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8 **UNITED STATES DISTRICT COURT**
9 **NORTHERN DISTRICT OF CALIFORNIA**
10 **OAKLAND**

11 MARCIANO PLATA, et al.,

12 *Plaintiffs,*

13 v.

GAVIN NEWSOM., et al.,

14 *Defendants.*

Case No. C01-1351 JST

**DECLARATION OF ARTHUR
REINGOLD, M.D.**

15
16 I, Arthur Reingold, hereby declare:

17 1. I am the Division Head of Epidemiology and Biostatistics at the University of
18 California, Berkeley, School of Public Health. I have worked on the prevention and
19 control of infectious diseases in both the United States, including eight years at the US
20 Centers for Disease Control and Prevention ("CDC"), and with numerous developing
21 countries around the world for over forty years. Since its inception in 1994, I have
22 directed or co-directed the CDC-funded California Emerging Infections Program. I am a
23 member of the Society for Epidemiologic Research and the American Epidemiological
24

25 I

26 REINGOLD DECLARATION
CASE NO. C01-1351 JST

1 Society; an elected Fellow of the Infectious Disease Society of America and of the
2 American Association for the Advancement of Science; and an elected member of the
3 Institute of Medicine of the National Academy of Sciences. I was previously the
4 President of both the Society for Epidemiologic Research and the American
5 Epidemiological Society. I have served on the editorial boards of the journals: American
6 Journal of Epidemiology, Epidemiology, and Global Public Health.

7
8 2. I received my A.B. in biology from the University of Chicago in 1970, and my
9 M.D. from the University of Chicago in 1976. Among other things, I completed a
10 residency in internal medicine and a preventative medicine residency with the CDC.

11 3. My career in public health has been in the area of infectious diseases and
12 epidemiology. Following my positions at the CDC (1979–87), I joined the faculty of the
13 School of Public Health at Berkeley as a Professor of Epidemiology (1987–present), the
14 faculty of the Department of Epidemiology and Biostatistics at the University of
15 California, San Francisco (“UCSF”) (1989–present), and as a Clinical Professor in the
16 Department of Medicine at UCSF (1991–present). From 1990–94, I was the Head of the
17 Epidemiology Program, Department of Biomedical and Environmental Health Sciences,
18 University of California, Berkeley; from 1994–2000, I was the Head of the Division of
19 Public Health Biology and Epidemiology, University of California, Berkeley; from 2000–
20 18, I was the Head of the Division of Epidemiology, School of Public Health, University
21 of California, Berkeley; from 2018 continuing through the present, I am the Head of the
22 Division of Epidemiology and Biostatistics, School of Public Health University of
23 California, Berkeley.

1 4. My research focuses on emerging and re-emerging infections in the United
2 States and in developing countries; vaccine-preventable diseases in the United States and
3 in developing countries; and disease surveillance, outbreak detection, and outbreak
4 response.

5 5. Attached and incorporated by reference to this declaration is a copy of my
6 curriculum vitae. (Attached here as Attachment A).

7 6. I am currently collaborating on research concerning SARS-CoV-2 and its
8 incidence, and serving on SARS-CoV-2 advisory groups for multiple organizations,
9 including UC Berkeley, the University of California system, and the City and County of
10 San Francisco, among others.

11 7. SARS-CoV-2 is a novel coronavirus that causes Coronavirus Disease 2019
12 (COVID-19). SARS-CoV-2 is a respiratory virus, with patients typically presenting with
13 acute respiratory signs and symptoms, which can escalate in some patients to respiratory
14 failure and other serious, life-threatening complications. The most common symptoms
15 are fever, cough, and shortness of breath. Other identified symptoms include muscle
16 aches, headaches, chest pain, diarrhea, coughing up blood, sputum production, runny
17 nose, nausea, vomiting, sore throat, confusion, loss of senses of taste and smell, and
18 anorexia. Due to the respiratory impacts of the disease, individuals may need to be put on
19 oxygen, and in severe cases, patients may need to be intubated and put on a ventilator.
20 People of every age can and have contracted COVID-19, including severe cases, but
21 geriatric patients are at the greatest risk of severe cases, long-term impairment, and death.
22 Likewise, those with immunologic deficiencies and with other pre-existing conditions,
23
24

1 such as hypertension, certain heart conditions, lung diseases (e.g., asthma, COPD),
2 diabetes mellitus, obesity, and chronic kidney disease, are at high risk of a life-
3 threatening COVID-19 illness. Information available to date shows that, if infected with
4 the SARS-CoV-2 virus, racial and ethnic minority populations, especially African-
5 Americans, are at a substantially elevated risk of developing life-threatening COVID-19
6 illnesses and to die of COVID-19.

