JOURNAL OF DENTAL HUMANITIES

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JOURNAL OF DENTAL HUMANITIES

The Journal of Dental Humanities is dedicated to presenting thought provoking material connecting dentistry to the humanities, and the social sciences. The journal places a priority on publishing quality material that supports the objective of dental professionals who seek to provide a patient-centered approach to health care. The mission purpose of the Journal of Dental Humanities aligns with the position that a functional democracy requires ethical, highly skilled professionals who are engaged, active members within their community and the larger society.

EDITORIAL BOARD

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THE DEVOLUTION OF THE ORAL HEALTH CARE WORKFORCE IN THE ERA OF COVID-19

ROBERT P. IOVINO, D.D.S., M.A.

In a career spanning 45 years, bracketed by two pandemics, I can personally attest there has never been a more challenging time than now to be an oral healthcare professional. Seemingly overnight, four decades of almost uninterrupted growth and prosperity in the oral health care sector has abruptly come to an end. Healthcare workforce statistics reported in June 2nd issue of the Washington Post bear this assertion out. [1] At the time of what likely will approximate the peak of the first wave of the COVID-19 pandemic, 503,000 job positions had disappeared from the U.S. dental workforce. The education of young dental professionals has been moved online. Viewed collectively, such an unprecedented number of jobs lost, and lives disrupted, is truly hard to fully comprehend. While many of these oral health care professionals are, or will be, returning to an altered workplace or campus, some are likely to never return.

Each of the hundreds of thousands of dental hygienists, dental assistants, students, front-desk office personal and dentists who capably provided exceptional care to the public while occupying these positions have an individual story to tell. Such individual narratives are more compelling than stark statistics. Career plans interrupted, or

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[1] Mellnik, Ted, Laris Karklis and Andrew Ba Tran. "Americans are delaying medical care, and it's devastating health-care providers." *The Washington Post*. 2 June 2020. Accessed 3 June 2020. <https://www.washingtonpost.com/nation/2020/06/01/americans-are-delaying-medical-care-its-devastating-health-care-providers/?arc404=true>;
Janes, Chelsea. "Amid coronavirus concerns, dentists face a fraught road to reopening." *The Washington Post.* 29 May 2020. Accessed 3 June 2020. <https://www.washingtonpost.com/health/amid-coronavirus-concerns-dentists-face-a-fraught-road-to-reopening/2020/05/28/187f5e30-9909-11ea-ac72-3841fcc9b35f_story.html>

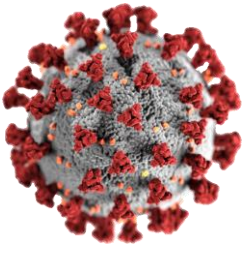
prematurely ended, paychecks on hold, outstanding student loans, etc. extract a punishing toll on individuals mere numbers fail to reveal. Those professionals fortunate enough to work on during the pandemic, risking exposure to this novel pathogen and providing emergency critical care, have been significantly affected in other ways. All are invited and most welcomed to tell their stories here.

Attention
Health Care Professionals

We are interested in impact stories related to the COVID-19 global health pandemic.

Do you have a story to share? Please consider submitting for publication. Narratives can be presented in either written form or by audio file [submissions subject to editing].

Please send submissions to:
robert.iovino@stonybrookmedicine.edu



No. 202

EXECUTIVE ORDER

Declaring a Disaster Emergency in the State of New York

WHEREAS, on January 30, 2020, the World Health Organization designated the novel coronavirus, COVID-19, outbreak as a Public Health Emergency of International Concern;

WHEREAS, on January 31, 2020, United States Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the entire United States to aid the nation's healthcare community in responding to COVID-19;

WHEREAS, both travel-related cases and community contact transmission of COVID-19 have been documented in New York State and more are expected to continue; and

WHEREAS, New York State is addressing the threat that COVID-19 poses to the health and welfare of its residents and visitors.

NOW, THEREFORE, I, Andrew M. Cuomo, Governor of the State of New York, by virtue of the authority vested in me by the Constitution and the Laws of the State of New York, hereby find, pursuant to Section 28 of Article 2-B of the Executive Law, that a disaster is impending in New York State, for which the affected local governments are unable to respond adequately, and I do hereby declare a State disaster emergency for the entire State of New York. This Executive Order shall be in effect until September 7, 2020; and

IN ADDITION, this declaration satisfies the requirements of 49 C.F.R. 390.23(a)(1)(A), which provides relief from Parts 390 through 399 of the Federal Motor Carrier Safety Regulations (FMCSR). Such relief from the FMCSR is necessary to ensure that crews are available as needed.

FURTHER, pursuant to Section 29 of Article 2-B of the Executive Law, I direct the implementation of the State Comprehensive Emergency Management Plan and authorize all necessary State agencies to take appropriate action to assist local governments and individuals in containing, preparing for, responding to and recovering from this state disaster emergency, to protect state and local property, and to provide such other assistance as is necessary to protect public health, welfare, and safety.

IN ADDITION, by virtue of the authority vested in me by Section 29-a of Article 2-B of the Executive Law to temporarily suspend or modify any statute, local law, ordinance, order, rule, or regulation, or parts thereof, of any agency during a State disaster emergency, if compliance with such statute, local law, ordinance, order, rule, or regulation would prevent, hinder, or delay action necessary to cope with the disaster emergency or if necessary to assist or aid in coping with such disaster, I hereby temporarily suspend or modify, for the period from the date of this Executive Order through April 6, 2020 the following:

Section 112 of the State Finance Law, to the extent consistent with Article V, Section 1 of the State Constitution, and to the extent necessary to add additional work, sites, and time to State contracts or to award emergency contracts, including but not limited to emergency contracts or leases for relocation and support of State operations under Section 3 of the Public Buildings Law; or emergency contracts under Section 9 of the Public Buildings Law; or emergency contracts for professional services under Section 136-a of the State Finance Law; or emergency contracts for commodities, services, and technology under Section 163 of the State Finance Law; or design-build or best value contracts under and Part F of Chapter 60 of the Laws of 2015 and Part RRR of Chapter 59 of the Laws of 2017; or emergency contracts for purchases of commodities, services, and technology through any federal GSA schedules, federal 1122 programs, or other state, regional, local, multi-jurisdictional, or cooperative contract vehicles;

Section 162 of the State Finance Law and Article 4-C of the Economic Development Law, to the extent necessary to allow the purchase of necessary commodities, services, technology, and materials without following the standard notice and procurement processes;

Section 97-G of the State Finance Law, to the extent necessary to purchase food, supplies, services, and equipment or furnish or provide various centralized services, including but not limited to, building design and construction services to assist affected local governments, individuals, and other non-State entities in responding to and recovering from the disaster emergency;

Section 359-a, Section 2879, and 2879-a of the Public Authorities Law to the extent necessary to purchase necessary goods and services without following the standard procurement processes;

Sections 375, 385 and 401 of the Vehicle and Traffic Law to the extent that exemption for vehicles validly registered in other jurisdictions from vehicle registration, equipment and dimension requirements is necessary to assist in preparedness and response to the COVID-19 outbreak;

Sections 6521 and 6902 of the Education Law, to the extent necessary to permit unlicensed individuals, upon completion of training deemed adequate by the Commissioner of Health, to collect throat or nasopharyngeal swab specimens from individuals suspected of being infected by COVID-19, for purposes of testing; and to the extent necessary to permit non-nursing staff, upon completion of training deemed adequate by the Commissioner of Health, to perform tasks, under the supervision of a nurse, otherwise limited to the scope of practice of a licensed or registered nurse;

Subdivision 6 of section 2510 and section 2511 of the Public Health Law, to the extent necessary to waive or revise eligibility criteria, documentation requirements, or premium contributions; modify covered health care services or the scope and level of such services set forth in contracts; increase subsidy payments to approved organizations, including the maximum dollar amount set forth in contracts; or provide extensions for required reports due by approved organizations in accordance with contracts;

Section 224-b and subdivision 4 of section 225 of the Public Health Law, to the extent necessary to permit the Commissioner of Health to promulgate emergency regulations and to amend the State Sanitary Code;

Subdivision 2 of section 2803 of the Public Health Law, to the extent necessary to permit the Commissioner to promulgate emergency regulations concerning the facilities licensed pursuant to Article 28 of the Public Health Law, including but not limited to the operation of general hospitals;

Subdivision 3 of section 273 of the Public Health Law and subdivisions 25 and 25-a of section 364-j of the Social Services Law, to the extent necessary to allow patients to receive prescribed drugs without delay;

Section 400.9 and paragraph 7 of subdivision f of section 405.9 of Title 10 of the NYCRR, to the extent necessary to permit general hospitals and nursing homes licensed pursuant to Article 28 of the Public Health Law ("Article 28 facilities") that are treating patients during the disaster emergency to rapidly discharge, transfer, or receive such patients, as authorized by the Commissioner of Health, provided such facilities take all reasonable measures to protect the health and safety of such patients and residents, including safe transfer and discharge practices, and to comply with the Emergency Medical Treatment and Active Labor Act (42 U.S.C. section 1395dd) and any associated regulations;

