the before-and-after image demands [24]. A proximate jurisdiction has thus already codified the conclusion reached here independently. These rules sit atop layered general law and are actively defended by a professional association that has publicly protested discount-driven marketing. The comparison also cautions against complacency: content analysis of Malaysian dental social media found that most posts were advertisements and that, although only a modest fraction of individual posts were non-compliant, more than half of the accounts examined carried at least one non-compliant post [26]. The difference from the Indonesian picture is plausibly attributable not to culture, which is broadly shared, but to institutional design and professional attention [6].

7.4 The limits of transplant, and what transfers

Three qualifications discipline any inference. First, Indonesia's deficit is not primarily one of substantive norms but of enforcement architecture and institutional ownership; the transferable lesson is therefore institutional rather than textual. Second, legal transplant confronts real constraints of scale and capacity, and the mid-transition flux of the 2023 reform means there is at present no stable institution to receive a transplanted mechanism. Third, the comparators are contested and receding even at home. What survives these qualifications is a set of institutional features that Indonesia's framework conspicuously lacks and could realistically adopt: a single, clearly designated owner of digital advertising oversight; explicit, platform-aware provisions, including a separate-consent requirement for publication of clinical images on the Malaysian model; enforcement that is proactive rather than purely complaint-driven; and the treatment of the unlicensed sector's advertising as a distinct enforcement target rather than a regulatory blind spot.

8 SYNTHESIS: PROFESSION OR PROMOTION?

The question in this review's title invites a choice between two states, and the central finding of the preceding analysis is that the choice is already foreclosed, not by argument but by structure. The boundary has been renegotiated, and the renegotiation was not principally ethical: the professional prohibition on advertising was dismantled because its underlying concern was re-described in the vocabulary of restraint of trade, in which it could not be stated, and because the same demand-inducement that dental ethics counts as a harm competition law counts as a benefit [8]. The platform economy has since accelerated the movement through an incentive gradient that makes restraint costly, and the aesthetic reframing of dentistry has shifted the demand structure from remediation to need-construction. That even the

strictest comparators are relaxing their prohibitions confirms a general direction of travel rather than an Indonesian peculiarity. The binary of the title is therefore false: dentistry has not chosen between being a profession and being a promotion; it has become, everywhere, a profession that promotes, and the ethically consequential question is not whether promotion occurs but whether it remains governed.

Current Indonesian frameworks are inadequate, but not for the reason usually assumed. Indonesia possesses a dense thicket of applicable instruments whose substantive content largely tracks the functional, harm-based model this review endorses [15]. The inadequacy lies in coherence, currency, enforcement, and ownership: the layers cohere poorly, the governing instrument's status is unresolved, non-compliance attracts no evident consequence, and the 2023 reform dispersed disciplinary authority without assigning responsibility for digital conduct [3]. The frameworks fail as an operating system, not as a statement of principle, a distinction that points toward institutional reform rather than normative invention.

A defensible, context-sensitive Indonesian position therefore need not resurrect a lost prohibition, and should not. It would abandon the exhausted information-versus-promotion binary in favour of the continuum and the functional-plus-autonomy test [10], locating its firmest restrictions at the demanding end. But it would calibrate this frame to Indonesian conditions in four ways. First, given the country's substantial unmet oral disease burden, it would actively protect and encourage the health-education end of the continuum rather than restrict communication indiscriminately. Second, it would ground the case for restraint not only in imported principlism but in the indigenous commitment to keadilan sosial, which supplies a home-grown anchor for prioritising basic-need equity over the commercial expansion of elective care. Third, it would attend to the relational character of decisions about the body and to religious sensibilities in shaping consent and confidentiality norms for clinical imagery, without surrendering the individual's data-protection rights [19]. Fourth, and most distinctively, it would treat the unlicensed tukang gigi marketplace as a priority target, since it concentrates the gravest harm [16]. Above all, such a position is defensible only if it is owned: a coherent standard that no institution enforces is not a position but an aspiration.

9 RECOMMENDATIONS AND RESEARCH AGENDA

The recommendations that follow are deliberately institutional, because the analysis has located the deficit in enforcement architecture and ownership rather than in the content of norms.

9.1 Practitioners

The continuum is usable as a self-audit before publication: does this content operate to attract, and does it serve or subvert the viewer's capacity to appraise need, risk, and cost? Clinical images should be treated under a stratified-consent standard, with consent for publication obtained separately from consent for treatment, specific in its terms, informed as to permanence and reach, and withdrawable, and with outcomes represented as typical rather than exceptional [20,24]. Given that testimonials remain prohibited under the existing instrument, the prudent counsel is to avoid them altogether [15]. Weighting output toward the educational end of the continuum is both the ethically safest course and, on the comparative evidence, not commercially disadvantageous.

