Additionally, deskilling can significantly affect patient care quality. Practitioners withdrawing from complex treatments increasingly depend on specialist referrals. This reliance can overwhelm specialist services, prolong waiting lists, and restrict patient access to essential and timely care. Such practices may inadvertently convey to patients a lack of practitioner competence, potentially diminishing patient trust, satisfaction, and compliance with care plans.

Regulatory frameworks further complicate the issue of deskilling. While regulatory oversight is integral to maintaining patient safety, excessive caution stemming from stringent regulation can discourage practitioners from attempting procedures perceived as risky. Consequently, a restrictive practice culture emerges, diminishing opportunities for skill enhancement and diversification. This reduction in clinical skill breadth and depth undermines practitioners' professional confidence, job satisfaction, and longevity in practice.

Deskilling also notably impacts early-career practitioners entering primary care environments. The initial years in practice critically shape a clinician's professional identity and clinical habits. If deskilling becomes an accepted norm within practice culture, new graduates may adopt overly cautious and restrictive approaches, limiting their scope of practice early in their careers. Such defensive practice habits can profoundly influence long-term clinical decision-making and career trajectories, potentially reducing future generations' overall competence and adaptability.

Another under-explored aspect is the potential impact of deskilling on professional innovation. Clinical innovation often requires practitioners to embrace new technologies and techniques that inherently carry some degree of risk or uncertainty. A culture steeped in avoidance behaviours and litigation fear significantly undermines practitioners' willingness to engage in such innovations. The resulting stagnation limits professional growth, reduces opportunities for technological advancement, and ultimately impairs the profession's ability to effectively meet evolving patient needs.

Finally, deskilling may affect collaborative practices within multidisciplinary teams. Practitioners who avoid complex clinical scenarios may be less inclined to participate fully in collaborative care planning and problem-solving. Reduced involvement can weaken the effectiveness of multidisciplinary approaches, diminish the overall quality of patient care, and adversely impact the team's collective clinical competence and decision-making capabilities.

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References

1. Mehta S, Wassif H S. Defensive dentistry: perceptions and experiences among general dental practitioners in primary care. *Br Dent J* 2025; DOI: 10.1038/s41415-025-8603-9.

https://doi.org/10.1038/s41415-025-9265-3

Stress in dentistry

A look at burnout

Medical literature has recently seen an uptick in burnout-related research. It appears timely to examine the concept of burnout and its entailing research.

There is a fundamental issue with burnout-related research which is that decades of research has not been able to provide any proper diagnostic criteria for the condition.[1,2] A number of studies consequently utilise criteria which are arbitrary to begin with and are thus unable to make a clear distinction between burned out and non-burned-out individuals which purports this construct rife with internal contradiction.[3]

The most popular tool to measure burnout, the Maslach Burnout Inventory (MBI), does not actually seem to measure burnout (misconceived as it might be in its very definition) but also misaligns with the syndromic framework.[4] This is because the MBI aims to measure cynicism, exhaustion and inefficacy as being representative of burnout but its manual recommends that these scale scores should be calculated and then interpreted in isolation and should not be combined to form a cumulative burnout score (deemed inappropriate by the manual).[4] Further, the MBI has been demonstrated to have psychometric issues, particularly with factorial validity.[4]

The World Health Organization (WHO) definition for burnout aligns closely with that of the MBI.[2] It has been demonstrated that the aetiology and symptomatology of burnout were defined before any systematic research took place.[2]

There is also contention in literature that there is no unequivocal evidence to the fact that work-related stress primarily causes burnout.[2] In fact, there is evidence in literature to suggest that job stressors tend to constitute weak predictors for burnout.[5] However, this is in line with the fact that organisation level interventions for burnout have limited effect.[6]

Further, it is also argued that the tenets of cynicism, exhaustion and inefficacy (questionable pathognomic symptoms) do not tend to produce a syndrome which is cohesive.[2]

These issues warrant attention seeing as burnout is touted as being a rampant occurrence of epidemic proportions. Using potentially flawed criteria might risk the pathologisation of day-to-day inconveniences and divert attention from individuals truly in need of help. This can further undermine proper resource allocation as well as the identification of a truly serious condition such as depression. Proper burnout research is crucial for which there first need to be well defined diagnostic criteria and at least a definition backed by proper scientific evidence.

