

U.S. DEPARTMENT OF LABOR
OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION
INFORMAL PUBLIC HEARING

Amending the Medical :
Evaluation Requirements in :
the Respiratory Protection :
Standard for Certain Types :
of Respirators :
:

Wednesday,
August 19, 2026

Videoconference

The above-entitled matter came on for
hearing, pursuant to notice, at 9:30 a.m. EDT

BEFORE: THE HONORABLE KEITH E. BELL,
Administrative Law Judge

DEPARTMENT OF LABOR PANEL MEMBERS:

ANDREW LEVINSON, MPH, Director, Directorate of
Standards and Guidance
JONATHAN BEARR, PhD, Health Scientist
TOM MOCKLER, Economist
MINDA NIEBLAS, MD, MPH, FACOEM, Director, Office
of Occupational Medicine and Nursing

DEPARTMENT OF LABOR OFFICE OF THE SOLICITOR:

JOSEPH BERNDT, ESQ.
TESSA ZAVISLAN, ESQ

ALSO PRESENT:

ALEX DUNCAN, Department of Labor
GRACE BURKE, Eastern Research Group
KATIE HARRISON, Eastern Research Group
STEPHEN SCHAYER, Department of Labor
JESSICA STONE, Department of Labor
RYAN TREMAIN, Department of Labor

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P-R-O-C-E-E-D-I-N-G-S

9:25 a.m.

JUDGE BELL: Thank you very much.

Let's go on the record, please. And, good morning to all of you.

The hearing will now come to order.

This is an informal public hearing on the Occupational Safety and Health Administration's proposed rule on amending the medical evaluation requirements in the respiratory protection standard for certain types of respirators.

The notice of proposed rulemaking was published in the Federal Register on July 1, 2025, in volume 90 of the Federal Register, beginning at page 28,463.

I'm Judge Bell, an Administrative Law Judge for the U.S. Department of Labor, and I'll be presiding over the hearing today. The purpose of the hearing is to receive, from interested parties, oral testimony as well as other information pertinent to the proposed rule.

1 After this hearing and post-hearing
2 comment period have closed, OSHA will review the
3 entire record in determining the content of the
4 final rule.

5 My rule as Presiding Judge today will
6 be limited to conducting this hearing to ensure
7 that a complete and accurate record is made,
8 that all interested parties receive a fair
9 hearing and have an opportunity to submit their
10 information.

11 The hearing schedule and OSHA's
12 procedures governing this hearing are available
13 on the Deregulatory Rulemaking page of OSHA's
14 website. These documents were sent to people
15 and organizations who filed a timely notice of
16 intention to appear at this hearing.

17 A few words here about the nature of
18 the hearing. Despite the informal nature of the
19 hearing, it is governed by rules, both OSHA's
20 rules governing hearings, which can be found at
21 29 CFR Part 1911, and the hearing procedures
22 which were issued that are specific to this

1 rulemaking.

2 These rules are meant to assure that
3 everyone has a fair opportunity to speak and
4 express an opinion about the proposed rule. To
5 that end, they will also allow me to hold
6 witnesses to their allotted times and limit
7 undue repetition or excessive argument, and
8 generally keep the hearing on schedule.

9 Any written comments you have submitted
10 to the docket are already part of the record of
11 this rulemaking. In the rare case where
12 witnesses wish to provide any other documents
13 that have not already been entered into the
14 docket, they should provide them by email to
15 oshaevents_dsg@dol.gov before the witnesses
16 begin their testimony, so that they can be put
17 in designated exhibit files in the record.

18 Because all pre-submitted documents
19 have already been made a part of the record,
20 your oral testimony should concentrate on
21 presenting the highlights of your written
22 comments and clarifying or expanding your

1 written submissions.

2 Hearing participants may also submit
3 additional evidence or statements for a period
4 following the end of the hearing and will have
5 an additional period of time after that to
6 submit any briefs based on the record as a
7 whole.

8 I will set deadlines for these periods
9 at the end of the hearing. At that point, the
10 record for the hearing will close.

11 Today, after each speaker or panel of
12 speakers completes giving oral testimony, OSHA
13 representatives will have the opportunity to ask
14 questions of the speaker or a panel.

15 When the OSHA folks have finished
16 asking their questions, there will be an
17 opportunity, as time permits, for persons who
18 filed a timely notice of intention to appear, to
19 question the witness or a panel.

20 Participants may only direct questions
21 to witnesses with whom they have no
22 organizational affiliation. This is intended to

1 prevent the use of the question period to extend
2 testimony.

3 This is the process I intend to follow.

4 After OSHA has finished asking questions of
5 witnesses or the panel, I will ask participants
6 who wish to ask questions of the witness or
7 panel to identify themselves by raising the
8 raise hand button in the Zoom or by pressing
9 star nine on their phones for those who have
10 called in.

11 Based on the hearing schedule and the
12 number of participants who wish to ask
13 questions, I will determine the order in which
14 participants will question the particular
15 witness or panel and any time restrictions that
16 will apply to that questioning.

17 If there are more questions than we
18 have time for during the scheduled period, it
19 may be possible to ask additional questions
20 after the conclusion of the final witness's
21 testimony today.

22 Further, if witnesses are unable to

1 answer a question during today's hearing or
2 would like to expand on the answers provided,
3 they're welcome to use the post-hearing comment
4 period to submit such information.

5 I'd like to remind you that this
6 proceeding is being recorded and transcribed by
7 a court reporter.

8 To ensure that the reporter is able to
9 provide an accurate record of all testimony,
10 questions, and responses, please try to remember
11 to provide verbal responses to all of your
12 questions. The court reporter will have a hard
13 time seeing you if you only nod or shake your
14 head in response to a question.

15 In addition, please remember to
16 identify yourself at the beginning of your
17 testimony and before asking or answering a
18 question. I know many participants are not
19 accustomed to doing these things, and I'll try
20 to help remind you as we go along.

21 The transcript of the hearing will be
22 uploaded on the hearing docket on

1 regulations.gov approximately two weeks after
2 the following of the hearing.

3 I'll now ask the OSHA panel to
4 introduce themselves.

5 MR. LEVINSON: Thank you, Your Honor.
6 Andrew Levinson for OSHA Directorate of
7 Standards and Guidance.

8 DR. BEARR: Dr. Jonathan Bearr for
9 OSHA's Directorate of Standards and Guidance.

10 DR. NIEBLAS: Dr. Minda Nieblas from
11 the Directorate of Technical Support and
12 Emergency Management.

13 JUDGE BELL: Okay. Thank you all.
14 Finally, I believe, Mr. Berndt from the
15 Solicitor's Office may have some Exhibits to
16 enter into the record before we get to our first
17 witness.

18 MR. BERNDT: Thank you, Your Honor. My
19 name is Joseph Berndt and I'm one of the
20 attorneys representing the Solicitor's Office
21 for this hearing.

22 And, my colleague, Tessa Zavislan will

1 also be representing the Solicitor's Office for
2 portions of this hearing.

3 The role of the Solicitor's Office in
4 this hearing is to facilitate a complete,
5 accurate, and clear record upon which OSHA can
6 base its final rule.

7 We will do this through asking
8 questions, eliciting information on various
9 issues, and helping to resolve any procedural
10 matters that may arise.

11 I would like to designate as Exhibit 1,
12 the Master Index of the complete record of this
13 rulemaking as of today's date for the hearing
14 record.

15 This is not a copy of all documents
16 that have been submitted to the docket. Rather,
17 it is a list of all documents that are part of
18 the public docket of this rulemaking, Docket
19 Number OSHA 2025-0006.

20 All of the documents listed here are
21 available for inspection and, as permissible,
22 copying at the OSHA docket office. In addition,

1 all of the documents are listed in the Docket
2 Index for this rulemaking at
3 www.regulations.gov, the federal eRulemaking
4 portal.

5 JUDGE BELL: Thank you, Mr. Berndt.
6 The Master Index will be designated as Exhibit
7 1.

8 (Whereupon, the above-referred
9 to document was marked as Exhibit No. 1 for
10 identification.)

11 MR. BERNDT: Thank you, Your Honor. I
12 also have a few other Exhibit related requests.

13 First, I would like to reserve Exhibit Number 2
14 for a complete list of Hearing Exhibits, which
15 we will prepare after the close of the hearing.

16 Second, I would like to designate
17 copies of two other Exhibits for the record.
18 The hearing procedures are designated as Exhibit
19 Number 3, and a copy of the hearing schedule is
20 designated as Exhibit Number 4.

21 JUDGE BELL: Those requests will be
22 granted. I'll reserve Exhibit Number 2 for the

1 complete list of Hearing Exhibits as requested.

2 (Whereupon, the above-referred
3 to document was marked as Exhibit No. 2 for
4 identification.)

5 JUDGE BELL: The hearing procedures
6 will be designated as Exhibit Number 3.

7 (Whereupon, the above-referred
8 to document was marked as Exhibit No. 3 for
9 identification.)

10 JUDGE BELL: And, the schedule will be
11 designated as Exhibit Number 4 for the hearing
12 record.

13 (Whereupon, the above-referred
14 to document was marked as Exhibit No. 4 for
15 identification.)

16 MR. BERNDT: Thank you, Your Honor.
17 That's all from me.

18 JUDGE BELL: All right. So, now,
19 unless there are other further announcements or
20 other housekeeping matters, I believe we are
21 ready to proceed with the public testimony.

22 The expected speaking order is going to

1 be displayed on the screen momentarily. Our
2 contractor will introduce each speaker in turn
3 and promote them to be panelists.

4 When you are called on to testify,
5 please state your name and affiliation for the
6 record. Speak slowly and clearly so that our
7 court reporter can record these processes
8 accurately. Thank you all.

9 MS. HARRISON: All right. Thank you,
10 Judge Bell. Rebecca Reindel, I have promoted
11 you to panelists. If you would like to unmute
12 and turn your webcam on to provide your
13 testimony whenever you're ready.

14 MS. REINDEL: Thank you so much. Good
15 morning, I'm Rebecca Reindel. I'm the AFL-CIO
16 Safety and Health Director, and I'll be speaking
17 today as the Federation of 65 National Unions,
18 representing 15 million workers across many
19 different industries where workers use
20 respirators.

21 Some of our unions from specific
22 industries will be testifying today and others

1 have submitted written comments to the record.
2 The AFL-CIO has written comments in this record
3 as well.

4 I'm going to speak on four main points
5 today. And, I just want to make sure that I'm
6 setting a timer so that I can keep track here.

7 The first is that respirators are a
8 very important line of defense for workers. We
9 go into this in greater detail in our written
10 comments, but they're critical in combination
11 with other measures within the framework of the
12 hierarchy of controls.

13 So, they're the last line of defense
14 under the hierarchy. And, because of that, we'd
15 want to make sure that the implementation of
16 ensuring effective fit and filtration is as
17 strong as possible.

18 But, in ensuring proper fit, we don't
19 want to put anyone at further risk of health
20 complications. And, we wouldn't want discomfort
21 or medical issues to lead to respirators not
22 being worn properly, decreasing their

1 effectiveness, and increasing exposures to
2 hazardous substances.

3 So, a comprehensive risk, I'm sorry, a
4 comprehensive respiratory protection program is
5 necessary and the enforcement of it has saved
6 lives.

7 Since OSHA sets the floor or minimum of
8 what's expected of employers, we believe that
9 finalizing this proposal would lower the level
10 of protection currently provided to workers and
11 encourage a downward drive in complying with the
12 respiratory protection standard overall.

13 My second point is that there are sound
14 reasons for the need for medical evaluations,
15 even for FFRs and for loose-fitting PAPRs, which
16 is what the proposals target.

17 Medical evaluations for using
18 respirators ensure a worker can perform their
19 duties safely without endangering their health.

20 And, to prevent respirators from being worn
21 properly, improperly if they are bothering
22 workers, as I mentioned before.

