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NDA JOURNAL

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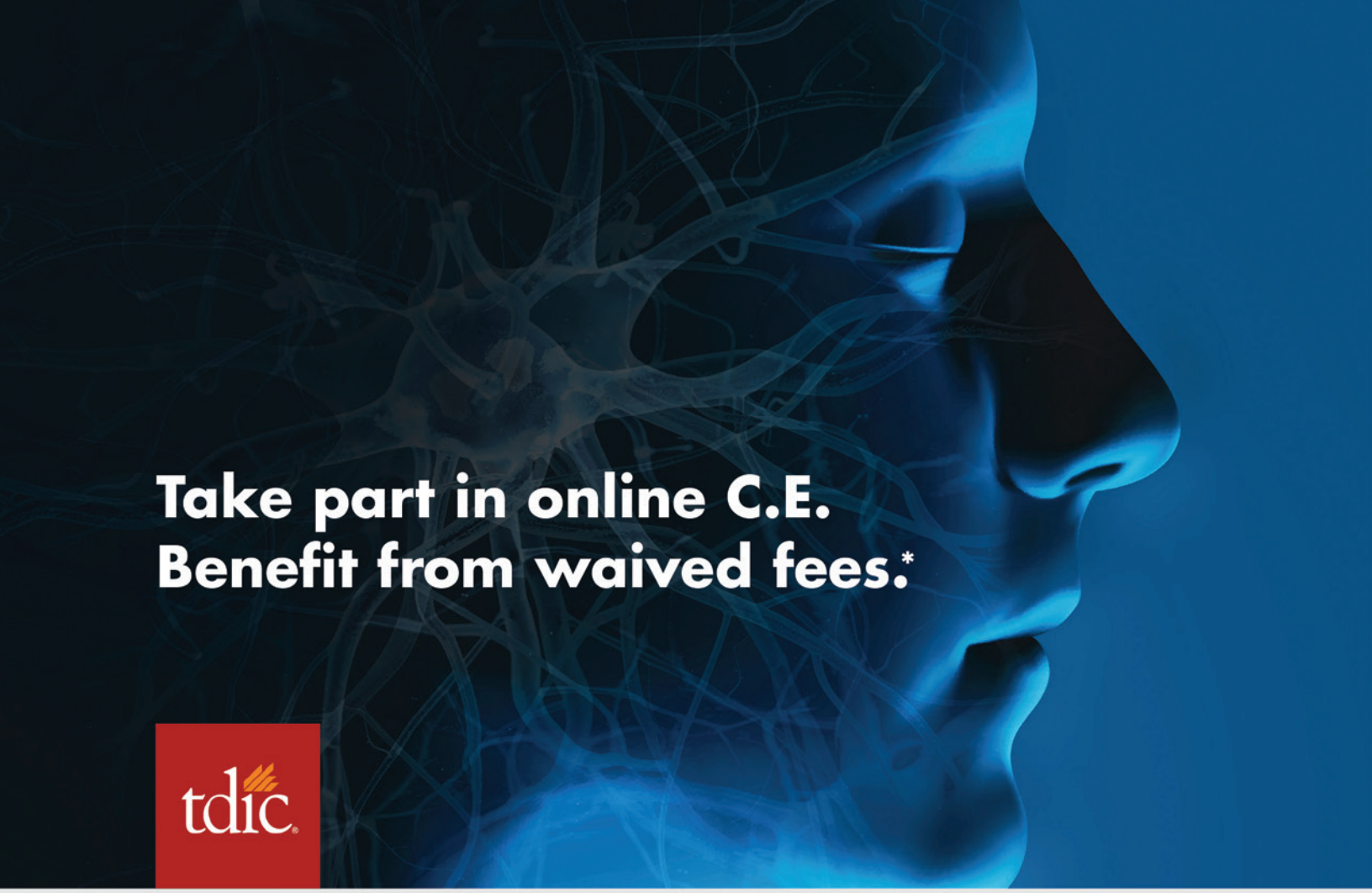
A Peer Reviewed Journal



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SUMMER 2020

On the Cover

Nevada's COVID-19 response severely restricted dentistry as political supervision replaced dental oversight of dental health, with the predictable result that Nevada's dental health suffered significantly.

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Like the World Health Organization and the New England Journal of Medicine, the Editor is not a believer in mask utility in non-healthcare settings.

1) Curtis L, WHO Advice About Public Masks, 07 Apr 2020,
2) Klompas M, Morris C, Sinclair J et al, Universal Masking, NEJM, 21 May 2020.

Dr. Orr practices Anesthesiology and OMS in Las Vegas, is an Adjunct Professor (Surgery) at UNLV SM and Touro University SM (Jurisprudence), Professor Emeritus at UNLV SDM, and a member of the CA Bar and Ninth Circuit Court of Appeals.

Johnny Carson, TP, and Memories of Woodstock

The Chinese Coronavirus COVID-19 (COVID) led to the second toilet paper (TP) crisis of my lifetime. Some readers will remember the first. In 1973 Johnny Carson joked about an imminent TP shortage,[1] but people took the comedian seriously. Immediately there was a panic buying surge and TP did disappear from the shelves, just like it did in March. Johnny Carson was obviously joking, but many fell for it. The link between COVID URI issues and TP used for terminal GI system hygiene is questionable, but COVID is real, and contagious.

However, as with both the Johnny Carson and COVID artificial TP shortages, our overall COVID response has been illogical. Absent testing, the vast majority of individuals who contract COVID have not known, and will never know, if they were infected because the virulence is not statistically significant compared to more lethal pandemics.

What is statistically significant about COVID was predicted in the *NDAJ* prior to the lockdowns[2]:

> Society's reaction to the perceived viral threat has proven to be much more problematic than the viral threat itself.

Indeed, the wildly inconsistent and dysfunctional emergency orders initially foisted and continuing upon states by governors and lesser officials have been devastating. Here in Nevada, the guidelines/mandates, depending on what regulator one is dealing with, change daily. At the time of this writing, one can't attend church but can attend the Governor's briefings; students cannot go to school but daycare centers are open; shoppers can buy liquor at a convenience store but not a liquor store; we cannot go to drive-in events as families, but we can cram into the petri dishes known as city busses. There are counties in Nevada without a single reported case of COVID that are under shutdown orders.

What should be disconcerting to Nevada doctors, especially after the political fiasco of AB474 and the resulting impossibility to legally write a controlled substance Rx according to the published law,[3] are similar ramifications on the health professions because of the COVID excuse. Doctors are now practicing medicine not according to their own training and experience, but according to the bureaucrats' non-training and non-experience. We have been told that we cannot Rx hydroxychloroquine (HCQ) for COVID. Of course, HCQ was developed to treat malaria, but it is also used, as many Rx's are, off-label for entities such as arthritis and lupus. There are now innumerable anecdotal reports, how many new treatments start universally, about HCQ being effective with early-onset COVID. Even if HCQ is ultimately shown to be minimally effective for COVID treatment, we don't know that now. If a doctor and patient decide they want to try HCQ, how is it that politicians can veto that plan? In the law, absent self-bestowed immunity for the government, the Loss-of-Chance doctrine allows a plaintiff to recover in tort if another artificially prohibits the

plaintiff from using reasonable therapeutic measures.

Agreeing with the last *NDAJ*, thousands of doctors from across the country have submitted "second opinion" letters to the President and to state Governors that the draconian economic and social restrictions placed in our nation are not helping anything and in fact are much more problematic than the viral threat itself.[4]

Nevada dentists hit the social planning lottery by being proclaimed "essential," kind of. We were ordered not to treat unless the patient had an "emergency." But our diagnoses of emergency are subject to solicited retroactive review by others. Some dentists have reported their professional colleagues for investigation by third-parties based on hearsay only. Dentistry, in large part secondary to the efforts of the NDA and its component societies, including all our affiliated officers and staff, received a little more wiggle room after negotiations between the Governor, the NSBDE, and the NDA. Dentists who think that dentistry should be guiding dental health care in Nevada should be very grateful to the NDA for fighting the good fight. For those that may want to say thank you, NDA and component society contact information is regularly listed in the *NDAJ.*

Sadly, there are still businesses subjectively dismissed out-of-hand with the arbitrary, illogical, and senseless non-essential label. For instance, what about tattoo parlors? Like dental offices, tattoo artists use gloves, masks, autoclaves, etc. One thing these artists do not do is cover their walls with aerosolized body fluids via handpieces spinning away at up to 800,000 rpm.[5] Almost a half-million private sector Nevada workers have been deemed non-essential and have lost their jobs. Meanwhile, there have been no layoffs of any government workers.[6]

Regarding "emergencies," the *NDAJ* has documented previously why phenomena such as COVID may be a political something, but cannot be a medical or legal emergency.[7] Both Dorland's Medical Dictionary and Black's Legal Dictionary require that the element of unexpectedness be associated with any event before it is an emergency.

Thousands of lawyers are also starkly critical of political pandemic power plays.[8] Several legal CE courses related to COVID have been presented recently. Of the 3 that dealt with emergency executive orders, 2 ultimately opined that the vast majority of such orders are not based in the law,[9] the other didn't address the issue. For the more legal minded, a 2002 legal monograph, *The Use and Abuse of Executive Orders in Modern-Day America*[10] provides an academic review of executive orders.

Doctors know COVID is not an emergency; pandemics are regular, foreseeable events we are trained to deal with. Even some politicians understand this, such as President George W. Bush who addressed, in 2005, the need, to prepare for pandemics after he had studied the 1918 Spanish Flu (over 60,000,000 estimated deaths worldwide).[11] As noted in a 2013 warning, judicious planning should include not outsourcing essential medical supplies to potential enemies.[12] Sadly, when COVID was noted in the United States late last year, we were woefully underprepared with regards to PPE. Happily, China offered to help and sent millions of units of masks, gloves, etc. to us. Sadly, the PPE China sent, and resent, was defective and useless for the purposes intended.[13]

Since before graduation, doctors have been taught to wash their hands, don gloves and masks, etc. in order to deal with communicable disease. A list of diseases appearing in our practice lifetimes is extensive, including but not limited to: surgical infections, subacute bacterial endocarditis (SBE), hepatitis variants, tuberculosis (TB), West Nile Virus, Rocky Mountain Spotted Fever, Lyme Disease, Ebola Hemorrhagic Fever, Middle East Respiratory Syndrome (MERS), Methicillin Resistant Staphylococcus Aureus (MRSA), Valley Fever, Lassa Fever, Severe Acute Respiratory Syndrome (SARS), Aids/Human Immunodeficiency Syndrome (HIV), bird flus, swine flus (60,000,000 US infections), the annual flu flu (approximately 60,000 US associated deaths/year), etc. No doubt some diseases are missing from our list. I was surprised when the Clark County Health District advised I diagnosed the first case of Legionnaire's Disease in Las Vegas, but no dentist was surprised that the entity presented. I have even diagnosed Hoof and Mouth Disease. All doctors know that when COVID is long-gone, more communicable diseases will regularly appear, and we will treat them with the same expertise we have always provided. COVID itself is just another permutation of what has been around for millennia.

