

infective cases in the community. In fact, the modelling used suggests that 5,000 tests would need to be performed to identify one asymptomatic infective case.

There is an opportunity here to perform a prospective study by testing patients who have been selected for an AGP, to assess this model/hypothesis. Recruiting practices from various geographical locations would be necessary to attempt to catch any local variations but if one or two thousand consecutive cases came back negative, how reassuring that would be?

N. Malden, Kinross, UK

Reference

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<https://doi.org/10.1038/s41415-020-1934-7>

Testing reprise

Sir, I have just read Dr J. A. Woodcock's letter¹ in the *BDJ* on testing and find that his proposal has one major flaw. As Prof Jason Leitch has said several times

at the Scottish First Minister's briefings, if someone is tested today and the result comes back negative tomorrow, that only proves that they were negative today. It does not prove that they will be negative tomorrow, or on whatever date they may be given an appointment under Dr Woodcock's proposal. Regrettably, I cannot see, therefore, that his suggestion is of any help.

J. Watt, Biggar, UK

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<https://doi.org/10.1038/s41415-020-1935-6>

Vertical transmission

Sir, in connection with the interesting discussion of Richards *et al.* on coronamolars as a possible congenital disorder of the coronavirus disease (COVID-19), we suggest maternal-foetal transmission (vertical transmission) to predict the coronamolars' development.¹

Mulberry molars and Hutchinson's teeth are characteristic dental stigmata of children born to mothers with syphilis infection during pregnancy.

Although a recent systematic review has concluded that there is no evidence of the vertical transmission in neonates of mothers with confirmed COVID-19 infection 0.0% (0/310),² the possibility of vertical transmission cannot be completely ruled out due to the few individual neonate cases which were reported positive a few hours after their birth. Vertical infection therefore remains a possibility in the context of COVID-19 thus implying a potential call-to-action for dental researchers and professionals to look for possible orofacial manifestations either in the short- or long-term, once cohorts of congenital COVID-19 are reported.

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<https://doi.org/10.1038/s41415-020-1936-5>

Racism

A global pandemic

Sir, the tragic death of George Floyd has caused great anguish around the world but, in response, the devaluation and dehumanisation of black people has again come to the fore. This is not an American problem; structural and institutional racism is a problem everywhere around us. Such racism can be overt or covert and it is important to recognise that dentistry is not immune.

Research has shown that dentists' decision making is affected by patient race, with black patients having a greater likelihood of having extractions than white patients.^{1,2} Mistrust of dentists is demonstrated in a study reporting that Black Minority Ethnicity (BME) participants in London believe that, because of their background, they received a poor service, were not respected, listened to or cared about by dentists compared to other non-BME patients.³ More generally, within the NHS, ethnic minority patients

and clinicians face many injustices. The 2019 Workforce Race Equality Standard (WRES) data report showed that a higher proportion of BME staff experienced harassment, bullying, or abuse from staff compared to white staff.⁴

The *BMJ* have a special issue on racism in medicine which is eye-opening and powerful. It reflects the experiences of doctors and patients from ethnic minority backgrounds.⁵ I believe the *BDJ* should undertake a similar enterprise to encourage more publications on race and racism. Such conversations are needed within dentistry as it is not talked about as much and openly as it should be.

In order to understand this subject, we must look beyond clinical dentistry and appreciate the study of social sciences, philosophy and humanities. It is engraved as a GDC Standard to 'treat patients fairly, as individuals and without discrimination'. It should be embedded within us as humans from the very beginning and we must acknowledge and challenge our own personal prejudices we may have.

I want to stress the importance of acknowledging the structural and institutional racism in dentistry specifically and in society more generally. This is an ongoing issue and we need to not only act and speak up whenever we witness injustice but to engage more in the conversation about race and racism.

K. Villanueva, Hull, UK

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