1 In the current standard, there's an
2 explicit need for medical evaluations to be
3 performed prior to any respirator use, including
4 fit tests for those two reasons. And, if a fit
5 test fails, workers may need to be reevaluated
6 medically before being fit tested again.

7 These initial medical evaluations also
8 serve as an important baseline for when workers
9 need to be evaluated in the future. Under the
10 current standard, employers must provide the
11 healthcare professional with the conditions the
12 workers will have to wear respirators in.

13 And, the employer is not medically
14 trained or licensed to make these determinations
15 on their own and that would put workers and
16 themselves at risk to do so. This is as
17 important for loose-fitting PAPRs and FFRs as it
18 is for other types of respirators.

19 The 1998 standard and its preamble is
20 instructive here. There is not only strong
21 justification for requiring medical evaluations,
22 stronger than anything presented in the 2025

1 proposal.

2 For good reason, the standard also does
3 not automatically allow the use of an FFR or
4 PAPR if other types of respirators don't work,
5 but it still requires that workers and their
6 working conditions are evaluated to ensure it is
7 safe to wear them.

8 But, medical evaluations are not only
9 used to decide if a worker can wear a respirator
10 at all. They are also used to determine
11 accommodations and respirator type and
12 accommodations in use conditions when wearing
13 respirators.

14 Some examples of the need for a change
15 in use condition while wearing an FFR or a PAPR
16 may include reduced work intensity, like light
17 labor versus heavy labor, temperature
18 restrictions, certain medications like blood
19 pressure medications can have an effect,
20 duration if a worker is recovering from a recent
21 cardiovascular event.

22 And, some examples of the need for a

1 change in respirator type away from FFRs or
2 loose-fitting PAPRs may include workers with
3 preexisting neck or spinal injuries who may be
4 restricted from wearing heavy or full face
5 respirators, if workers can't have any exposure
6 to certain chemicals due to severe allergies or
7 immune deficiencies, and if workers have hearing
8 impairment, if workers have claustrophobia,
9 there are many other examples as well.

10 My third point is that OSHA's
11 justification for this proposal still remains
12 unclear.

13 OSHA's current proposal and its
14 reasoning makes some assumptions or seems to be
15 leaning into these assumptions. And, permitting
16 changes to the respiratory protection standard
17 based on them would really be erroneous and
18 harmful.

19 The first is that it assumes workers
20 will know a respirator isn't working medically
21 for them or isn't working at all for them.
22 People often do not have a comprehensive

1 understanding of their own health and history,
2 and symptoms do not always appear when something
3 like this is happening.

4 The proposal also seems to assume that
5 workers will be able to raise concerns with
6 management if a particular respirator isn't
7 working for them under certain conditions. Many
8 workers simply just don't have the power to do
9 this.

10 And, medical evaluations often serve as
11 the only avenue for workers to raise respirator
12 concerns in a nonthreatening environment and to
13 a third party professional, a healthcare
14 professional.

15 The proposal also seems to assume that
16 workers take enough breaks and they take them as
17 planned and as the employer says happens. This
18 is simply just not the reality.

19 We can think about healthcare, but this
20 is also other industries too where there's
21 mandatory overtime and other conditions that
22 lead workers to not be able to take breaks away

1 from their respirator.

2 The proposal also seems to assume that
3 it is safe to take off PAPRs and FFRs briefly in
4 these working conditions, because they're not
5 used in immediately dangerous to life and health
6 atmospheres.

7 We don't believe this to be true
8 either. And, I believe other unions will
9 testify to this. For all of these, the COVID
10 pandemic didn't necessarily create these
11 conditions, it brought them to light.

12 And, another assumption is that FFRs
13 and PAPRs don't present issues for those who
14 wear them. The COVID pandemic was a free for
15 all and we would be in terrible shape if that's
16 really the goalpost that we're aiming for.

17 Assumptions about medical evaluations
18 that they are onerous and costly, are also in
19 the proposal. In the 1998 standard, OSHA
20 specifically chose the regulatory option of
21 reliance on a medical questionnaire as the
22 minimum standard for medical evaluation with a

1 hands-on medical evaluation follow up if there
2 were positive responses that are given to
3 selected questions on the questionnaire.

4 The Agency specifically justified them
5 not requiring full medical examinations for
6 every single worker. And, that was based on the
7 record that it collected this information.

8 The evidence provided by OSHA in that
9 final rule only support that respiratory
10 protection standard is cost efficient approach
11 as a minimum level of protection. In other
12 words, that a company could eliminate
13 unnecessary exams for say 98 percent of its
14 workforce if only 2 percent required medical
15 examinations based on answers to its
16 questionnaire.

17 Other ways the 1998 standard was
18 specifically designed to accommodate employer
19 flexibility and compliance and reduce cost,
20 include allowing the medical evaluations to be
21 conducted either by a physician or another
22 licensed healthcare professional, giving a lot

1 of discretion to the type of information the
2 healthcare professional feels they need to
3 obtain to be useful at arriving at a final
4 medical recommendation and not limiting them
5 only to the questionnaire, making the frequency
6 of medical evaluations after the initial
7 assessment event-related instead of time-
8 related, when a condition indicates a need for a
9 reevaluation, reducing paperwork requirements
10 with medical evaluations and flexible
11 requirements related to other areas of the
12 standard.

13 This new proposal now seems to be an
14 unnecessary exercise given what's already been
15 done and been in place for so many decades.

16 Fourth and lastly, my point is that
17 evidence in the record lead us to a different
18 conclusion than what OSHA's proposal does.
19 There simply isn't good data to change the
20 trajectory of OSHA's medical evaluation
21 requirements when workers need to wear
22 respirators.

1 The 1998 standard relied on a wide
2 variety of strong evidence and developed a sound
3 record. The 2025 proposal is arbitrary and the
4 record only seems to support keeping medical
5 evaluations for all respirators for the precise
6 purpose that they provide.

7 Evidence cited by OSHA in its proposal
8 provides recommendations that medical
9 evaluations be more comprehensive and that
10 OSHA's requirements be followed more
11 consistently. The evidence shows that a good
12 medical evaluation program catches exactly who
13 the standard was designed to, those with
14 preexisting conditions that affect respirator
15 use and detecting medical issues that put
16 workers at risk.

17 As justification in its new proposal,
18 OSHA cites that only a small number of workers
19 have needed medical evaluations resulting in
20 limitations on respirator use. But, in 1998,
21 OSHA expected just this.

22 Its preamble in its 1998 standards

1 stated that OSHA expects that the number of
2 cases where PLHCPs, physician or other licensed
3 healthcare professionals, would have to provide
4 follow-up examinations will be small, because it
5 is generally possible to recommend against
6 respirator use or determine the limitations to
7 place on an employee's use of respirators and in
8 the basis of responses to the medical
9 questionnaire.

10 However, where difficult medical issues
11 are involved, such as the need to make a
12 differential diagnosis or to assess an
13 employee's ability to handle the physical stress
14 imposed by an extra hazardous job, a medical
15 examination and involvement of a physician may
16 be needed.

17 So, it cannot be costly for employers
18 to have licensed medical professionals
19 administer a simple questionnaire and conduct
20 medical examinations for such a small number of
21 workers who really need them.

22 But, the lack of medical evaluations

1 don't just put workers at risk, it would put
2 companies and manufacturers of respirators at
3 risk for when something goes wrong. For these
4 reasons, we urge OSHA not to move forward with
5 finalizing this rule.

6 The potential inefficiencies have
7 already been addressed, and the Agency should
8 focus on enforcing the 1998 respirator standard
9 and educating employers on its requirements.

10 Thank you.

11 JUDGE BELL: Thank you very much. Are
12 there questions for this witness from the OSHA
13 people?

14 MR. LEVINSON: Your Honor, we had
15 planned to ask questions after the full AFL-CIO
16 panel presented.

17 JUDGE BELL: That's fine.

18 MS. REINDEL: I'm the only one
19 presenting today.

20 MR. LEVINSON: Oh, I'm sorry. We had
21 other names on there, Rebecca.

22 MS. REINDEL: Yep. I emailed the other

1 night, but I know things weren't fluid.

2 MR. LEVINSON: Got it.

3 MS. REINDEL: No problem.

4 MR. LEVINSON: Didn't make the meeting.

5 Your Honor, yes, OSHA does have questions.

6 The first question for Ms. Reindel
7 comes from Dr. Jonathan Berr.

8 DR. BEARR: Thank you, Andy. Ms.
9 Reindel, are you aware of any studies or reports
10 published that consider how often screening
11 identifies workers with underlying conditions?

12 How often these identified workers
13 require use limitations for FFRs and loose-
14 fitting PAPRs? And, how often workers who
15 somehow were not identified as needing a medical
16 evaluation wound up having an adverse health
17 outcome from wearing these respirators?

18 MS. REINDEL: Sure. There are
19 certainly, whether or not large epidemiological
20 studies, there are certainly smaller studies
21 that have been done during COVID. And, we'd be
22 happy to follow up with that in the post-hearing

1 record.

2 DR. BEARR: Thank you. And, I have one
3 more question. In your testimony, you mentioned
4 how with FFRs and loose-fitting PAPRs that even
5 a short-term removal of these respirators would
6 place the workers at harm.

7 Could you run through an example or two
8 of what type of exposure a worker would receive
9 an adverse health outcome from?

10 MS. REINDEL: Sure. I think something
11 that immediately comes to mind are infectious
12 diseases. This is a big one.

13 You know, the outcome of workers
14 getting sick from infectious diseases is
15 largely, is dose dependent and is exposure
16 dependent. And, I think we noticed this during
17 COVID, not only, but this happens with others as
18 well, not typically considered under the IDLH
19 scenarios.

20 DR. BEARR: Thank you.

21 MR. LEVINSON: Your Honor, the next
22 questions for this witness come from Dr. Minda

1 Nieblas.

2 DR. NIEBLAS: Thank you. And, thank
3 you so much for your testimony, Ms. Reindel.

4 Would your concerns about removing the
5 initial medical evaluation requirements for FFRs
6 and for loose-fitting PAPRs be addressed if
7 employers were required to discontinue
8 respirator use and provide medical examinations
9 under certain circumstances, especially
10 circumstances like you mentioned, that the
11 employee is concerned they may have symptoms, or
12 is concerned something is medically interfering
13 with their ability to safely use the respirator?

14 MS. REINDEL: Sure. We don't think
15 that would be adequate, because workers really
16 aren't given the opportunity to raise those
17 concerns.

18 We also don't believe that that would
19 be any easier for OSHA to enforce. We think
20 that would make those kinds of exceptions much
21 more difficult to enforce than say a higher
22 standard or the existing standard.

1 I believe also, and I'm looking at my
2 paper, because the 1998 preamble actually, I
3 believe, I know it cites, I cannot find it in
4 front of me at the moment. But, it came to the
5 conclusion, based on the record, where many
6 alternatives were proposed and commenters
7 suggested certain exceptions.

8 Largely, the commenters rejected the
9 effectiveness of those exceptions. But, the
10 commenters and OSHA also rejected them based on
11 the fact that it would be administratively very
12 difficult for the Agency to enforce those kinds
13 of exceptions.

14 DR. NIEBLAS: Thank you. In the
15 written comments on the proposed changes, it was
16 stated that these changes would shift the burden
17 of proof onto the worker for basically proving
18 that the respirator harmed their health.

19 Could you elaborate a little bit more
20 on a scenario that you know of or where that
21 would occur?

22 MS. REINDEL: Sure. We can work on

1 actually spelling this out in the post-hearing
2 comments.

3 But, workers really, often what we see
4 is that workers are retaliated against for
5 raising concerns around whether it's respirator
6 use, or other measures of control in the
7 workplace, if they think they need to happen
8 differently. And, these are usually related to
9 productivity quotas and work organizational
10 issues.

11 And so, one is, there's not always,
12 there's often not an opportunity to do that.
13 Two, when workers do it, they're really putting
14 themselves at risk of, you know, retaliatory
15 measures that we see often.