To date, according to recent independent studies from Stanford and USC[14], there are not enough deaths directly related to COVID to warrant a heightened response relative to other infections. Although nuanced, the direct COVID death result appears to be falling precipitously, the current estimate is less than 0.1%, or equivalent to the annual flu. This reality is one reason the COVID modelers have had to constantly readjust their, thus far, always inaccurate predictions, including a death rate of up to 15% for some populations initially announced.[15] The modelers have not been correct yet.

The statistical website 538 crunches numbers on everything from sports

»

to political races. Recently 538 noted that media reports of a rapidly expanding number of COVID cases was actually seriously out-of-context in that the diagnoses were secondary to rapidly expanding testing, not because of increasing COVID penetrance.[16]

Similarly, deaths reported as because of COVID are really multifactorial and almost always are associated with comorbidities.[17] Historically, death certificate studies have documented significant discrepancies 50% of the time when comorbidities are involved.[18] The inaccurate COVID death reporting is reminiscent of the "Rx Overdose Crisis" coverage wherein death cases, which averaged 7 toxic substances, only listed a possibly Rx'ed controlled substance that was identified as the cause of death.[3] At times conflicts of interest affect death certificate diagnoses, such as when hospitals coach doctors to diagnose COVID in order to be eligible for from $13,000 to $39,000 in additional payment from taxpayers.[19]

What is singularly unprecedented is our societal/political response to COVID. The social and economic chaos we have been ordered to acquiesce to is calamitous. Long after this year's virus burns itself out, we will be dealing with the unnecessary economic devastation foisted upon us. Even doctors, some of the top 1% of wage earners in the country, are applying for government aid and establishing go-fund-me[20] sites.

The Constitution and Bill of Rights are being compromised on a daily basis... we don't need to iterate all the amendments currently under attack. But a quick review of the First Amendment, which guarantees inalienable natural rights, with or without a virus, is demonstrative of the shredding taking place this year.

Amendment I

Congress shall make no law respecting an establishment ~~of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or~~ of the press~~; or the right of the people peaceably to assemble, and to petition the government for a redress of grievances.~~

Although we have not seen bans on the press, we have seen illegal prohibitions on religion and the free exercise thereof, abridgements of free speech, the right to peaceably assemble, and the ability to petition the government about grievances.

It is telling when one is forbidden to peaceably protest. When governors in California[21], North Carolina,[22] and counting have banned protests, many citizens become even more concerned... not Facebook however.[23] In a governor's own words was the admission that our Constitutional rights were never considered during his despotic decision making.[24]

Ironically, many of the same jurisdictions that were banning truly peaceful protests about COVID restrictions are now supporting violent protests about other issues.

And what does Woodstock have to do with all this? Well, in 1969, as usual, we were dealing with another pandemic. The H3N2 Hong Kong Flu killed 1,000,000 world-wide, compared with 300,000 statistically inflated COVID deaths at this writing. Celebrities Tallulah Bankhead and former CIA Director Allen Dulles died. President Lyndon Johnson, Apollo 8 astronaut Frank Borman (while in orbit), and Shamu all got sick.[25] This was another pandemic that was significantly worse than the pedestrian COVID-19 version. So what did we do in 1969? To start, we left H3N2 to the health professionals, went out to eat, shook hands, and sent our kids to school. And, a lot of us just partied. 300,000 politically liberal hippies, when liberals zealously advocated for and defended personal freedom, rather than demanding house arrest under threat of criminal prosecution because someone else is sick, crammed into Max Yasgur's farm near Bethel, NY. The music was awesome, but the non-hygiene was third-world and social distancing was not even 6mm. And no one declared hippies non-essential.

Calling a non-emergency an emergency is serious business. When will the next non-emergent emergency be declared, and what will Americans be ordered to do about it? A Johnny Carson emergency is one thing, but when government apparatchiks enforce the false premise, not to protect citizens but for political advantage, it's another.

After the initial plan for two weeks of self-quarantine to flatten the curve was renewed interminably, citizens realized that our health and safety was not really the reason for the ubiquitous executive orders; the *NDAJ* will leave to readers to decide what the actual goal of the COVID chaos is.

Who knew Johnny Carson's joke would devolve to become a feverish reality.

Long after this year's virus burns itself out, we will be dealing with the unnecessary economic devastation foisted upon us.

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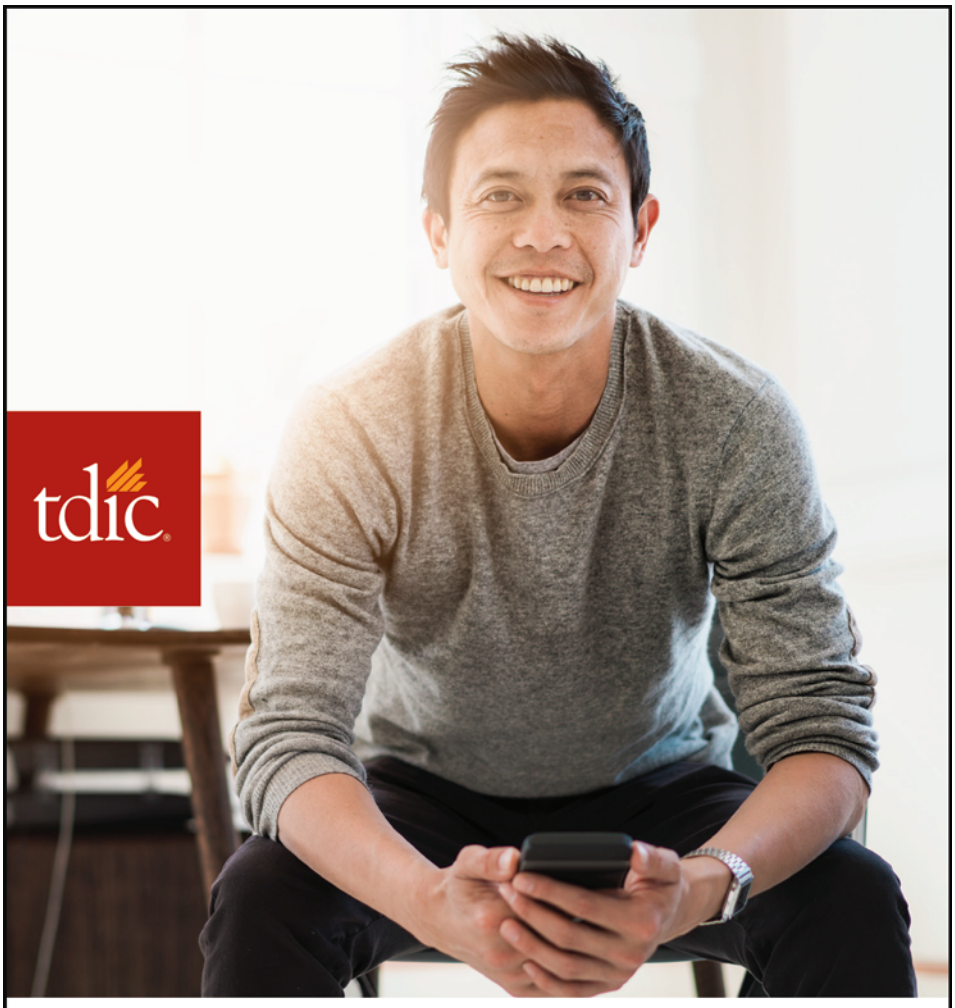

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News Briefs

Mayor Carolyn Goodman

Las Vegas City Council, 15 APR 2020

Mayor Goodman said that "this shutdown has become one of total insanity." Adding, "For there is no backup of data as to why we are shutdown from the start. No plan in place how to move through the shutdown or how to even come out of it."

Mayor Goodman said that according to experts who she has spoken to, the coronavirus is "not going away."

"It's not going to be going away this month, next month, and much like the flu and other viruses that have impacted populations around the world, this virus, or a derivative thereof will be part of what we work through going forward," Mayor Goodman said.

Mayor Goodman went on to point out that Nevada is a state of 3.2 million people, with 2.6 million living in Southern Nevada, she said.

"Tragically, we have already lost, to this virus, 128 individuals in Nevada," she said. Goodman offered her sympathies and condolences to those who have lost friends and loves ones to the virus.

"But let me tell you, with a population of 3.2 million living in Nevada, those whom we have lost represent less than a half of one percent of our population, which has caused us to shut down our entire state and everything that makes Nevada unique," Mayor Goodman said.

Goodman emphasized that of the estimated 900,000 people who have lost their jobs, 300,000 have already filed for unemployment. "These are families that no longer have the ability to buy food for their children and other loved ones. Pay their bills. Pay their rent. Pay their mortgage. Pay their car payment. Or enjoy the life that they had prior to this shut down," she said.

"Small businesses and those on week-to-week paychecks have been forced to close. Entire savings that were invested in these small businesses are being lost or are have already been lost. Hotels and restaurants, our entire tourism and convention industry business, has been shut down," Goodman said. "It makes no sense."

Mayor Goodman once again called for Gov. Sisolak to reopen the state of Nevada.

"From my perspective, we must open our city. We must open Southern Nevada and we must open the state of Nevada," Goodman said. "We cannot live, going forward, with the medical and health industry telling us that this virus is going to be around longer than a month or two, maybe even a year."

"We cannot keep our heads in the sand and think it's going to go away. We are adults with brains, who know to wash our hands, to take precautions not to spread this disease. But we cannot put our heads in the sand and think it's going to go away."

"From my perspective, open the city, open Clark County, open the state. For heaven's sake, for being closed is killing us already and killing Las Vegas, our industry, our convention and tourism business that we have all worked so hard to build.

Dear Dr. Orr,
As usual you are the best my friend. Yes, I agree with the current Mayor Goodman that we need to reopen Nevada as soon as possible. I don't need to tell you the shutdown is just plain unhealthy. It's always great for the Goodmans to get press time in the NDAJ[1] and we'll look forward to our copy this time around.

Sincerely,
Oscar Goodman
Former Mayor, Las Vegas, NV

1) Goodman O, Similarities Between Bill Cosby and Dr. Greg Minton, NDAJ 19:3, 34-35, 2017

Dear Dr. Orr,
It was great seeing you again recently. Thank you for the fine care you have rendered to my family and friends over the years. Please let the dentists of Nevada know I agree strongly with my Las Vegas colleague Mayor Carolyn Goodman that the current economic restrictions placed on our state are devastating economically and were quickly shown to be unnecessary. We are doing all we can to reopen North Las Vegas.