9.2 The professional body

The central institutional recommendation is that the professional association revise KODEKGI to include explicit, platform-aware provisions on advertising and on clinical-image consent, modelled on the functional definition and on the separate-publication-consent rule already codified in Malaysia [10,24]. This should be accompanied by practical, public-facing guidance translating the code into concrete standards for social media, on the Malaysian model of a dedicated public-information guideline [25]. Beyond drafting, the association should revitalise its ethics council's role in online conduct and, within the unsettled post-2023 landscape, advocate for the clear designation of an institutional owner of digital advertising oversight.

9.3 Educators

Digital professionalism should be embedded in the undergraduate curriculum as a distinct competency rather than an incidental warning, and its content should move beyond the impropriety-focused, attitude-measuring paradigm that has dominated the field to encompass the ethics of self-promotion, the consent and confidentiality demands of clinical imagery, and the commercial fault lines examined above [6]. The continuum and the functional-plus-autonomy test are usable directly as teaching instruments, and the curriculum should situate the licensed profession within the wider ecosystem that includes the unlicensed sector.

9.4 Regulators

Four measures follow. The status of Regulation No. 1787 of 2010 should be resolved and, whether it is retained or replaced, its categories modernised to define advertising functionally and to encompass promotional content published from personal accounts [15]. An institutional owner of digital advertising oversight should be clearly designated, the single most important corrective to the 2023 reform's dispersal of authority [3]. Enforcement should move, even in resource-constrained form, from the purely complaint-driven toward the proactive, through periodic content audits and prioritised triage. And the unlicensed sector's online marketing of irreversible procedures should be treated as a distinct, high-priority enforcement target [16,17].

9.5 A research agenda

This review has repeatedly reached the limit of the available evidence, and in doing so has defined the empirical work it cannot itself perform. Five priorities stand out. The foremost is a systematic, current content analysis of Indonesian dental social media, coded against the continuum, to replace the analytic scaffold with evidence. Second, patient- and public-perception studies are needed to test the review's central behavioural claims directly, including whether before-and-after imagery induces perceived need and how testimonials shape trust. Third, the tukang gigi online marketplace warrants dedicated study as a distinct phenomenon. Fourth, an audit of clinical-image consent practices among Indonesian dentists would establish the extent of compliance with the data-protection regime. Fifth, a cross-jurisdictional compliance comparison using a common coding frame, Indonesia against Malaysia in particular, would allow rigorous testing of the hypothesis that the compliance gap is institutional rather than cultural [26].

Limitations

Several limitations qualify the foregoing. The review is narrative rather than systematic, its retrieval purposive rather than exhaustive or reproducible, and its conclusions correspondingly interpretive [11]. Its most consequential constraint is empirical: the paucity of current Indonesia-specific data meant that the landscape rested on a small number of studies and on an analytic scaffold whose mapping onto the continuum awaits validation. The analysis relies in places on sources of uncertain legal status, most notably the unresolved standing of Regulation No. 1787 of 2010, and on accounts of a post-2023 institutional settlement that is itself still in flux, so that the regulatory picture is a snapshot of a moving target. Specific provisions of the profession's own code and certain claims about the Indonesian cultural context are matters for confirmation against primary sources. The comparative analysis draws on a small set of jurisdictions, and the constraints on legal transplant limit the direct transferability of their mechanisms. Finally, the insider vantage is both the source of the review's dental emphasis and a standing invitation to the reader to weigh its sympathies.

10 CONCLUSION

The opposition the title proposes between profession and promotion does not describe a choice still open to dentistry but a threshold it has already crossed: the discipline has become, in Indonesia as elsewhere, a profession that promotes, and the ethical and institutional task is not to relitigate a prohibition that was lost on grounds unrelated to its merits but to govern the promotion that has taken its place. The Indonesian case is distinctive less for the promotion itself than for the conditions surrounding it: an existing but incoherent and unenforced regulatory thicket, a reform that redistributed authority without assigning responsibility, an aesthetic reframing of dentistry that manufactures demand, and an unlicensed shadow market continuous with the regulated one, all set against genuine burdens of disease and access that raise both the beneficent promise and the distributive peril of dental social media above what a wealthier setting would face. What the profession requires is not a retreat from the platform but a coherent, context-calibrated, and actively enforced standard, owned by an institution with the remit and the will to apply it, and informed by an evidence base that does not yet exist. Whether Indonesian dentistry is remembered as a profession that promoted or as a promotion that was once a profession will be decided not by the platform but by the choices its practitioners, its professional body, its educators, and its regulators make now.

STATEMENTS ON COMPLIANCE WITH ETHICAL STANDARDS

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