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.

Sweden, however, did not implement this ban, and continues to allow its use, on the grounds that it may be a safe alternative to cigarette smoking.[1]

While snus may be safer than tobacco smoking, it does carry significant risks, most importantly, it can lead to oral cancer.[2]

It seems counterintuitive for the government to suggest reintroducing a known carcinogen when safe smoking cessation alternatives are already available.[3]

As a profession, it is important that we remain cognisant of current political trends, and attempt to exert a positive influence on the direction of public health policy. Through promoting safe smoking cessation methods, and warning against carcinogenic substances like snus, the wellbeing of people who smoke can be protected.

D. Shanahan, by email

1. Foulds J, Ramstrom L, Burke M, Fagerström K. Effect of smokeless tobacco (snus) on smoking and public health in Sweden. *Tobacco Control* 2003 **12:** 349–359.
2. Warnakulasuriya S, Sutherland G, Scully C. Tobacco, oral cancer, and treatment of dependence. *Oral Oncol* 2005 **41:** 244–260.
3. Cahill K, Stevens S, Perera R, Lancaster T. Pharmacological interventions for smoking cessation: an overview of reviews. *Cochrane Database Syst Rev* 2013: CD009329. DOI: 10.1002/14651858.CD009329.pub2.

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Periodontal diseases

New classification for periodontal diseases

Sir, I am writing in regard to the new classification for periodontal and peri-implant diseases and conditions which was launched during the EuroPerio 9 conference in Amsterdam in June 2018.[1]

This new classification replaced the 1999 classification and was co-commissioned by the American Association of Periodontology and the European Federation of Periodontology.

Experts from all over the world participated in its development. Some important changes were introduced including a multidimensional staging and grading system for periodontitis. The peri-implant diseases and conditions were recognised as an independent group. Periodontal health was defined for the first time. New terms were introduced, including traumatic occlusal force, gingival/periodontal phenotype and supracrestal tissue attachment.

The new classification scheme sets to help 'clinicians with diagnosis and management of patients'. However, neither main oral healthcare providers, ie general dental practitioners (GDPs) and dental care professionals (DCPs) (eg oral hygienists and dental therapists), nor patients were represented in the process of its development.

The importance of engaging general practitioners and patients in different stages of developing new healthcare guidelines has long been established and adopted by the world leading institutions, eg the National Institute for Health and Care Excellence.

Therefore, as national societies of periodontology prepare to adopt the new classification, it is pertinent to consider engaging GDPs, DCPs and patients' representatives in the process of planning, the adoption of the new classification, the potential modifications before local implementation, and the roll out strategy.

This will help ensure that the excellent work produced by high calibre international specialists is relevant and acceptable to the main body of oral healthcare providers and the patients.

M. Dorri, by email

1. Caton J, Armitage G, Berglundh T *et al.* A new classification scheme for periodontal and peri-implant diseases and conditions – Introduction and key changes from the 1999 classification. *J Clin Periodontol* 2018; **45 (Suppl):** S1–S8.

Editor-in-Chief's note:

I thank Dr Dorri for this letter which is timely and makes some important and pertinent points. The European Federation of Periodontology (EFP) designed a large educational outreach plan in September 2018 which will involve a range of formats and delivery methods.

The implementation challenge lies in the fact that there are multiple different healthcare systems across the globe and implementation within each country may look quite different.

The British Society of Periodontology (BSP) have written an implementation paper and this will be published soon in the BDJ, with case examples, explaining how the new system can be simply applied on the back of the current BPE screening system that is embedded in UK dental practice.

Additionally, I understand that the BSP have held focus groups that are providing positive feedback on this plan, with a series of BSP webinars by Professor Iain Chapple discussing the work of Group 1 of the World Workshop and defining health and gingival diseases.

Further webinars by Profs Needleman, Hughes and Donos will follow.

Please see: http://www.efp.org/newsupdate/bsp-holds-4-webinars-on-classification/. (accessed on 9 October 2018).

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