I am one of those who might be an older adult, I have a complex and complicating medical history and I have numerous complexities, but I am not a complex person. Such sweeping categorisation can cause inadvertent offence when used in relation to patients.

A more appropriate title would be 'A guide to treatment planning for older adults with dental and medical complexities'.

S. Morganstein, by email

1. Geddis-Regan A, Walton G. A guide to treatment planning in complex older adults. *Br Dent J* 2018; **225**: 395–399. <https://www.nature.com/articles/sj.bdj.2018.742> (accessed on 22 October 2018)

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Associate specialists

The lost tribe

Sir, I am currently a dental core trainee in a district hospital. My sessions are often under the direct supervision of an associate specialist in oral and maxillofacial surgery (OMFS), and in Orthodontics.

I am grateful for their vast clinical experience. I am in a district hospital and there is nothing much to do. I spend my days going to the gym and pondering why I've moved to a remote location. I remind myself that I am getting good experience.

During one particularly wet day, jogging on the treadmill and playing sudoku, a thought occurred which worried me.

An associate specialist working on the pre-2006 contract could have earned from £38,836 up to £84,240¹ more if on-call. This was the case for dentists working in a maxillofacial and oral surgery department.

An associate specialist in OMFS has disappeared as a job title for dentists and replaced with 'speciality doctor'. The pay scale is from £37,923 to £70,718¹. The role of a speciality doctor in OMFS usually requires one to have two years' experience as a DCT in oral and maxillofacial surgery and MFDS/MJDF.

An orthodontist associate specialist, on a pre-2006 contract and top banding, might take a pay cut if he were to train to become a consultant, as the pay-scale starts from £76,761 up to £103,490².

If the orthodontist decided to retire, he/she could be replaced with a 'speciality doctor' potential starting salary £37,923 or 'associate specialist' starting £53,169,¹

or perhaps even a part-time consultant orthodontist and an orthodontic therapist.

I don't have a mortgage yet, due to the lowly DCT salary, but if I did, I would bet my mortgage that the DCT post I have will cease to exist in the future.

I worry that there are many associate specialists in OMFS and orthodontic departments working as educational and clinical supervisors for DCTs and they will soon be (or already are) the 'tribe of forgotten associate specialists'.

I am concerned the lack of consultant posts available for oral surgery will have a knock-on effect for our education and the running of the OMFS departments in some regions, particularly at district hospitals.

A. Hassan, by email

1. British Medical Association. 2018 'Pay scales for SAS doctors in England'. Available at <https://www.bma.org.uk/advice/employment/pay/sas-pay-england> (accessed 21 September 2018).
2. British Medical Association. 2018 'Pay scales for consultants in England'. Available at <https://www.bma.org.uk/advice/employment/pay/consultants-pay-england> (accessed 21 September 2018).

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Oral and maxillofacial surgery

MaxFax training opens up the world of dentistry

Sir, having come to the end of Year 1 DCT in oral and maxillofacial surgery, I would like to reflect on what a valuable experience it has been.

Coming out of foundation training it was difficult to know if I'd made the right decision to abandon my newly developed and (very nearly) honed skills in general practice to venture into the unknown world of maxfax, especially with the threat of 'deskilling' on the horizon.

However, despite this being a common concern voiced by many of my peers who chose to progress into practice, what I found was quite the opposite; my skillset has vastly expanded in a way which I feel will be invaluable in whatever career path I eventually pursue.

I chose DCT1 in OMFS to improve my oral surgery techniques, widen my knowledge of the management of medically compromised patients and get exposure to facial trauma and disease – reasons I'm sure are generic amongst other trainees in similar posts.

As it turned out, this was just a small part of what I was to gain. My ability to

cope with and perform in stressful situations was tested right from the first day on call, where I learned that prioritisation and time management would be key.

My communication skills blossomed. I began to more fully appreciate the value of effective teamwork, whether between members of my own department, doctors from other specialities, ward staff or the A&E department. Finding myself in new and varied settings made me tailor my approach to patient management according to the situation.

One aspect that I feel particularly grateful for is the knowledge that I will have the confidence and ability to manage more cases independently should I return to practice.

Having been on the receiving end of a number of questionable referrals and patients sent directly to the emergency department I know how frustrating it can be when something could have been dealt with more appropriately in practice. The thought of how some of my consultants would react would certainly make me think twice before submitting a referral in future!

While many remain of the opinion that maxfax is not relevant to dentistry, I would strongly argue the contrary.

I would encourage anyone contemplating a post in the specialty to seize the opportunity. I feel it has provided me with all the tools I might need to become a good clinician in whatever field I find myself. Not only that, I have had my eyes opened to the big wide world outside of the dental surgery where life or death situations are a daily occurrence.

As I go in to my second year of OMFS Dental Core training, I hope to continue to build on skills I have developed, and look forward to where it may lead me.