Sincerely,
John Lee
Mayor, North Las Vegas, NV

COVID-ology

Bank Tellers

Bank tellers now wear the masks, which may be appropriate considering the fees and charges.

COVID symptomology

I made the mistake of telling my husband that an early symptom of COVID-19 is a loss of smell. He's taken to volitional flatulence in my vicinity, and then when I react, informs me he is "performing a health check." He taught the children the technique. I may divorce him.

Grocery Shopping

Grocery shopping has become a real-life version of Pac-Man. Avoid everyone, get the fruit, and take any route out that avoids contact.

Toilet Paper

In an effort to avoid classical TP spousal contention, COVID has provided a solution. Based on obvious popularity, the Editor's choice of off the bottom wins. We're not sure what TP has to do with the COVID URI, but there was that run on TP...

"Woman Eaten by Shark, Dies of COVID"

In 2020, death by natural causes has become an anachronism.

Courtesy of Jaws the movie, 1975.

Mother's Day vs Father's Day

You know we're going to be quarantined for Mother's Day, but get out just in time for Father's Day. Typical...

Nevada Assembly District 29

The general election for Assembly District 29 will feature incumbent Lesley Cohen, a divorce attorney[1], versus challenger NDA Member Dr. Steven DeLisle[2]. Dr. DeLisle is an anesthesiologist who primarily serves special needs patients.[3]

1) https://cohenfornevada.com/bills/, accessed 01 MAR 2019 | 2) https://stevenfornevada.com/, accessed 01 MAR 2019 | 3) UNLV SDM Advanced Pain Control Update, NV Dent Assn J, 11:4, 31, Fall 2009

EpiPen Auto-injector Errors

In March 2020 the Food and Drug Administration (FDA) confirmed that, as reported in the NDAJ two years ago, EpiPens are not fool- or doctor-proof.[1] Epinephrine injections can be compromised by device failure from spontaneous activation caused by using sideways force to remove the blue safety release, from inadvertent or spontaneous activation due to a raised blue safety release, from difficulty removing the device from the carrier tube, or secondary to user errors.

The FDA recommends that patients and caregivers review the user instructions and practice using a trainer autoinjector. The FDA did not mention the NDAJ's suggestion that 1/1,000 or 1/10,000 epinephrine can be drawn from a vial into a standard syringe and injected safely and predictably within seconds and at a cost savings of over $700.00/dose.

1) Orr D, Autoinjectors are not doctorproof, NDAJ 20:4, 4, 2018

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Social Distancing is Snake Oil, Not Science

By William Sullivan

Governor Andrew Cuomo of New York says that it's "shocking" to discover that 66 percent of new hospitalizations appear to have been among people "largely sheltering at home."

"We thought maybe they were taking public transportation," he said, "but actually no, because these people were literally at home."

"Much of this comes down to what you do to protect yourself," he continues. "Everything closed down, government has done everything it could, society has done everything it could."

It's your fault, he says to the hospitalized New Yorkers who loyally complied with his government directive. But here's an interesting alternative theory as to why, mostly, old people who are staying at home are being hospitalized. What if the government directive to close everything down and mandate "social distancing" actually made the problem worse?

Dr. David Katz predicted precisely this outcome on March 20, in an article that is proving every bit as correct in its predictions and sober policy recommendations as Dr. Anthony Fauci has been proven incorrect—which is another way of saying that the article has proven flawless, so far.

Dr. Katz writes:

[I]n more and more places we are limiting gatherings uniformly, a tactic I call "horizontal interdiction"—when containment policies are applied to the entire population without consideration of their risk for severe infection.

But as the work force is laid off en masse (our family has one adult child home for that reason already), and colleges close (we have another two young adults back home for this reason), young people of indeterminate infectious status are being sent home to huddle with their families nationwide. And because we lack widespread testing, they may be carrying the virus and transmitting it to their 50-something parents, and 70- or 80-something grandparents. If there are any clear guidelines for behavior within families—what I call "vertical interdiction"—I have not seen them.

One might be inclined to simply accept this as an unintended consequence of "social distancing," but accepting that would require there to be some kind of benefit to "social distancing" that would make it worth the cost. Is there?

Very likely, you already instinctively know that the guidelines suggesting that it's somehow helpful to keep a six-foot space between healthy people, even outdoors, is not based on science, but just an arbitrary suggestion we've been conditioned to accept without evidence.

And your gut feeling would be right. There's a reason that "social distancing" wasn't a buzzword common to the American lexicon prior to 2020. There's very little science behind "social distancing" at all.

"It turns out," Julie Kelly writes at American Greatness, "as I wrote last month, "social distancing" is untested pseudoscience particularly as it relates to halting the transmission of the SARS-CoV-2 virus. On its website, the CDC provides no links to any peer-reviewed social distancing studies that bolster its official guidance."

There's a reason for the lack of peer-reviewed studies on the CDC website. She continues:

The alarming reality is that social distancing never has been tested on a massive scale in the modern age; its current formula was conceived during George W. Bush's administration and met with much-deserved skepticism.

"People could not believe that the strategy would be effective or even feasible," one scientist told the New York Times last month. A high school science project—no, I am not joking—added more weight to the concept.

"Social distancing" is very much a newfangled experiment, not settled science. And, Kelley writes, the results are suggesting that our "Great Social Distancing Experiment of 2020" will be "near the top of the list" of "bad experiments gone horribly wrong."

You also don't have to be a scientist to also instinctively know that "two weeks to flatten the curve" becoming "America must lock down until a vaccine is created" is more social experimentation than science. But what the data have fleshed out, beyond the point of argument, is that the proximity of one human being to another has proven to be a very small factor in determining the impact of COVID-19 infections. What's far more important is which human beings happen to be in close proximity of one another.

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According to Dr. Steven Shapiro and the University of Pittsburgh Medical Center:

Crowded indoor conditions can be devastating in nursing homes, while on the USS Theodore Roosevelt 1,102 sailors were infected, but only 7 required hospitalization, with one death. This contrast has significant implications that we have not embraced. Epidemiologic prediction models have performed poorly, often neglecting critical variables.

The USS Theodore Roosevelt had a crew of 4,800. Given the acute sample, testing was holistic. This yields an actual infection rate of roughly 23 percent, and among those infected, the fatality rate is 0.09 percent. Among the Roosevelt's entire crew of assumedly healthy and able-bodied sailors, on a floating Petri dish, during the thick of viral outbreak that shut down all schools and placed healthy citizens across America under house-arrest, the fatality rate was .002 percent.

It seems more than obvious that there is little sense in quarantining the young and healthy. As Dr. Shapiro also observes:

Our outcomes are similar to the state of Pennsylvania, where the median age of death from COVID-19 is 84 years old. The few younger patients who died all had significant preexisting conditions. Very few children were infected and none died. Minorities in our communities fared equally well as others, but we know that this is not the case nationally. In sum, this is a disease of the elderly, sick, and poor.

Here's another thing you likely already know. Politicians and the media are committing to damage control to hide all of these facts from you. In fact, finding any news relating to Dr. Shapiro's somewhat revelatory comments online is, so far, quite difficult.

That's because, for the people who pushed "social distancing" and destroying the economy as an absolutely necessary evil, this is a matter of self-preservation. If this information were widely known, citizens might be more inclined to demand that schools and parks and restaurants and malls be opened. But if schools open tomorrow, without testing, and there is not a surge in hospitalizations or deaths, then the obvious question is why the schools closed in the first place. If restaurants and other shuttered businesses open without a spike in hospitalizations and deaths, then why did they ever close?

There's value in the media and government officials maintaining the public perception that the costs of "social distancing" have been offset by its benefits. But while those benefits are elusive in the data, and require mountains of presumption to imagine that they even exist at all, the costs of "social distancing" couldn't be clearer.

As Dr. Steven Shapiro concludes:

What we cannot do is extended social isolation. Humans are social beings, and we are already seeing the adverse mental health consequences of loneliness, and that is before the much greater effects of economic devastation take hold on the human condition...

In this particular case, the problem we're not going to be able to fix in the short term is the complete eradication of the virus. The problem we can fix is to serve and protect our seniors, especially those in nursing homes. If we do that, we can reopen society, and though infectious cases may rise as in the Theodore Roosevelt, the death rate will not, providing time for the development of treatments and vaccines.

At this point, this is little more than common sense, and the truth can't continue to be suppressed for much longer. It's becoming more and more obvious that it's well past time to take a more tactical approach to mitigation, as Dr. Katz suggested back on March 20, allocating resources and efforts toward protecting and caring for those most at-risk, and ending this soul-crushing and economy-crashing experiment with holistic "social distancing."

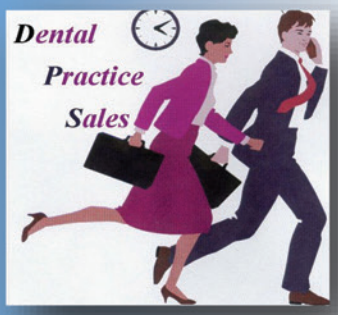
William Sullivan is a frequent commentator on social issues. This article was originally published at American Thinker (americanthinker.com) 11 May 2020, page: https://www.americanthinker.com/articles/2020/05/social_distancing_is_snake_oil_not_science.html

Editor's Note

The Editor attempting to social distance with a rude paddleboarder, North Shore. Paddleboarders have reportedly been particularly insensitive to COVID social distancing guideline executive orders. Mothers taking their children to parks have also been problematic.

