WSDA
WASHINGTON STATE
DENTAL ASSOCIATION

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June 17, 2020

Alan Lundeen, Senior Program Manager
Standards, Technical and Laboratory Services
Division of Occupational Safety & Health (DOSH)
P.O. Box, 44600
Olympia, WA 98504-4600

Dear Mr. Lundeen:

Thank you for your June 11, 2020 response. The Washington State Dental Association (WSDA) appreciates the continued dialogue between our two organizations as we work to best understand current DOSH requirements for dental offices in Washington state and the rationale behind such requirements.

To that end, we respectfully request further clarification and action on the items below.

In your response, you state that:

> The category labels are chosen based on an assessment of overall risk. Although most tasks in the "Extremely High Risk Category" have a higher overall risk, this is based on the fact that exposure is continual, where many "High Risk Category" tasks actually have a higher intensity exposure, but for a shorter time. This higher intensity exposure could overwhelm a surgical mask.

In order to better understand the underlined statement and its applicability within a dental setting, please provide us with the scientific evidence for which the above underlined statement is based upon.

Appendix A of DOSH Directive 11.80 lists "minimum required mask or respiratory protection for employees without additional engineering controls or personal protective equipment (PPE)" (emphasis is from DOSH). The identifier "***" assigned to the above statement elaborates that "without additional engineering controls or PPE for employees like barriers or face shields or local ventilation."

Dental offices across the state (not to mention across the country and around the world) are utilizing additional engineering controls such as high evacuation suction, rubber dams, and four-handed dentistry as well as the use of a full face shields and other PPE that significantly reduces the risk of transmission of COVID-19 and other pathogens.

Given that dental offices are routinely using additional engineering controls and PPE, the inherent logic of DOSH Directive 11.80 indicates that alternative, appropriate PPE such as a surgical mask combined with a face shield is acceptable.

Once again, we implore DOSH to resolve the continued inconsistency between Directive 11.80 and Directive 1.70. DOSH's insistence on not resolving this discrepancy is having a detrimental impact the oral health of many of our state's residents.

Throughout the COVID-19 pandemic, dental offices across the country and around the world have been using surgical masks combined with face shields to provide necessary dental care. **To date, there has been no documented transmission of COVID-19 in a dental setting anywhere in the world.**

According to the Centers for Disease Control and Prevention (CDC): "To date in the United States, clusters of healthcare personnel who have tested positive for COVID-19 in hospital settings and long-term care facilities, no clusters have been reported in dental settings or among dental healthcare personnel" (emphasis added). The WSDA and the American Dental Association routinely check with the CDC to verify that this remains the case, and to date, there are still no reported cases of transmission of COVID-19 in dental settings.

Why does DOSH's guidance not take into consideration the fact that there have been no reported cases of transmission of COVID-19 in dental settings? What scientific evidence is DOSH referencing in determining that a surgical mask and face shield is not sufficient for workers who fall under the "High-Risk Category"?

Even though there have been no COVID-19 transmissions in dental offices, DOSH is insisting that dental workers adhere to a higher level of mask use than workers in settings with documented transmission of COVID-19. It is illogical to have stricter mask requirements for dentists and dental hygienists working in dental settings with no reported cases of COVID-19 transmission and less strict mask requirements for those with a higher risk of exposure to COVID-19 transmission, such as long-term care facility workers.

Lastly, while DOSH references the impact that Directive 1.70 has on the dental community, the reality is, that restrictive rules that are neither evidence-based nor reflective of the current PPE supply chain, have the biggest impact on patients. The pent-up demand for dental care in our state caused by the pandemic is of great concern, and additional barriers to care will only exacerbate this need. Directive 1.70 is literally resulting in worse patient outcomes.

We implore DOSH to promptly reevaluate Directive 1.70 so that it aligns with Directive 11.80 and existing scientific evidence.

Thank you for your consideration.

Respectfully,

Bracken Killpack

Bracken Killpack
Executive Director
Washington State Dental Association

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Joel Sacks, Director, Washington State Department of Labor and Industries
Anne Soiza, L&I Assistant Director, Division of Occupational Safety & Health
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