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RESPONSE TO THE ARTICLE: "DOES CORONAVIRUS DISEASE 2019 INFECTION AFFECT DENTAL IMPLANT INTEGRATION?"

To the Editor:— I read with interest the article, "Does coronavirus disease 2019 (COVID-19) infection affect dental implant integration?" I would like to commend the author on investigating a possible link between COVID-19 infection and dental implant failure. First, I am unclear why this publication is necessary if it merely represents a communication that is "preliminary to a manuscript being submitted." Has this "communication" gone through the normal Journal of Oral and Maxillofacial Surgery peer review process? Regarding the content, to suggest at this stage that "A patient who has had recent positive testing for COVID-19 should be counseled as to possible risks that can adversely affect implant treatment, until systemic effects of COVID-19 have passed,"[1] is perhaps a premature recommendation. Does this indicate that COVID-19 infection is a relative or absolute contraindication for dental implant placement? Are specific informed consent documents required, similar to those for patients who have undergone bisphosphonate therapy? Are we not to place implants on patients with COVID-19 with long-term symptoms? How about those patients with subclinical myocarditis secondary to COVID-19? If we are making such suggestions for COVID-19, how about the other respiratory viruses that may also trigger similar inflammatory and cytokine responses? With paranoia and misinformation still present regarding many aspects of COVID-19, I do not believe we need to add an additional component of concern for patients or practitioners. All the author's concerns may be proven true, but should we not encourage the development of some multicenter randomized clinical trials to determine whether the results of a study are clinically significant? Clinical observations can serve as an excellent starting point to establish future research. It is in the best interest of the specialty to encourage the publication of well-researched and evidence-based studies to determine conclusions to best influence our clinical practice guidelines.

Thank you and be safe.

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Reference

1. Block MS: Coronavirus Disease 2019 may affect dental implant integration. J Oral Maxillofacial Surg 79:1196, 2021

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RESPONSE TO LETTER TO THE EDITOR: DOES CORONAVIRUS DISEASE 2019 INFECTION AFFECT DENTAL IMPLANT INTEGRATION?

*Dear Dr. Hussain,—*Thank you for your enthusiastic and appropriate response to my opinion published in this journal.[1] The use of the perspective article before manuscript submission has been used previously to introduce an observation that may be important for clinicians to consider. It does undergo a review process similar to other perspectives/letters to the editor. The questions you ask are exactly those we need to evaluate. Each of your questions requires a prospective evaluation which will take an extended time period or a retrospective evaluation which will most likely have less than excellent data available to test hypotheses you request.

The recommendation to counsel our patients is based on the early observations compared with a group of patients with naïve coronavirus disease (COVID). You are absolutely correct that before a definitive conclusion, more data are necessary, but the early observation may benefit several patients. A multicenter prospective or retrospective evaluation is a great idea; however, the time it takes to create the protocol, gather the researchers, provide evidence that they actually have specific documentation on their patients with follow-up, and achieve the IRB approval for this type of multicenter study may result in an extended time before bringing this early observation to our colleagues. If these observations prove to be correct, then it is prudent to bring this to the attention of those treating patients.

Experimental problems in any retrospective evaluation are the sample size and established documentation. In my practice, my electronic medical record does have the necessary documentation. I have asked 2 others and either their sample size is small or the records at 1 institution were not very detailed as per COVID status in March/April/May 2020 and so on. I hope that the perspective article may have resulted in you examining in detail every implant you placed in patients since March 2020 and the documented results of the implant placement. To be included in this type of retrospective study, you must have excellent evidence including

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their COVID status with timing from COVID status to implant placement, including those who developed positive COVID testing after implant placement but prior to implant integration. Please let us know your results which can be added to others to develop a consensus on this question. Hopefully, the perspective article and our manuscript that is under peer review can be used as preliminary data to justify a large and costly study, as you have appropriately suggested.

Thank you again for your response.

