The other strand says: 'Teleradiologists reporting imaging of British patients should be registered on the General Medical Council (GMC) Clinical Radiology Specialist Register and indemnified to the same standards as those of the base healthcare organisation.'

This can be extrapolated into dentistry that teleradiology services for CBCT reporting should only be prepared by GDC registered specialists in dental and maxillofacial radiology or GMC registered specialist (head and neck) radiologists.

Reports prepared by practitioners outside the UK who are not registered with the GDC (even if they are registered with their own national body) are unlikely to satisfy this criteria and potentially leave the patient and clinician vulnerable.

S. Harvey, by email

1. The Royal College of Radiologists. Teleradiology and outsourcing census. London: The Royal College of Radiologists, 2010. Ref No. BFCR(10)8. Available at https://www.rcr.ac.uk/publication/teleradiology-and-outsourcing-census (accessed 9 October 2018).
2. The Royal College of Radiologists. Standards for the provision of teleradiology within the United Kingdom, second edition. London: The Royal College of Radiologists, 2016. Ref No. BFCR(16)8. Available at https://www.rcr.ac.uk/publication/standards-provision-teleradiology-within-united-kingdom-second-edition (accessed 9 October 2018).

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Patient safety

Never say never

Sir, we read the opinion article by Dr Barclay regarding 'Never Events' with interest.[1]

In view of the comments in the final paragraph it is worth pointing out that this has been an issue of interest to the Association of Dental Hospitals (ADH) for several years, including as shown in work published in this Journal.[2]

In the English NHS, 'Never Events' were initially introduced in 2009, with 'wrong tooth extraction' being explicitly identified in the 2012 revision. Since then, this has been found to be the most frequent wrong site surgery 'Never Event' reported with most of the reports emanating from hospitals and community services, so clearly dentistry has room to improve on issues of patient safety.[3,4]

In 2016, NHSI went out to consultation on the Never Events policy and framework and in its submission the ADH made several of the points raised by Dr Barclay.

NHSI of course ultimately decides which views it wishes to follow and the resulting new guidance, to which Dr Barclay refers, was only released in late January of this year (2018) for implementation shortly thereafter at the start of February.

Since then, several ADH member hospitals have raised concerns such that in October 2018, an ADH meeting has been arranged to discuss our individual interpretations of the current guidance with the aim of forming a consensus ADH view.

M. N. Pemberton, immediate past Chair of ADH, Manchester and A. Macpherson, current Chair of ADH, Liverpool

1. Barclay S C. Is it the world or is it me? *Br Dent J* 2018; **225:** 117–118. Available at https://www.nature.com/articles/sj.bdj.2018.533 (accessed 9 October 2018).
2. Pemberton M N. Surgical safety checklists and understanding of Never Events in UK and Irish Dental hospitals. *Br Dent J* 2016; **220:** 585–589. Available at https://www.nature.com/articles/sj.bdj.2016.414 (accessed 9 October 2018).
3. Pemberton M N, Ashley M P, Saksena A, Dickson S. Wrong tooth extraction: an examination of 'Never Event' data. *Br J Oral Maxillofac Surg* 2017; **55:** 187–188.
4. Cullingham P, Saksena A, Pemberton M N. Patient safety: reducing the risk of wrong tooth extraction. *Br Dent J* 2017; **222:** 759–763. Available at https://www.nature.com/articles/sj.bdj.2017.448 (accessed on 9 October 2018).

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Child capacity and protection

Gillick research needed

Sir, 1984 saw a landmark legal ruling on the issue of child capacity – Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security.

This, in essence, was subsequently upheld by the House of Lords in 1985 with Lord Scarman's test which is generally considered to be that which defines 'Gillick competency'.

It said: 'As a matter of Law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to understand fully what is proposed.'

This decision had profound implications for the provision of all healthcare services, including dental care, to children under 16 years old. Its importance is reflected in the clear, concise public statements on Gillick competency (and consent in relation to 16- and 17-year-olds) provided by the Department of Health (NHS Choices)[1] and the CQC.[2]

Evidence of the profession's regard for and concern with child protection in general and children's capacity to make decisions relating to their dental care is to be found in the dental discussion forum, https://www.gdpuk.com/.

Since 2008 and as at the time of writing, there were 367 posts which included the keywords 'child' and 'protection', nearly 200 posts which include 'child' and 'consent', and over 50 which included the term 'Gillick'.

Additionally, a short survey (poll) on the subject was posted on https://www.gdpuk.com/ and ran for seven days and asked what percentages ([<25%], [25% to <50%], [50% to <75%] and [75% to 100%]) of patients they believe are Gillick competent among 12–13-year-olds and 14–15-year-olds.

A third question asked if members believe girls generally achieve Gillick Competency before boys or at the same age as boys.

The results indicated that the belief that 51% (n = 23) of 12–13-year-olds and 69% (n = 27) of 14–15-year-olds have capacity to consent to general dental treatment.

Also, 69% (n = 26) believe girls generally achieve Gillick competency before boys.

Although limited in extent, the poll strongly suggests that GDPs view a large proportion of 12–15-year-olds as being Gillick competent and that they consider gender to be a factor which influences that capacity.

Despite the strong engagement of the profession with this issue and the findings reported above, the apparent paucity of other Gillick-competency-related research does suggest there are deficits in our knowledge in this field of dental ethics. The authors hope that this letter will spur more formal research Gillick competence across the relevant age range.

P. V. McCrory and A. V. Jacobs, by email

1. Department of Health. Children and young people – Consent to treatment (2016). Available at https://www.nhs.uk/conditions/consent-to-treatment/children/ (accessed 9 October 2018).
2. Care Quality Commission. Nigel's surgery 8: Gillick competency and Fraser guidelines (2018). Available at https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-8-gillick-competency-fraser-guidelines. (accessed 9 October 2018).

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Tobacco control

Safer without snus

Sir, I was alarmed to see that a recent report on e-cigarettes, by the Science and Technology Committee (17 August 2018), suggested a review on the 'discontinuation' of the ban on snus after Brexit.

Snus is a smokeless snuff tobacco, typically placed under the lip. It is carcinogenic and was banned throughout the EU in 1992.

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