Paddle Boarder Arrested for not Social Distancing…While Alone in Ocean, Informed American, 06 APR 2020, https://www.informedamerican.com/paddleboarder-arrested-for-not-social-distancing-while-alone-in-ocean/, accessed 13 May 2020

Protest Starts After Idaho Woman Arrested at Playground Closed Due to Coronavirus, CBS News, 22 April 2020, https://www.cbsnews.com/news/coronavirus-idaho-woman-arrested-closed-playground-protests-meridian-city-hall/, accessed 13 May 2020



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National Vital Statistics Death Rates

Table B. Number of deaths, percentage of total deaths, death rates, and age-adjusted death rates for 2017, percent change in age-adjusted death rates in 2017 from 2016, and ratio of age-adjusted death rates by sex and by race and Hispanic origin for the 15 leading causes of death for the total population in 2017: United States

[Crude death rates are on an annual basis per 100,000 population; age-adjusted rates are per 100,000 U.S. standard population; see Technical Notes in this report. Asterisks (*) preceding cause-of-death codes indicate they are not part of the *International Classification of Diseases, 10th Revision* (ICD–10); see Technical Notes. Race and Hispanic-origin categories are consistent with 1977 Office of Management and Budget (OMB) standards]

Rank[1]	Cause of death (ICD–10)	Number	Percent of total deaths, 2017	Crude death rate, 2017	Age-adjusted death rate, 2017	Percent change, 2016 to 2017	Ratio: Male to female	Ratio: Non-Hispanic black[2] to non-Hispanic white	Ratio: Non-Hispanic white[2] to Hispanic
...	All causes	2,813,503	100.0	863.8	731.9	0.4	1.4	1.2	1.4
1	Diseases of heart (I00–I09,I11,I13,I20–I51)	647,457	23.0	198.8	165.0	–0.3	1.6	1.2	1.5
2	Malignant neoplasms (C00–C97)	599,108	21.3	183.9	152.5	–2.1	1.4	1.1	1.5
3	Accidents (unintentional injuries) (V01–X59,Y85–Y86)	169,936	6.0	52.2	49.4	4.2	2.1	0.8	1.7
4	Chronic lower respiratory diseases (J40–J47)	160,201	5.7	49.2	40.9	0.7	1.2	0.7	2.7
5	Cerebrovascular diseases (I60–I69)	146,383	5.2	44.9	37.6	0.8	1.0	1.4	1.1
6	Alzheimer disease (G30)	121,404	4.3	37.3	31.0	2.3	0.7	0.9	1.3
7	Diabetes mellitus (E10–E14)	83,564	3.0	25.7	21.5	2.4	1.6	2.1	0.7
8	Influenza and pneumonia (J09–J18)	55,672	2.0	17.1	14.3	5.9	1.3	1.1	1.3
9	Nephritis, nephrotic syndrome and nephrosis (N00–N07, N17–N19,N25–N27)	50,633	1.8	15.5	13.0	–0.8	1.4	2.2	1.0
10	Intentional self-harm (suicide) (*U03,X60–X84,Y87.0)	47,173	1.7	14.5	14.0	3.7	3.7	0.4	2.6
11	Chronic liver disease and cirrhosis (K70,K73–K74)	41,743	1.5	12.8	10.9	1.9	1.9	0.7	0.8
12	Septicemia (A40–A41)	40,922	1.5	12.6	10.6	–0.9	1.2	1.7	1.3
13	Essential hypertension and hypertensive renal disease (I10,I12,I15)	35,316	1.3	10.8	9.0	4.7	1.1	2.1	1.0
14	Parkinson disease (G20–G21)	31,963	1.1	9.8	8.4	5.0	2.3	0.5	1.5
15	Pneumonitis due to solids and liquids (J69)	20,108	0.7	6.2	5.1	–1.9	1.9	1.0	1.7
...	All other causes (residual)	561,920	20.0	172.5	...	...	...	...	...

... Category not applicable.
[1]Rank based on number of deaths; see Technical Notes.
[2]Multiple-race data reported according to 1997 OMB standards were bridged to the single-race categories of 1977 OMB standards. For more information on areas reporting multiple race, see Technical Notes.

SOURCE: NCHS, National Vital Statistics System, Mortality.

6 National Vital Statistics Reports, Vol. 68, No. 9, June 24, 2019

Death in Utero

U.S. Federal Law and the Uniform Code of Military Justice both recognize an embryo or fetus in utero as a legal victim if injured or killed during the commission of a violent crime.[1]

Historically, Mosaic Law states that life begins once fetal blood begins to flow (Leviticus 17:11), or by day 26 in utero. In addition to: “thou shalt not kill” (Exodus 20:13), if a pregnant woman is hurt and “her…fruit departs from her…he shall be surely punished.” (Exodus 21:22-25)

The question of fetal rights was widely discussed during the 2004 California murder trial of Scott Peterson. Peterson was ultimately convicted of 1st degree murder of his wife Laci and 2nd degree murder of their unborn child Connor.

The World Health Organization estimates there are 50–60 million abortions worldwide annually, or 125,000 abortions per day.

The women’s rights advocacy group Guttmacher Institute estimates there are approximately 1,000,000 U.S. abortions annually, or over 2,700 abortions per day.

In the U.S. criminal sanctions against in utero death are waived in the case of abortion approved by the mother. Two states, Virginia and New York, allow infanticide for babies that survive the abortion attempt. 18 states, including Nevada, do not require any medical care for babies who survive an abortion.[2]

Worldometer Death Statistics 01 June 2020

HEALTH

5,426,645	Communicable disease deaths this year [+]
203,598	Seasonal flu deaths this year [+]
3,177,409	Deaths of children under 5 this year [+]
17,775,005	Abortions this year [+]
129,206	Deaths of mothers during birth this year [+]
41,834,646	HIV/AIDS infected people [+]
702,721	Deaths caused by HIV/AIDS this year [+]
3,433,184	Deaths caused by cancer this year [+]
410,031	Deaths caused by malaria this year [+]
9,665,467,345	Cigarettes smoked today [+]
2,089,707	Deaths caused by smoking this year [+]
1,045,513	Deaths caused by alcohol this year [+]
448,265	Suicides this year [+]
$ 167,229,274,275	Money spent on illegal drugs this year [+]
564,287	Road traffic accident fatalities this year [+]

1) The Unborn Victims of Violence Act, PL 108-212.
2) Ertelt S, 19 States Allow Infanticide, Let Abortionists Leave Babies to Die Who Survive an Abortion, https://www.lifenews.com/2019/02/14/19-states-allow-infanticide-let-abortionists-leave-babies-to-die-who-survive-an-abortion/, 14 FEB 2019, accessed 09 MAY 2020.

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Bioethics and COVID-19: The Tension of Quarantine and Civil Liberties

By Jeffrey Hall Dobken, MD, MPH

Courtesy of the American Association of Physicians and Surgeons

COVID-19 is a recent events in the eyes of the general public, but human *strains of coronavirus have long been identified as causes of upper respiratory infections, a.k.a. "colds"* [1]. As a species we have lived a long time with colds. Disease and illness associated with civilization are older than written history. In public health parlance we have gone through the "Epidemiologic Transition," defined as the statistical switch from the "untreatable" contagions and the great historic calamitous pandemic plagues of our ancestors (such as bubonic plague, smallpox, cholera, dysentery, typhus, syphilis, poliomyelitis, etc.) to the "modern" problems of deterioration and aging: cancer, heart disease, lung disease, dementia, metabolic diatheses, and physical accidents[2], amongst others. Infectious events have fallen off the public's radar as untreatable issues and are seen as treatable which may explain why COVID-19 is perceived as "unprecedented."

Coronaviruses have a singular talent for recombination, for absorbing stray bits of genetic material. In 2003, Dr. Susan Baker, a virologist at Loyola University in Chicago, observed that "with high frequency recombination, you always have potential for a new virus to emerge." One day, virologists warned, the recombination tendency of coronavirus family might suddenly turn a benign coronavirus into a deadly one.[3]

Foundations of Current Public Health Law

It is the legacy of the events of late 2001 that revealed our nation's vulnerability to the threats of biological, chemical, nuclear, and radiological assaults. Efforts to prepare for such contingencies became the focus of the Department of Homeland Security. The arena of addressing the safety of Americans from modified infectious diseases became the responsibility of the Department of Health and Human Services. The emphasis was to be on surveillance plus activities to promote public health awareness, led by the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH), particularly the National Institute of Allergy and Infectious Diseases (NIAID).[4]

Americans were directed on preparation for a potential infectious disease event through assorted public health agencies that advocated increased surveillance and mandated reporting of PUI (Persons Under Investigation) by providers to LHD (Local Health Departments)[5] and epidemiological methods. It had been asserted that isolation and quarantine would provide an adequate response to an infectious event.

The threat of a pandemic and the legacy of the post-9/11 anthrax attacks changed public health regulations in the United States. The responsibility for public health is a primary defined duty and responsibility of the states ever since the founding of the Republic. The federal government affects the public's health and safety through its constitutional authority to spend money, regulate commerce, and provide for the national defense. The Congress established the Public Health Service and CDC with federal money and used its authority under the commerce clause of the Constitution to establish the FDA. The creation of these federal agencies, however, did not alter or preempt the states' responsibilities for public health. The post-9/11 anthrax attacks did.

Driven by concern over the use of weaponized microbes, such as anthrax or smallpox or plague, broadly described as "bioterrorism," and under the aegis of the CDC as the coordinating agency to develop our responses to bioterrorist activity, the CDC developed the *Interim Smallpox Response Plan and Guidelines*. This provided direction to state and local health officials for "responding" to an intentional infectious event. In their own words: "the document … (defined) the CDC's strategies and approaches for **responding** (CDC emphasis) to a smallpox emergency."[6] The plan calls for post-exposure vaccination and monitoring of a "ring" of people around each identified case and thereby preventing the spread of disease.

The scenario developed from deployment of a contagious infectious agent in the unprotected public was predicted to result in medical and social chaos, according to experts[7]. The prediction was that physicians and hospitals would bear the brunt of the health nightmare. Mass casualties and the "worried well" would swamp hospitals and health care facilities that barely cope with normal health care needs. Confusion and fear would dominate physicians called upon to respond. "Contaminated" hospitals, ER's, doctor's offices, medical walk-in clinics would suddenly close to the public under rules of quarantine. Isolation hospitals and clinics would be created as designated by local or state health authority. Vaccination clinics would need to be opened in school gymnasia or armories.[8] Supplies of antibiotics and equipment would likely be rapidly used up. Efforts to treat the sick and

control contagion would be hampered by shortages of competent trained and vaccinated personnel. Public order would be imperiled. Local and state police supported by militia would enforce restrictions on public travel and access.

The COVID-19 public health response is based on law and concepts developed to address an act of bioterrorism. In the absence of a specific treatment or vaccine for an identified patient with COVID-19 this is fundamentally a statistical approach to preserve the general healthy population rather than address the needs of the individual patient.

Public Health Law and Individual Liberty

What is often neglected in thinking about the threats an infectious agent might pose to public health is the foundation that law provides for effective public health activities. Any pandemic constitutes a grave threat to each and every citizen, rich or poor, empowered or enfeebled, but it also constitutes a grave threat to the role that law plays in regulating public and private behavior.[9] The very bedrock of freedoms we so identify as "American freedoms" would be, if not destroyed, then at least suspended, for in effect every infected or exposed citizen's rights would evaporate in the public health paradigm to protect the remaining well. Such would in effect turn every patient or potential patient into an enemy of the state, along with their husbands or wives or children or friends or business associates who know them, want to see them, or merely want to interact or help them and be with them.