16 So, having a blanket requirement
17 actually removes a lot of that variability and
18 uncertainty. And, also removes, it provides a
19 baseline for workers to be asked those questions
20 and probed about those questions instead of
21 relying on them to have to come forward.

22 DR. NIEBLAS: Thank you.

1 MS. REINDEL: Sure.

2 DR. NIEBLAS: No further questions.

3 MR. LEVINSON: And, Your Honor, the
4 last questions for this witness come from Tom
5 Mockler.

6 MR. MOCKLER: Hi, this is Tom Mockler,
7 OSHA's Office of Regulatory Analysis. In your
8 written comments, you stated OSHA's economic
9 analysis only considers cost savings to
10 employers, not a wide range of costs to
11 employers or cost to workers that should have
12 been included.

13 Now and in post-hearing comments,
14 please elaborate on the sometimes hidden costs
15 to employers and workers when medical screenings
16 are no longer central to the fit testing
17 protocol of certain respirators.

18 MS. REINDEL: Sure. We'd be happy to
19 follow up on that in post-hearing.

20 MR. MOCKLER: Okay, great. Thanks.

21 MS. REINDEL: Sure.

22 MR. LEVINSON: Your Honor, that

1 concludes OSHA's questions for this witness.

2 JUDGE BELL: Thank you. Are there
3 questions from the Solicitor's Office?

4 MR. BERNDT: Yes, Your Honor, one
5 question. This is Joseph Berndt from the Office
6 of the Solicitor.

7 Ms. Reindel, you stated that employees
8 may not be aware of their own symptoms or
9 problems associated with wearing a respirator.
10 Can you explain that more or provide examples?

11 And, do you have information about how
12 often this occurs?

13 MS. REINDEL: Sure. I think, you know,
14 if we go back to the assumptions, my piece on
15 assumptions here, it's that they really think
16 that we're dealing with all of a healthy
17 population, which we know that workers are made
18 up of the other population where not everybody
19 has the same, people have different conditions.

20 I think, you know, we'll be happy to
21 follow up on this too, as with all other
22 comments. But, there can be a couple scenarios

1 here.

2 One is workers may not understand that
3 they have certain breathing resistance factors
4 or that certain medications will lead to
5 different symptoms if they're in certain types
6 of respirators.

7 And then, also sometimes if they've had
8 recent surgeries, they don't understand that the
9 effect of it's not just a breathing situation
10 with respirators, it can also be a weight of a
11 respirator or the physical fit of one,
12 especially if they're larger respirators.

13 We've also seen studies and documented
14 evidence that many workers don't realize that
15 they're claustrophobic until they go through the
16 fit testing, the medical evaluations and the fit
17 testing process and have to be re-medically
18 evaluated for different kinds of respirators or
19 different working conditions based on, you know,
20 dizziness or other things that they might feel
21 during that process.

22 And then, sometimes, and all of that is

1 to actually prevent this from happening on, you
2 know, for a broad term use, the shop floor.
3 That's not where you want to see these things
4 played out.

5 You want to get ahead of them, and
6 that's the reason that we believe, and we still
7 agree that the requirements need to be done up-
8 front and prior. You don't need workers on the
9 shop floor dealing with these scenarios or
10 whether they could be potentially putting
11 themselves at risk and other workers at risk as
12 well.

13 MR. BERNDT: Thank you for that. And,
14 you said you would follow up potentially in
15 post-hearing.

16 If you have any additional information,
17 kind of, specifically about how often these
18 kinds of things are happening, that would be
19 greatly appreciated.

20 MS. REINDEL: Sure.

21 MR. BERNDT: Nothing else from me, Your
22 Honor.

1 JUDGE BELL: Thank you. Any questions
2 for this witness from the public?

3 (No response.)

4 JUDGE BELL: I don't see any. Ma'am,
5 thanks very much for your testimony. We really
6 appreciate it.

7 MS. REINDEL: Thank you very much.

8 JUDGE BELL: Okay. All right. Do we
9 have the next panel ready?

10 MS. HARRISON: Yes. Travis Parsons,
11 Nate Schreiber, and Ryan Papariello, I have
12 promoted you to panelists.

13 If you would like to unmute and turn
14 your camera on to provide your testimony. And,
15 as a reminder, we do have a courtesy timer on
16 the bottom right-hand side of your screen.

17 MR. PARSONS: Can you hear me? It won't
18 let me do my video. I think you disabled it.

19 JUDGE BELL: Could you identify who,
20 was that Mr. Parsons?

21 MR. PARSONS: This is Travis Parsons,
22 yeah, sorry. Yeah.

1 JUDGE BELL: Okay.

2 MR. PARSONS: Oh, there it is. Okay.

3 JUDGE BELL: All right. There you go.

4 Thanks very much. Go ahead, please.

5 MR. PARSONS: All right. Let me get my
6 stuff in order here. All right. Thank you very
7 much for the opportunity to testify today.

8 And, my name is Travis Parsons. I will
9 state for the record also, we are affiliates of
10 the AFL-CIO who just testified and the North
11 America's Building Trades Unions, and we support
12 their comments as well, as help them build them.

13 So, we are an individual union where we
14 are landowners. So, good morning, and thank you
15 for the opportunity to testify today for OSHA's
16 proposal to amend the medical evaluation
17 requirements and the respiratory protection
18 standard.

19 My name is Travis Parsons and I serve
20 as the Director of Occupational Safety and
21 Health for the Laborers' Health and Safety Fund
22 of North America. Joining me today are my

1 colleagues, Industrial Hygienist, Nathan
2 Schreiber, and Safety and Health Specialist,
3 Ryan Papariello.

4 Together, we represent the Laborers'
5 Health and Safety Fund of North America, which
6 is dedicated to advancing safety, health, and
7 wellbeing of members of the Laborers'
8 International Union of North America, its
9 signatory contractors and affiliated
10 organizations.

11 LIUNA represents over 540,000 skilled
12 workers, hardworking members across North
13 America. Our members build and maintain the
14 vital infrastructure that powers our economy and
15 sustains our communities from roads, bridges,
16 and skyscrapers to renewables, oil, gas, and
17 nuclear energy facilities.

18 Beyond the construction environment,
19 our members also include approximately 70,000
20 employees that work in healthcare and deliver
21 essential public services every day, and 47,000
22 postal workers representing the National Postal

1 Mail Handlers Union.

2 Our members perform physically
3 demanding labor and potentially hazardous
4 environments every day, every hour. It is our
5 core responsibility to ensure that they possess
6 the necessary protective safety measures to
7 return home unharmed at the end of every shift.

8 All of these workers at some time in
9 their career and sometimes every minute of their
10 career, rely on crucial safeguards provided by
11 respiratory protection programs and qualified
12 medical professionals and personnel to safely
13 perform their jobs.

14 We are here today in opposition to
15 OSHA's proposed proposal to eliminate mandatory
16 medical evaluations for workers required to
17 utilize filter and facepiece respirators,
18 including N95s and loose-fitting PAPRs or
19 powered air purifying respirators. This
20 proposed regulatory rollback effort lacks
21 scientific justification, ignores established
22 physiological evidence, and compromises worker

1 safety and health.

2 While removing this requirement may
3 superficially appear to reduce administrative
4 burdens and lower operational costs, worker
5 health cannot be sacrificed by marginal
6 convenience. In occupational safety and health
7 practice, simpler is not always inherently safer
8 and cheaper is rarely better.

9 Next, I would like to discuss the
10 reality of a respirator use focusing on
11 filtering facepieces and specifically on N95s.
12 N95s are categorized as tight-fitting, negative
13 pressure respirators, and they are frequently
14 mischaracterized as purely light dust masks.

15 In reality, they are NIOSH-certified
16 protective devices that can impose a documented
17 physiological burden on the wearer or the
18 worker. And, this burden increases
19 significantly when workers operate under extreme
20 ambient heat, undergo prolonged exertion,
21 perform heavy manual labor, or possess
22 underlying health conditions, especially when

1 they're unidentified.

2 OSHA's existing respiratory protection
3 framework was designed around this reality.

4 Medical evaluations serve as a critical
5 diagnostic safety net, allowing qualified
6 healthcare professionals to identify preexisting
7 cardiovascular or respiratory conditions before
8 a worker is placed in a high risk environment
9 and even puts a respirator on.

10 Additionally, for many workers, this
11 evaluation represents one of their few formal
12 interactions with a medical professional.
13 Eliminating this opportunity removes a vital
14 preventative defense for workers and their
15 employers.

16 Rescinding this mandate does not
17 eliminate risk. It merely transfers it, it
18 transfers that risk by removing medical
19 professionals from the decision-making process.

20 The worker is forced themselves to
21 self-assess their own physiological fitness to
22 tolerate respirator stress under strenuous

1 conditions and working environments. The
2 employer is then exposed to heightened liability
3 and uncertainty regarding whether their
4 workforce can safely execute high exertion tasks
5 while masked up.

6 The healthcare system is stripped of
7 its ability to intervene before a preventable
8 medical event occurs in the field. This shift
9 is particularly dangerous in construction, where
10 workers regularly face compound hazards such as
11 silica, asbestos, and toxic volume fumes while
12 performing heavy lifting and manual labor and
13 fluctuating high heat environments.

14 The physical strain of wearing a
15 respirator cannot be evaluated in isolation from
16 these operational realities. Our position is
17 also shared by OSHA's own advisory committee on
18 construction, safety and health, ACCSH.

19 In a recent meeting, ACCSH formally
20 voted to recommend that OSHA abandon this
21 proposal and to remove these mandatory medical
22 evaluations.

1 This recommendation reflects the lived
2 realities of the job site and recognizes that
3 respiratory demands compound physical strain.
4 OSHA should honor the expert advice of its own
5 body, ACCSH.

6 A foundational principle of
7 occupational safety and health is proactive
8 prevention. We do not and should not require
9 workers to suffer injuries or cardiovascular
10 events before implementing protective standards.

11 We identify hazards, evaluate risk,
12 implement controls, and rely on medical
13 expertise to ensure workers can safely perform
14 their job duties.

15 Furthermore, OSHA's mission is not to
16 minimize the cost of protecting workers. Its
17 mission is to ensure America's workers have safe
18 and healthful working conditions free from all
19 unlawful retaliation.

20 Now, I'm going to turn it over to my
21 colleague, Nathan Schreiber, who is going to
22 speak from his firsthand experience and his

1 value of utilizing medical evaluations from his
2 time working in the field.

3 Go ahead, Nate.

4 MR. SCHREIBER: Good morning everyone.

5 Nate Schreiber with the Laborers' Health and
6 Safety Fund of North America.

7 As an Industrial Hygienist with a
8 decade of experience in administering
9 respiratory protection programs, I urge OSHA to
10 withdraw the proposed removal of medical
11 evaluation requirements for filtering facepieces
12 or FFRs and loose-fitting PAPRs.

13 While I appreciate the administration's
14 efforts to reduce administrative burden, this
15 proposal removes the only mechanism in which
16 employers can identify workers who suffer from
17 cardiovascular, pulmonary, or other medical
18 conditions that could make respirator usage
19 hazardous.

20 In the executive summary of the
21 proposed rule, OSHA cites a lack of documented
22 adverse outcomes from the COVID-19 pandemic when

1 millions of members of the public and healthcare
2 systems wore N95s for a limited period of times,
3 you know, as the basis for its proposed removal
4 of the standard. That experience is not
5 representative of our more than 540,000 members
6 at LIUNA.

7 Laborers wearing FFRs or PAPRs are
8 frequently doing so while also heavily exerting
9 themselves physically, often in high
10 temperatures with additional personal protective
11 equipment on, such as coveralls, harnesses, and
12 helmets. This added physiological burden is not
13 negligible for our workers and can certainly
14 exacerbate an undiagnosed or poorly controlled
15 cardiovascular pulmonary disease.

16 The pandemic experience the Agency
17 cites is not a good measure of data for our
18 representative workforce, and I encourage them
19 to consider the factors that affect our members
20 such as heat load, added weight of PPE, and
21 inhalation resistance from dusty environments.