Section 400.11 of Title 10 of the NYCRR, to the extent necessary to permit Article 28 facilities receiving patients as a result of the disaster emergency to complete patient review instruments as soon as practicable;

Section 405 of Title 10 of the NYCRR, to the extent necessary to maintain the public health with respect to treatment or containment of individuals with or suspected to have COVID-19;

Subdivision d and u of section 800.3 of Title 10 of the NYCRR, to the extent necessary to permit emergency medical service personnel to provide community paramedicine, transportation to destinations other than hospitals or health care facilities, telemedicine to facilitate treatment of patients in place, and such other services as may be approved by the Commissioner of Health;

Paragraph 3 of subdivision f of section 505.14 of Title 18 of the NYCRR, to the extent necessary to permit nursing supervision visits for personal care services provided to individuals affected by the disaster emergency be made as soon as practicable;

Sections 8602 and 8603 of the Education Law, and section 58-1.5 of Title 10 of the NYCRR, to the extent necessary to permit individuals who meet the federal requirements for high complexity testing to perform testing for the detection of SARS-CoV-2 in specimens collected from individuals suspected of suffering from a COVID-19 infection;

Subdivision 4 of section 6909 of the Public Health Law, subdivision 6 of section 6527 of the Education Law, and section 64.7 of Title 8 of the NYCRR, to the extent necessary to permit physicians and certified nurse practitioners to issue a non-patient specific regimen to nurses or any such other persons authorized by law or by this executive order to collect throat or nasopharyngeal swab specimens from individuals suspected of suffering from a COVID-19 infection, for purposes of testing, or to perform such other tasks as may be necessary to provide care for individuals diagnosed or suspected of suffering from a COVID-19 infection;

Section 596 of Title 14 of the NYCRR to the extent necessary to allow for rapid approval of the use of the telemental health services, including the requirements for in-person initial assessment prior to the delivery of telemental health services, limitations on who can deliver telemental health services, requirements for who must be present while telemental health services are delivered, and a recipient's right to refuse telemental health services;

Section 409-i of the Education Law, section 163-b of the State Finance Law with associated OGS guidance, and Executive Order No. 2 are suspended to the extent necessary to allow elementary and secondary schools to procure and use cleaning and maintenance products in schools; and sections 103 and 104-b of the General Municipal Law are suspended to the extent necessary to allow schools to do so without the usual advertising for bids and offers and compliance with existing procurement policies and procedures;

Article 7 of the Public Officers Law, section 41 of the General Construction Law, and section 3002 of the Public Health Law, to the extent necessary to permit the Public Health and Health Planning Council and the State Emergency Medical Services Council to meet and take such actions as authorized by law, as may be necessary to respond to the COVID-19 outbreak, without meeting quorum requirements or permitting the public in-person access to meetings, provided that any such meetings must be webcast and means for effective public comment must be made available; and

FURTHER, I hereby temporarily modify, for the period from the date of this Executive Order through April 6, 2020, the following laws:

Section 24 of the Executive Law; Sections 104 and 346 of the Highway Law; Sections 1602, 1630, 1640, 1650, and 1660 of the Vehicle and Traffic Law; Section 14(16) of the Transportation Law; Sections 6-602 and 17-1706 of the Village Law; Section 20(32) of the General City Law; Section 91 of Second Class Cities Law; Section 19-107(ii) of the New York City Administrative Code; and Section 107.1 of Title 21 of the New York Codes, Rules and Regulations, to the extent necessary to provide the Governor with the authority to regulate traffic and the movement of vehicles on roads, highways, and streets.

GIVEN under my hand and the Privy Seal of the State in the City of Albany this seventh day of March in the year two thousand twenty.

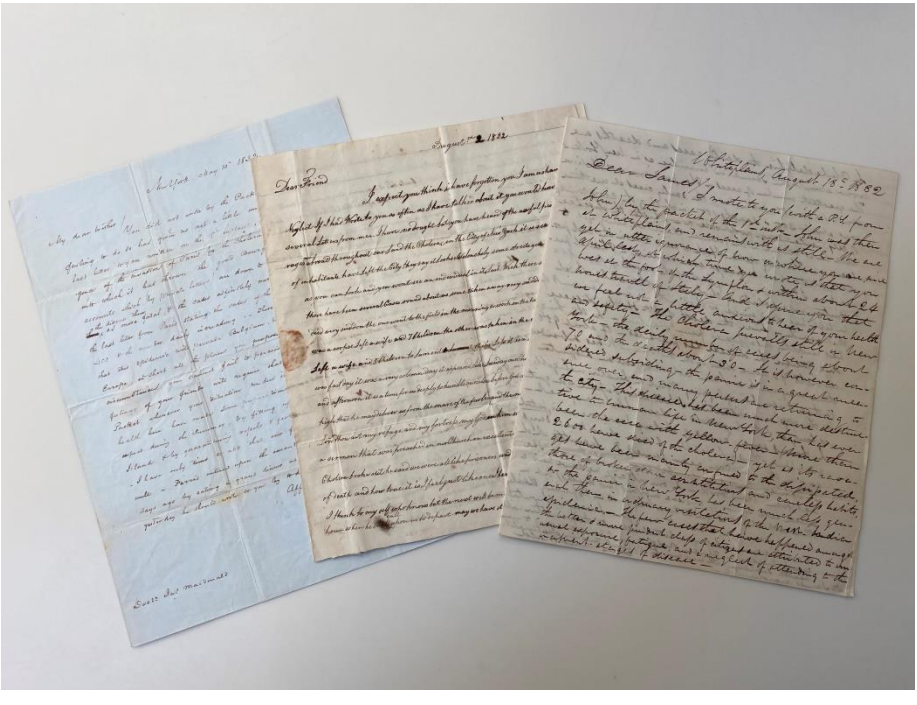
BY THE GOVERNOR

Secretary to the Governor

This facsimile of the executive order (printed on pages 3-5) was published by the State of New York on 7 March 2020 and accessed on 3 June 2020. <https://www.governor.ny.gov/news/no-202-declaring-disaster-emergency-state-new-york>

LESSON FOR PANDEMICS TODAY: THREE LETTERS – NEW YORK CITY & THE CHOLERA EPIDEMIC OF 1832

ROBERT P. IOVINO, D.D.S., M.A.



COVID-19 is not the first pandemic to arrive on the shores of New York City and its environs, and, nor will it be the last. As New Yorker's come together to contain and battle the COVID-19 viral outbreak, the posted folded "plague letters" of three New York residents, written during the city's Cholera pandemic of 1832, are worth unfolding.

As an academic resource, these "plague letters" provide a riveting human narrative. Students pay attention to their authors long-silent voices and ask questions. For this very reason I have utilized these plague letters as a springboard to discuss the polar concepts of quarantine and autonomy in a seminar series, focused on current issues in oral health care ethics, I conduct at Stony Brook's School of Dental Medicine. For decades the American public's default position has strongly supported a robust concept of personal autonomy. This was evident in-part when, throughout Africa's Ebola outbreak in 2014, sections of the American public, even though perceptively on-edge, still rallied behind the efforts of the courageous healthcare workers who, upon their return from plague-stricken Africa, publicly pushed-back against state executives who requested, or ordered, their going into quarantine.[1]

Not so in 2020. Long standing social standards have quickly been revised; voluntary self-quarantine has become today's accepted norm. The arrival of the COVID-19 virus offers us, and future theorists, a keen vantage point, by which to view, and examine, how the mechanisms of the disciplines of sociology, philosophy, medicine and law intertwine. Since COVID-19's arrival J.S. Mill's "Harm Principle" has clearly been re-visited, and, the norm for what constitutes "harm" in our society quickly redefined. Measles anti-vaxxers take notice. The modern world of the heretofore smug secular radical autonomist has been exponentially altered. It is fair going forward to ask: What impact will the aftereffects of restrictive public-health measures, enacted to combat the COVID-19 pandemic, have on

[1] Hartocollis, Anemonaand Emma Fitzsimmons. *"*Tested Negative for Ebola, Nurse Criticizes Her Quarantine." *New York Times.* 25 October 2014. <https://www.nytimes.com/2014/10/26/nyregion/nurse-in-newark-tests-negative-for-ebola.html >;
American Civil Liberties Union/Yale Global Health Justice Partnership. "Fear, Politics, and Ebola: How Quarantines Hurt the Fight Against Ebola and Violate the Constitution" (2015). <https://www.aclu.org/report/report-fear-politics-and-ebola?redirect=report/fear-politics-and-ebola>

the priority the western world places on society's ubiquitous principle of autonomy?