7
8 8. SARS-CoV-2 is readily spread through respiratory transmission. All people are
9 susceptible to and capable of getting COVID-19 because of the ease with which it
10 spreads. The virus is spread through droplet transmission; that is, when an infected
11 individual speaks, coughs, sneezes, and the like, they expel droplets which can transmit
12 the virus to others in their proximity. There also is growing evidence that the virus is
13 aerosolized, such that tiny droplets containing the virus remain in the air and can be
14 inhaled by others who come into contact with that air. The virus is also known to be
15 spread through the touching of contaminated surfaces, for example, when an infected
16 person touches a surface with a hand they have coughed into and then another person
17 touches that same surface before it has been disinfected and then touches their face. Each
18 infected individual is estimated to infect two to eight others. In addition, some people are
19 so-called "superspreaders," who cause widespread infections.

20
21 9. There is not yet an FDA-approved vaccine against SARS-CoV-2, which could
22 be used to immunize the population to the virus. As a result, the only ways to limit its
23 spread are self-isolation, social distancing, frequent handwashing, masks and disinfecting
24 surfaces. Self-isolation involves not physically interacting with those outside one's

1 household. Social or physical distancing is maintaining at least six feet of distance
2 between individuals. Both of these interventions are aimed at keeping infected
3 individuals far enough apart from other individuals so that they are less likely to pass the
4 virus along. Frequent handwashing and regular disinfecting of surfaces can curb the
5 spread via contaminated surfaces.

6
7 10. Transmission of SARS-CoV-2 can occur in any location where there is close
8 proximity (less than six feet) between individuals. And because transmission of the virus
9 can occur via environmental surfaces, there is also risk of spread of the virus at any
10 location where multiple individuals touch surfaces. Some individuals who are infected
11 with the virus do not have any symptoms but can transmit the virus and/or are infectious
12 before they develop any symptoms. This means that isolating only persons who are ill or
13 known to be infected will not stop the spread of infection. Rather, to prevent increasing
14 the scope of the outbreak of COVID-19, we must assume that anyone could be infected
15 with SARS-CoV-2 and infect another person.

16
17 11. Due to the lack of adequate testing, the time lag in getting results back from
18 laboratories, and the lengthy incubation time, we cannot yet definitely determine the full
19 effects of stay-at-home orders and social distancing. But social distancing has worked to
20 slow the spread of respiratory viruses. However, transmission of the virus will continue
21 through the population until the development and widespread use of a vaccine and/or
22 herd immunity.

23
24 12. It is unlikely that an FDA-approved vaccine will be available for at least 12 to
25 18 months, and indeed may take longer than that due to the number of steps in the

1 process of development, trial and error, scaling to clinical trials, assessing side effects,
2 and assessing efficacy across the population at large.

3 13. As SARS-CoV-2 is a new virus, also referred to as a novel virus, only those
4 who have been infected and who have recovered are possibly immune; there is not a pre-
5 existing population already immune to the virus. Anyone who has not yet been infected is
6 susceptible to infection. Also, due to the virus's novelty, we do not know whether any
7 immunity generated by previous infection lasts permanently, for a specified period, or
8 whether reinfection is possible. Only once serologic antibody testing is widely available
9 might we be able to determine who in the population is not susceptible to either infection
10 or transmission based on their immunity due to earlier infection.
11

12 14. At the request of the Prison Law Office I have reviewed Alison Hardy's May
13 7, 2020 letter to Mr. Kelso and Ms. Toche. In that letter Ms. Hardy requests that the
14 California Department of Corrections and Rehabilitation (CDCR) and the California
15 Correctional Health Care Services (CCHCS) identify people living in California's prisons
16 who are at high risk for injury or death from COVID-19; determine whether those at high
17 risk are particularly vulnerable to infection because they live in a dormitory or other
18 congregate living unit; and then move those individuals to housing that would better
19 protect them from SARS-CoV-2 infection.
20