National emergencies push the rule of law: the concept that laws and not the arbitrary exercise of power beyond the principal of "fairness" or equity govern us.[9] History and war favor the notion that rules must be made to serve the majority interests. Examples abound. The precedent of suspending the writ of habeas corpus (guarantee against unlawful detention or restraint) brought Abraham Lincoln into direct confrontation with Chief Justice Taney in April 1861. Lincoln could simply not allow the state of Maryland to secede from the Union at the onset of the Civil War, thus isolating the federal capital from what remained of the Union. A contemporary newspaper stated that "no power in executive hands can be too great, no discretion too absolute, at such moments as these."[10] Many citizens of Maryland were arrested for suspicion of harboring confederate sympathies, just as 80 years later at the onset of World War II Japanese-Americans were incarcerated after Pearl Harbor was attacked.

The COVID-19 pandemic calls for legal responses to circumstances that have limited precedent in America. Public health law seeks to protect the unaffected by isolating the sick, identified either by virtue of a positive test or symptom profile. Since antiviral treatment or vaccines are not offered or are unavailable, the ethics of isolation and containment of those who are ill to "benefit the healthy well" is questionable. The existing legal frameworks exacerbate pressure on governments to take drastic actions that might sweep away the rule of law in the midst of panic or uncertainty[9] such as requiring physicians or providers to act as police and report patients as "PUI" while limiting autonomous medical treatment decisions, such as restrictions in prescribing medications.

What must be established with regard to these responsibilities amounts to a task worthy of the wisdom of the Founding Fathers for *not only is the health and safety of the public at risk, so too are all the rights and duties of citizens as potential victims.* What can be said of the ethics of quarantine of an unprotected and poorly informed public that is twice victimized: once, by the disease, then subsequently by its own public officials?

Existing public health statutes actually exacerbate these circumstances. They are derivative of public health law as developed from The Model State Emergency Health Powers Act[8] and its offspring, the Turning Point Model State Public Health Act.[11] In effect, the law allows, once an emergency is declared, that the public health authority can control treatment decisions, enforce travel restrictions, commandeer, ration, and otherwise control water, food and medication supplies, and use medical and/or public facilities as deemed necessary for the management of the health crisis. The language and recommendations are derived from Lawrence Gostin's Model State Emergency Health Powers Act.[8]

The Act permits the governor to declare a "state of public health emergency," and this declaration, in turn, gives the state public health officials the authority to take over all health care facilities in the state, order physicians to act in certain ways, and order citizens to submit to examinations and treatment, with those who refuse to do so subject to quarantine or criminal punishment. Public health officials and those working under their authority are immune from liability for their actions, including actions that cause permanent disability or death; the only exceptions are in cases of gross negligence or proven willful misconduct. A public health emergency is defined as "an occurrence or imminent threat of an illness or health condition, caused by bioterrorism, epidemic or pandemic disease, or a novel and highly lethal infectious agent or biological toxin, that poses a substantial risk of a significant number of human fatalities or incidents of permanent or long-term disability."[8]

The governor is permitted under the act to suspend state regulations, change the functions of state agencies, and mobilize the militia. Under the act, all public health personnel will be issued special identification badges, to be worn "in plain view," that "shall indicate the authority of the bearer to exercise public health functions and

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emergency powers…"[8] Public health personnel may compel "a health care facility to provide services or the use of its facilities if such services or use are reasonable and necessary for emergency response… including the transfer of … the health care facility to the public health authority."

According to the act, failure of physicians and citizens to follow the orders of the public health authority is a crime. Section 502 of the act states:

"Any person refusing to submit to the medical examination and/or testing is liable for a misdemeanor. If the public health authority is uncertain whether a person who refuses to undergo medical examination and/or testing may have been exposed to an infectious agent or otherwise poses a threat to public health, the public health authority may subject the individual to quarantine or isolation… Any (health care provider) refusing to perform a medical examination or test as authorized herein shall be liable for a misdemeanor… An order of the public health authority given to effectuate the purposes of this subsection shall be immediately enforceable by any peace officer."[12]

Many of the provisions of this act, especially those giving public health officials blanket authority over physicians and hospitals seem based on the assumption that neither physicians nor citizens are likely to cooperate with public health authority in a pandemic.

In the opinion of George Annas[12], there are several problems. First, public health law should respond to *real problems*. It is not clear what problem the act is intended to solve. Second, the authority to respond to a new epidemic that the model act provides is *much too broad* granting *carte blanche* authority to public health functionaries in nonemergency conditions as diverse as annual influenza epidemics, SARS or the AIDS epidemic.[13]

Annas' third concern is with the arbitrary use of governmental authority by public health or elected officials (who enjoy legal immunity from liability) to exercise control over civil liberties. Such actions are incompatible with medical ethics, constitutional principles and basic democratic values. Although it may make sense to put public health officials in charge of responding to a pandemic, it may not make sense to place them in charge without oversight of all possible scenarios. The state's public health department has the role of limiting the public's exposure to the agent, but not to limit autonomous medical decisions, or informed consent, or treatment options. Taking away one's civil liberties because he or she has the misfortune of becoming infected cannot be construed as ethical.

But the task of identifying affected persons, of maintaining the clinical index of suspicion in diagnosis, then reporting those suspicions, then trying to treat them, plus taking preventive actions will all be performed by physicians, nurses, emergency medical personnel, and hospitals. The primary role of public health authorities should be to provide guidance to the public and other government officials in identifying and dealing with the disease and to provide laboratory facilities where exposure can be evaluated and diagnoses definitively established.[14]

There is absolutely no compelling evidence that physicians, nurses, or members of the public are in any way unwilling or reluctant to cooperate in the response to the event or are reluctant to take the medications or vaccines recommended by public health or medical officials or their health care teams. Indeed, the medical personnel in the affected areas volunteer their time and expertise to help the victims.

It has recently been reported that transmission of novel coronavirus (SARS-CoV-2) can occur before symptom onset occurs clinically in a vector and thus confounding efforts to limit spread.[15] The key to an effective public health response is identifying and helping those that have been exposed.

Clearly, quarantine in a virgin turf epidemic like this pandemic requires an educated and prepared public. A defined treatment strategy for those likely to be "sheltered in place" and/or "isolated and contained" should not be withheld or obfuscated by the public health bureaucracy.

There exists federal quarantine law based on the commerce clause of the Constitution (with special provisions mentioning cholera, plague, smallpox, typhus, and yellow fever). Congress could examine and update it to deal with pandemics.[16]

Each of the states, the governors and the assorted public health agencies have developed policy or issued administrative orders that currently place limitations on prescribing and/or dispensing medications, establishing protocol for sheltering-in-place, public comportment (social distancing, use of masks, hand washing), hospitalization rules and utilization, school closings, designation of "essential versus non-essential" businesses, etc. As an example, the State of New Jersey, the governor fears hoarding and an impact on medication availability based on the CDC's therapeutic guidelines.[17] Neither the governor of NJ nor the director of consumer affairs have any formal medical training.

Civil Liberties, the Concept of Autonomy and Public Health Emergencies

The public health law assumes a trade-off between the protection of civil rights and effective public health interventions, and that a threatened public may not cooperate or is inherently uneducable with regard to the key issues involved with crisis management in the absence of legislative authority. Precedent is cited: *Jacobsen v. Massachusetts* involving a state statute requiring vaccination when "deemed necessary for the public health or safety"[18]. *At that time (more than 100 years ago)* when hospitals, medication, technology and physicians were

neither universally trusted, universally available nor necessarily effective, such tradeoffs between civil liberties (right to refuse treatment) and public health interventions (mandatory vaccinations) were somehow reconcilable.

The Constitution gives the government wide latitude to respond in times of crisis and war. But is such paternalism and arbitrariness consistent with twenty-first century science and knowledge? As Annas inquires, can we not rely upon Americans to follow reasonable instructions issued by knowledgeable and trustworthy experts?[19]

In the 100 plus years since *Jacobsen* and both medicine and constitutional law have evolved. We now accept the right of a competent adult to refuse any medical treatment,[20] even life-saving treatment. And we still permit health officials to quarantine persons with serious communicable diseases; such as multi-drug resistant tuberculosis but only if they do not or will not accept treatment. Even so, we require health officials to employ "least restrictive alternatives" and resort to quarantine only after failure of alternatives. And provisions for quarantine are accompanied by due-process protections, including the right to legal representation and a hearing.[21]

The current law appears more appropriate to America of the nineteenth century. Autonomy in medical decision-making is essential for both physician and patient. All Americans today have the right to refuse examination and treatment. In America of the 21st Century, a citizen should be able to pick the physician of his or her choice, and the method and means of treatment appropriate to circumstances and informed choice, such as off-label use of a medication recommended by their physician. Similarly, the physician must have professional autonomy in medical judgment and decision-making unencumbered by arbitrary administrative code promulgated by non-medical bureaucrats, and based primarily on statistical assessments. Centrally planned and determined health care does not and cannot provide individual patient care.

It is also worth remembering that the science of epidemiology is inherently retrospective, and data based post-event analysis is *de rigueur*.[22] For naturally occurring diseases, this has been the very foundation for nearly all modern medical advances. But can a physician and clinician be satisfied that quarantine automatically and arbitrarily accords with the best standard of care for an individual patient as well as the greater good of society? Such an approach deserves the closest of scrutiny and professional and intellectual criticism since it appears to be so singularly narrow in perspective.

Conclusion

The Centers for Disease Control and Prevention (CDC) have expanded on the measures *responding* to emerging threats to the public health. It is understandable that the primary role of public health is to recognize, report and thus contain the outbreak.

The primary roles of public health authorities is to provide guidance to the public and other health professionals and government authorities in identifying and dealing with the disease, meaning the promise of an effective treatment, as well as provide laboratory facilities where exposure can be evaluated, diagnoses definitively established, and treatment plans proposed. That is what the public seeks and expects, and has shown itself as clearly engaged in cooperating with the public health authorities.

The use of public health law to dominate the entire spectrum of clinical decisions, to modify professional behavior, to control the public's comportment, to dominate all commerce and interpersonal interactions and to ration or control medication choices needs clear thinking and apolitical judgement based on objective factual determinations and ethical standards. Methods used by the public health community should respond to the mechanics of the pandemic in a global sense while at the same time respecting and permitting professional judgement and the medically trained caregiver to operate at the bedside unencumbered by arbitrary centralized decisions.

Limiting the spectrum of legitimate clinical choices regarding patient treatment before they are even made denies autonomy for the professional as well as the patient. Such cannot serve either the general good or the individual patient. The prism of public health law and regulations that are advanced to achieve the goal of "protecting the health, safety, and welfare" of Americans[16] can and should abide by the same ethical standards to which all of the healing arts are held.