The following excerpts selected from these three letters were composed in a time, in many ways, like ours. They were written during a period of high-stress, uncertainty and anxiety. The two eras also differ. In 2020 science affords us an imperfect understanding the virus that is our killer, in ways that what constituted science, for those beset by the Cholera, in 1832 did not. Tragically, however, individuals in both eras acutely suffered from the lack of a cure. This fatal characteristic provides sufficient reason for sharing excerpts from these plague letters now. These letters provide us with a narrow portal through time by which to view how New Yorkers during the Cholera pandemic of 1832 worried, prepared (Possibly better than we.), endured and persevered. Their authors past voices will sound both familiar to us, and troubling. However, at the very least I hope that we, like they, can find solace in the knowledge that all pandemics throughout the ages share a common characteristic. Pandemics have a beginning, middle, and, thankfully, an end.

Here now are three New Yorkers of 1832 unedited long-silent voices:

Letter #1:

To: Doct. James Macdonald c/o…Paris
Letter dated New York, May 10th, 1832
Received in Le Havre 3 June 1832

My dear brother,
You did not write by the Packet of April 1st and your failing to do so has given us not a little (distress), for since my last…letter written on the 1st…, we have received intelligence of the invasion of Paris by the cholera & of the terrible consternation into which it has thrown the good Bourgeois of that city…accounts… by private letter…(report) the disease there as more fatal & the cases infinitely more numerous than London, - the last letter from Paris stating the cases of the preceding 24 hours at about 400 & the number daily increasing. – There cannot be a doubt now that this epidemic will pervade Belgium, England, France, the South of Europe, in short all of the places you propose visiting, & under these circumstances you cannot fail to perceive that a decent respect for the feelings of your friends will require that you write regularly by every Packet whenever your situation renders it practicable. – Our Board of health has made some preparations to meet the disease which we expect during the summer, by fitting up a Cholera Hospital on Staten Island[2] *& by quarantining vessels & goods coming from infected places…*

Affectionately Yours,
J.M. Macdonald
No. 15 Wall St. New York

[2] The Staten Island Quarantine Hospital was burned in an insurrection by Island inhabitants in 1858. See: Garrison H. Fielding "The Destruction of the Quarantine Station on Staten Island in 1858: Reprinted from *The Bulletin of The New York Academy of Medicine*, 1926; 2: 1-5" in the *"Journal of Urban Health: Bulletin of the New York Academy of Medicine,* Volume 76, Number 3 (September 1999) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3456834/>

Letter #2:

To: Miss Elizabeth Mandeville
Caroline New York
To be left at the Caroline Post Office

Letter, postmarked New York, dated August 2nd, 1832

Dear Friend,

…I have no doubt you have heard of the awful pestilence that rages about throughout our Land the Cholera in the City of New York it is really awful hundreds of inhabitants have left the City they say it looks melancholy some streets you can look up as far as you can look and you wont see an individual in it. Last week there were 884 deaths in it there have been several Cases round about us some taken away very suddenly 2 of our acquaintances died very sudden the one went to the field in the morning to work in the harvest and in the evening he was a corpse Left a wife and 7 children the other was taken in the evening and died next morning Left a wife and 5 Children to lament their loss it is a solemn time Last Thursday it was fast day it was a very solemn day it appeared like Sunday our Church was full both morning and afternoon it is a time for us deeply to humble ourselves before God and to lift up our voices unto the most high that he may deliver us from the snare of the fowler and the…pestilence…

I Remain Your affectionate Cousin

Miss Margaret Mandeville

Letter #3:

Doct. James Macdonald c/o…Paris
Per Le Havre Packet
Letter dated Whiteplains, August 18th - 1832
Received Le Havre 12th, Sept. 1832

Dear James

I wrote to you…and…we feel not a little anxious to hear of your health and safety – The Cholera prevails still in New York – the daily number of cases being about 70 and deaths about 30 – It is however considered subsiding – the panic is in a great measure over, and many persons are returning to the city – This disease has been much more destructive to human life in New York, than has ever been the case with yellow fever – (More than 2600 have died of the cholera)[3] *– yet as it ravages have been mainly confined to the dissipated those of broken down constitutions and careless habits, so the panic in New York has been much less general than in ordinary visitations of…epidemic the few cases that have happened among the more (affluent) class of citizen are attributed to unusual exposure, fatigue, and neglect of attending to the incipient stages of disease—*
In Philadelphia the daily cases and deaths are now about the same in number as in New York – The greatest number of cases in Philadelphia was I believe about 140 or 150: but in N.Y. the daily cases onetime about 300 & deaths 100 – including the city & county of N.Y, penitentiary – poorhouse…in the Sing sing prison the disease has prevailed – of about 950 convicts 90 have died of the cholera – It has subsided there very much.

Bidding you to have a regard to your health I remain, with some anxiety at present yours very affectionately

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[3] David Oshinsky in his book *Bellevue* confirms Allan Macdonald's contemporary report. Oshinsky writes: "By autumn, cholera had killed 3,500 in a city of 200,000 people. Statistics showed foreign-born deaths at 2.486, or 71 percent of the total, at a time…when immigrants…comprised barely 10 percent of its population." See: David Ochinsky, *Bellevue: Three Centuries of Medicine and Mayhem at America's Most Storied Hospital*, Doubleday (2016).

Allan Macdonald
A brief note in postscript form was then added to this folded letter by James's other brother, the first letter's author J.M. Macdonald, it reads:

I have nothing to add to what Allan has written, but…My residence here for three weeks has improved me much in health and strength and I shall return to the City again next week…I remain my dear brother ever yours J.M. Macdonald

Conclusion

An awareness of history is instructive. Seminar participants at Stony Brook learn how a working knowledge of the history of the subject is key to a critical understanding of the present, and projecting what is possibly to come. This very point is borne out here. As recounted in these "plague letters," and now seen duplicated in the demographics behind the rising death toll inflicted by COVID-19, pandemics exact a disproportionate toll on society's most vulnerable (Fifteen percent of the immigrant population of New York City perished during the Cholera of 1832, compared to less than one percent of its native population).[4] Knowledge of the past can help mobilize important action. Recent effort to affect the early release of a portion of America's, historically high, incarcerated prison population is an attempt to avoid duplication of the exceptional high death toll at Sing Sing Penitentiary experienced during the Cholera epidemic in 1832. As it concerns autonomy, the outgrowth of Federal HIPPA guidelines coincided with the AIDS epidemic; the full impact of the more readily transmitted air-born pathogen COVID-19 on the modern bioethical form of the complex principle of autonomy remains still to be seen.

While we can take comfort in the good news that all pandemics have an end, a candid look at their history dictates that we acknowledge another characteristic, pandemics can also return. Such was the case with the cholera. It wasn't until the Cholera revisited

[4] David Ochinsky, *Bellevue: Three Centuries of Medicine and Mayhem at America's Most Storied Hospital*, Doubleday (2016).

London in August of 1854 that the British physician John Snow quelled the epidemics spread when he requested Broad Street's polluted well's water pump handle be removed. Unlike airborne transmitted COVID-19, Cholera is a waterborne disease caused by the bacillus Vibrio cholerae found primarily in foul water and transmitted via the fecal-oral route. Unfortunately, knowledge of this final life-sparing microbiological fact had to wait until the German scientist Robert Koch discovered it in 1884. During the COVID-19 pandemic today we pray, and have reason to hope, that we will not have to wait quite as long for an effective, lasting cure.

Photo by Anastasia Pruden

DECODING AND DECONSTRUCTING THE CONTAGION '19

IMBESAT MAHEEN SYED, D.H.A.[1]

What is a contagion and has it been around for a while?

Well answer to the first half of the question is that a contagion is a disease spread by close contact and for the answer to the second half of the question let's looks at it from a holistic perspective.
They say we are the creators of our own reality. We create two things in our lives at the individual and collective levels, things that we want, and things that we don't want, dread, and fear.

If now people are responding to the contagion (a disease spread by close contact, in this case, COVID 19), with fear, anxiety and isolation, lack of sense of purpose, susceptibility, so why were people globally already in a state of apprehension, anxiety and fear and sense of isolation even long before this pandemic happened?

In the light of the above-mentioned list of experiences let's decode and deconstruct the contagion genome (The genome of an organism is the whole of its hereditary information encoded in its DNA (or, for some viruses, RNA) components), here in this article, it is metaphorically deconstructed to answer the above question; let's assume it has the following components:

1. Fear of unknown/uncertainty
2. Isolation
3. Apprehension/anxiety
4. Lack of sense of purpose
5. Consuming your energy

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[1] Resident of surgery, innovator, writer, poet, and artist. D.H.A., College of Physicians and Surgeons, Pakistan.

In the lines below we will evaluate genome of contagion one by one.

1. Fear of unknown/uncertainty

As a clinician I'll describe having a fear of the unknown as a flight and fight response (a survival mechanism) present in the absence of a real threat.

