Oregon
Kate Brown, Governor

Department of Consumer and Business Services
Oregon Occupational Safety & Health Division (Oregon OSHA)
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April 27, 2020

Catherine Roth
2788 Sorrel Way
Eugene, OR, 97401
Catherineroth56@yahoo.com

Dear Ms. Roth-

Oregon OSHA received your petition for rulemaking, titled: "COVID-19 Protection in Dental Offices", dated March 24, 2020, and received in our office via email on March 24, 2020.

Per Oregon Revised Statute (ORS) 183.390, the agency had 90 days from receipt to review and make a decision regarding your petition. At this time, Oregon OSHA is denying your petition for rulemaking.

Instead of embarking on the rulemaking process, which can be lengthy and time consuming, the agency believes that, at this time, in light of emergent circumstances caused by COVID-19, dental offices and their employees would be better served with more information about how to prevent infection from these pathogens in their specific setting. To that end, we will be providing more information specifically to dealing with pathogen protection in a dental setting. At this time, the agency is working on a document specific to dental offices.

Thank you for submitting your petition, we sincerely appreciate the opportunity to discuss this issue in more depth at our agency, and look forward to creating materials to help protect workers from airborne pathogens, specifically in dental offices. We appreciate you bringing forward the concerns of this particular industry. Please feel free to reach out to Oregon OSHA at any time if you wish to further discuss policy actions related to this issue.

Sincerely,

Michael Wood, CSP
Administrator, Oregon OSHA
350 Winter St. NE
Salem, OR 97301

From:	Catherine Roth
To:	DCBS WEB TECH * DCBS
Cc:	Catherine Roth
Subject:	Covid-19 Protection in Dental offices
Date:	Tuesday, March 24, 2020 11:08:48 AM

To Whom it may concern at Oregon OSHA:

I am an Oregon dental hygienist, temporarily laid-off because of Covid-19. I have been a hygienist for many years, having worked through the beginning of the AIDS crisis and the SARS epidemic.

What is happening now is akin to the AIDS crisis and the evolution of the Blood Borne Pathogens rules. We need new rules concerning the safety of dental health care workers (DHCW) in light of the novel Corona Virus.

While I want to go back to work, I have grave concerns about returning to work and what awaits me and my fellow DHCW across this country.

On the news, I watch the Health Care Workers swab patients for the virus. They are standing as far away as possible and wearing complete body suits, with full face shields, masks, and head covering. Just for a nasal swab!
Compare this to a visit to your dental hygienist.

Before your hygienist puts on her mask, she takes your blood pressure and updates your medical history. She is very close to you, conversing. Before treatment, typically, she puts on the face mask her office provides (non-N95), protective glasses, gloves, and wears a lab coat which she puts on at the beginning of the day and wears all day long. She is less than two feet from your face for the next 45 minutes.

For 20-30 min, she uses an ultrasonic scaler, well documented to be the primary source of aerosols in the dental office. It spews bacteria and viruses in minuscule droplets and mist everywhere in the room. As ultrasonic scaling commences, a low-volume saliva ejector is used to remove the excess water and saliva from the patient's mouth.

This low volume saliva ejector is connected to the main vacuum system. It is less effective at evacuating material than the High Volume Evacuation (HVE) that the dentist and assistant use to evacuate while performing a dental procedure. Nonetheless, the saliva ejector is typically the equipment a hygienist is required to use to evacuate during ultrasonic scaling. The lack of HVE during ultrasonic scaling spreads the aerosol four feet from the mouth, covering everything from the room atmosphere, to the patient's head, hair, face, chest and arms, to the counters, floor, chair, the equipment, to the operator's head, hair, face and arms, especially including the operator's working arm which is a source of cross contamination throughout the day. DHCW rarely change that lab coat in between patients. This aerosol contaminant lasts for 30 minutes in the air of the operatory after ultrasonic scaling ends. The same hazards can be applied to hygienists who use lasers, as the laser plume is also very infectious.

This is repeated hourly for eight patients or more per day.

This is terrifying to me. New rules for dentistry need to be adopted as soon as possible.

It should be mandatory that DHCW use high volume evacuation (HVE) for all ultrasonic and laser procedures.
This can be done by having a dental hygiene assistant who is always there to use the HVE effectively for the dental hygienist.
If it is not feasible for the additional personnel this would require, there are HVE adapters for the ultrasonic scalers which could be purchased. At the very least, having the patient hold the HVE next to the corner of their mouth during ultrasonic scaling has been shown to reduce aerosols in the environment.

It should be mandatory for DHCW to wear N95 masks for all aerosol creating procedures. This includes dentists, hygienists, assistants, and lab workers.

I pray that OSHA will take Airborne Pathogens as seriously as they did Blood Borne Pathogens.

Sincerely,

Catherine Roth
2788 Sorrel Way
Eugene, OR
97401