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Reference

1. Block MS: Coronavirus Disease 2019 may affect dental implant integration. J Oral Maxillofac Surg 79:1196, 2021

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RESPONSE TO "SO YOU THINK WHITE PRIVILEGES IS A MYTH? THE FIGHT FOR EDUCATIONAL EQUALITY"

To the Editor:— To my surprise, our journal has become entangled with critical race theory and its presupposition that humans can be described by a reductionist view that emphasizes class, power, and phenotype as core essentials. The accomplished author begins the editorial with a sweeping generalization that automatically characterizes the oppressor and the oppressed: "White privilege has affected every aspect of non-White lives and livelihood, including their education and career opportunities." Aside from the argument about whether White privilege exists, is it possible that heterogeneity in thought can exist within a particular complexion group, especially in terms of what one perceives as adversity?

The author highlights the educational disparities within predominately Black school districts and cites asymmetric funding as the primary culprit. Unfortunately, this is lacking relevant contextual consideration. The five US districts with the highest spending per pupil are New York, Boston, Atlanta, Montgomery County, and Baltimore.[1] Four of these are inner city districts and, importantly, governed by racially diverse groups of elected officials. To what degree does accountability lie with the fiduciary stakeholders? The singular, demonstrable intervention that has consistently narrowed the chasm in educational outcomes in inner cities is charter schools; economist Thomas Sowell has intensely investigated this phenomena and has all but proven the presence of other primary causal factors toward educational disparities.[2]

The author goes on to demonstrate racism in the professional sector by offering anecdotes of encounters with ancillary staff and peers who were not mindful of the author's professional status. To reflect on these instances, is it possible that humans make assumptions based on past accumulated experiences and may be ignorant rather than outright racist? I say this with concern about the equivocation occurring with the word "racism." To use such a polarizing word so ubiquitously will undoubtedly discourage meaningful conversation.

In light of this ongoing dialog, my central concern is regarding mentorship. As an oral and maxillofacial surgeon in military academia, I have recently begun to think critically about transformative versus transactional relationships concerning residents. Undeniably, transformative relationships are preferred because they allow a mentor to walk alongside their mentee and develop not only the surgeon but also the individual. This means there must be a collective, inherent equality that both members share irrespective of their socially constructed identity. My appeal here is not to dismiss the necessity of race-based discussion but to ask the following questions:

- What do we as a profession and as educators prioritize, diversity in thought or diversity in skin color?
- Should I allow unbridled self-identification among my residents or demand a collective uniformity based on missional goals?
- Should I abstain from critical interrogation or espouse bidirectional critical interrogation?

These propositions are not either/or, but given the onslaught of critical race theory and its influence in the scientific community, we need to clarify these distinctions and prioritize what is most constructive for creating and improving lifelong virtues. My final question is this: if the notion of White privilege were objectively true, would it be possible for a White educator to mentor a person of color as an equal and cultivate a transformative relationship? No. Instead, they would have to mentor from a position of superiority because of the systemic, inherent underpinning of White privilege. If we indulge this ideology, I am afraid that transformative mentorship will become a rarity.

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References

1. United States Census Bureau. Spending per pupil Increased for Sixth Consecutive Year. Available at: https://www.census.gov/newsroom/press-releases/2020/school-system-finances.html#:~:text=Of%20the%20100%20largest%20(based,Montgomery%20County%20School%20District%20in. Accessed November 17, 2020.
2. Sowell T: Charter Schools and Their Enemies. New York, NY, Basic Books, 2020

https://doi.org/10.1016/j.joms.2021.02.015

REPLY TO LETTER TO THE EDITOR

To the Editor:— Thank you for sharing your perspective on my opinion piece. Your response affirms your assertion that "heterogenicity in thought can exist within a particular complexion group, especially in terms of adversity." However, there are many who self-identify as people of color who have experienced racism and recognize it as such. My intent was to show them that they have allies within our profession.

The social, economic, and political impact of racism has been prevalent in our country throughout American history. This is no secret. Many brilliant researchers, artists, musicians, academics, politicians, authors, lawyers, doctors, and so on have highlighted the elements of racism that persist in our society in different, often subtle, forms.