It seems like many people were living in a state of fear even in the absence of a real threat, soon a reason appeared before their eyes to be actually afraid (current pandemic).

2. Isolation

Many people were living a life that seemed to be full of many reasons, where they would actually do things to earn external validation and not internal satisfaction.

Life was more about making things 'look good and impressive' rather than living in the moment, and living your life for the purpose of social media only that looks more like a fast forward button you've pressed on your life without living it, you're constantly posting your life on social media and in turn, experiencing a sense of isolation even when you're not isolated. Nothing wrong with social media, but putting a happy family picture to earn likes rather than working on your relationships, adding hundreds of people as your friends rather than spending time and catching up people and friends you actually connect with and are like-minded, putting up impressive pictures of vacation rather than soaking in and taking in the moment, left many people feeling isolated. It was the result of the choices that you made. Aren't you worthy of a life that's for you and has a true sense of connectedness?

As we've decoded the second strand lets jump to the next paragraph and decode 3rd strand.

3. Apprehension/anxiety

A lot of people were already living in the state of anxiousness, every little thing would be a source of apprehension, such as sending children to school, going to work, next bill to pay and the list goes on, little did they know that there would be days when they wouldn't have to do these things for a while.

Deactivate this strand and press on to reboot.

4. Lack of sense of purpose

Many of us do things for external validation and not for internal satisfaction. So that you'll earn a title or a position that will not serve you nor others but only feeds your ego, in the rut of this hence many people losing their sense of purpose

Can you deconstruct this strand now? Think over it; I'm sure you can.

5. Consuming your energy

Let me tell you and remind you this again that a virus is not really an alive organism. It's borderline between a living and non-living.

So all it has is an RNA or DNA strand and it uses the body of the host and its cells to replicate or survive, in other words, consume the host [living body it is inside].

Have you ever thought that there had been experiences, people, or places that have been toxic and have consumed you like a pathogen? But you have a choice to not let negative experiences run you anymore.

You can deactivate this strand by stop paying attention to it and de-clutter your heart and mind from it and move on.

So you see that even in the absence of a real virus or Pandemic people were already living in fear, anxiety, isolation, lack of purpose, and susceptibility. We had contagious behaviors like a Pandemic of apprehension and uncertainty infesting human life like a pathogen before.

So this Pandemic is an opportunity to self reflects and see that negative behaviors and choices that have existed like a contagious Pandemic worldwide. We have the choice to let go of these contagious behaviors where ever we can for ourselves and others.

We cannot just physically distance ourselves but also distance ourselves from choices that don't serve us; we can wash our hands and also cleanse our minds and hearts of maleficence and negative place holders.

The purpose of this article is not to substitute for medical advice and theories but an opportunity to reflect on yourself and life and see how you've been infecting your life or influencing that of others is not a favorable way that is the same as the traits of a virus. Therefore to make it easy I deconstructed the contagion to mirror to you things you can change.

Even in the midst of all the things going on, it's an opportunity for humanity to grow in terms of values and expansion. Since the pace of life has slowed down, it's an opportunity for everyone to look at many areas of life holistically and introspect.

Maybe it's time to check on people. Maybe it's time to realize that we all go through challenges; like in this Pandemic people are experiencing similar challenges. Maybe it's time to develop more empathy. Maybe it's time to re-prioritize things in life. Maybe it's about living in the moment and not dreading the next thing in life, maybe it's about connecting with humanity and life around you. For sure it's about living your life for the first time and not just racing against time.

Along with following all of the current medical advice and recommendations to deal with Pandemic, we can all add more value to humanity and life, starting today.

COMPUTERS AND DENTAL HUMANITIES

H. BARRY WALDMAN, D.D.S., M.P.H., PH.D.[1], STEVEN P. PERLMAN, D.D.S., M.SC.D., D.H.L.(HON.)[2]

The two of us are members of the **Silent Generation** (born between 1928 and 1945). It is unclear from where the term originated. However, as young adults during the Senator McCarthy Era, many members of this generation felt it was dangerous to speak out. During the 1950s, *Senator McCarthy* (from Wisconsin) spent almost five years trying in vain to expose communists and other left-wing "loyalty risks" in the U.S. government and the entertainment world.[3]

We grew up in the black and white television era when you had to get up from you chair to change the channel. You dialed telephone numbers (all telephone numbers began with two letter – not for texting – they were the exchange abbreviations - long distance calls involved an operator). There were phone booths in most communities. (As time went on, in one Superman movie, Clark Kent was unable to find a booth in which he could change into the man of steel.) All cars had a clutch pedal for the driver to use the left foot for shifting gears.

Millennials, also known as Generation Y, include anyone born between 1981 and 1996 (ages 24 to 39 in 2020) and represent about a quarter of the US population. Much of this cohort entered the workforce at the height of the Great Recession, and have struggled with the subsequent widening of the generational wealth gap.

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[1] SUNY Distinguished Teaching Professor, Department of General Dentistry, Stony Brook University.

[2] Global Clinical Director, Special Olympics, Special Smiles, Clinical Professor of Pediatric Dentistry, the Boston University Goldman School of Dental Medicine.

[3] Footnote 1

Generation Z, also known as centennials, refers to the generation that was born between 1996 and 2010; following the millennials. This generation has been raised on the internet and social media, with some the oldest members finishing college by 2020 and entering the workforce.

Generation Alpha (includes anyone born after 2010). Some members of that generation can barely walk, but it's already envisioned to be the most transformative generation yet. Alphas haven't just grown up with technology — they've been completely immersed in it since birth. Early in their formative years, these children are comfortable speaking to voice assistant devices and swiping on smartphones. They don't consider technologies to be tools used to help achieve tasks, but rather as deeply integrated parts of everyday life.[4]

As aging Silent Generation members, the two of us smile as young parents wheel their two and three year old Generation Alpha babies in carriages (or whatever they are now called). The youngsters are playing on their "mesmerizing computer game boards" rather than squeezing the soft and fluffy stuffed toys that earlier generations carried around.

[4] Carlisle, R.P. *Handbook to Life in America*, Vol. 8. InfoBase Publishing, 2009. 22; Insider Corp. Generation Z: Latest characteristics and research facts. Accessed 10 January 2020. <https://www.businessinsider.com/generation-z>

Quaint, but does this material relate to dentistry and the humanities?

If you have to ask, then you have not been in a college or dental school lecture room in a long time. The consequences of these hypnotic computer games for the new generations has become the increasing foundation for all levels of the educational setting. For example:

1. We must eliminate the word "lecture" from the title of these rooms; students are not satisfied being verbally instructed.
2. You must not challenge a student with a question posed in an open class setting – too embarrassing.
3. Instructors are in competition with laptops, iphones or any other computer assisted means of communication which occupies the eyes and ears of the school room audience that is connected to games, merchandise sales, daily news, "essential" personal communication with friends and families or just about anything you can and cannot imagine during these educational sessions.

These obstacles are more pronounced in schools of dentistry when (from the students' perspective) sessions or discussions are not what would be considered associated with "how to proceed" with the technical aspects of clinical dental services (e.g. dental humanities).

Let's start from the beginning (among applicants for a career in dentistry)

In the past, the emphasis in the college years to prepare for entrance to the health sciences was on the "hard sciences" (e.g. chemistry, biology and physics) with limited concern for the "soft sciences" e.g. sociology, psychology, public health and demographics). The concern was that college students who had majored in the social sciences would be inadequately prepared for health profession training programs. However, during the 1970s and 1980s studies reported that the performance of dental and medical students who had majored in the social sciences in college were equal to, or surpassed, the performance of students who had majored in the physical sciences.[5] When these results of these studies were brought to the attention of dental school admissions committees, they were brushed aside with unusual sarcasm.

Even today, all too often when current applicants to schools of dentistry are interviewed and asked whether they had completed college courses in sociology, psychology, public health issues and other social sciences during their college years; their answer will be in the affirmative. But when asked why, almost all respond; "**they are required to meet distribution requirements."**

[5] Waldman, H.B. A study of the performance of community activities by private dental practitioners related to undergraduates predental education, dental school performance and professional status. Unpublished doctoral dissertation. University of Michigan, 1970;
Waldman, H.B. "Academic performance in dental school in relation to predental school emphasis." *Journal American College of Dentists*, 39(4):235-240, 1971;
Yens, D.P. and B. Stimmel. "Science versus nonscience undergraduate studies for medical school: a study of nine classes." *Journal Medical Education*, 57(6):429-435, 1982.

Responses are almost never in terms of the need to develop an appreciation for the marked developments in the demographics of our country, the impact on their future practices and how to better meet the needs of this increasing diverse population, the dramatic increases in the geriatric population and numbers of individuals with disabilities. Similarly, there is never a dialogue indicating knowledge regarding the evolving settings for care – including the progressive change from the solo to multi-practice arrangements, the influx of corporate ownership and potential impact on the delivery of services as a consequence of insurance regulations and government programs. (As an aside note: all too often when these regulations are discussed in dental school class sessions, comments by many students emphasize that due to their active schedule in their clinic activities, that they would prefer to review these matters just before [or after] dental school graduation.)