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Partial Exodontic Technique

By Dave Mahon, DDS, Ed De Andrade, DDS

The partial exodontic technique (PET) is a straightforward procedure suitable for single rooted teeth without periodontal disease and a favorable crown to root ratio. The procedure can be performed on vital teeth before root canal therapy is initiated or after endodontic therapy. PETs may be treated with a regimen of antibiotics. Rigid fixation of the repositioned root can result in ankylosis and should be avoided. There should also be no occlusal influences on the healing repositioned tooth root during the healing process. After two months, if needed, endodontic therapy can be performed and the tooth restored. The benefits include relatively short overall treatment time, reduced patient cost, and natural gingival architecture.

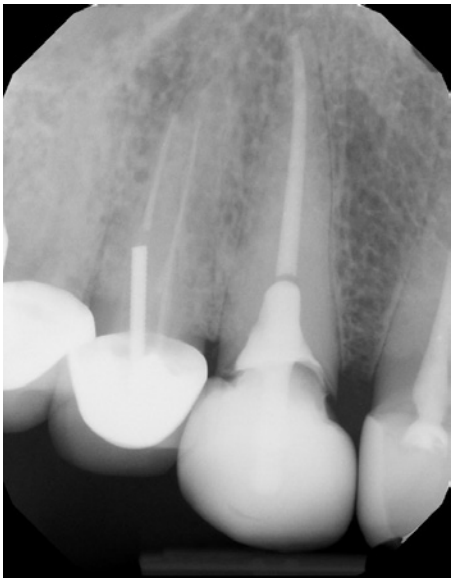


Figure 1: PAX #6 pre-op

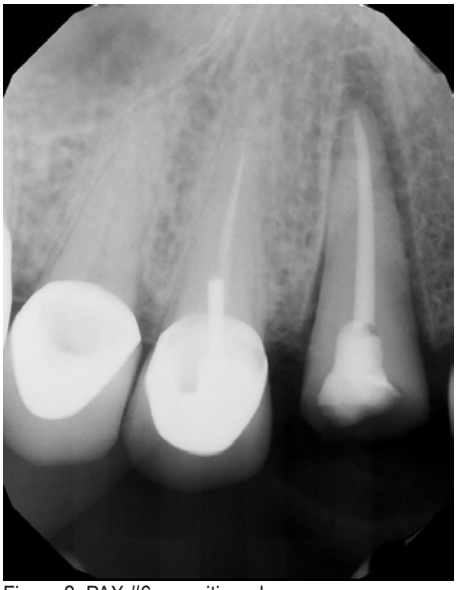


Figure 2: PAX #6 repositioned

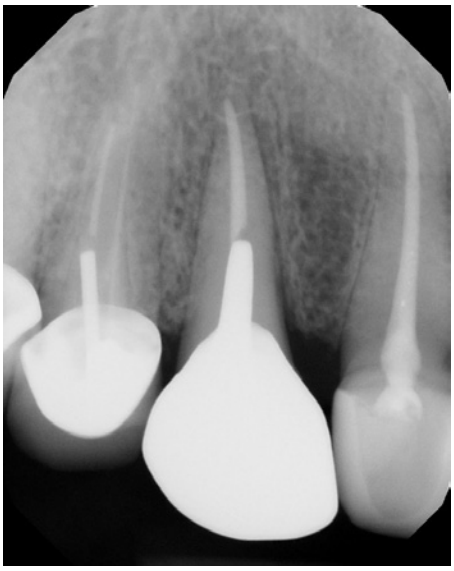


Figure 3: PAX #6 final

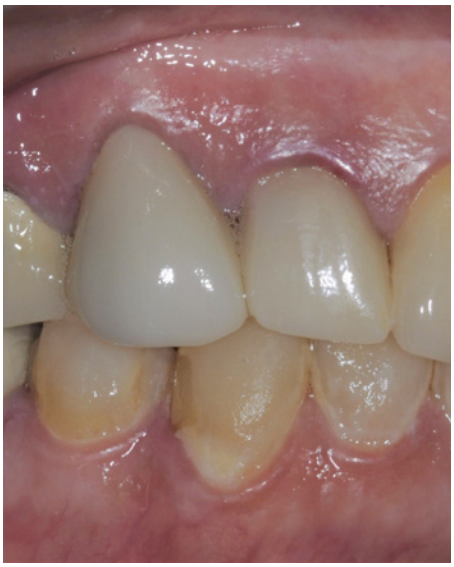


Figure 4: PAX #6 post op

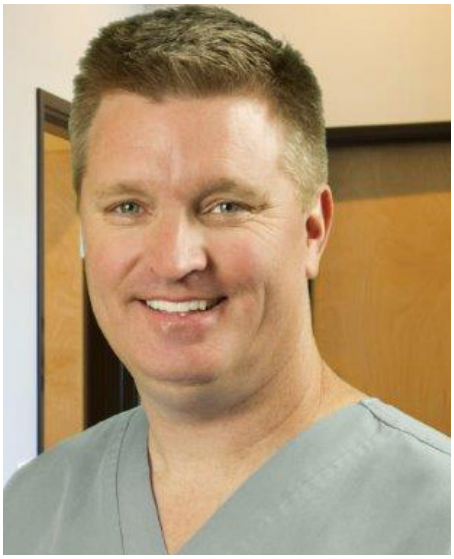
Case Report: A 62-year-old male presented with a fractured tooth #6, his post and crown in hand. The restoration had recently been recemented but failed during normal function. Figure 1. Significant decay precluded recementing the crown again or preparing the tooth for a new crown. After removing the decay, a prefabricated post was bonded in place, and the crown cemented on a glass ionomer core. An alginate impression was taken in order to fabricate an Essix stayplate. The patient was referred to an OMS familiar with PET but the patient's insurance redirected him to another specialist whom was unfamiliar with PET. Ultimately the patient found his way to co-author Dr. DeAndrade.

Via local anesthetic the crown and core were horizontally sectioned from the root, then the root judiciously luxated with periotomes and coronally repositioned. Figure 2. Horizontal and vertical mattress sutures provided the only stabilization of the tooth. The patient was dismissed with an Essix stayplate making sure that there was no contact between the tooth and the stayplate. The patient was instructed to avoid function in the area and to maintain hygiene with gentle rushing and chlorhexidine rinses. He was asked to return in

one week for suture removal. During suture removal the tooth was stable and found to be healing within normal limits. Eight weeks later the tooth was restored with a cast post-core and zirconia crown.

Dr. David Mahon has lived in Nevada since 1999 and practices general dentistry in Henderson. He is currently the Nevada Dental Association's Officer at Large.

Dr. Ed De Andrade has practiced in Nevada since 2000. He is a board certified periodontist with offices in Henderson and Las Vegas and is currently serving as Vice President of the NDA. He and his wife have one daughter.



Dr. David Mahon

Dr. Ed De Andrade

DR. TOM BROOKSBANK DDS, ESQ.

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HIPAA + OSHA
License Regulations
Opioid Rx Compliance
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DR. TOM BROOKSBANK DDS, ESQ.
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Las Vegas, NV 89169
(702) 337-6772
DrTom@NVDentalLaw.com

Letters to the Editor

Dear Editor

Thank you for the wonderful editorial about Oregon dentists administering vaccines, funny yet poignant in its tragic undertones of reality vs fantasy. Generally the Oregon dentists are unique in their views that range from euthanasia advocacy to socialized, no-choice medicine. Bringing the vaccination advocacy into your article was a great bit of irony. Our profession has fought hard for years to remain independent of medicine, yet the ODA president advocates for another "first step" toward that end. Corporate medicine would love to get its hands on 30% of dentists' incomes by making them all employees of hospitals and satellite clinics. Many dentists would "sell out" in the same way the physicians did when they sold their practices to corporate medicine. But, financially secure dentists would never have to make that Faustian bargain and sell the freedoms of private practice to the highest bidder. Current medical practitioners and the American public are now paying the piper for physicians' mass sell-out to corporate medicine over the past two decades.

Sincerely,
L. Donald Guess, DMD
Doctors' Economic Research Project

Dear Dr. Orr

As you recall I was scheduled for surgery to remove squamous cell carcinoma from my left orbit. 24 hours before the procedure I was told I could come to the hospital but they weren't guaranteeing that my surgery would be done because administration ordered that I be tested for COVID-19 first. The COVID test would take at least a week to obtain. My cancer surgery, with 5 doctors involved, involved some serious scheduling issues. It took a month to line things up for the planned date. The test didn't make any sense to me and thankfully to you either. Evidently my surgeons prevailed with administration because that morning the COVID test was not required. I was later advised my surgery went well.

Thank you for your input,
Anonymous

Dear Editor

An ICD-10 code of "U07.1 COVID-19, virus identified" is assigned to a disease diagnosis of COVID-19 confirmed by laboratory testing. An ICD-10 code of "U07.2 COVID-19, virus not identified" is assigned to a clinical or epidemiological diagnosis of COVID-19 whose laboratory confirmation is inconclusive or not applicable. Either may be used to code COVID as the cause of death.

Kelly Victory, MD

Editor's Note: As with the misdiagnosis of Rx Opioid Deaths, where an average of six other toxic substances were ignored when found in the deceased (i.e. alcohol, amphetamine, cocaine, etc.),[1] COVID-19 deaths generally include serious co-morbidities that are never mentioned as a contributing cause of death. Well over 98% of COVID patients recover. An ICD-10 diagnosis of COVID URI allows hospitals to bill Medicare for an additional $13,000-$39,000.[2]

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Dear Editor

I know it is anecdotal, but I have noticed a significantly increased number of patients asking for OMS extractions of potentially restorable teeth since mid-March when Nevada dental offices were ordered closed for "elective" procedures. These patients simply do not want to wait interminably to have restorations and are sadly opting for extractions. I also received a report that since GP's are not allowed to do "elective" dentistry, many of those patients are opting for extractions rather than wait. Who knows how many teeth have been unnecessarily lost?

Sincerely
Dr. Jay S. Selznick

Dear Editor

Texas is slowly re-opening but the main stream media have done such a good job of scaring rational thought out of the general public that most are afraid to go out. The entire COVID situation is ridiculous and has crossed over to the criminal, and not just the politics. For example:

- Who thought it was a good idea to house active COVID patients in nursing homes?
- What is the scientific evidence that there is any merit in social distancing 6 feet?
- Why is it "racist" to name COVID the Chinese virus?
- Why are 70% of the new cases in NYC occurring in people who have stayed at home?
- Why are the case numbers and death counts so inflated?
- Why did the CDC instruct hospitals to count untested/confirmed deaths as COVID?