21 15. I also have reviewed an email dated Friday May 15, 2020 from Samantha
22 Wolff, responding to Ms. Hardy's May 7 letter on behalf of CDCR and CCHCS. Ms.
23 Wolff's email makes three points in rejecting Ms. Hardy's proposal. First, she states that
24 CCHCS has already identified patients with at least one factor that puts them at high risk
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26

1 of severe COVID-19. Second, Ms Wolff appears to refer to general policies that classify
2 patients according to their medical risk for purposes of institution placement. Third, Ms.
3 Wolff states that “mass movements” of high risk individuals would be dangerous because
4 movement of these patients would increase the risk of spreading the virus at different
5 institutions. CDCR and CCHCS apparently agree that the risk of keeping high risk
6 individuals in institutions where the SARS-CoV-2 has spread “throughout the housing
7 units” is less than transferring these people to other institutions.
8

9 16. A review of the data from the CDCR COVID-19 tracking webpage clearly
10 shows that there have been SARS-CoV-2 infections of prison staff at multiple locations,
11 and infections/deaths among prisoners at several locations. Given that staff come from
12 the community, where SARS-CoV-2 is undoubtedly present, that is not surprising and
13 supports the importance of taking measures to minimize introduction of the virus into the
14 various prisons and to detect and control spread of the virus if it does manage to get into a
15 facility.

16 17. I also understand from reviewing CDCR’s COVID web page that CDCR has
17 implemented several measures to prevent and control the spread of and infection with
18 SARS-CoV-2. These include limiting the population of certain housing units, creating
19 space between beds in some dormitories, utilizing tents and gymnasiums for housing, and
20 providing staff and those confined with masks and cleaning material. While general
21 measures that keep people separated certainly are warranted under the current
22 circumstances, the data indicate that in some prisons such as the California Institution for
23 Men (CIM) and California State Prison at Lancaster (LAC) they have not been sufficient
24

1 to control the spread of the virus. To date, six people have died at CIM, and I have been
2 informed that at least four of them were at high risk and living in dormitories.

3 18. In my opinion, protecting high risk persons from contracting COVID-19 is a
4 fundamental and critical feature of any institution's plan for addressing the pandemic.
5 Just as there are special procedures for protecting people in nursing homes
6 (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>), high risk
7 individuals in prisons should receive special protection.
8

9 19. At this time it is clear that the risk of SARS-CoV-2 infection depends upon
10 the amount of the virus that gets into a person's system. That in turn is related to the
11 length of time that a person is exposed to virus particles and the amount of distance
12 maintained from other people who are infected. So, for example, crowded indoor rooms,
13 such as dormitories, with poor ventilation, are prime environments for the spread of
14 SARS-CoV-2 infection. Prolonged confinement in such spaces dramatically increases the
15 transmission of SARS-CoV-2 infection and it is particularly important that people at high
16 risk of serious injury from SARS-CoV-2 not be exposed to those environments. This is
17 especially true where the virus has spread throughout the housing units at a prison.
18

19 20. For these reasons, it is my opinion that prison cells rather than dormitories
20 should be used to house patients who are at medically high risk, even in prisons where
21 there is not yet an outbreak. In addition, in a prison such as CIM, where there is an
22 outbreak of SARS-CoV-2, patients at high risk (and who have not tested positive for
23 SARS-CoV-2) should be moved to another institution that has fewer or no known
24 infections. I understand that surveillance testing has not yet been done at all CDCR
25

1 prisons, but is supposed to take place in the near future. Such testing is critical to
2 understanding which prisons are safer from infection than others. In the meantime, to
3 avoid a substantial risk of serious harm CDCR should act on the best available
4 information and transfer high risk patients to prisons without COVID-19 outbreaks or
5 low known rates of infection. I understand from Ms. Wolff's letter that CDCR and
6 CCHCS are considering that as an option, and I urge them to pursue that approach at
7 CIM and other prisons with COVID-19 outbreaks.