Some realities of schools of dentistry

> "By its nature, clinical teaching involves supporting small groups of dental students at the chairside as they treat their own patients... The students' main concerns throughout are not primarily with the technical skills required, which they have already been taught in the clinical skills laboratories, but dealing with the complex realities and ambiguities of clinical practice; the 'hidden curriculum' of decision making, judgement calls, issues of communication and what it actually means to be professional."[6]

[6] Zahra, F.S. and K. Dunton. "Learning to look from different perspectives - what can dental undergraduates learn from an arts and humanities-based teaching approach?" *British Dental Journal* 10;222(3):147-150, 2017.

> "Yet, in an already packed curriculum little time is spent helping the students develop these higher order skills. (Many dental schools) now incorporate arts and humanities-based initiatives into their curricula. This allows for a greater balance between the objectivity of evidence-based (care) and the pluralism and subjectivity of the arts and humanities, providing a more holistic, patient-centered education that promotes a tolerance of ambiguity…We conclude that in today's complex world we must educate not just for competence, but for capability and that the interdisciplinary afforded by the 'clinical humanities' is both a promising area for further educational research and potentially a valuable addition to the curriculum."[7]

Other references to the humanities in predoctoral dental education found limited evidence of a clear impact, either in short or long-term.; in terms the development of the ideal dentist-patient relationship, enhancement of empathy for patients, and most importantly, construction of professional moral values.[8]

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[7] Zahra, F.S. and K. Dunton. "Learning to look from different perspectives - what can dental undergraduates learn from an arts and humanities-based teaching approach?" *British Dental Journal* 10;222(3):147-150, 2017.

[8] Marti, K.C., A.I. Mylonas, M. MacEachern, et al. "Humanities in Predoctoral Dental Education: A Scoping Review." *Journal Dental Education* 83(10):1174-1198, 2019;

Dentistry IQ. A Survey says dental patients are dissatisfied: Solving the patient experience problem. Accessed 14 January 2020. <https://www.dentistryiq.com/practice-management/patient-relationships/article/16365771/survey-says-dental-patients-are-dissatisfied-solving-the-patient-experience-problem>

> "Providers may argue that customer experience isn't as important in dentistry as it is in other industries, but they should consider how the sector is changing. As with many other verticals, dentistry is being increasingly defined by a consumer-driven model where patients shop around for providers based on public customer review sites, modern amenities, flexibility, and communication methods. In this way, dentistry is beginning to look a lot like retail. This is why dentists should turn to retail for lessons learned and best practices in customer experience success."[9]

Computers and the humanities

It is an understatement to admit that computers run (and rule) our lives. The youngsters in the Generation Alpha (born after 2010) all too soon will be "invading" our high schools, colleges and health profession schools with their lifelong emersion and dependence on computers for any and all processes. A prime example is the impact of texting, rather than verbal communication. Increasingly, applicants to professional health schools (as well as in many employment opportunities) when faced with interviews, (and eventual contact with patients) too often, lack the experience to present their knowledge and self-personality in a most favorable verbal manner.

[9] Dentistry IQ. A Survey says dental patients are dissatisfied: Solving the patient experience problem. Accessed 14 January 2020. <https://www.dentistryiq.com/practice-management/patient-relationships/article/16365771/survey-says-dental-patients-are-dissatisfied-solving-the-patient-experience-problem >

The two of us may be members of the Silent Generation (born between 1928 and 1945), but collectively we have spent more than three-quarters of a century in academia and learned the importance of verbal communication in understanding and presenting the significance of the humanities in the delivery of dental services to an evolving population in a changing health care system.

Role-playing is but one approach that can effectively introduce the students to the importance of the humanities when dealing with evolving demographics and the impact on needed health care. Role-playing involves standardized patient interviews, recorded and reviewed individually with each student. Debate formats also are used to present public health issues. Depending on the particular issue, the class serves as a concerned population of religious leaders, politicians, parents of families with children with disabilities or other appropriate groups.

There is no single standardized approach to overcome the "new age umbilical cord" (i.e. the computer) which provides all forms of information and directs our lives (sometimes with purposeful misinformation). Nevertheless, we must never forget the consequences that total reliance on automatons (while neglecting **humanities**) may impact our efforts to provide care for the Silent Generation, Millennials, Generation Z and the maturing Generation Alpha (the little ones playing with their first computers).

P.S.

All the previous words, thoughts and realities were composed prior to the invasion of the new world of the COVID-19 disaster. We stay safe in our quarantined homes, supplied with food delivered by strangers gloved and masked for safety; entertained by television programs, old and new movies and attempting to maintain some sense of normality for our children, and, in our cases, our grandchildren – while exploring the long term impact on padlocked dental practices.

As dental educators, we have been introduced to the world of Zoom, where lectures (forgive the use of this forbidden word) and presentations are delivered by computers to students who are sequestered in their quarantined locations. (Incidentally, the word 'quarantine' is derived from the Italian word for the number 40. In ancient times, when boats arrived at the ports of the country, they were required to remain at anchor for 40 days in the bays before tying up at the port. If all the crew were healthy after that period, they could disembark. If not, the boats were burned to the water level. As to the crew…)

Now, consider the diminished interaction between students and faculty when new concepts are introduced. As the eventual essential necessary direct contact with patients and providing care…*that is yet to be determined*. The growth of virtual consultations with physicians is increasingly becoming common – but would have limited probable use in the provision of the technical aspects of dentistry. Now, add the absence of the personal interplay between dental practitioners and their potential patients.

Given the consequences of the world of COVID-19 tragedies, how do we ensure the preparation of the next generation of dental students and practitioners? The difficulties already faced in introducing the humanities in the world of dental technologies have only become more complex; but must not be overlooked as an essential component of the preparation of the next generation of dental practitioners.

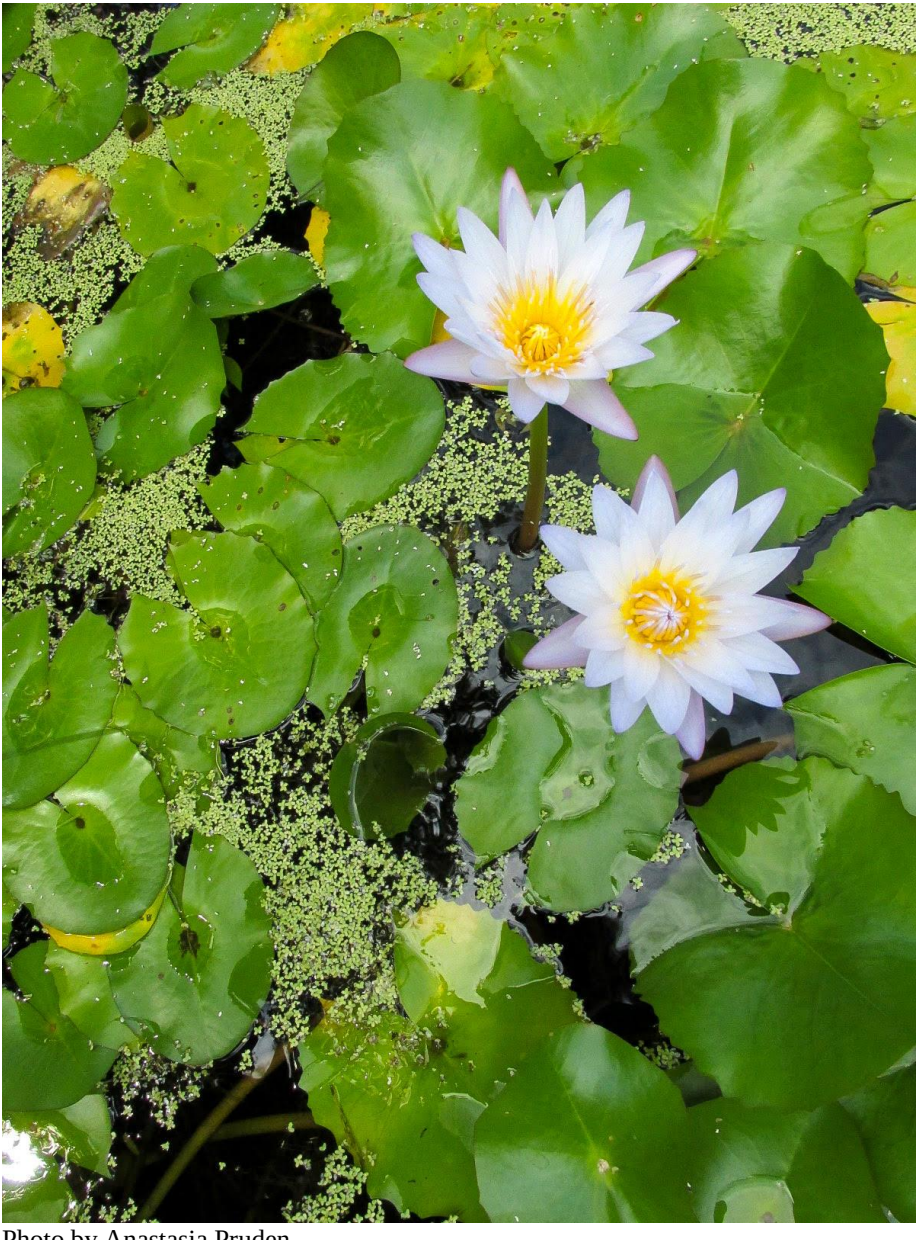

Photo by Anastasia Pruden

NEW YORK STATE | Department of Health

INTERIM GUIDANCE FOR DENTISTRY DURING THE COVID-19 PUBLIC HEALTH EMERGENCY

When you have read this document, you can affirm at the bottom.