Christine Haskin, DDS
Former Professor in Residence, UNLV SDM

Letters *not* to the Editor

At this time it seems very poignant to avoid all public spaces. Even at bars, as I told Hemingway, but to that he punched me in the stomach, to which I asked if he had washed his hands. He hadn't. He is much the denier, that one… The officials have alerted us to ensure we have a month's worth of necessities. Zelda and I have stocked up on red wine, whiskey, rum, vermouth, absinthe, white wine, sherry, gin, and lord, if we need it, brandy.

F. Scott Fitzgerald, quarantined in the south of France, 1916, during the Spanish influenza

For so it had come about, as indeed I and man might have foreseen had not terror and disaster blinded our minds. These germs of disease have taken toll of humanity since the beginning of things-taken toll of our prehumen ancestors since life began here. But by virtue of this natural selection of our kind we have developed resisting power; to no germs do we succumb without a struggle, and to many-those that cause putrefaction in dead matter, our living frames are altogether immune. But there are no bacteria on Mars. By the toll of a billion deaths man has bought his birthright of the earth, and it is his against all comers; it would still be his were the Martians ten times as mighty as they are.

H.G. Wells, 1897, War of the Worlds

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Robert H. Talley, DDS, CAE
robert.talleydds@nvda.org

Executive Director's Summer Message

Your NDA Executive Committee has done a great job keeping all members informed on all aspects of this challenging time we now live in. They have worked well with state authorities and have kept dentistry at the table during re-opening discussions. They have communicated to the Governor and his staff the role dentistry plays in overall health. Without the strong leadership of your officers, dental offices would still be closed.

The House of Delegates has voted to move the office to Northern Nevada. The NDA has signed a contract with Coldwell Banker Realty to sell the NDA Office. This will probably take a few months. Plans are being made for a smooth transition.

The NDA has hired the Griffin Company for the rest of the year to help with legislative and regulatory issues. This is an interim position as the Association plans to conduct interviews on a permanent lobby firm later this year.

The search for a new Executive Director continues but has slowed to some extent due to the pandemic. This is a national search and travel for interviews is a key problem. I have been asked by the Executive Committee to stay on month to month until the position is filled.

Plans are being made for the NDA Summer meeting. It will be a one-day meeting on Saturday June 20. We hope to be able to have a video conference between a north and south location. Details will be sent to the House of Delegates participants as soon as they are finalized.

This is probably my last *Journal* report and let me just say it has been an honor to serve as your Executive Director these last 14 years. I look forward to the next chapter in my life and more time with friends and family.

This is probably my last Journal report and let me just say it has been an honor to serve as your Executive Director these last 14 years. I look forward to the next chapter in my life and more time with friends and family.

Editor's Note

Dear Dr. Talley,
The *NDAJ* thanks you so much for your years of dedicated service and expertise as the Executive Director of the Nevada Dental Association.

President's Summer Message

Mark Funke, DDS

I hope this message finds you safe, healthy, and moving forward as you resume essential care to your patients. Due to the COVID-19 health crisis and the ever changing Federal and State restrictions, guidelines, etc.; there have been an overwhelming number of changes, whether it be the way we practice dentistry or how the NDA conducts meetings at the local, state and national levels. The NDA Executive Committee has changed to Zoom video conferencing. The American Dental Associations has cancelled the Dentists and Student Lobby day in Washington DC and the Western States Conference in Monterey, CA. The 14th District Caucus I in Salt Lake City, Utah; the President-Elect conference; the ADA Management conference and the ADA Management conference currently have all been changed to a Zoom conferencing format. The format for ADA Caucus II & III as well as the ADA Annual Meeting is currently being discussed.

Scheduled interviews with a number of lobby firms have been postponed due to travel requirements and social distancing. Although the NDA has postponed these interviews, there is still an immediate need for a lobbying firm. The NDA has hired the G3 Griffin Company Lobbying firm until the end of 2020. The Griffin Firm has offices in Reno and Las Vegas. The firm is communicating with Governor Sisolak as we continue to prepare for the 2020 legislative session regarding topics such as dentists administering immunizations, third party payors, SB366 (dental therapists), and more. Griffin will be one of several lobbyists we will still continue to vet for a more extensive contract starting January 1, 2021 and prior to the Nevada legislative session.

The NDA Summer meeting of the House of Delegates is generally a two-day meeting which has been changed to a one-day meeting to be held on Saturday, June 20, 2020. The strategic planning session of this meeting—with Brett Kessler (14th District Trustee) and Chris Chico (ADA Outreach Manager)—has been postponed until further notice. The intent is to have this meeting sometime in the fall. Of course, this will depend upon State restrictions and social distancing guidelines. Dr. Dwyte Brooks has been the NDA Treasurer for 14 years. He has provided a selfless commitment to the organization. His term as Treasurer ends at the Summer HOD meeting and the reigns will go to Dr. Perry Francis. Thank you, Dr. Brooks, for all your years of commitment, service, historical knowledge, and advice of fine Bourbon's.

For the past few years, Christine Chico was Nevada's Dental Society Outreach Manager. Mrs. Chico has taken on a new role as the director of client services overseeing all of the outreach managers. Our new outreach manager is Autumn Wolfer. She is also the outreach manager for CT, MA, ME, MI, MN, NH, PA, RI, VT, and WI. She has already proven to be wonderful to work with. The NDA looks forward to building a great relationship with Mrs. Wolfer.

The NDA is working with Dr. Antonina Capurro, Dr. Ihsan Azzam, and the Department of Health and Human services to amend a Nevada Administrative Code (NAC) 652.397 to include Dentists. It is already within the scope of dentistry to administer tests, such as a COVID-19 test; however, until dentists are listed in the NAC, we cannot administer the test. It is our hope that this will be rectified within the next few weeks. This would help with safety between patients, dentists, and staff; and it would help guide proper PPE use.

The NDA has also been working to get FEMA to remove their restrictions of PPE directed merely towards the medical community and open more distribution to the dental community. This is not as simple as one would think. This involves Federal and State bureaucratic red tape. It is

»

fortunate that COVID-19 infections are declining nationwide, and manufacturing companies are producing more supplies. However, it will still take some time for dental offices to obtain enough appropriate supplies for the long term.

The ADA tripartite is made up of three tiers. The first tier is the component level. In our state we have three components. Northern Nevada Dental Society (NNDS), the Northeast Dental Society (NENDS) and the Southern Nevada Dental Society (SNDS). The middle tier is at the State level which is referred to as a constituency and formally referred to as the Nevada Dental Association (NDA). The final tier is the American Dental Association.

The ADA is governed by a House of Delegates consisting of 483 Dentists nationwide, along with a Board of Trustees, elected officers, and necessary staff. The HOD consists of 17 separate districts which either represent single large states, or a conglomerate of smaller states. Nevada is part of the fourteenth district which is composed of 7 smaller states. The HOD reviews resolutions every year at the annual meeting to determine how business is to be conducted as well as establish rules on how to proceed with advocacy activities, education, third party payers, research, etc. Elections for ADA president and lesser officers are carried out at the annual HOD meeting as well.

All states are represented through the nomination of their own delegates. The number of delegates a state is allowed to have is dependent on the number of members in any particular state. Nevada has three delegates. Two of these positions have come up for re-nomination, one unopposed and another which is being challenged. Voting for these positions will be carried out at the NDA's annual summer meeting. These elections are crucial in order to bring forward those best qualified to represent Nevada at the national level.

The Nevada Dental Association has a number of councils: Membership; Ethics, Bylaws and Judicial Advisory (CEBJA); Dental Benefit program; Communication; Advocacy for Access and Prevention (CAAP) and Government Affairs (CGA). If you are interested in being involved with one of these committees; please contact the NDA office (775-255-4211). We encourage and welcome new member involvement.

After many, many years of devotion, commitment, guidance, historical knowledge, leadership, and friendship; our beloved Executive Director Dr. Bob Talley has chosen to retire. His last day in office was to be June 12, 2020; however, Dr. Talley has committed to continue as the Executive Director until the new executive director is chosen and installed. Bob, thank you for everything you have done and most of all—thank you for your friendship. We wish you and Becky a wonderful, happy, healthy, and lengthy retirement; go live life and create memories with each other. You will be greatly missed.

Event Calendars

Nevada Dental ASSOCIATION

2020			
June 18	Executive Committee	Zoom Conference	TBA
June 20	Annual Summer HOD Meeting	TBA	8am–3pm
July 6	Executive Committee	Zoom Conference	6pm
July 20–21	President Elect's Conference	Zoom Conference	TBA
July 20–24	ADA Management Conference NDA Excutive Director	Zoom Conference	TBA
July 23–24	ADA Management Conference NDA Membership Chair	Zoom Conference	TBA
July 30–Aug. 1	Western States Conference NDA Pres., NDA Pres. Elect, NDA Exec. Dir.	Monterey, CA	TBA
Aug. 3	Executive Committee	Zoom Conference	6pm
Aug. 27–29	ADA Caucus 1 (ADA Delegates, ADA Alternate Delegates, ADA Delegate at Large, NDA President)	Salt Lake City, UT	TBA
Sept. 14	Executive Committee	Zoom Conference	6pm

Southern Nevada DENTAL SOCIETY

2020			
Sept. 25	Community Night 2020	JW Marriott Las Vegas Resort & Spa	5:30pm–8:00pm

Northern Nevada DENTAL SOCIETY

2020			
July 14	NNDS Executive Committee Meeting	TBD - Webinar www.nvda.org	5:30pm
Aug. 11	NNDS Executive Committee Meeting	5605 Riggins Court, #101A, Reno	5:30pm
Aug. 27	NNDS Open House Picnic	Bartley Ranch Park, Reno	5:30pm
Sept. 8	NNDS Executive Committee Meeting	5605 Riggins Court, #101A, Reno	5:30pm
Sept. 25	NNDHP/Joel F. Glover 18th Annual Charity Golf Tournament	Red Hawk Country Club, Sparks	8:00am

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Monica Rexius
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SNDS Executive Director's Summer Message

I want to start off by saying that I hope you and your family is staying healthy physically and mentally. It is an incredibly stressful time, as we try to navigate this recent pandemic. I want to thank our leadership for stepping up during this crisis and getting resources and information out to our members. Now that offices are starting to open, we hope that the we can help you with the process by providing CE and other resources.

Due to COVID-19 we had to postpone our Member Appreciation Night until further notice, as well as cancel many events that we had planned in March and April. Moving forward, we will follow the CDC guidelines and governors' orders when planning events. We also are looking into producing more webinars that provide CE and will continue this indefinitely. Currently, there is Infection Control and Substance abuse CE available, on demand, online.

We are still working on a way to offer dental care in underserved areas. We will have a survey sent out to gauge interest in volunteering in Tonopah, NV. We also have plans to hold a SNDS Give Back to the Community day, and will be sending out a call for members to volunteer for a day to give free dental treatment, which we would like to hold at the end of the year.