22 Furthermore, OSHA stated it is not

1 aware of data identifying adverse outcomes among
2 individuals who used FFRs or PAPRs during the
3 pandemic. I would caution the assumption that
4 this absence of reported data is the equivalent
5 to the absence of risk.

6 It should be noted that there was no
7 systematic mechanism to capture the data OSHA
8 pointed out, and without a way to report or code
9 respirator-associated events, it's highly
10 unlikely they were accurately captured. So,
11 building a case on the absence of data while not
12 actively tracking said data is not a strong
13 foundation for permanently removing an effective
14 screening requirement.

15 So, having administered over a thousand
16 fit tests and medical questionnaires throughout
17 my career, I've seen the real benefit they
18 contribute to workers and respiratory protection
19 programs. I've had multiple individuals in my
20 career identify cardiovascular or pulmonary
21 issues as a result of these medical
22 questionnaires.

1 That percentage, although low,
2 prevented the possibility of aggravating an
3 underlying medical condition on the job while
4 they were surrounded by hazards, which makes
5 questionnaires more than worth it in my eyes.

6 In my case, medical screenings did
7 exactly as intended and prevented medical
8 complications for the select few with underlying
9 conditions. Removing this screening would be
10 similar logic to eliminating a safety protocol
11 because it is effectively preventing incidents.

12 Construction is a high turnover
13 industry with the workforce that includes older
14 workers and individuals with limited access to
15 routine healthcare, limited access to adequate
16 healthcare and a higher potential for
17 undiagnosed medical conditions is a reality for
18 many construction workers.

19 An OSHA required medical questionnaire
20 may be the only formal point of contact at which
21 an undiagnosed medical condition might be
22 identified and referred for follow-up. And,

1 relying on self-selection or after the fact
2 symptom reporting places the burden of medical
3 judgment on the worker who may not know they
4 have that underlying condition and they may fear
5 retaliation as it jeopardizes their employment.

6 OSHA additionally states that work
7 requiring respirators with high physical demand
8 usually self-selects healthy individuals to
9 complete it.

10 I would argue that is not the case.
11 Many workers in the country do not have broad
12 choices for their employment or the tasks
13 they're assigned at work.

14 Workers also do not self-select their
15 underlying health conditions such as COPD or
16 heart disease. And, without a screening
17 mechanism in place, it is logical to predict an
18 increase in adverse effects as a result of
19 respiratory usage would occur.

20 So, removing this requirement does not
21 reduce underlying medical risk. It simply
22 removes the mechanism for detecting it before

1 the worker is exposed.

2 So, thank you for the opportunity to
3 speak. I'll now hand it to my colleague, Ryan
4 Papariello, to wrap up our statements.

5 JUDGE BELL: All right, Mr. Papariello,
6 your time's already expired, so please move
7 quickly.

8 MR. PAPARIELLO: I'll be brief, thank
9 you. Good morning, my name is Ryan Papariello
10 and I'm the Safety and Health Specialist for the
11 Laborers' Health and Safety Fund of North
12 America.

13 In closing, we urge OSHA to withdraw
14 this proposal and maintain the existing medical
15 evaluation requirements for workers who use
16 filtering facepiece respirators and loose-
17 fitting powered air purifying respirators.

18 A medical evaluation is a simple
19 preventive measure. It identifies conditions
20 that a worker may not know that they have before
21 that worker faces the combined stresses of a
22 respirator, strenuous exertion, heat, and

1 hazardous conditions.

2 Our LIUNA members, there's 540,000 of
3 them, do not get to choose when the air becomes
4 contaminated with silica, asbestos, welding
5 fumes, or other hazardous substances. What they
6 can depend on is the safety standards designed
7 to protect them will be based on sound science
8 and prevention, not on reducing regulatory
9 requirements.

10 We believe strongly that every worker
11 deserves the opportunity to go to work, perform
12 their job safely, and return home to their
13 family at the end of the day. Maintaining
14 medical evaluations is a small but meaningful
15 part of making that promise a reality.

16 OSHA has an obligation to look beyond
17 the immediate cost of a requirement and consider
18 the human cost of removing it.

19 The consequences of a missed medical
20 condition are not measured in administrative
21 hours or dollars saved. They are measured in
22 illnesses, lost livelihoods, and potentially

1 lost lives.

2 We respectively recommend OSHA to
3 listen to the workers, the safety professionals,
4 industrial hygienists, healthcare professionals,
5 and its own advisory committee who have raised
6 concerns with this proposal. We urge OSHA to
7 reject the removal of these medical evaluation
8 requirements and instead preserve a standard
9 grounded in prevention.

10 Thank you for the opportunity to
11 testify, and we look forward to your questions.

12 JUDGE BELL: Mr. Levinson, are there
13 questions for this panel from OSHA?

14 MR. LEVINSON: Yes, Your Honor. The
15 first question for the panel comes from Dr.
16 Jonathan Bearr.

17 DR. BEARR: Thank you, Andy. Jonathan
18 Bearr at OSHA. This is a question for Mr.
19 Schreiber in the panel.

20 Mr. Schreiber, you mentioned how you've
21 done over 1,000 medical evaluations or medical
22 questionnaires, and that your workforce works in

1 high heat and humidity and has high exertion.

2 And, I was wondering if you could speak
3 from your experience and the experience of your
4 members, instances where the questionnaire
5 evaluation may have missed an underlying
6 condition that then because of these
7 environmental conditions resulted in an adverse
8 health outcome as a result of wearing an FFR or
9 a loose-fitting PAPR?

10 MR. SCHREIBER: I'd say in my
11 experience, the medical questionnaire actually
12 caught the underlying condition before they
13 began wearing the FFR or the PAPR.

14 Typically, what would happen, they
15 would take an electronic medical questionnaire
16 via a clinic of our choice. They would answer
17 said questions about their previous health
18 conditions, and then they would be screened as
19 to whether or not they could safely wear an FFR
20 or a PAPR.

21 So, typically it would catch them
22 before they put it on. You know, so it did its

1 job in my experience.

2 DR. BEARR: Are you aware of any
3 reports or studies that have also looked at this
4 and found that the medical questionnaire
5 performed the same way that your experience
6 suggests?

7 MR. SCHREIBER: Off the top of my head,
8 I don't have any to reference. But, we can
9 certainly point to those in our post-hearing
10 comments.

11 DR. BEARR: Thank you. That's all the
12 questions I have.

13 MR. LEVINSON: Your Honor, the next
14 question from OSHA comes from Tom Mockler.

15 MS. BURKE: Oh, Tom, you're muted.

16 MR. MOCKLER: I'm sure someday I'll get
17 that down.

18 Do your members have any survey data or
19 have there been any studies within your
20 membership on current practices regarding HEPA
21 filtration usage and training on respirator
22 usage?

1 MR. PARSONS: I'll jump in here. This
2 is Travis Parsons. We do a ton of training. I
3 don't know how much we track that or if it's
4 data driven.

5 But, we'd be happy to follow up with
6 whatever we can dig up in our post-hearing
7 comments. But, we absolutely train our workers
8 on respirator usage, fit testing, the medical
9 evaluation, all that.

10 So, we'll dig into that and reply in
11 post-hearing comments.

12 MR. MOCKLER: Okay, thanks.

13 MR. LEVINSON: And, Your Honor, Dr.
14 Minda Nieblas has a question.

15 DR. NIEBLAS: Thank you. This is for
16 the answer to actually the prior question from
17 Dr. Bearr for Mr. Schreiber. But, anyone in the
18 panel, please feel free to also join in.

19 When the question was asked about
20 clarifying whether the respirator was finding or
21 addressing undiagnosed conditions, the statement
22 was made that the respirator questionnaire was

1 reviewed for pre-existing medical conditions.
2 So, those would be conditions that were probably
3 diagnosed.

4 So, I would like to clarify you know,
5 and ask, could you clarify a little bit further
6 about circumstances where unknown conditions
7 were identified through the respirator medical
8 evaluation?

9 MR. SCHREIBER: Yeah, just to
10 understand the question correctly, you want
11 conditions that were exacerbated by respirator
12 usage?

13 DR. NIEBLAS: I thought I heard you say
14 that there were undiagnosed conditions
15 discovered by the respirator questionnaire.

16 MR. SCHREIBER: That is correct.

17 DR. NIEBLAS: And so, that's what I
18 wanted to hear a little bit more about. But, it
19 had been mentioned that people identified
20 preexisting conditions on the questionnaire and
21 that was addressed through that.

22 But, more a little bit about

1 undiagnosed or unknown conditions.

2 MR. SCHREIBER: Yeah, I had one
3 individual in my career who identified like, a
4 shortness of breath, symptoms that he was
5 having. And, basically, when the medical
6 questionnaire comes back, you answer yes to that
7 question, it gets tagged and you have to follow
8 up with a physician.

9 And, that's the point of contact that
10 we're referencing in our comments. So, that
11 discussion with the physician led for him to
12 basically discover he had some sort of pulmonary
13 condition, some sort of cardiovascular condition
14 that previously was unknown to him.

15 And, I believe, you know, that this was
16 a result of, you know, the lack of medical care
17 that a lot of workers have access to, you know,
18 is really his only contact with the doctor was
19 in that instance in my experience.

20 So, yes, that did actually happen.

21 DR. NIEBLAS: Thank you for that
22 clarification.

1 MR. LEVINSON: Your Honor, that
2 concludes the questions from the OSHA panel.

3 JUDGE BELL: Thank you. Mr. Berndt,
4 questions from the Solicitor?

5 MR. BERNDT: Yes, Your Honor, I have
6 one question. This is Joseph Berndt for the
7 Office of the Solicitor.

8 My question is directed at something
9 Mr. Schreiber said, but I also welcome anybody
10 responding to this.

11 Mr. Schreiber, you stated that in your
12 experience, medical questionnaires have
13 identified pulmonary and respiratory issues and
14 prevented complications. I'm wondering if
15 either now or in post-hearing comments, you
16 could provide any information about how
17 frequently this happens and the complications
18 that are prevented?

19 MR. SCHREIBER: Yeah, as I stated in my
20 comments, the percentage was low. But, I think
21 that low percentage is still important because
22 we're talking about human lives.

1 We're talking about those adverse
2 effects possibly coming to fruition whenever
3 they're in a respirator on a, you know, on a job
4 site with job hazards around them.

5 So, I'd be happy to elaborate if we can
6 compile any data regarding that question and
7 post-hearing comments.

8 MR. BERNDT: That would be great.
9 Thank you. Anything you can provide.
10 Otherwise, that's it.

11 Thank you all for your helpful
12 testimony.

13 JUDGE BELL: Thank you. Do we have any
14 questions from the public?

15 MS. BURKE: We have one raised hand.
16 Dan Glucksman, I'll allow you to unmute
17 yourself.

18 MR. GLUCKSMAN: Thank you. Hi, I'm Dan
19 Glucksman with the International Safety
20 Equipment Association.

21 And, I had a question that sort of is
22 the little bit of an intersection of not only

1 respiratory protection, but also some heat
2 stress.

3 I'd heard in this panel, and if I
4 recall correctly, in the other just before, that
5 there's some concern about heat stress with use
6 of respiratory protection, especially N95s.
7 And, I saw that, it got to the question that
8 ASSP A10.50 notes there's no added value that
9 involves a temperature device for full face and
10 negative pressure respirators.

11 And so, I guess my question is, because
12 in some cases respirators are needed, aren't
13 there other ways to address heat stress so that
14 say, someone mixing, loading, and applying
15 pesticides can do that safely, you know, wearing
16 a respirator and doing that safely, while
17 managing the heat in other ways?

18 That is to say, shouldn't respirators
19 be able to be worn when they're needed while
20 administratively managing heat stress in other
21 ways?

22 MR. PARSONS: This is Travis. I'll

1 jump in real quick, Dan. How you doing, Dan?