As of May 31, 2020

Purpose

This Interim Guidance for Dentistry during the COVID-19 Public Health Emergency ("Interim COVID-19 Guidance for Dentistry") was created to provide dental healthcare personnel (DHCP) with precautions to help protect against the spread of COVID-19 as dentistry facilities re-open or continue to operate for elective and emergency procedures. This guidance applies to all dental care, including emergency and non-emergency/elective care.

These guidelines are minimum requirements only and any employer is free to provide additional precautions or increased restrictions. These guidelines are based on the best-known public health practices at the time of Phase II of the State's reopening, and the documentation upon which these guidelines are based can and does change frequently. The Responsible Parties – as defined below – are accountable for adhering to all local, state and federal requirements relative to operating dentistry facilities and providing emergency and non-emergency dental care to patients. The Responsible Parties are also accountable for staying current with any updates to these requirements, as well as incorporating same into operational and safety plans.

Background

On March 7, 2020, Governor Andrew M. Cuomo issued Executive Order 202, declaring a state of emergency in response to COVID-19. Community transmission of COVID-19 has occurred throughout New York. To minimize further spread, social distancing of at least six feet must be maintained between individuals, where possible.

On March 20, 2020, Governor Cuomo issued Executive Order 202.6, directing all non-essential businesses to close in-office personnel functions. Essential businesses, as defined by Empire State Development Corporation (ESD) guidance, were not subject to the in-person restriction, but were, however, directed to comply with the guidance and directives for maintaining a clean and safe work environment issued by the New York State Department of Health (DOH), and were strongly urged to maintain social distancing measures to the extent possible Emergency dental was designated as an essential health care operation.

On April 12, 2020, Governor Cuomo issued Executive Order 202.16, directing essential businesses to provide employees, who are present in the workplace, with a face covering, at no-cost, that must be used when in direct contact with customers or members of the public during the course of their work. On April 15, 2020, Governor Cuomo issued Executive Order 202.17, directing that any individual who is over age two and able to medically tolerate a face-covering must cover their nose and mouth with a mask or cloth face-covering when in a public place and unable to maintain, or when not maintaining, social distance.

On April 26, 2020, Governor Cuomo announced a phased approach to reopen industries and businesses in New York in phases based upon a data-driven, regional analysis. On May 4, 2020, the Governor provided that the regional analysis would consider several public health factors, including new COVID-19 infections, as well as health care system, diagnostic testing, and contact tracing capacity. On May 11, 2020, Governor Cuomo announced that the first phase of reopening would begin on May 15, 2020 in several regions of New York, based upon available regional metrics and indicators.

In addition to the following standards, businesses must continue to comply with the guidance and directives for maintaining clean and safe work environments issued by the DOH.

Please note that where guidance in this document differs from other guidance documents issued by New York State, the more recent guidance shall apply.

Standards for Responsible Dentistry Activities in New York State

No dentistry activities can occur without meeting the following minimum State standards, as well as applicable federal requirements, including but not limited to such minimum standards of the Centers for Disease Control and Prevention (CDC), Environmental Protection Agency (EPA), and United States Department of Labor's Occupational Safety and Health Administration (OSHA).

The State standards contained within this guidance apply to all dentistry activities in operation during the COVID-19 public health emergency until rescinded or amended by the State. The dentistry facility owner/manager, or another party as may be designated by the dentistry facility owner/manager (in either case, "the Responsible Parties") shall be responsible for meeting these standards.

References to "DHCP" include all paid and unpaid personnel in the dental health care setting who might be occupationally exposed to infectious materials, including body substances and contaminated supplies, equipment, environmental surfaces, water, or air. DHCP include dentists, dental hygienists, dental assistants, dental laboratory technicians (in-office and commercial), students and trainees, contractual personnel, and other persons not directly involved in patient care but potentially exposed to infectious agents (e.g. administrative, clerical, housekeeping, maintenance, or volunteer personnel), per CDC's Guidelines for Infection Control in Dental Healthcare Settings.

The following guidance is organized around three distinct categories: people, places, and processes.

I. PEOPLE

A. Physical Distancing

- Responsible Parties must ensure that a distance of at least six feet is maintained among patients, accompanying visitors, and staff at all times, unless safety of the core activity requires a shorter distance (e.g. provision of care during dental visits and procedures); and
- Responsible Parties must ensure that patients and accompanying visitors wear face coverings at all times when in the dental facility, except when undergoing dental procedure.
    - Acceptable face coverings for COVID-19 include but are not limited to cloth-based face coverings and disposable masks that cover both the mouth and nose.
    - For more information protective equipment requirements for staff, See Section II "People," Subsection B "Protective Equipment."

- Responsible Parties must modify or restrict access to any waiting area seating, as needed, to allow six feet of distance in all directions (e.g. spacing chairs, instructing people to sit in alternating chairs).
  - Responsible Parties should remove any frequently touched objects that cannot be cleaned regularly (e.g. toys, magazines, pens).
  - Responsible Parties should encourage visitors to wait outside or in vehicles until their designated appointment time.
  - When distancing is not feasible within seating areas, Responsible Parties may enact physical barriers (e.g. plastic shielding walls in areas where they would not affect air flow, heating, cooling, or ventilation).
    - If used, physical barriers should be put in place in accordance with OSHA guidelines, especially in reception areas to limit contact between patients and staff.
    - Physical barrier options may include: strip curtains, plexiglass or similar materials, or other impermeable dividers or partitions.
- Responsible Parties should take measures to prevent congregation in elevator waiting areas and limit density in elevators, such as enabling the use of stairs.
- Responsible Parties should put in place measures to reduce bi-directional foot traffic using tape or signs with arrows in narrow aisles, hallways, or spaces, and post signage and distance markers denoting spaces of six feet in all commonly used areas and any areas in which lines are commonly formed or people may congregate (e.g. elevator entrances, escalators, lobbies, patient check-in, reception, health screening stations, etc.).
- Responsible Parties must post signs throughout the dental facility, consistent with DOH COVID-19 signage. Responsible Parties can develop their own customized signage specific to their workplace or setting, provided that such signage is consistent with the Department's signage. Signage should be used to remind DHCP, patients, and visitors to:
  - Cover their nose and mouth with a face-covering.
  - Properly store and, when necessary, discard PPE.
  - Adhere to physical distancing instructions.
  - Report symptoms of or exposure to COVID-19, and how they should do so.
  - Follow hand hygiene and cleaning and disinfection guidelines.
  - Follow appropriate respiratory hygiene and cough etiquette.

B. Gatherings in Enclosed Spaces

- In order to reduce the proximity of individuals, Responsible Parties should advise patients to limit accompanying visitors to dental appointments, to the extent possible.
- As mentioned above, Responsible Parties should attempt to limit the number of persons in waiting areas by considering asking patients and accompanying individuals to wait in personal vehicles or outside the dentistry facility if appropriate, and by attempting to minimize overlapping appointments for dental visits or procedures.
- Responsible Parties must limit in-person gatherings (e.g. staff meetings) to the greatest extent possible and use other methods such as video or teleconferencing whenever possible, per CDC guidance "Interim Guidance for Businesses and Employers to Plan and Respond to Coronavirus

Disease 2019 (COVID-19)". When videoconferencing or teleconferencing is not possible, Responsible Parties should hold meetings in open, well-ventilated spaces and ensure that individuals maintain six feet of social distance between one another (e.g. if there are chairs, leave space between chairs, have individuals sit in alternating chairs).

- Responsible Parties should consider tele-dentistry options where appropriate for non-emergency consultations to potentially minimize in-office care according to the CDC guidelines and OSHA recommendations.

- Responsible Parties must put in place practices for adequate social distancing in small areas, such as restrooms and breakrooms, with appropriate signage and systems (e.g. flagging when occupied) to restrict occupancy when social distancing cannot be maintained in such areas.

