

By definition

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Science, by its very nature, is defined by having answers to problems. Patient presents with A, practitioner does B. It's linear and relies upon diagnosing and definitions. I have always thought of editorial as the opposite of this coin. We can try to blend different ingredients together in the form of voices and opinions to make a delicious delicacy. We have the scope to ask more questions, seek more answers, and bestow rhetorical questions upon a readership. After all, who am I to give you answers – I merely pose the questions for you to put that legwork in yourself.

This made the perusal of June's issue of *BDJ* even more interesting than usual. In it there were two articles that snared my attention: *Models of dental care for people experiencing homelessness in the UK: a scoping review of the literature* and *A scoping review to explore patient trust in dentistry: the definition, assessment and dental professionals' perception*.^{1,2} In the first of these papers, authors attempted to describe and compare dental services that exist for people who experience homelessness in the UK. In the second, authors attempted to identify how

trust is defined, measured and perceived by dental professionals.

The results? In the first paper, authors stated 'Nine dental services in the UK were identified who treated people who experience homelessness. Most did not explore definitions of homelessness.' In the second, authors concluded 'No consensus was found on the definition of trust, nor on a preferred assessment tool to measure dentist-patient trust.'

I find it most bizarre that in a profession such as this, research has identified a lack of a basic definition. Definition gives us structure. How can these two very basic elements of the profession and the patients it interacts with lack such basic definitions? How can trust then be measured? 'You just know' probably wouldn't satisfy a Fitness to Practise panel. Those experiencing homelessness deserve a definition – services can then be built around them rather than nine individual organisations filling in the gaps of a service that does not appear to care. Patients deserve better – no definition and no preferred tool for measuring leaves the system open to interpretation.

Take this edition's cover feature. In it I ask *what makes skill mix work in practice, how do you make skill mix work in practice, and what does that success look like.* The definition of success will be different, as will the definition of how it works, but should it be that way? Yes, there is a discussion to

be had about flexibility – particularly with the implementation of skill mix – and that's understandable. But, in an environment where targets are a staple diet for the vast swathes of dental professionals offering NHS dentistry, isn't it baffling?

All of these are significant enough to warrant specific definitions coming from decision-makers. The spotlight may be firmly fixated on the discredited Dental Contract, but there are practitioners out there who haven't performed NHS dentistry and have different goals. How can dental services for those experiencing homelessness be unified and defined? How can skill mix – often implemented to great success in fully private practices – be defined? And what about the notion of patient trust in dentistry – something that cuts through every single aspect of the profession?

Ironically, this is me demonstrating the very definition I suggest relates to editorial. These aren't questions for me to answer, but for me to ask of you. What is in a definition? ♦

References

1. Bradley N, Heidari E, Andreasson S. *et al.* Models of dental care for people experiencing homelessness in the UK: a scoping review of the literature. *Br Dent J* 2023; **234**: 816-824.
 2. Yuan S, John D, Shambhunath S. *et al.* A scoping review to explore patient trust in dentistry: the definition, assessment and dental professionals' perception. *Br Dent J* 2023; <https://doi.org/10.1038/s41415-023-5882-x>.
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