2 But, thank you for the question. But,
3 yeah, I would say to the way you diagnosed that,
4 absolutely, that that can happen if these
5 controls are put in place properly. But, that
6 doesn't always happen.

7 And, we're testifying on behalf of the
8 burden that respirators place physiologically on
9 workers today. While heat may exacerbate that
10 situation, you can definitely mitigate it
11 through those other means if applied.

12 I just don't know if that happens on an
13 everyday job.

14 MR. GLUCKSMAN: Okay, thank you.

15 JUDGE BELL: Other questions from the
16 public?

17 (No response.)

18 MS. BURKE: No other questions.

19 JUDGE BELL: Okay. Thanks to all of
20 you on this panel for your testimony. We very
21 much appreciate it.

22 MR. PARSONS: Thank you.

1 JUDGE BELL: Okay. Do we have our next
2 panel ready to go?

3 MS. HARRISON: Yes. I am promoting,
4 let's see, Kayla Flowers, Wes Parcell, Christian
5 Kane.

6 MS. FLOWERS: It's only the three of us
7 today. Steve and George are not able to
8 participate.

9 JUDGE BELL: Okay.

10 MS. FLOWERS: Thank you.

11 JUDGE BELL: Thanks very much. Thanks
12 very much. Go ahead with your testimony,
13 please.

14 MS. FLOWERS: Okay. Good morning. My
15 name is Kayla Flowers and I'm a Health and
16 Safety Specialist in the United Steel Workers
17 Health, Safety and Environment Department.

18 I'm joined today by Wes Parcell and
19 Christian Kane, representatives from two of our
20 locals. Unfortunately, Steve Sallman is missing
21 from our panel today as he is responding to the
22 fatality of one of our union brothers.

1 The United Steel Workers Union or USW
2 is the largest industrial union in North America
3 representing workers in steel, aluminum, and
4 other metals, paper, oil, rubber, plastics,
5 glass, cement, mining, energy, chemicals,
6 refining, utilities, healthcare, atomic,
7 education, manufacturing service, among other
8 sectors.

9 I'd like to start by reading part of
10 section 6B5 of the OSHA Act, which states that
11 when promulgating standards, the Secretary of
12 Labor "shall set the standard which most
13 adequately assures, to the extent feasible, on
14 the basis of the best available evidence that no
15 employee will suffer material impairment of
16 health or functional capacity."

17 In developing the 1998 Final
18 Respiratory Protection Rule, based on the
19 results of the studies in the record as well as
20 the comments received, OSHA determined the use
21 of any respirator requires a prior medical
22 evaluation to determine fitness.

1 After 28 years, OSHA now concludes that
2 it is important to consider new evidence in the
3 years since the rule was published. Let's look
4 at that new evidence presented.

5 "The Agency is not aware of any
6 epidemiological studies that evaluate medical
7 evaluations efficacy for FFRs and loose-fitting
8 PAPRs. The Agency knows of no data related to
9 these worker protections showing that the lack
10 of medical evaluations is causing adverse health
11 effects."

12 "The Agency is not aware of any data
13 identifying adverse outcomes from individuals
14 with underlying medical conditions during the
15 COVID-19 pandemic. We currently have no ability
16 to estimate to the Agency's knowledge how many
17 adverse events are being avoided by restricting
18 the use of FFRs and PAPRs by workers."

19 "While psychological stressors have
20 been observed and can induce physiological
21 impairment the Agency is unable to adequately
22 qualify the degree to which this occurs in the

1 affected workplaces. Fifty-one point two
2 percent of establishments reviewed in the
3 immediate wake of the 1998 Respiratory
4 Protection Standard may not have performed
5 medical evaluations."

6 A study conducted over 10 years ago
7 determined that "14 percent of hospital workers
8 in Illinois and 23 percent in Minnesota, did not
9 receive a medical evaluation."

10 "Workers in hog farms commonly wear
11 respirators, but are generally not subject to
12 the respiratory protection standard and are
13 likely not following it."

14 "It is reasonable to assume that work
15 that requires high exertion could impact the
16 health of a wearer, but that high exertion work
17 likely self-selects for individuals who would be
18 medically fit to wear an FFR or a PAPR."

19 "FFRs and loose-fitting PAPRs are not
20 permitted to protect employees in IDLH
21 environments. Therefore, the workers should be
22 able to seek safety with an exposure well below

1 expected thresholds for adverse health
2 outcomes."

3 Assumptions, lack of data, examples of
4 workers that are exposed to a hazard by
5 employers not adhering to current federal
6 workplace protection laws, is this really the
7 best available evidence, or has OSHA shifted
8 their focus from protecting workers to
9 accommodating executive orders?

10 Is OSHA the Agency that exists to
11 assure safe and healthful working conditions for
12 working men and women really proposing to
13 utilize the American workforce as guinea pigs in
14 order to turn around a deregulation item with no
15 supporting evidence?

16 Is the assumption that employees
17 provided with FFRs and loose-fitting PAPRs won't
18 have adverse health effects, or at least not
19 that many employees will, enough to justify this
20 amendment?

21 And, for those workers that do end up
22 developing symptoms, is OSHA really proposing to

1 make workers choose between developing adverse
2 health effects from being exposed to toxic
3 substances in the workplace and developing
4 adverse health effects from wearing respiratory
5 protection?

6 Does this sound like the Agency whose
7 entire purpose for existing is to protect
8 workers?

9 USW certainly does not think that the
10 Agency has done its job in proposing this rule.

11 Although we are sensitive to the position OSHA
12 has been placed by this Administration, that is
13 not an excuse to abandon the statutorily
14 required duties owed to workers, including our
15 members.

16 One study cited by the Agency, the 1999
17 Pappas Study concluded, "data on the adverse
18 events from respirator use are needed to help
19 design appropriate medical evaluations and
20 uniform criteria for work restrictions or denial
21 of medical clearance."

22 If there are research needs on adverse

1 events from respirator use, instead of
2 attempting to manipulate that lack of data into
3 support for removing the protections currently
4 in place, OSHA needs to do their job.

5 We urge OSHA to work with NIOSH to get
6 updated studies and updated data about the
7 frequency and severity of adverse health effects
8 from wearing respiratory protection, including
9 FFRs and loose-fitting PAPRs. This must happen
10 prior to even considering the removal of any
11 protections that are currently in place.

12 If the current medical evaluation
13 process does not consistently capture those
14 individuals that may experience adverse health
15 effects from utilizing respiratory protection,
16 the regulation should be improved, not removed.

17 We urge OSHA to utilize what is learned
18 from the research conducted with NIOSH to
19 develop a more appropriate medical evaluation
20 process and design that is more protective for
21 workers, not cheaper for employers.

22 And, until this is all completed, we

1 strongly urge OSHA to cancel this amendment and
2 focus on developing stronger standards and
3 protections for our members and for all workers
4 across the country, not on deregulation efforts.

5 Wes?

6 MR. PARCELL: Thank you, Kayla. Hello
7 everyone, my name is Wes Parcell and I'm
8 currently the Vice President of USW Local 8495.

9 We represent the workers employed by
10 BAE Systems at the Radford Army Ammunition Plant
11 in Radford, Virginia. We are in the business of
12 manufacturing rocket propellant for the United
13 States Army, producing critical components for
14 munitions that defend our nation and our war
15 fighters.

16 It is vital, grueling, and dangerous
17 work. Our members operate in a facility
18 originally built in the 1940s to support World
19 War II. And, almost every turn you see the
20 physical deterioration of an 80-year-old plant.

21 Day in and day out, our workers are
22 exposed to heat stress and a heavy rotation of

1 severe chemical hazards, including but not
2 limited to nitroglycerin, lead, acids, asbestos,
3 toxic dust. Because of these extreme exposures,
4 many of our members are required to wear
5 respirators just to perform their job safely.

6 The proposed deregulation of medical
7 evaluations will have dire consequences. If you
8 roll this back, someone somewhere will die.

9 The statutory purpose of the OSHA Act
10 is simple, and I quote, "to assure so far as
11 possible, every working man and woman in the
12 nation safe and healthful working conditions."

13 OSHA itself acknowledges that
14 respirator use placed a physical burden on a
15 worker's body. To strip away medical
16 evaluations directly contradicts the core
17 mission on which the Agency was founded, the
18 protection of the worker, first and foremost.

19 Nearly 30 years ago, the public health
20 experts and safety officials recognized the
21 severe risk of putting a worker in a respirator
22 without prior screening. They established

1 medical evaluations because they knew it would
2 save lives, and for three decades it has.

3 Now, OSHA is considering undoing that
4 legacy. Let me ground this in reality of our
5 shop floor with two brief examples.

6 First, consider the operators in a
7 mixing area of our plant, a high hazard area
8 dealing directly with nitroglycerin and lead.
9 These workers are required to wear PAPRs.

10 Out of our 830 plus members, this is
11 widely known as the most physically punishing
12 job in the plant. NG exposure causes, you know,
13 splitting headaches, intense body aches.
14 Turnover is high simply because the work is so
15 brutal.

16 One of our operators, Matt, described
17 what these shifts look like. Workers emerge
18 after eight hours ringing wet with sweat under
19 extreme heat stress, and the PAPRs do very
20 little to relieve that thermal load.

21 Meanwhile, you cannot just walk away
22 from a volatile rocket propellant to take a

1 breather. Placing a worker into that
2 environment with an undetected heart condition
3 or underlying respiratory issue, is a recipe for
4 a catastrophic medical event.

5 The medical evaluation is a crucial
6 safety net that catches those preexisting
7 conditions before a worker ever steps a foot
8 onto the floor.

9 Second, consider our insulators to wear
10 both PAPRs and FFRs while performing asbestos
11 abatement. Our facility is eight decades old,
12 asbestos is everywhere, and our team is actively
13 working to identify and remove it.

14 These insulators are routinely working
15 on ladders and elevated scaffolding in
16 temperatures exceeding 90 degree heat. The heat
17 stress is overwhelming.

18 If a worker suffers a sudden
19 cardiovascular or respiratory collapse on a
20 ladder because an underlying heart condition or
21 respiratory condition wasn't screened out, there
22 is no time to prevent a fall.

1 The claim that historical data no
2 longer justifies mandatory medical evaluations,
3 is to say that a small percentage of workers
4 simply do not matter.

5 Even if only 2 percent of workers
6 evaluated are found unfit to wear a respirator,
7 that is two out of every 100 people saved from
8 harm. Applied to my Local alone, that it
9 equates to 16 of our members' lives who would be
10 placed directly at risk in my plant alone.

11 When I told my coworkers I was
12 testifying today, they were stunned. The most
13 common response I heard was, "I thought OSHA was
14 on our side."

15 Even our plant's corporate safety staff
16 at BAE expressed confusion over this proposal.
17 Who does this rollback actually benefit?

18 It certainly doesn't benefit the
19 worker. Decades ago, safety professionals in
20 the very positions you hold today decided these
21 evaluations were necessary. What has changed?

22 Where is the evidence that workers'

1 bodies have suddenly become less vulnerable to
2 chemical and heat strain?

3 OSHA has a long, proud history of
4 standing up for worker safety. But, rolling
5 back these protections turns your back on that
6 history.

7 On behalf of the workers at the Radford
8 Army Ammunition Plant and the United Steel
9 Workers, I strongly urge OSHA to reject this
10 proposed deregulation and maintain mandatory
11 medical evaluations.

12 Thank you for your time. I will now
13 turn it over to my Union brother, Christian
14 Kane.

15 MR. KANE: Thank you, Wes. Good
16 morning everyone, my name is Christian Kane.
17 I'm a Registered Nurse and I am Second Chief
18 Steward for USW Local 4200, which represents
19 over 2,000 RNs in New Jersey.

20 Our Local is deeply familiar with
21 respirators on account of being among the first
22 to care for patients with COVID-19 and cared for

1 nearly 3,000 of them in the first year of the
2 pandemic.

3 Anyone doubting how physically
4 demanding wearing an N95 can be, ought to try
5 doing CPR with and without one. Much like my
6 brother Wes's members, even in our work area if
7 we can no longer bear the burden of breathing
8 through a respirator may come with significant
9 danger to others.