8
9 21. The major reason Ms. Wolff gives for not transferring high risk patients to
10 more protected environments is the risk that SARS-CoV-2 will spread to other prisons. I
11 understand that CDCR and CCHCS have an extensive protocol for testing and isolating
12 people as they arrive from county jails or when they are transferred to a state hospital for
13 mental health treatment. For new arrivals, that protocol involves testing people upon
14 arrival, putting them in isolation for 14 days at the reception center, testing them again
15 before transfer to a general population prison, transferring them in less densely populated
16 buses, and then guaranteeing them for 14 days at the the destination institution before
17 they are released to the general population. That is an excellent process and I would
18 expect that process to effectively mitigate, if not eliminate, the risk of transmission of
19 SARS-CoV-2 to other institutions. There is no medical reason that the same process
20 cannot be used to safely transfer medically high risk patients to safer conditions—celled
21 housing—in other prisons or to safe locations outside of the prison system.

22
23 22. Ms. Wolff also seems to assume that this would require mass movement of
24 high risk patients. Although I understand that there are approximately 50,000 patients in

the prison system with a factor that makes them high risk of severe COVID-19, I do not believe that all of them necessarily are at the same level of risk. For example, patients who do not have immune deficiencies or those whose diabetes mellitus is well-controlled are probably at less risk. This will allow prison authorities to avoid a mass transfer by prioritizing patients whose conditions that put them at the greatest risk. Moreover, because many prisons have both dormitories and celled housing, presumably some "rehousing" will involve moving people from a dorm to celled housing at the same prison, avoiding the need for a transfer to a different prison.

23. Page 4 of the CDCR tracking [website](#) shows that while the COVID-19 curve for California and the United States is flattening, the curve for confirmed cases in prison is rising at a much higher rate:

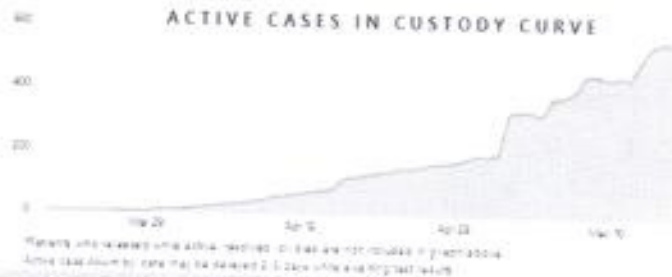
CDCR PATIENTS: COVID-19 TRENDS

[Click Here For Table View](#)

Week-to-Week Change in Confirmed Case Count

Week Of	# of New Confirmed Cases	% Change From Prior Week
May 10, 2020	180	2%
May 3, 2020	177	-10%
April 26, 2020	197	186%
April 19, 2020	69	6%
April 12, 2020	65	71%
April 5, 2020	38	100%

ACTIVE CASES IN CUSTODY CURVE



CONFIRMED CASES - COMPARISON



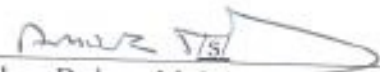
Data last updated May 11, 2020 11:45 AM

Therefore, in the near term I expect that there will be more COVID-19 outbreaks at other prisons. Under these critical circumstances, I strongly recommend that additional

1 precautions related to the housing of medically vulnerable patients be taken immediately.
2 If adequate space is not available in the state prison system, I recommend that state
3 officials explore other safe alternatives, especially for individuals who pose a low risk to
4 public safety.

5 24. I am also concerned with CDCR's decision to allow the density of the prisons
6 to increase rather than to continue efforts to reduce population density and thus to allow
7 for additional social distancing. In my opinion, CDCR should be continuing efforts to
8 reduce density even further in order to avoid further COVID-19 related injury and loss of
9 life.
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11 I declare under penalty of perjury that the foregoing is true and correct and that
12 this declaration was issued on May 21, 2020 at Berkeley, California.
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17 Arthur Reingold, M.D.
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November, 2019

CURRICULUM VITA

Arthur Lawrence Reingold

PRESENT POSITION: Professor of Epidemiology
Head, Division of Epidemiology and Biostatistics
School of Public Health
University of California, Berkeley
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Berkeley, California 94720-7360
Phone: (510) 642-0327
Fax: (510) 643-5056
E-mail: Reingold@berkeley.edu

DATE OF BIRTH: October 31, 1948

PLACE OF BIRTH: Chicago, Illinois

MARITAL STATUS: Married

EDUCATION: 1966 - 70 A.B. University of Chicago
1970 - 76 M.D. University of Chicago

POSTGRADUATE TRAINING: 1976 - 78 Internal Medicine Resident, Mount Auburn Hospital
Cambridge, Massachusetts
1980 - 82 Preventive Medicine Resident, Centers for Disease
Control (CDC) - Atlanta, Georgia