C. Workplace Activity

- Responsible Parties must take measures to reduce interpersonal contact and congregation, through methods such as:
  - limiting in-person presence to only those staff who are necessary to be on site;
  - adjusting workplace hours;
  - reducing on-site workforce to accommodate social distancing guidelines;
  - shifting design (e.g. A/B teams, staggered arrival/departure times).
- Responsible Parties should consider limiting dental care to as few patients as can safely be treated simultaneously with appropriate distancing whenever possible.
- Responsible Parties must allow adequate time between dental procedures for DHCP to fully and appropriately clean rooms and equipment, replace soiled PPE, and perform appropriate hand hygiene as described below.
- Responsible Parties should practice the following workplace activities in accordance with CDC "Interim Infection Prevention and Control Guidance for Dental Settings During the COVID-19 Response"
  - Make sure that all unused supplies and dental instruments are appropriately covered and stored (e.g. closets, drawers, cabinets).
  - Set up patient rooms so that only necessary sterile equipment is accessible. Any supplies or equipment that are exposed but not used should be considered contaminated.
  - Attempt to limit or avoid aerosol-generating procedures whenever possible (e.g. avoid dental handpieces, air/water syringe, ultrasonic scalers) and prioritize hand instruments and minimally invasive/atraumatic restorative techniques. If aerosol-generating procedures are necessary, take precautions to minimize exposure (e.g. four-handed dentistry, high evacuation suction, dental dams, limited personnel for procedure support).
  - Maintain appropriate ventilation systems to provide adequate air movement from clean to contaminated areas, refer to the CDC guidelines and OSHA recommendations for additional details on HVAC setup and appropriate air filtration.

D. Movement of Individuals

- Responsible Parties should limit on-site interactions (e.g. designate an egress for individuals leaving their shifts and a separate ingress for individuals starting their shifts) and movements (e.g. employees should remain near their workstations as often as possible).
- Responsible Parties should limit the number of entrances in order to (1) manage the flow of visitors into the building and (2) facilitate health screenings, as described below in Section III "Processes," Subsection A "Screening and Testing," while remaining in compliance with fire safety regulations.
- Develop a plan for people to maintain six feet of social distance while queuing inside or outside of the facility for screening, as applicable.

II. PLACES

A. Protective Equipment

- As mentioned above, Responsible Parties must ensure that patients and visitors wear face coverings at all times, except when undergoing dental procedure. Acceptable coverings include at minimum cloth face coverings or surgical masks that securely cover the nose and mouth.
    - Responsible Parties should advise patients and all accompanying individuals to wear appropriate face coverings. If patients arrive at dental facilities without appropriate face coverings, consider providing face coverings if supplies are adequate or asking patient to reschedule and return with an appropriate face covering.
        - Responsible Parties can turn visitors away if visitors are not wearing face coverings or refuse to wear provided face coverings, per Executive Order 202.34.
- Responsible Parties must ensure that DHCP wear appropriate PPE when providing care to patients in accordance with appropriate OSHA standards, including surgical masks, eye protection, gloves, and protective clothing when performing any dental procedures that do not generate aerosols. For aerosol generating procedures, providers should wear a properly fit-tested, NIOSH-certified, disposable N95 or higher-rated respirator, eye protection (e.g. goggles, face shield) gloves, and gowns.
- Responsible Parties must establish policies for DHCP PPE removal and replacement before and after seeing patients. Responsible Parties must ensure DHCP follow CDC recommendations for and are properly trained in donning and doffing PPE.
- Responsible Parties must ensure that staff with duties unrelated to patient care such as clerical staff also wear appropriate face coverings at all times.
- Responsible Parties must procure, fashion, or otherwise obtain acceptable face coverings and PPE, and provide such coverings to their employees while at work at no cost to the employee. An adequate supply of face coverings, gloves, masks and other required PPE should be on hand in the event an employee needs a replacement, or a patient is in need.
- Responsible Parties must ensure that DHCP follow detailed instructions per CDC guidance on suggested sequences for donning and doffing PPE.

- Face coverings must be cleaned or replaced after use and may not be shared. Please consult the CDC guidance for additional information regarding PPE instructions and best practices.
- Note that cloth face coverings or disposable masks shall not be considered acceptable face coverings for workplace activities that impose a higher degree of protection for face covering requirements. For example, if N95 respirators are required for specific aerosol-generating dental procedures, a cloth face mask would not suffice. Responsible Parties must adhere to OSHA standards for such safety equipment.
- Responsible Parties must allow DHCP to use their own acceptable face coverings but cannot require staff to supply their own face coverings. Further, this guidance shall not prevent staff from wearing their personally owned additional protective coverings (e.g. surgical masks, N95 respirators, or face shields), or if the Responsible Parties otherwise requires staff to wear more protective PPE due to the nature of their work. Employers should comply with all applicable OSHA standards.

- Responsible Parties should also remind patients to wear appropriate face coverings in shared spaces before entering/exiting the facility (e.g. lobby, corridors, elevators).
- Responsible Parties must put in place measures to limit contamination from high-touch areas, such as installing touchless appliances such as contactless payments, contactless soap/towel dispensers, and contactless trash cans.

B. Hygiene, Cleaning and Disinfection

- Responsible Parties must ensure adherence to hygiene and cleaning and disinfection requirements following each patient visit or procedure as advised by the CDC and DOH, including "CDC Guidelines for Infection Control in Dental Health Care Settings", "Guidance for Cleaning and Disinfection of Public and Private Facilities for COVID-19," and the "STOP THE SPREAD" poster, as applicable. Responsible Parties must maintain logs that include the date, time, and scope of cleaning and disinfection.
- Responsible Parties must ensure that DHCP wait at least 15 minutes after completion of dental visit or procedure to allow potential contagious droplets to sufficiently fall from the air before beginning cleaning and disinfecting of surfaces in the dental operatory per CDC Guidance on Generation and Behavior of Airborne Particles.
- Responsible Parties must ensure that DHCP clean operatory while wearing at minimum gloves, surgical mask, and eye protection such as goggles or face shield.
  - Responsible Parties must provide and maintain hand hygiene stations on site, as follows:
    - For handwashing: soap, running warm water, disposable paper towels, and a lined garbage can.
    - For hand sanitizing: an alcohol-based hand sanitizer containing at least 60% alcohol for areas where handwashing facilities may not be available or practical.
    - Make hand sanitizer available throughout common areas (e.g. lobbies). It should be placed in convenient locations, such as at entrances, exits, waiting areas. Touch-free hand sanitizer dispensers should be installed where possible.
    - Responsible Parties should place signage near hand sanitizer stations indicating that visibly soiled hands should be washed with soap and water; hand sanitizer is not effective on visibly soiled hands.

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    - Responsible Parties should place signage near hand sanitizer stations indicating that visibly soiled hands should be washed with soap and water; hand sanitizer is not effective on visibly soiled hands.

- Per CDC's "Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19)," considerations when assessing close contact include the duration of exposure (e.g. longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g. coughing likely increases exposure risk as does exposure to a severely ill patient).
- Further, per CDC's "Principles of Contact Tracing," a close contact is someone who was within 6 feet of an infected person for at least 15 minutes starting from 48 hours before illness onset until the time the patient is isolated. The local health department should be contacted if the extent of contact between an individual and a person suspected or confirmed to have COVID-19 is unclear. Individuals who had close contact should stay home, maintain social distancing, and self-monitor until 14 days from the last date of exposure.

o If more than seven days have passed since the person who is suspected or confirmed to have COVID-19 visited or used the facility, additional cleaning and disinfection is not necessary, but routine cleaning and disinfection should continue.

- Responsible Parties must prohibit shared food and beverages, encourage bringing lunch from home, and reserve adequate space for employees to observe social distancing while eating meals.

C. Phased Reopening

- Responsible Parties are encouraged to phase-in reopening activities so as to allow for operational issues to be resolved before production or work activities return to normal levels. Responsible Parties should consider limiting the number of staff, hours, and number of patient appointments available when first reopening so as to provide operations with the ability to adjust to the changes.

D. Communications Plan

- Responsible Parties must affirm that they have reviewed and understand the state-issued industry guidelines, and that they will implement them.
- Responsible Parties should develop a communications plan that includes applicable instructions, training, signage, and a consistent means to provide individuals with information. Responsible Parties may consider developing webpages, text and email groups, and social media.
- Responsible Parties should institute a training plan for all DHCP to educate staff on new practices and responsibilities before re-opening or expanding operations
- Responsible Parties should encourage individuals to adhere to CDC and DOH guidance regarding the use of PPE, specifically face coverings, when a social distance of six feet cannot be maintained, through verbal communication and signage.
- Responsible Parties should post signage inside and outside of the facility to remind individuals to adhere to proper hygiene, social distancing rules, appropriate use of PPE, and cleaning and disinfecting protocols.

