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**UNITED STATES DISTRICT COURT**

**NORTHERN DISTRICT OF CALIFORNIA**

**OAKLAND**

MARCIANO PLATA, et al.,

*Plaintiffs*,

v.

GAVIN NEWSOM., et al.,

*Defendants*.

Case No. C01-1351 JST

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

I, Arthur Reingold, hereby declare:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

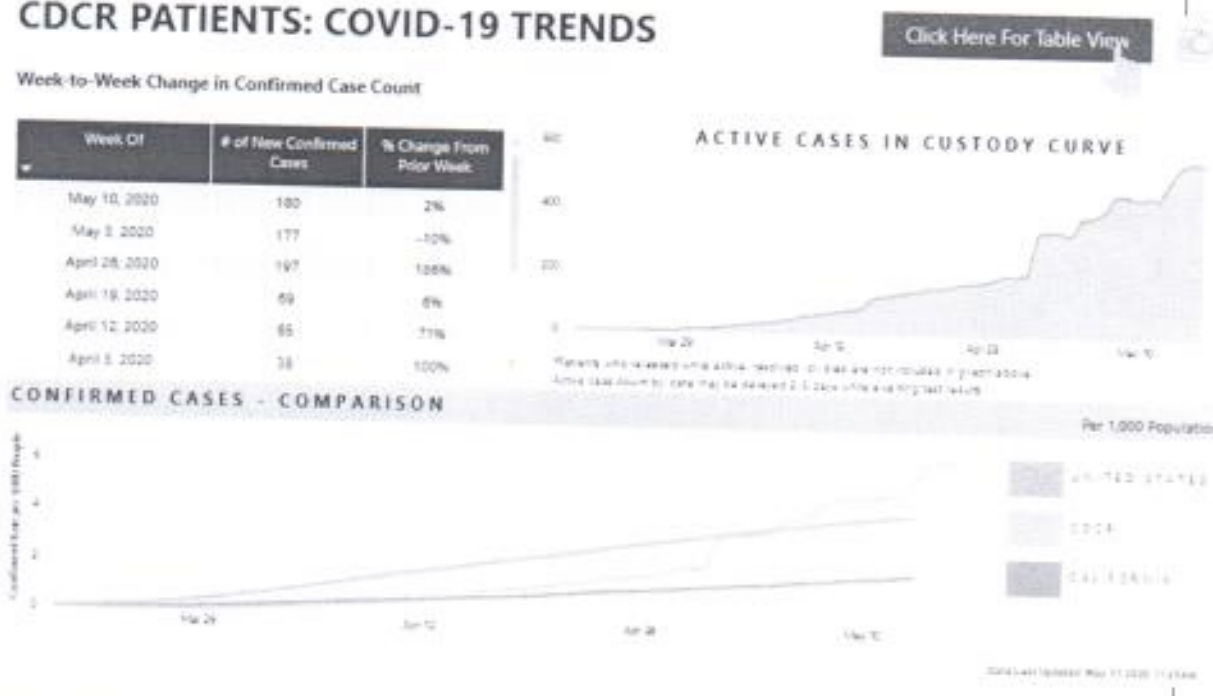
prisons, but is supposed to take place in the near future. Such testing is critical to understanding which prisons are safer from infection than others. In the meantime, to avoid a substantial risk of serious harm CDCR should act on the best available information and transfer high risk patients to prisons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

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

22. Ms. Wolff also seems to assume that this would require mass movement of 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:




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

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

24. I am also concerned with CDCR's decision to allow the density of the prisons to increase rather than to continue efforts to reduce population density and thus to allow for additional social distancing. In my opinion, CDCR should be continuing efforts to reduce density even further in order to avoid further COVID-19 related injury and loss of life.

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was issued on May 21, 2020 at Berkeley, California.

/s/
Arthur Reingold, M.D.

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**

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| **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 |

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| **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 accellular 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 INCLEN "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 |

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**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 $I^{125}$ - 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;6:871-874.

7. Broome CV, Hayes PS, Ajello GW, Feeley JC, Gibson RJ, Graves LM, Hancock GA, Anderson RJ, Highsmith AK, Mackel DC, Hargrett NT, Reingold AL. In-vitro studies of interactions between tampons and Staphylococcus aureus. Ann Intern Med 1982;96:959-962.

8. Guinan ME, Dan BB, Guidotti RJ, Reingold AL, et al. Vaginal colonization with Staphylococcus aureus in healthy women: a review of four studies. Ann Intern Med 1982;96(pt.2):944-947.

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.

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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 feeleii 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.

22. Hayes PS, Graves LM, Feeley JC, Hancock GA, Cohen ML, Reingold AL, et al. Production of toxic-shock-associated protein(s) in Staphylococcus aureus strains isolated from 1956 through 1982. J Clin Microbial 1984;20:42-46.

23. Reingold AL, Thomason BM, Brake BJ, Thacker L, Wilkinson HW, Kuritsky JN. Legionella pneumonia in the United States: the distribution of serogroups and species causing human illness. J Infect Dis 1984;149:819.

24. Blaser M, Reingold AL, Alsever RN, Hightower A. Primary meningococcal pericarditis: A disease of adults associated with serogroup C Neisseria meningitidis. Rev Infect Dis 1984;6:625-632.

25. Jones EE, Alford PL, Reingold AL, et al. Predisposition to invasive pneumococcal illness following parainfluenza type 3 virus infection in chimpanzees. JAVMA 1984;185:1351-1353.

26. Reingold AL, Thomason BM, Kuritsky J. Results of Legionnaires' disease direct fluorescent-antibody testing at Centers for Disease Control, 1980-1982. In: Thornsberry C, Balows A, Feeley JC, and Jakubowski J, eds. Legionella, ASM 1984;21-22.

27. Kuritsky JN, Reingold AL, Hightower AW, Broome CV. Sporadic Legionellosis in the United States, 1970 to 1982. In: Thornsberry C, Balows A, Feeley JC, and Jakubowski J, eds. Legionella, ASM 1984;243-245.

28. Fleming DW, Reingold AL. Legionella. In: Braude AI ed. Medical Microbiology and Infectious Diseases, Second Edition W.B. Saunders 1985;352-358.

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29. Garbe PL, Arko RJ, Reingold AL, et al. Staphylococcus aureus isolates from patients with non-menstrual Toxic Shock Syndrome: Evidence for Additional Toxins. JAMA 1985;253:2538-2542.

30. Garbe PL, Davis BJ, Weisfeld J, Markowitz L, Miner P, Garrity F, Barbaree JM, Reingold AL. Nosocomial Legionnaires' Disease: Epidemiologic Demonstration of Cooling Towers as a Source. JAMA 1985;254:521-524.

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