Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

not subadditive or superadditive.[4] Guidelines can be created for applicable criteria to be satisfied before co-enrolment is approved.[5] The statistical hurdles can be addressed. In most cases, each trial can be analysed separately and validly with the use of standard intention to treat principles; selection and other biases can be avoided if enrolment into the second trial is not dependent upon randomised treatment in the first trial; and valid interaction analyses can be done for each trial by considering the patient's status in the other trial at the time of randomisation in the index trial.[1]

The cornerstones of ethical conduct of research include respect for patients, beneficence, and justice. With COVID-19 infection, access to a second treatment protocol where no other treatment is available should, at times, be strongly considered. In reviewing studies, both the Institutional Review Board and physician researchers should look more in depth at prohibitions on co-enrolment and ask for a justification of any prohibition if it will not affect the goal and the implementation of the study.

I declare no competing interests.

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COVID-19 is an opportunity for reform in dentistry

The COVID-19 global pandemic continues to have devastating health, economic, and social effects, and is profoundly affecting the delivery of health services. Because of the infection risks associated with aerosol generated procedures, such as the use of high-speed drills, dental services across much of the world have been essentially closed since late March, 2020. During this period there was limited access to emergency dental care. Consequently, many desperate people with excruciating dental pain and acute oral infections have resorted to do-it-yourself dentistry, including the extraction of molar teeth without any local analgesia[1]—a scene reminiscent of medieval times. Dental services are now slowly and tentatively beginning to re-open, although there is considerable variation in the guidance being issued on the safety procedures required.[2] Rather than resuming normal service, this crisis presents an opportunity to rethink the future of dentistry and address system-level failures.

During the pandemic, many dental personnel have been redeployed to frontline health services to provide a range of clinical procedures beyond their usual scope of practice. The scale and pace of this integration of dental personnel into the wider health system has been remarkable. Dentists, dental hygienists or therapists, and dental nurses, have all had a substantial effect in supporting health service delivery during this crisis and have developed new skills and clinical knowledge in the process. Rather than being isolated and separated from mainstream health care, this crisis has clearly shown that dental personnel can be integrated into the wider system—the challenge ahead is to delineate the clinical roles of dental personnel in a more integrated model of care.

The COVID-19 pandemic has exacerbated socioeconomic and ethnic inequalities[3] and will undoubtedly worsen oral health inequalities. Dental care systems now need to be more responsive to the needs of their local populations and prioritise care for groups with a high need for care, such as low-income, marginalised, and vulnerable groups, including those with multiple morbidities. Current restrictions on aerosol generating procedures provide an opportunity to re-orientate dental care towards a less invasive and more preventive approach, one in which the dental team work in partnership to tackle the shared risks for oral diseases and other non-communicable diseases. This is also a time to stop delivering unnecessary and ineffective treatments. A perfect example of this is the routine provision of tooth scaling and polishing, a procedure that does not have an evidence base and is a costly waste of resources.[4] Radical reform of oral health-care systems will require brave and bold decision making from our political and professional leaders. The time however is ripe for change.

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