POSITIONS HELD: 1979 - 80 Epidemic Intelligence Service Officer,
State of Connecticut - Department of Health Services
Hartford, Connecticut
1980 - 81 Epidemic Intelligence Service Officer,
Special Pathogens Branch - Bacterial Diseases Division
Centers for Disease Control (CDC) - Atlanta, Georgia
1981 - 85 Assistant Chief, Respiratory & Special Pathogens
Epidemiology Branch, Center for Infectious Diseases
Centers for Disease Control (CDC) - Atlanta, Georgia
1985 - 87 CDC Liaison Officer, Office of the Director
Centers for Disease Control - Atlanta, Georgia

FACULTY APPOINTMENTS: 1979 - 80 Instructor, Department of Medicine (Epidemiology)
University of Connecticut - Hartford, Connecticut
1985 - 87 Visiting Lecturer, Department of Biomedical and
Environmental Health Sciences (Epidemiology)
University of California, Berkeley
1987 - Professor of Epidemiology, School of Public Health,
University of California, Berkeley
1989 - Professor, Department of Epidemiology and
Biostatistics - University of California, San Francisco

Arthur Lawrence Reingold

FACULTY APPOINTMENTS: (CONTINUED)	1990 - 94	Head, Epidemiology Program, Department of Biomedical and Environmental Health Sciences, University of California, Berkeley
	1991 -	Clinical Professor, Department of Medicine University of California, San Francisco
	1994 - 2000	Head, Division of Public Health Biology and Epidemiology University of California, Berkeley
	2000 - 2018	Head, Division of Epidemiology, School of Public Health, University of California, Berkeley
	2018 -	Head, Division of Epidemiology and Biostatistics, School of Public Health University of California, Berkeley
	2008 - 2014	Associate Dean for Research, School of Public Health, University of California, Berkeley
	2009 - 2014	Edward Penhoet Distinguished Chair for Global Health and Infectious Disease

MEDICAL LICENSURE: California

BOARD CERTIFICATION: 1980 American Board of Internal Medicine

AWARDS: 1970 - 74 Medical Scientist Training Program
1985 Commendation Medal, U.S. Public Health Service
1986 Charles Shepard Award, Centers for Disease Control (CDC)

MEMBERSHIPS: 1970 Sigma Xi
1978 American College of Physicians
1983 American Society for Microbiology
1984 Society for Epidemiologic Research
1986 Infectious Disease Society of America (Fellow)
1988 American Epidemiological Society
1991 American College of Epidemiology (Fellow)
1994 AAAS (Fellow)
2003 Institute of Medicine (Member)

PROFESSIONAL ACTIVITIES

CONSULTATIONS:	1981	Institute of Medicine: Toxic-shock syndrome
	1981	Food and Drug Administration: Toxic-shock syndrome
	1982	United States Agency for International Development: Control of meningococcal meningitis in West Africa
	1983	World Health Organization (WHO): Control of meningococcal meningitis in Nepal
	1983	East-West Center, University of Hawaii: Role of indoor air pollution in acute respiratory infections in developing countries
	1984	Institute of Medicine: Meningococcal vaccines

Arthur Lawrence Reingold

CONSULTATIONS: (CONTINUED)	1986	World Health Organization (WHO): Control of meningococcal meningitis in South Asia
	1987 - 1993	Center for Child Survival, University of Indonesia: Control of Acute Respiratory Infections
	1988	Evaluation of the Combating Communicable Childhood Disease Program, Ivory Coast
	1994	Evaluation of National Epidemiology Board Program, Rockefeller Foundation
	1995	Planning of a School-based Acute Rheumatic Fever Prevention Project - New Zealand Heart Foundation
	1995	Vaccines Advisory Committee, Food & Drug Administration Approval of acellular pertussis vaccine
	1996	External Reviewer, NIAID Group B Streptococcus Research Contract with Harvard University
	1996 - 2000	U.S. Food and Drug Administration; Consultant to the Vaccines Advisory Committee
	1996	World Health Organization, Consultation on Control of Meningococcal Meningitis in Africa
	1998 – 2002	Advisor to the INCLIN "Indiaclen" project
	2002 – 2003	Evaluation of a School-based Acute Rheumatic Fever Prevention Project – New Zealand Heart Association
ADVISORY BOARDS AND PANELS:	1988 - 1989	Member, Advisory Committee on Ground Water and Reproductive Outcomes, State of California Department of Health Services
	1989 - 1990	AIDS Advisory Committee, Alameda County Board of Supervisors
	1989 - 1993	Advisory Committee, Birth Defects Monitoring Program, State of California Department of Health Services
	1993 - 1995	Centers for Disease Control (CDC): Public Health Service Advisory Panel on the Case Definition for Lyme Disease
	1992 - 1994	World Health Organization (WHO): Task Force on Strengthening Epidemiologic Capacity; Childhood Vaccine Initiative
	1996 - 2000	Armed Forces Epidemiological Board
	1997 - 2012	University of California, San Francisco AIDS Research Institute Steering Committee
	1998 - 2003	Emerging Infections Committee of the Infectious Diseases Society of America
	1998 – 2000	Panelist, Howard Hughes Medical Institute Predoctoral Fellowship
	2001 - 2006	Technical expert, Sub-Committee on the Protection of Public Health; California State Strategic Committee on Terrorism