Thank you to all who have renewed their memberships for 2020, especially those that are having financial difficulty during these times. Your support for organized dentistry at National, State, and Local levels is always appreciated. We are here to help you succeed, please do not hesitate to call if you have any suggestions. Also don't forget to reach out to your colleagues during this time. We are all going through a stressful time, and sometimes it is nice to hear from a friend. We are in this together and are stronger when we work together.

Your support for organized dentistry at National, State, and Local levels is always appreciated. We are here to help you succeed, please do not hesitate to call if you have any suggestions.

SNDS President's Summer Message

Robin Lobato, DMD

Greetings from the Southern Nevada Dental Society! As we all find ourselves trying to navigate through these uncharted times of the "COVID-19" pandemic era with new and improved OSHA guidelines and more strict CDC protocols we notice it has affected ALL of us. We begin to realize our sense of community, comradery, and kindness to our fellow dentists. Not just in our local area but also in other areas of the city, the state, and even our country. At a time like this it is easy to forget the trivial things that bothered us with our profession and focus on the good. I found myself reconnecting with my colleagues from dental school and during those Zoom meetings it was apparent that "they" too were struggling with the same issues I was. It was comforting to know this impact on my office was not isolated to me or my area of town I practice or what part of the state I lived or what part of the country or what part of the world. I felt this had bonded not only strangers but also our profession. It was kind of a reset button to allow more conversations, webinars, continuing education classes, or just a "Happy Hour" Zoom meeting with family and friends. Our NDA leadership did a great job trying to communicate everything they heard or recently learned to help us prepare for the "New Normal" we were about to embark upon. Our NDA President, Mark Funke, spent everyday on phone calls, webinars, Zoom meetings and devoted himself to the members to disseminate as much information he could to keep us updated and informed. I am happy to say that this unfortunate tragedy brought the dentists within our state closer together.

So as the saying goes "there is a silver lining." I think there were a lot of positives that came out of this pandemic. We are communicating more and better. Families were forced to shelter together and renew their relationships. They were playing games and talking and eating together. We reconnected with old colleagues and made new friendships. We were able to take a long look on how we did dentistry and how we want to do dentistry in the future. We reset the PPE protocols to ensure safety amongst our staff and patients. We were forced to reevaluate our lives, smell the roses, and renew our love and dedication to this great profession of dentistry. Although I am not comfortable with all the changes, I am excited about the changes and the good that has come out of this. Good luck to all of you and stay safe.

We were able to take a long look on how we did dentistry and how we want to do dentistry in the future. We reset the PPE protocols to ensure safety amongst our staff and patients.

Lori Benvin
nnds@nndental.org

News from the Northern Nevada Dental Society

In writing this editorial for the summer 2020 issue, I always like to look back at my prior year and season edition and what I wrote about at that time. In the summer 2019 article, I referenced one of most challenging years for dentists and the NDA legislatively. In comparison to 2020, I can say with confidence that 2020 has truly been, and continues to unfold, unparalleled for all of dentistry and our country as I have ever witnessed.

I was extremely grateful to the leaders of the NNDS that my office stayed open. I was able to assist the Nevada Dental Association leadership in bringing our dentists, members and non, some valuable information they needed along with resources at the ADA, to get us through the plandemic. With dental practices reopening in providing dental care more than emergencies services effective 5/4 I am hopeful all are now able to assist their patients and recover as businesses. We hope our weekly webinars helped and continue to assist you and we appreciate all of the ongoing feedback.

June 1 is a new society year, and as I am sorry to see a true leader end his term on the NNDS Executive Board, I am extremely grateful to have had the opportunity to work with him through his many roles in leadership. Thank you, Dr. Adam Welmerink, we hope you will come back into leadership for organized dentistry in some capacity in the future. I'd like to welcome Dr. Hannah Beus as our new Secretary/Treasurer, Dr. Ben Brooks now as Vice President, Dr. Craig Andresen as Immed. Past President, Dr. Erin Anderson as President, and Dr. Meagan Struby Member at Large, Dr. Benita Ng Brooks Member at Large and Dr. John McLennan as 3rd Member at Large and CE Chair to round out our 2020/21 NNDS Executive Board members. We have a team of young leaders on our Board and on our Executive Committees; thank you for your volunteerism, your dedication to this profession and to your peers.

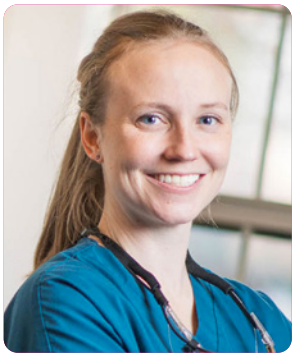
As we prepared our 2020/21 budget it was with hope. Hope to come together again possibly for our annual NNDS Open House picnic in late August and returning to our schedule of successful and informative general membership dinner meetings and continuing education opportunities beginning in October. See Page 25 for a list of our events or check our website at www.nndental.org for our Calendar.

Welcome Newest NNDS Members

Adam York, DMD – General (welcome back)

Caitlyn Menicucci, DMD – General

NNDS President's Spring Message



Erin Anderson, DMD

Over the past few weeks, I have had more time than I would like to reflect on what dentistry means and, as dentists, what is our role in our community. I am very fortunate to have been brought up by two dentists who emphasized the importance of doing good and helping those in need. For those of you who didn't know my mom, Dr. Lynn Brosy, she was a force in any room and taught me that being privileged comes with a large responsibility to help others. My father, Dr. Paul Brosy, has always believed if you can help than you must in any capacity worth serving. I've seen through their patients and their staff how they took their ideals and made sure the dentistry they provided was filled with compassion and care. They had an interesting teamwork and only worked part time so that each helped raise my sister and I. My mom wrote a letter to the editor in a 1992 *JADA* magazine and said "One can always practice dentistry—the opportunity to be there for your children is fleeting."

This quotation is always one I have admired. The decision to put your family first before a driven career path is not always easy. However, in the past eight weeks our careers were put on hold and we were not able to "always practice dentistry." Instead, like many of you, I spent more time with my children. I have two daughters, ages four and one, and they keep us very active. My husband has a much more time demanding job than dentistry, and I was given the opportunity to spend more time with my children. Don't let the sentiment fool you, while it has been extremely rewarding it has also been extremely hard. We weren't able to practice dentistry, yet our offices still needed to be managed. I would like to applaud both Dave White and Mark Funke who spent tireless hours helping provide resources and guidance during these difficult times. Through their help and the support from all three levels of the tripartite I am optimistic that we can as a profession rise out of quarantine as better dentists and better humans.

I anticipate that next year, as President of the Northern Nevada Dental Society, I will be faced with unique challenges. I am very fortunate for the leadership that has come before me; Craig Andresen has continued to move the NNDS forward with strength and integrity. I am also very fortunate for our upcoming board and committee chairs who have volunteered to serve: Ben Brooks, Hannah Beus, Benita Brooks, Meagan Struby, John McLennan, Troy Savant, Kellie McGinley, John Eric-Cercek, and Andrew Leland.

The NNDS board and all of us as members are extremely grateful for our incredible executive director, Lori Benvin. Without Lori, the NNDS would not be able to run seamlessly between changes in leadership. Her support and compassion for all of our members is unmatched and we cannot thank her enough.

As we move forward as a society, we must continue to ask ourselves what more can we be doing, but we must also realize when we need a break. To be able to ask for help is often harder than many things we do on a daily basis and I would like to extend to any member who is needing help my contact. My email is drerin@brosyfamilydentistry.com.

Thank you all for the opportunity to serve our members.

UNLV School of DENTAL MEDICINE

REPORT

FROM THE DEAN
Lily T. García, DDS, MS, FACP

Patience, perseverance, and resilience are traits that can be advantageous characteristics in managing the impact of events we cannot control, most especially experienced during the COVID-19 pandemic impact on Nevada. People are defined in times of crisis, and while this one is no different than responses during Hurricane Katrina, it is made even more difficult since recovery is ill-defined, and neither quick nor easy. Many faculty and staff at UNLV Dental Medicine have worked daily and continue their commitment to meet the mission of the School in support of the predoctoral education program, the General Practice Residency, Pediatric Dentistry and Orthodontics residencies. The disruptive impact on course work, teaching and learning, and the delivery of patient care will be referenced and re-examined in the coming months as we debrief and learn how to make us stronger and better. Our friends and colleagues can take pride in the remarkable outcomes in support of the Class of 2020, while balancing essential issues to ensure continuity of curriculum for all dental students and residents.

Some of the accomplishments that occurred over the two months from mid-March to mid-May included:

- Administration and faculty shifting all didactic courses from in-person instruction to remote instruction—both asynchronous and real-time—for the remainder of the spring 2020 semester.
- Designed and refined protocol to ensure appropriate social distancing for DS4 students to complete their competency assessments, among the many components required for curriculum completion prior to graduation.
- Established a means for DS4 students to complete their chart audits and confirm continuity of clinical patient care through approved student-to-student transfers.
- Implemented strict protocols to ensure appropriate social distancing for DS1 and DS2 students to complete their Clinical Simulation Lab courses for spring semester 2020.
- Developed an innovative summer semester beginning May 11, 2020, and allowed for remote didactic instruction during the first seven weeks while faculty continued to complete spring semester Clinical Simulation Lab courses. During the remainder of the summer semester, dental students will complete clinic and Clinical Simulation Lab curriculum components.
- Advanced education programs —GPR, Pediatric Dentistry, Orthodontics—provided emergency patient care throughout. Advanced education or resident clinics reopen May 18, 2020 for urgent care patient services. Program directors are developing protocol to reopen patient clinical services along with faculty developing the protocol for the predoctoral, dental student clinics with an initial target date of June 1, 2020.
- Devised a training program for all faculty, students, residents, and staff as a refresher practicum about the proper donning and doffing of PPE. Elevated from standard PPE to include face shields, surgical head coverings, and shoe coverings, which were added for use in aerosol generating procedures.
- Implemented engineering controls such as glass partitions and air purification machines to reduce aerosols in designated clinics, to complement personal protective equipment and elevate safety protocol for patients, students, staff and faculty.
- Providing emergency care to patients with persistent swelling, bleeding, or infection. Based on the date of submission of this message for publication, General Practice Residents and faculty screened more than 400 patients and provided treatment to more than 100, thus reducing the need for hospital emergency room visits.

As the relatively new dean for UNLV School of Dental Medicine, I expected to face multiple challenges, but would not have anticipated managing the impact on Nevada's academic dental institution from a global health crisis. These accomplishments along with many others serve as a testament to the caliber, resilience, innovation, and perseverance of the students, residents, staff, and faculty at UNLV Dental Medicine. I hope you will join me in congratulating this amazing group of people.

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