R. Unyolo, by email

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Cosmetic dentistry

Facial aesthetic treatments and clinical and radiological implications

Sir, cosmetic facial treatments are a rapidly developing area of clinical practice with increasing numbers of GPs providing facial aesthetic treatments. As their popularity grows, more patients are now undertaking such procedures. We would,

however, like to highlight the possible radiological implications of the use of certain aesthetic treatments, especially to our colleagues who provide these treatments for their patients.

A 49-year-old female was referred by her dental surgeon to the maxillofacial department with severe and worsening right-sided facial pain. Having undertaken a comprehensive clinical assessment and examination, relevant investigations were arranged, including an MRI scan. The use of MRI scans in the investigation and assessment of facial pain is well documented.¹

The resulting images were reviewed by a consultant radiologist and reported as showing 'unexplained bilateral subcutaneous malformations of possible vascular origin'.

At the following review appointment, it became evident that our patient had undertaken non-surgical cosmetic treatment with dermal fillers, which she had failed to mention.

Dermal fillers have long been used to mitigate the effects of ageing, with the aim of temporary replacement or augmentation of lost tissue volume.²

Several types of dermal filler are in current use by practitioners: these comprise short-term, medium-term (temporary) and long-term (permanent) fillers.

Whilst patients are inclined to provide a full history of all treatments to their

aesthetic practitioner, they are less likely to disclose these cosmetic treatments to other healthcare providers and therefore this should be communicated by the clinician.

We would suggest that patients should disclose any history relating to their receiving aesthetic (facial) treatments. Colleagues performing these procedures, such as injecting dermal fillers, should also be aware of the possible radiological implications,³ as is evidenced with MRI scanning images (Fig. 1).

Furthermore, chronic facial pain has been noted following injections in the region of the tear trough, leading to pain within the distribution of the infra orbital and zygomatico facial nerve territories. Whilst at present the exact mechanism for such pain is not understood, the use of permanent rather than temporary fillers may be more difficult to resolve⁴.

*J. Turner and C. J. Mannion,
Maxillofacial Surgery Department,
by email*

1. Zakrzewska J.M. Differential diagnosis of facial pain and guidelines for management. *Br J Anaesth* 2013; **111**: 95–104.
2. Fallacara A *et al*. Hyaluronic acid fillers in soft tissue regeneration. *Facial Plast Surg* 2017; **33**: 87–96.
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4. Foroglou P, Kirkpatrick N. Treating Permanent dermal filler complications. *Aesthetics* 2016; **12**: 34–36.

DOI: 10.1038/sj.bdj.2018.985

Never events

Patient safety definitions

Sir, we thank Horton and Cottam for their interest¹ in our study in which we sought to develop an international expert consensus-based list of 'never events' for primary care dentistry.²

Horton and Cottam question our understanding of never events and propose we re-label these 'significant events'. Horton and Cottam's suggestion is conceptually misaligned with modern patient safety theory and definitions being operationalised in health systems worldwide.

Our list of candidate never events are consistent with the NHS definition for patient safety incidents and the four never event criteria.³

The purpose of the Delphi study was to reach consensus about 'preventability', 'severity' and finally expert opinion on whether candidate never events should 'be

classified as never events' as per the NHS definition.

The list of possible never events was identified from our systematic scoping review of the international literature over a 20-year period⁴ and a detailed analysis of relevant patient safety incidents reported to the National Reporting and Learning System (NRLS) in England and Wales over a period of eight years.⁵

Thus, we empirically drew upon learning from incidents that have occurred as a result of a medical error and not an expected trajectory of a disease process. In our paper, we demonstrate the majority of candidate never events (which reached expert consensus) in our study were retrieved from the NRLS database.

Significant events and never events are overlapping concepts related to the term 'patient safety incident'. A patient safety incident is defined as 'an event or circumstance that could have resulted, or did result, in unnecessary harm to a patient'.⁶

In this context, never events are 'serious, largely preventable patient safety incidents that should not occur if the available preventive measures are implemented'.

Horton and Cottam's cited definition for significant event is 'any event which has an outcome either beneficial or detrimental, which differs significantly from that expected'.

The level of abstraction of this definition is greater than the term 'patient safety incident'.

As this definition for significant events suggests these events are linked to an outcome, which can range from a serious patient safety incident to an event demonstrating high-quality dental care provision.

Labelling our list of 'never events' as 'significant events' will bring confusion to dental professionals and their staff for reporting.

A 'significant event' is linked with an outcome whereas a 'never event' includes 'near misses' and 'no harm incidents', which should all be used for professional learning and practice improvement purposes.⁷

Patient safety in dentistry is an emerging field with a paucity of empirical evidence about the frequency and burden of patient safety incidents in dentistry, and limited understanding of why errors occur.⁸

This lack of data hinders progress to develop effective interventions to reduce

Fig. 1 MRI scan indicating the subcutaneous areas identified by the radiologist as being of concern