Arthur Lawrence Reingold

ADVISORY BOARDS PANELS (CONTINUED)	2003 - 2008	Advisory Board, Chinese University of Hong Kong – Centre for Emerging AND Infectious Diseases
	2004 -	Advisory Board, University of California, Berkeley Clinical Research Center
	2004 - 2008	Advisory Board, New York University School of Medicine Fellowship in Medicine and Public Health Research
	2004 - 2005	Institute of Medicine Committee on Measures to Enhance the Effectiveness of CDC Quarantine Station Plan for U.S. Ports of Entry
	2005 - 2012	Strategic Advisory Group of Experts (SAGE) for Vaccine Policy, World Health Organization (WHO) (Deputy Chairman, 2010-2012)
	2005 -	Data and Safety Monitoring Committee; F.I. Proctor Foundation, University of California, San Francisco (UCSF)
	2007 - 2012	NIH Fogarty International Center External Advisory Board
	2007 - 2009	Chair, Working Group on Pneumococcal Vaccine, Strategic Advisory Group of Experts (SAGE), World Health Organization (WHO)
	2008 - 2012	Working Group on H5N1 Influenza Vaccines, Strategic Advisory Group of Experts (SAGE), World Health Organization (WHO)
	2008 - 2011	Chair, Leptospirosis Burden Epidemiology Reference Group, World Health Organization (WHO)
	2008 - 2012	National Biosurveillance Advisory Subcommittee of the Advisory Committee to The Director, Centers for Disease Control and Prevention (CDC)
	2008 - 2009	Institute of Medicine Committee on the Review of Priorities in the National Vaccine Plan
	2009 - 2012	Chair, Working Group on Hepatitis A Vaccine, Strategic Advisory Group of Experts (SAGE), World Health Organization (WHO)
	2011 - 2013	Member, Institute of Medicine Committee on Vaccine Priorities
	2011 - 2014	Member, Working Group on Vaccine Hesitancy, Strategic Advisory Group of Experts (SAGE), World Health Organization (WHO)
	2012 - 2014	Chair, Review of the Heterologous Effects of Childhood Vaccines, World Health Organization (WHO)
	2012 - 2014	Chair, External Review of the Measles Rubella Initiative (of WHO, CDC, UNICEF, American Red Cross, and United Nations Foundation)
	2013 - 2018	Advisory Committee on Immunization Practices (ACIP), U.S. Department of Health and Human Services
	2016-2017	Member, Institute of Medicine Committee on a National Strategy for the Elimination of Hepatitis B and C
	2018 -	Member, Independent Review Committee, Global Alliance for Vaccines and Immunizations (GAVI)
	2018 -	Member, Strategic Advisory Group, Partnership for Influenza Vaccination Introduction

Arthur Lawrence Reingold

LEADERSHIP POSITIONS:

1997 - 2012	Secretary-Treasurer, American Epidemiological Society
2009 - 2010	President, Society for Epidemiologic Research
2015 – 2016	President, American Epidemiological Society (AES)

EDITORIAL BOARDS:

1995 - 2000	Board of Editors, American Journal of Epidemiology
2001 - 2005	Board of Editors, Epidemiology
2005 -	Editorial Advisory Board, Global Public Health
2009 - 2010	Editorial Advisory Board, American Journal of Epidemiology