III. PROCESSES

A. Screening and Testing

- Responsible Parties must implement mandatory health screening practices of DHCP, patients, and visitors.
  - Screening practices may be performed remotely (e.g. by telephone or electronic survey), before the employee or patient reports to the facility, to the extent possible; or may be performed on site.
  - Screening should be coordinated to prevent individuals from intermingling in close contact with each other prior to completion of the screening.
    - At a minimum, screening is required for all DHCP, patients, and visitors and completed using a questionnaire that determines whether the individual has:

    (a) knowingly been in close or proximate contact in the past 14 days with anyone who has tested positive for COVID-19 or who has or had symptoms of COVID-19;

    (b) tested positive for COVID-19 in the past 14 days; and/or

    (c) has experienced any symptoms of COVID-19 in the past 14 days.

- According to the CDC guidance on "Symptoms of Coronavirus," people with COVID-19 have had a wide range of symptoms reported, ranging from mild symptoms to severe illness. Symptoms of COVID-19 include, but are not limited to: cough, shortness of breath or difficulty breathing, fever, chills, muscle pain, sore throat, or new loss of taste or smell.

- Responsible Parties should require DHCP to immediately disclose if and when their responses to any of the aforementioned questions changes, such as if they begin to experience symptoms, including during or outside of work hours.

- In addition to the screening questionnaire, daily temperature checks may also be conducted per U.S. Equal Employment Opportunity Commission or DOH guidelines. Responsible Parties are prohibited from keeping records of employee health data (e.g. temperature data).

- Responsible Parties must ensure that any personnel performing screening activities, including temperature checks, are appropriately protected from exposure to potentially infectious individuals. Personnel performing screening activities should be trained by employer-identified individuals who are familiar with CDC, DOH, and OSHA protocols.

- Screeners should be provided and use PPE, including at a minimum, a face mask.

- Dental treatment for an individual who screens positive for COVID-19 symptoms should be deferred if possible and patient is not in need of urgent dental care. If emergency dental care is necessary, conform to CDC's Interim Infection Prevention and Control Recommendations or refer to a facility that has appropriate engineering controls in place to take care of the patient.

- A DHCP who screens positive for COVID-19 symptoms should not be allowed to enter the worksite and should be sent home with instructions to contact their healthcare provider for assessment and testing. Responsible Parties must immediately notify the local health department and DOH about any positive case. Responsible Parties should provide the employee with information on healthcare and testing resources.

- A DHCP who has responded that they have had close contact with a person who is confirmed or suspected COVID-19 may not be allowed to enter the site without abiding by the precautions outlined below and the Responsible Parties has documented the employee's adherence to those precautions.

- Responsible Parties must immediately notify the local health department of confirmed positive cases. Responsible Parties should provide the individual with information on healthcare and testing resources.

- Responsible Parties must review all responses collected by the screening process on a daily basis and maintain a record of such review. Responsible Parties must also identify a contact as the party for individuals to inform if they later are experiencing COVID-19-related symptoms, as noted in the questionnaire.

- Responsible Parties must designate a site safety monitor whose responsibilities include continuous compliance with all aspects of the site safety plan.

- To the extent possible, Responsible Parties should maintain a daily log of all DHCPs and visitors who may have had close contact with other individuals in the in the facility; excluding deliveries that are performed with appropriate PPE or through contactless means. Logs should contain contact information, such that all contacts may be identified, traced, and notified in the event an individual is diagnosed with COVID-19. Responsible Parties shall encourage but not require patient and visitor information as part of this log. Responsible Parties must cooperate with local health department contact tracing efforts.

- Responsible Parties should designate a central point of contact, which may vary by activity, location, shift or day, responsible for receiving and attesting to having reviewed all' questionnaires, with such contact also identified as the party for individuals to inform if they later are experiencing COVID-19-related symptoms, as noted on the questionnaire.

    - Identified point of contact for the facility should be prepared to receive notifications from individuals of positive cases and initiate the respective cleaning and disinfection procedures.

- Responsible Parties should take the following actions related to COVID-19 symptoms and contact:

    - Any symptomatic DHCP or patient should be referred home, self-quarantine, and discuss options with primary care physician. DHCP should be expeditiously tested for COVID-19.

    - If a DHCP has COVID-19 symptoms AND EITHER tests positive for COVID-19 OR did not receive a test, the individual may only return after completing a 14-day self-quarantine. If an individual is critical to the operation or safety of a site, the Responsible Parties may consult the local health department and the most up-to-date CDC and DOH standards on the minimum number of days to quarantine before an individual is safely able to return to work with additional precautions to mitigate the risk of COVID-19 transmission.

    - If a DHCP does NOT have COVID-19 symptoms BUT tests positive for COVID-19, the individual may only return to work after completing a 14-day self-quarantine. If an individual is critical to the operation or safety of a site, the Responsible Parties may consult the health department where the facility is located and the most up-to-date CDC and DOH standards on the minimum number of days to quarantine before an individual is safely able to return to work with additional precautions to mitigate the risk of COVID-19 transmission.

    - If a DHCP has had close contact with a person with COVID-19 AND is symptomatic, the individual should notify the Responsible Parties and follow the above protocol for a positive case.

- If a DHCP has had close contact with a person with COVID-19 AND is NOT symptomatic, the individual must notify their employer and quarantine for 14 days. However, if the employee is critical to the operation or safety of the workplace AND is NOT symptomatic, the Responsible Parties may consult with their local health department on precautions to permit a return to work in adherence to the following practices prior to and during their work shift, which should be documented:
  1) The employee or contractor must take their temperature before work to confirm they do not have a fever.
  2) Regular monitoring: If the individual does not have a fever or symptoms, they should self-monitor under the supervision of their employer's occupational health program.
  3) Wear a mask: The individual should wear a face mask at all times while in the workplace for 14 days after last exposure to a person with COVID-19. The individual may not share headsets or other objects used near the face.
  4) Social distance: The individual should continue social distancing practices, including maintaining, at least, six feet distance from others. The individual may not congregate in the breakroom or other crowded places.
  5) Clean and disinfect work spaces: Continue to clean and disinfect all areas such as offices, bathrooms, common areas, and shared electronic equipment routinely. Increase the frequency of cleaning and disinfection of high-touch surfaces.
  6) Responsible Parties should work with facility maintenance staff to increase air exchanges in the room or facility.
- If a DHCP is symptomatic upon arrival at work or becomes sick during the day, the individual must be separated and sent home immediately, following the above protocol for a positive case.

B. Tracing and Tracking

- Responsible Parties must notify the local health department and DOH immediately upon being informed of any positive COVID-19 test result by an DHCP at their facility. Responsible Parties must be prepared to receive reports of positive cases from DHCP, patients, or visitors, and notify as follows.

- In the case of a DHCP, patient, or visitor testing positive, the Responsible Parties must cooperate with the local health department as required to trace all contacts in the workplace, and the local health department where the facility is located must be notified of all individuals who entered the site dating back 48 hours before the individual first experienced COVID-19 symptoms or tested positive, whichever is earlier. Confidentiality must be maintained as required by federal and state law and regulations.

- Local health departments may, under their legal authority, implement monitoring and movement restrictions of infected or exposed persons including home isolation or quarantine.

- Individuals who are alerted that they have come into close or proximate contact with a person with COVID-19, and have been alerted via tracing, tracking or other mechanism, are required to self-report to their employer at the time of alert and shall not be permitted to remain or return to the facility until they have completed quarantine, as described above in Section III "Processes," Subsection A "Screening and Testing."

IV. EMPLOYER PLANS

Responsible Parties must conspicuously post completed safety plans on the premises of the workplace. The State has made available a business reopening safety plan template to guide business owners and operators in developing plans to protect against the spread of COVID-19, and such plans are adaptable for dentistry facilities to use.

Additional safety information, guidelines, and resources are available at:

New York State Department of Health Novel Coronavirus (COVID-19) Website
https://coronavirus.health.ny.gov/

Centers for Disease Control and Prevention Coronavirus (COVID-19) Website
https://www.cdc.gov/coronavirus/2019-ncov/index.html

Occupational Safety and Health Administration COVID-19 Website
https://www.osha.gov/SLTC/covid-19/

Occupational Safety and Health Administration Recommendations for Dental Workers and Employees
https://www.osha.gov/SLTC/covid-19/dentistry.html

American Dental Association: Return to Work – Interim Guidance Toolkit
https://success.ada.org/~/media/CPS/Files/Open%20Files/ADA_Return_to_Work_Toolkit.pdf

At the link below, affirm that you have read and understand your obligation to operate in accordance with this guidance:

https://forms.ny.gov/s3/ny-forward-affirmation

This facsimile of the "Interim Guidance for Dentistry During the COVID-19 Public Health Emergency" was published by the New York State Department of Health on 31 May 2020 and accessed on 3 June 2020. <https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/DentistryMasterGuidance.pdf >

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