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References

1. Rotenstein L S, Torre M, Ramos M A *et al*. Prevalence of burnout among physicians: a systematic review. *JAMA* 2018; **320:** 1131–1150.
2. Bianchi R, Schonfeld I S. Examining the evidence base for burnout. *Bull World Health Organ* 2023; **101:** 743–745.
3. Brisson R. On the vis inertiæ within burnout research. *Ann R Coll Surg Engl* 2025; DOI: 10.1308/rcsann.2025.0032.
4. Bianchi R, Swingler G, Schonfeld I S. The Maslach Burnout Inventory is not a measure of burnout. *Work* 2024; **79:** 1525–1527.
5. Guthier C, Dormann C, Voelkle M C. Reciprocal effects between job stressors and burnout: A continuous time meta-analysis of longitudinal studies. *Psychol Bull* 2020; **146:** 1146–1173.
6. Dreison K C, Luther L, Bonfils K A, Sliter M T, McGrew J H, Salyers M P. Job burnout in mental health providers: a meta-analysis of 35 years of intervention research. *J Occup Health Psychol* 2018; **23:** 18–30.

https://doi.org/10.1038/s41415-025-9270-6

Oral health

Residential instability and children's oral health

Oral health is a critical component to the overall health and wellbeing for a child. Oral health is influenced by a variety of factors including socio-economic status. Residential instability, namely parental divorce, can significantly impact on access

to dental care. Parental status information is not often captured by standard socio-economic determinants and often not screened for in the social history.

There has been a rise in joint legal custody arrangements in recent decades due to a shift towards more egalitarian gender roles.[1] As a result there has been increased interest in how children fare in different post-divorce child residence arrangements.[1] There is little evidence detailing how stable residence arrangements are in the long run and whether instability poses a risk to a child's overall well-being.[1]

Instability in housing arrangement can cause access to care issues. Barriers to accessing care leads to untreated dental disease. Untreated dental disease has consequences including pain, sepsis, sleepless nights, missed days at school and disruption to quality of life.[2] The burden of untreated dental disease can prevail into adulthood. In addition to unmet physical dental needs, there are psychological needs that this population face. Dental fear, anxiety and phobia are a complex triad often experienced among patients with residential instability.[3,4] Dental anxiety can have profound social and psychological effects that can persist into adulthood.[5] It can create avoidance-type behaviour and symptom-driven treatment that can escalate over time. Paediatric dentists have a role and responsibility to alleviate anxiety. They work hard to build a rapport among anxious patients through continuous regular care and thus avoiding the creation of a dentally anxious adult. Despite this, with an unestablished dental home due to residential stability there runs a risk of diminishing the work of the paediatric dentist.

To conclude, residential stability can have an impact on a child's oral health due to access to care challenges. It is essential that clinicians do not overlook the importance of obtaining a thorough social history. Early recognition of instability can allow a clinician to provide an individualised care plan for a child so that they receive the care that they deserve.

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References

1. Brons M D, Poortman A R. Instability in post-divorce residence arrangements and child difficulties. *J Marriage and Family* 2025; DOI: 10.1111/jomf.70003.
2. Finucane D. Rationale for restoration of carious primary teeth: a review. *Eur Arch Paediatr Dent* 2012; **13:** 281–292.
3. Appukuttan D P. Strategies to manage patients with dental anxiety and dental phobia: literature review. *Clin Cosmet Investig Dent* 2016; **8:** 35–50.
4. Stein Duker L I, Grager M, Giffin W, Hikita N, Polido J C. The relationship between dental fear and anxiety, general anxiety/fear, sensory over-responsivity, and oral health behaviors and outcomes: a conceptual model. *Int J Environ Res Public Health* 2022; DOI: 10.3390/ijerph19042380.
5. Abed R, Bernabe E, Sabbah W. Family impacts of severe dental caries among children in the United Kingdom. *Int J Environ Res Public Health* 2019; DOI: 10.3390/ijerph17010109.

https://doi.org/10.1038/s41415-025-9269-z