ASSOCIATE EDITORSHIPS:

2017 -	Current Epidemiology Reports
2018 -	Vaccine

Arthur Lawrence Reingold

PUBLICATIONS:

1. Hayes RV, Pottenger LA, Reingold AL, Getz GS, Wissler RW. Degradation of I¹²⁵ - labeled serum low density lipoprotein in normal and estrogen-treated male rats. *Biochem Biophys Res Comm* 1971;44:1471-1477.
2. Reingold AL, Kane MA, Murphy BL, Checko P, Francis DP, Maynard JE. Transmission of hepatitis B by an oral surgeon. *J Infect Dis* 1982;145:262-268.
3. Reingold AL, Dan BB, Shands KN, Broome CV. Toxic-shock syndrome not associated with menstruation: a review of 54 cases. *Lancet* 1982;1:1-4.
4. Bartlett P, Reingold AL, Graham DR, et al. Toxic-shock syndrome associated with surgical wound infections. *JAMA* 1982;247:1448-1450.
5. Reingold AL, Hargrett NT, Shands KN, et al. Toxic-shock syndrome surveillance in the United States, 1980-1981. *Ann Intern Med* 1982;96:875-880.
6. Reingold AL, Hargrett NT, Dan BB, Shands KN, Strickland BY, Broome CV. Nonmenstrual toxic-shock syndrome: a review of 130 cases. *Ann Intern Med* 1982;96:871-874.
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9. Schlech WF III, Shands KN, Reingold AL, et al. Risk factors for development of toxic-shock syndrome: association with a tampon brand. *JAMA* 1982;248:835-839.
10. Reingold AL, Bank JD. Legionellosis. In: Easmon CSF, Jeljaszewicz J, eds. *Medical Microbiology*. London: Academic Press 1982 (I):217-239.
11. Reingold AL. Toxic-shock syndrome. In: Spittell JA Jr., ed. *Clinical Medicine*. Philadelphia: Harper & Row Publishers 1982 (II):1-6.
12. Kornblatt AN, Reingold AL. Legionellosis. In: Steele JH, Hillyer RV, Hopla CE, eds. *CRC Handbook Series in Zoonoses*. CRC Press 1982:313-324.
13. Wilkinson HW, Reingold AL, Brake JB, McGiboney DL, Gorman GW, Broome CV. Reactivity of serum from patients with suspected Legionellosis against 29 antigens of legionellaceae and *Legionella*-like organisms by indirect immunofluorescence assay. *J Infect Dis* 1983;147:23-31.
14. Meenhorst PL, Reingold AL, Gorman GW, et al. *Legionella pneumonia* in guinea pigs exposed to aerosols of concentrated potable water from a hospital with nosocomial Legionnaires' disease. *J Infect Dis* 1983;147:129-132.

Arthur Lawrence Reingold

15. Reingold AL. Nonmenstrual toxic-shock syndrome: the growing picture. JAMA 1983; 249:932 (editorial).
16. Reingold AL. Meningococcal meningitis. Nepal Paed Soc J 1983; 2:144-148.
17. Reingold AL, Broome CV, Phillips CJ, Meda H, Tiendrebeogo H, Yada A. Evidence of continuing protection against group A meningococcal disease one year after vaccination: a case-control approach. Med Trop 1983;43:225.
18. Reingold AL, Kane MA, Hightower AW. Disinfection procedures and infection control in the outpatient oral surgery practice. J Oral Maxillofac Surg 1984;42:568-572.
19. Broome CV, Reingold AL. Current issues in toxic-shock syndrome. In: Remington JS, Swartz MN, eds. Current clinical topics in infectious diseases. McGraw Hill 1984;65-85.
20. Herwaldt LA, Gorman GW, McGrath T, Toma S, Brake B, Hightower AW, Jones J, Reingold AL, et al. A new Legionella species, Legionella feeleeii species nova, causes Pontiac fever in an automobile plant. Ann Intern Med 1984;100:333-338.
21. Ajello GW, Feeley JC, Hayes PS, Reingold AL, Bolan G, et al. Trans-isolate medium: a new medium for primary culturing and transport of Neisseria meningitidis, Streptococcus pneumoniae, and Haemophilus influenzae. J Clin Microbial 1984;20:55-58.
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