10 While we may not be in scenarios that
11 qualify as immediately dangerous to life or
12 health, our failure to remain where we are
13 needed places others in that scenario. The
14 notion that workers can simply walk away to
15 catch some fresh air is deeply insulting and
16 ignorant of the work that is done wearing them.

17 Instead of focusing on how offensive
18 this proposed rule change is to those who it
19 impacts, I will spend my remaining time on a
20 single question. Why should an employer want
21 this deregulatory action?

22 Aside from reading the 19-page

1 proposal, I searched for the number of instances
2 of the following words and excluding their use
3 as part of an organization's name or in other
4 sub-naming conventions. The following terms
5 related to worker safety, injury, danger,
6 hazard, harm, safety, and health collectively
7 accounted for 39 instances.

8 For monetary related terms, the dollar
9 sign itself was used 41 times. Savings was used
10 42 times, and cost was used a total of 56 times.
11 So, how much cost savings could employers
12 expect?

13 Supposedly \$83 million a year, which
14 using OSHA's own figures, comes down to \$633 per
15 year, per employer. But, that's only if an
16 employer's willing to risk their business's
17 productivity and take on the liability for
18 workplace injuries and safety events.

19 If there's a single asthma attack, then
20 an employer's likely to have lost far more than
21 the savings they were promised. And, this is
22 putting aside the dubious savings calculations

1 that were used.

2 They're riddled with questionable
3 assumptions and reflect either a general
4 unfamiliarity or disinterest with the actual
5 facts.

6 These calculations mistakenly use the
7 full length 15-minute questionnaire, half of
8 which is skipped for filtered facepieces and
9 PAPRs. They assume an astounding 23 percent of
10 questionnaires result in further evaluations
11 based on data used for the previous 1998
12 decision that included filtered facepieces for
13 the first time.

14 This shows a fundamental
15 misunderstanding of the history of the
16 regulation as a whole. The actual data from
17 industry and academic research show it's
18 actually 2 percent.

19 In another misunderstanding of the
20 data, the author of the proposal seems to have
21 subtracted the 2 percent from the 23 percent,
22 and used a 21 percent remaining to claim that

1 this is the amount of people that will no longer
2 need the evaluation after the rule change.

3 They then mistakenly say that the
4 remaining 2 percent would still receive follow-
5 up exams because "these employees are expected
6 to be referred for medical exams after
7 undergoing training as required under Paragraph
8 K, the existing respiratory protection
9 standard."

10 Paragraph K only covers training and
11 education on respirator use and does not place
12 any responsibility for referrals, nor does it
13 place the cost of worker initiated evaluations
14 on the employer.

15 In another instance of misunderstanding
16 the facts, OSHA is relying on a 1999 study by
17 Pappas et al, that used data gathered in 1996.
18 This is despite the fact that filtered
19 facepieces were not subject to 1910.134 until
20 1998.

21 This study's use is especially notable
22 given that it predates the questionnaire being

1 discussed today. A quotation of it, which I cut
2 for time, actually sounded optimistic that it
3 may cut down on unnecessary exams.

4 To summarize, I believe that this would
5 fail to benefit employers, would place
6 substantial burdens on workers, and that the
7 very premise is flat out irresponsible. To say
8 that the absence of evidence is cause to
9 eliminate these evaluations, is a classic appeal
10 to ignorance or what Carl Sagan described as an
11 impatience with ambiguity.

12 If OSHA proceeds with this change, then
13 it will certainly remove any doubts about the
14 necessity of these evaluations. Employers will
15 be complaining about the increased liability and
16 loss of productivity instead of the costs of
17 evaluations.

18 Meanwhile, the costs to the American
19 worker won't be measured in dollars and cents,
20 but in lives. How many will it cost before OSHA
21 decides that this regulation was warranted after
22 all?

1 Thank you.

2 JUDGE BELL: Thank you. Mr. Levinson,
3 questions for OSHA?

4 MR. LEVINSON: Yes, Your Honor. Dr.
5 Minda Nieblas has the first questions from OSHA.

6 DR. NIEBLAS: Thank you all. This
7 question would be geared to the whole panel, but
8 I think perhaps Mr. Kane may have more insight
9 or interest in answering this.

10 So, would your concerns about removing
11 the initial medical evaluation requirements for
12 FFRs and loose-fitting PAPRs be addressed if
13 employers were required to discontinue
14 respirator use and provide a medical evaluation
15 in the circumstance where say, an employee was
16 reporting symptoms or reporting concerns about
17 it?

18 MS. FLOWERS: I'm happy to jump in and
19 I'd like to echo the response that AFL-CIO gave
20 to the same question. We also feel that that
21 just wouldn't quite be adequate.

22 You know, relying on the worker to

1 self-report symptoms they may be experiencing,
2 also relies on the assumption that workers feel
3 comfortable making those reports to supervision.

4 And, in our workplaces across the
5 country, we know that's just not an accurate
6 assumption. There are many things that go
7 without being reported to management for fear of
8 retaliation.

9 And then, there's also just the simple
10 fact that employees should not have the
11 responsibility of, you know, making that medical
12 determination for themselves that something may
13 be happening.

14 For example, if a worker, you know, was
15 working in a hot scenario in some respiratory
16 protection and they start, you know,
17 experiencing the symptoms of heat stress, you
18 know, one of those symptoms is confusion.

19 So, we have people that are in a
20 situation that may not be thinking correctly,
21 having to communicate that to their employer or
22 their manager. And, even under the best of

1 circumstances, they may not feel comfortable
2 having those conversations.

3 So, no, I don't think that that would
4 really kind of ease our concerns, you know,
5 related to the regulations.

6 MR. KANE: And, just to add, I will
7 note that it was an intentional choice to put
8 the medical evaluation ahead of fit testing.
9 The reason being that it is possible that that
10 has a risk onto itself.

11 Additionally, it's just not how
12 prevention works in the workplace. We should be
13 doing low-cost screenings where possible.

14 I mean, these evaluations are available
15 for \$17 through the vendors that sell them, just
16 as the questionnaire and maintaining all of the
17 documents that OSHA's proposal onerously costed
18 out as a significant cost, whereas it is
19 maintained for \$17 per employee.

20 JUDGE BELL: Other questions, Mr.
21 Levinson, from OSHA?

22 You're muted, Mr. Levinson.

1 MR. LEVINSON: Sorry, Your Honor. Tom
2 Mockler has the next question from the OSHA
3 panels, Your Honor.

4 JUDGE BELL: Thank you.

5 MR. MOCKLER: Hi, Tom Mockler. I've
6 got a few questions about information you might
7 have about practices within your membership.

8 The first question is, does your
9 organization have any survey data or have there
10 been any studies within your membership on
11 current practices with regard to respirator use,
12 medical clearance practices and procedures, and
13 training on respirator usage?

14 MS. FLOWERS: I'm not aware of any data
15 within our organization. You know, many of
16 those things that you mentioned would be the
17 responsibility of the employer.

18 And, you know, we would rely on our
19 locals to hold the employers accountable to do
20 what is required of them. With that being said,
21 I can do some follow-up and we can address in
22 the post-hearing comments if any of that survey

1 data is available or does exist.

2 MR. MOCKLER: Okay. All right, thanks.

3 I have a second question regarding medical
4 evaluations.

5 Are you aware of any data on the number
6 or percentage of workers at USW work sites who
7 receive a medical evaluation from a physician?

8 Or, an alternate version, I'm going to
9 ask you sort of alternate version of this
10 question so you get a better sense of what we're
11 trying to get at.

12 Or, are you aware of any data on the
13 number or percentage of workers at USW work
14 sites who indicated on the screening survey that
15 they have a condition warranting a medical
16 evaluation?

17 For example, does USW have data on the
18 prevalence of medical evaluation among members
19 whose use of certain respirators may elevate
20 risk to employee health?

21 MS. FLOWERS: Again, unfortunately with
22 our Union, we leave a lot of the frontline

1 health and safety work to be done as required by
2 an employer and, you know, with our local unions
3 doing their best to make sure they're getting
4 the protections that they're owed.

5 So, kind of the same answer, it's not
6 really something that we track, because that
7 responsibility to carry out the medical
8 evaluations falls on the employer.

9 But, I will do some follow-up and if we
10 do have any data, we can share that in the post-
11 hearing comments.

12 MR. MOCKLER: Okay. All right, thanks.

13 MS. FLOWERS: Um-hum.

14 MR. LEVINSON: Your Honor, that
15 concludes the questions from the OSHA panel.

16 JUDGE BELL: Thank you very much. Mr.
17 Berndt, any questions from the Solicitor?

18 MR. BERNDT: Thank you, Your Honor.
19 Joseph Berndt from the Office of the Solicitor.

20 I have no questions, but would like to thank
21 the USW panel for their testimony.

22 MS. FLOWERS: Thank you.

1 JUDGE BELL: Any questions from the
2 public?

3 MS. BURKE: No questions from the
4 public.

5 JUDGE BELL: All right. Thank you to
6 this group for your testimony today. We very
7 much appreciate it.

8 MS. FLOWERS: Thank you.

9 JUDGE BELL: All right. Do we have our
10 next group ready, please?

11 MS. HARRISON: Yes, I am currently
12 promoting to panelists Chris Kane, MK Fletcher,
13 Esmeralda Aguilar, Travis Parsons, Tony
14 Longbrake, Gene Sicard, Glenn Minyard, Kalima
15 Ramsey-Walker, Dale Clark, and then I believe
16 there were two, I don't see Brian Cavey or Blue
17 Coble. But, I'll keep an eye on them.

18 Everyone else, I promoted you to
19 panelists. You may turn your cameras and your
20 microphones on.

21 And, as a reminder, we have a courtesy
22 timer on the screen that will start once you

1 begin your testimony.

2 JUDGE BELL: And, I think the timer, at
3 least as I'm seeing it, is set for an hour. Is
4 that correct?

5 MS. HARRISON: Yes, that's what we
6 asked for.

7 JUDGE BELL: Okay. My notes say you
8 were allotted 10 minutes. So, there's a big
9 difference.

10 Go ahead, please.

11 MS. CAIN: Thank you, Judge Bell. The
12 agenda was updated after the initial issuance
13 because of the error.

14 JUDGE BELL: Oh, okay.

15 MS. CAIN: So, thank you very much,
16 Judge Bell. My name is Chris Cain. I am the
17 Director of Safety and Health for North
18 America's Building Trades Unions, which is an
19 umbrella organization, an alliance of 14
20 national and international unions who do
21 building and construction work in the United
22 States and Canada, who collectively represent

1 3.2 million workers.

2 We have a large panel today, because we
3 wanted to ensure that several of the 14 member
4 unions have an opportunity to participate and to
5 be available to answer questions from OSHA.

6 Not everyone is slated to prepare
7 remarks or to deliver prepared remarks. So, I
8 believe we'll stay within our 60 minutes of
9 prepared remarks time that was requested.

10 I was going to have folks introduce
11 themselves, but I will wait until they develop
12 their prepared remarks while calling out. Folks
13 who are on to participate in the questions only
14 right now are our council, Esmeralda Aguilar,
15 sorry, Tony Longbrake with the Operative
16 Plasterers' and Cement Masons' International
17 Association of North America, Gene Sicard of the
18 International Brotherhood of Electrical Workers,
19 and Kalima Ramsey-Walker of the Sheet Metal
20 Workers or SMART.

21 So, everyone else who's on our panel
22 will be speaking and they can introduce

1 themselves at that time.

2 I would like to just mention that I
3 would like to have the opportunity to moderate
4 questions that are posed to the panel and direct
5 them, if appropriate, and you know, potentially
6 elect to address them in post-hearing comments.

7 I think the main thing I'd like to say
8 is that we request that this rule be withdrawn
9 immediately. It's somewhat ridiculous to
10 eliminate provisions in decades old standards
11 that are working and protecting working
12 Americans.

13 We've got some specific concerns that
14 we'll get into. But, I've got some initial
15 concerns I wanted to share.

16 One of the things that seemed odd to me
17 is that in the docket there were several
18 documents added as Hearing Exhibits just
19 yesterday.

20 So, we didn't have an opportunity to
21 review what those Hearing Exhibits were and what
22 they might suggest nor who submitted them. I

1 wonder if that might be corrected at some point
2 procedurally along the way.

3 The other thing that has not been
4 provided to the hearing participants, is a list
5 of people and organizations who filed a notice
6 of intention to appear. It's usually helpful so
7 that the hearing participants know what parties
8 may be asking questions and what parties are
9 allowed to ask questions.

10 And, if those parties have agreed to
11 testify themselves, I think it's helpful for us
12 to understand and to make sure that OSHA has the
13 record they need to move forward.

14 So, those are two procedural things
15 that I noticed I just wanted to put on the
16 record. The other thing is that really a lot of
17 what we're talking about was stated in our
18 written comments, so we're not here to repeat
19 those.

20 But, in our written comments we
21 flagged, and also in listening to the questions
22 that are posed by the OSHA staff, it's kind of

1 something that the Agency seems to be doubling
2 down on is that there's a perception that there
3 is, because there have been a lack of studies to
4 demonstrate the need, an ongoing need for an
5 OSHA standard, that somehow it's worthy of being
6 withdrawn.

7 The lack of data that documents that we
8 have to keep having this standard in place
9 because it's saving lives, it's really chilling.

10 If you think about it, there's no requirement
11 for the Agency to have an ongoing justification
12 for the existence of their standards.

13 You had to prove economic feasibility
14 when the standard was promulgated in 1998. You
15 had to prove technological feasibility.

16 And, the suggestion that the Agency has
17 to continuously prove that or we risk losing
18 protections that have been afforded and are
19 saving lives, is terrifying and chilling.

20 And, thinking about why is really,
21 who's going to pay for those studies? Is this
22 going to be a function of OSHA? You conduct

1 look back studies.

2 Do you need to have your administration
3 request additional funds so that you can conduct
4 scientific studies to continuously document the
5 need for provisions that you've already
6 documented the need for and the feasibility of
7 and have stood up in court?

8 There's so little money in the United
9 States that is devoted to occupational safety
10 and health research that the suggestion that
11 those dollars should be spent on justifying
12 protections that were already proven to be
13 essential to be feasible, is to me, like
14 personally inappropriate and terrifying.

15 And so, just kind of throwing that
16 marker down, that the argument that the lack of
17 an ongoing body of research that demonstrates a
18 continuing need for rules that have already been
19 put in place and are there is something that is
20 really out of the ordinary. And, I don't think
21 it's consistent with the mission of OSHA.

22 Moving on, the reason we make a panel

1 available to the Agency, is to support you in
2 your efforts to create a record in the
3 rulemaking that really relies on the best
4 available information to you.

5 And, not all of us are occupational
6 safety and health experts. We're not here to
7 necessarily describe to you the science, but
8 we're here to give you the opportunity to ask
9 this panel about the work.

10 The work is something that needs to be
11 considered and the actual way that standards are
12 implemented on the ground is something that OSHA
13 needs to complete the record. And, I implore
14 you to take advantage of these representatives
15 on this panel to build the record that you need
16 to build.

17 I have been literally, over my career,
18 in awe of OSHA and the staff, and how you build
19 the records, and how you promulgate rules that
20 are based on science and are completely doable
21 by all the affected industries that you
22 regulate.

1 And, I know how hard, you know, the
2 staff has worked over the years to get the
3 relatively small number of standards out that
4 you can get out. And, I just wanted to make
5 sure that, you know, you understood this
6 opportunity that's in front of you and use it to
7 the best of your ability from, you know, my
8 heart.

9 So, I'm going to go ahead and move onto
10 the next speaker. And yeah, I'm happy. I'm
11 looking forward to the questioning part.

12 But, I'm moving it over to MK Fletcher.
13 So, I'm up to you.

14 MS. FLETCHER: Yeah, thank you so much.
15 Hi, I'm MK Fletcher. I'm with the North
16 America's Building Trades Unions as well.

17 I just want to briefly kind of share an
18 overview of what our panel is going to present
19 to OSHA today and underscore a few points.
20 Today, our panel's planning to share more about
21 how the respiratory protection standard is
22 working in the construction industry.

1 We'll hear about how providing a
2 medical evaluation is already routine and built
3 into contractors' practices when they determine
4 a respirator is required for a worker. We're
5 going to hear how medical surveillance
6 provisions protect both workers and the
7 employer, ensuring workers' health is protected
8 prior to them wearing a respirator and reducing
9 the contractor's liability if an adverse health
10 effect does occur.

11 We'll hear from the panelists about the
12 nature of construction work and how the work
13 being done, including in hot humid conditions
14 and while performing manual labor, and then the
15 limitations of respirators can create a health
16 risk for construction workers. The exact risk
17 that an effective respiratory protection program
18 with medical evaluation components prevents.

19 We'll provide examples of how workers
20 often do not know the risks and the potential
21 exposures on the site, and they can't self-
22 identify the signs and symptoms of distress due

1 to either an exposure or the burden of a
2 respirator, especially while performing manual
3 labor. And, they can't really do this or
4 identify this until it becomes an emergency
5 situation.

6 We'll provide examples of how medical
7 evaluations for respirators have helped identify
8 health issues and have helped ensure workers
9 with a medical condition were fit to work while
10 wearing a respirator. This includes
11 cardiovascular issues, asthma, and some
12 claustrophobia.

13 The claustrophobia one we'll have to do
14 in post-hearing comments, because I just found
15 out about it a little bit earlier today and
16 didn't quite get all the details in time for you
17 guys.

18 And, also, I just want to note that
19 while we only have a few examples from our
20 industry today, this is just a small selection
21 of the industry and personal examples from just
22 this group.

1 And so, while we just have a couple of
2 examples, I think it speaks to how if you look
3 nationwide and if you were actually to go talk
4 to everyone, you would see a lot more examples.

5 And, the 2 percent that's in the proposed rule
6 is important and significant and you know,
7 perhaps even an under count.

8 Also, we'll hear from the NABTU
9 panelists about how employers don't always
10 follow the current respiratory protection
11 standard requirements. Not only by not
12 providing a medical evaluations, but by not
13 providing a respirator when required.

14 This does not mean that the respiratory
15 protection standard is not necessary, or that
16 any provision within the standard is not
17 necessary, like the medical surveillance
18 provisions for all types of respirators. It
19 shows that many low road employers do not
20 adequately address workplace hazards until
21 they're required to do so.

22 Everyone agrees that providing a

1 medical evaluation for all types of respirators
2 is a best practice for an effective respiratory
3 protection program. OSHA regulations include
4 those best practices, not only to ensure that
5 employers know the best practices, but because
6 it provides accountability to ensure that the
7 industry implements those best practices to
8 protect the health of workers.

9 Widespread failure to address workplace
10 hazards is precisely why Congress enacted the
11 OSHA Act. Congress determined that worker
12 safety could not be left to employer discretion
13 or subjective judgements about the need for
14 protective measures.

15 Having the best practices in the
16 standard and also having the same requirement
17 for all respirators, is also extremely helpful
18 in the construction industry. The construction
19 industry is primarily small contractors and they
20 really rely on straightforward information
21 that's not full of nuances.

22 Just how to do it, when to do it. Just

1 those straightforward and not, okay, well, if
2 you do X, then do A or B or C. You know, it's
3 just like a straightforward thing.

4 So, having something that's for all
5 types of respirators is very helpful, just one
6 respiratory protection program. And, kind of
7 with that of kind of just underscoring what
8 we're going to hear today.

9 I wish I could turn it over to Brian
10 Cavey from the Insulators Union, unfortunately,
11 he was not able to come today. But, he did
12 prepare a testimony and I get the great joy of
13 reading out his prepared remarks.

14 So, I am going to move towards that.
15 So, this was prepared by Brian Cavey. He's the
16 International Vice President of the
17 International Association of Heat and Frost
18 Insulators and Allied Workers.

19 Also, he wanted to underscore while he
20 was unable to make it today, he is happy to
21 answer any clarification questions in post-
22 hearing comments. And, we'll make sure that he

1 is able to do that.

2 So, on behalf of the officers and
3 members of the International Association of Heat
4 and Frost Insulators and Allied Workers, we
5 voice our strong opposition to OSHA's proposal
6 to remove mandatory medical evaluations for
7 workers who use filtering facepiece respirators
8 and loose-fitting powered air purifying
9 respirators. Our union has long supported
10 OSHA's efforts to strengthen respiratory
11 protection requirements.

12 In our previous comments on asbestos,
13 we emphasized asbestos is classified as a
14 carcinogen with no established safe level of
15 exposure. Health conditions linked to asbestos
16 fiber inhalation are typically irreversible and
17 more often than not fatal.

18 While those comments addressed asbestos
19 specifically, the underlying principle applies
20 universally. Respirators are lifesaving devices
21 and medical evaluations are a foundational
22 component of safe respirator use regardless of

1 the hazard.

2 OSHA's proposal would weaken
3 protections not only for workers exposed to
4 asbestos, but for every worker who uses any
5 respirator in any industry. This includes
6 construction, but it includes so much more.

7 Medical evaluations are essential for
8 all users of respiratory protection. OSHA's
9 proposal rests on the assumption that FFRs and
10 loose-fitting PAPRs impose a minimal
11 physiological burden, but this assumption is
12 incorrect.

13 Scientific literature shows that N95s
14 increase breathing resistance, heart rate, CO2
15 retention, heat stress, anxiety, and panic
16 symptoms. These effects occur regardless of the
17 contaminant, silica, welding fumes, infectious
18 aerosols, chemical particulates, or wildfire
19 smoke.

20 Workers with underlying conditions like
21 asthma, COPD, hypertension, cardiovascular
22 disease, obesity, anxiety disorders, et cetera,

1 are at increased risk when using these FFRs.
2 And, the medical evaluations are the only
3 mechanisms to identify these risks before harm
4 occurs.

5 There are also risks to using a loose-
6 fitting PAPR. PAPRs can increase the heat load,
7 exacerbate cardiac strain, interfere with
8 balance, hearing, or vision. They can cause
9 dizziness or disorientation, and they can also
10 create ergonomic challenges in confined spaces.

11 These risks apply to workers in
12 industries our memberships work in, including
13 construction, emergency response, hazardous
14 waste handling, utilities, but across all
15 industries. Removing medical evaluations
16 ignores these well-documented physiological
17 impacts.

18 Also, there is a strong foundation for
19 medical evaluation. Respirator performance
20 degrades during real world work.

21 So, to talk about that real world work
22 and how it degrades, the seal and filter

1 performance of an N95 can degrade particularly
2 rapidly during a typical construction shift and
3 moisture buildup is very common. Typically,
4 this involves in industries that involve heat,
5 humidity, heavy labor, extended shifts, and
6 contaminated environments.

7 So, the exact environments that
8 construction workers are in every single day.
9 And then, workers with respiratory or cardiac
10 conditions are at even heightened risk when that
11 respirator performance degrades.

12 PAPRs are also medically necessary for
13 many workers. Employees with health conditions
14 that may restrict their ability to use other
15 forms of respiratory protection can often use a
16 PAPR. This also applies to those same members
17 that work in the construction, emergency
18 response and haz-waste industry.

19 The medical evaluations identify which
20 workers might need a PAPR and removing those
21 evaluations eliminates that safeguard.
22 Respiratory protection training is also most

1 effective when it's paired with a medical
2 review.

3 The most effective respiratory
4 protection training occurs when workers are
5 taught along with the hazard training. Medical
6 evaluations are part of that integrated system.

7 And so, removing that part of it breaks
8 the chain of protection that the respiratory
9 protection programs provide. So, therefore,
10 OSHA's proposal will increase respirator-related
11 injuries across sectors.

12 Workers usually under-report their
13 symptoms. So, without a medical evaluation,
14 workers may not report or may not even know to
15 report shortness of breath, chest pain,
16 dizziness, panic symptoms, heat stress, or
17 respiratory distress.

18 And, this is particularly true as other
19 folks have said too, when workers fear job loss
20 or retaliation, which is significant in the
21 construction industry when you are literally
22 building something to work yourself out of a

1 job.

2 Employers may unknowingly also assign
3 respirators to medically unsuitable workers.
4 Small employers who really dominate the
5 construction industry rely on these clear
6 prescriptive rules.

7 Small contractors are unlikely to have
8 the safety and health expertise to understand
9 how to accurately comply. Removing medical
10 evaluations shifts the risk to workers and small
11 employers.

12 This proposal also contradicts OSHA's
13 own logic. OSHA has repeatedly emphasized the
14 importance of all of the elements of a
15 respiratory protection program from fit testing,
16 training, medical clearance, and ongoing
17 surveillance.

18 So, removing the medical evaluations
19 destabilizes that entire respiratory protection
20 framework. And, our final point, the
21 construction workforce illustrates why medical
22 evaluations must remain, and it applies

1 everywhere.

2 There's higher cancer mortality,
3 there's elevated respiratory disease, and
4 increased cardiovascular conditions within the
5 construction industry. That's not totally
6 unique to construction, there are some other
7 industries that also see these high rates of
8 disease as well, but it's prevalent in the
9 construction industry.

10 And, these workers frequently use and
11 are required to use FFRs or PAPRs to protect
12 them from the exposures in their workplace.
13 And, you know, taking away a medical screening
14 really puts these workers with underlying
15 conditions that they may or may not know about
16 at increased risk.

17 So, therefore, OSHA should strengthen
18 and not weaken the respiratory protection
19 requirements. The proposal to remove mandatory
20 medical evaluations for FFRs and loose-fitting
21 PAPRs, users would ultimately weaken protections
22 for millions of workers across the industry.

1 Medical evaluations are a foundational
2 element of respiratory protection, and
3 eliminating would then increase preventable
4 medical emergencies, increase respirator misuse,
5 increase risk for workers with underlying health
6 conditions, increase liability for small
7 employers, contradict decades of scientific
8 evidence, and undermine OSHA's mission.

9 For these reasons, the International
10 Association of Heat and Frost Insulators and
11 Allied Workers urges OSHA to withdraw this
12 proposal and instead pursue stronger, more
13 protective respiratory and medical surveillance
14 requirements for all workers.

15 Thank you very much. That's the end of
16 the prepared testimony by Brian Cavey of the
17 Insulators Union.

18 And, I am going to pass it to our next
19 panelist who is speaking Glenn Minyard of the
20 International Union of Operating Engineers.
21 Thank you.

22 MR. MINYARD: All right. Thank you for

1 this opportunity. My name is Glenn Minyard. I
2 am the Safety Coordinator from the International
3 Union of Operating Engineers, Local Union 150.

4 Just start with, the respiratory
5 protection standard is intended to protect
6 workers from inhaling hazardous airborne
7 contaminants in the workplace.

8 Employers are required to have written
9 respiratory protection program that includes
10 procedures for use, training, and fit testing.
11 The medical evaluation is a key part of ensuring
12 the employees can wear and use these respirators
13 safely out in the job site.

14 Removing this requirement from some
15 respirators is going to cause confusion when
16 evaluations are necessary and when they're not
17 necessary, and it's going to increase the number
18 of worker illnesses out in the field.

19 Workers do not wear respirators on a
20 job unless the air they breathe is above the
21 permissible exposure limit and must use a
22 respirator for protection. They're not out

1 there wearing these respirators just because
2 they want to, it's when they are required.

3 Filtering face respirators are handed
4 out to the employers by following the
5 respiratory protection standard already. They
6 do provide little or no explanation to some of
7 these employees.

8 They tell them they have to wear it and
9 then they go out there to do the job without any
10 training just because, you know, the employer
11 feels like it'll look good in the picture, I
12 guess.

13 It's easy to see on the faces of these
14 employees when they remove the filtering face
15 respirators, all the dust alongside their noses
16 and on their faces, as a poorly fit filtering
17 face respirator that did not go through the fit
18 testing is just exposing them as the airborne
19 concentrations just bypass the filter media that
20 they should be breathing through.

21 So, the respirator did not seal,
22 exposing all their lungs. The workers are at

1 risk of having adverse health events due to
2 wearing the respirator without that knowledge
3 and the strains that it can place on their
4 bodies.

5 Each element of the respiratory
6 protection program works together to ensure that
7 this doesn't happen. As a best practice,
8 medical evaluations will be done in correlation
9 with the fit test for the filtering face
10 respirators, and the physician or licensed
11 healthcare professional will be able to observe
12 the employee's ability to breathe through that
13 filter media.

14 A fit test is required for the assigned
15 protection factors listed in Table One of the
16 Respiratory Standards. Note, footnote number
17 two, the assigned protection factors in Table
18 One are only effective when the employer
19 implements a continuing and effective
20 respiratory program as required, including
21 training, fit testing, keyword, fit testing,
22 maintenance and use of requirements, use

1 requirements.

2 Medical evaluation is part of effective
3 respirator programs. There is no evidence that
4 this does not remain true.

5 When medical questionnaires show that
6 it is necessary, medical evaluations also
7 perform spirometry tests. This is a common
8 pulmonary function test measure how well a
9 person's lungs function.

10 We know workers were unaware that they
11 had lung issues until they were sent for the
12 medical evaluation. They did not realize they
13 had the early signs of COPD, maybe they had mild
14 forms of asthma and these things were identified
15 and then they would have to go and get them
16 addressed.

17 This is important when you wear a
18 proper fitting facepiece with a good seal,
19 because when you breathe, you are required to
20 draw that air through the filter media, making
21 it more difficult to breathe.

22 As this filter captures the

1 contamination out of the air, the particulate
2 filters will start to fill up all the little
3 holes in between the fibers. And, as it is used
4 throughout the day as they're doing the manual
5 labor, it is going to get more and more
6 difficult to breathe.

7 Without medical evaluation, a worker
8 that did not know they had a lung condition,
9 sometimes they will feel like they are
10 suffocating and then they start to panic.
11 They'll rip the mask off, take a deep breath of
12 the very air that they were wearing the
13 respirator to protect them from, because we wear
14 these when the concentrations are above the
15 PELs, at or above the PELs.

16 In addition to this, the filtering face
17 respirator will trap the person's exhalation and
18 making the hot air that is exhaled from the
19 body, which is 98.6 degrees and humid. All that
20 moisture is going to create more stress as it
21 starts taking up the space that the air they're
22 trying to breathe is inside that facepiece.

1 So, this is going to again, contribute
2 to the negative effects on the body and why the
3 medical evaluations must be done. The proposed
4 rule makes multiple references to the COVID-19
5 pandemic and the face covers that were worn in
6 workplaces everywhere without medical
7 evaluations.

8 My experience as Safety Coordinator
9 going to all these job sites, the N95s were
10 often worn incorrectly.

11 People would hang them on one ear and
12 let them dangle. They'd pull them down under
13 the chin. They would put inserts inside them to
14 pull the facepiece off their face, so there was
15 no way for it to seal whatsoever.

16 They would not remove the facial hair
17 in between the face-to-facepiece seals. Anytime
18 it was uncomfortable, they'd just take them off
19 and continue to work until safety came around
20 and would instruct them to put them back on.

21 So, face covers weren't worn in the
22 presence of a known hazard outside of

1 healthcare. In the construction sites, nobody
2 knew what the airborne concentration of the
3 virus was, and there was lots of misinformation
4 about the virus out in the workplace.

5 There was also a shortage of N95 rated
6 filtering face respirators. So, people use
7 filtering facepieces from China that did not
8 have NIOSH approval.

9 This time of international crisis in no
10 way is comparable to the industrial or
11 construction work environment that has a known
12 contaminant at or above the permissible exposure
13 limit that requires the respiratory protection.

14 Removing the medical evaluation
15 requirement will increase the worker's exposure
16 and negatively impact the employer's liability
17 and profit margins.

18 The workers who use respirators while
19 working will not always recognize that they are
20 being overexposed, recognize the symptoms of
21 exposure, or recognize the symptoms of adverse
22 health effects due to the use of respiratory

1 protection.

2 There are contaminants that cause
3 olfactory fatigue. A contaminant that has a
4 specific smell that the employees sense, but
5 they continue to work, over time the employee's
6 sense of smell will desensitize the olfactory
7 fatigue.

8 At that point, the employees assume
9 that the contaminations have gone away. They
10 get the impression that it is safe to continue
11 to work even though that the contaminations are
12 there at harmful levels. It goes back to the
13 whole respiratory program.

14 Employers are to provide a safe working
15 environment for employees, and when given the
16 flexibility to offer less protection, will risk
17 the U.S. workers' safety. One example of this
18 that I experienced, occurred at a landfill in
19 Indiana on July 12, 2024.

20 A construction crew was cutting in a
21 haul road for the project. The road was in an
22 area referred to as monofill by the employer.

1 And, that's all they were told, is we're going
2 to cut the road through monofill.

3 The employers complained to management
4 about a strong smell of ammonia and headaches,
5 after beginning the excavation in the morning.
6 Management pressed the workers to keep going, it
7 would only take a few more hours to complete
8 this task.

9 By lunch break, the job site had to be
10 shut down while four employees were sent to the
11 emergency room with respiratory issues. Three
12 of the employees received treatment and were
13 released.

14 But, one of the employees was admitted
15 with a stridor. When they would breathe, it
16 would rattle and he had difficulty breathing.
17 That took several days to resolve.

18 Although these employees reported to
19 the supervisor the signs and symptoms of
20 exposure, they told them to keep working until
21 the symptoms required medical attention. It was
22 only after the hospitalization that the employer

1 informed the employees that what they were
2 working with was aluminum dross.

3 The expectation that the workers can
4 respond quickly to signs and symptoms, does not
5 reflect the job site pressures of management to
6 get the job done.

7 Often when construction workers ask to
8 use a respirator, the employer will insist that
9 there is nothing at the job site that is in a
10 harmful concentration and resists providing that
11 respirator.

12 When the equipment operators are
13 involved in earth moving operations and the
14 equipment drives back and forth, the dirt or
15 clay will tend to dry out and will begin to get
16 dusty. The engineering control best practice
17 would be to have a water truck with an operator
18 to drive around and suppress the dust.

19 When employers do not want to spend the
20 money on the water truck, or the driver, or the
21 water needed to suppress dust and the employers
22 ask for that filtering face respirator, the

1 employer also does not want to have to create a
2 respiratory protection program with the medical
3 evaluation and fit testing.

4 Appendix D has instructions for
5 respirator use when not required by this
6 standard, but the employer still will resist the
7 use of respirators. In my experience, because
8 if somebody sees a respirator, they're afraid
9 that they have to have all the different aspects
10 of this.

11 So, they do not give the respirators
12 out when the employees ask for them out on the
13 job site. It has been the best practice for the
14 employer to conduct medical evaluations as part
15 of an effective respiratory program for
16 employees to wear respirators in the workplace.

17 This ensures the employees are healthy
18 and physically fit to use this respirator and
19 make sure proper fit of the facepiece for the
20 worker's protection before working in an
21 atmosphere that has a known contamination at or
22 above the permissible exposure limits. This is

1 why that this change should not be made.

2 Thank you for your time.

3 MS. CAIN: Dale, you're up.

4 MR. CLARK: Thank you, everybody. I'm
5 Dale Clark from SMART, which stands for Sheet
6 Metal, Air, Rail Transportation.

7 So, panelists, I can stand up here and
8 talk to you about, you know, what OSHA says the
9 rules or regulations, but I won't. I actually
10 just want to speak to you as a 25-year
11 construction worker with 13 years in the safety
12 field.

13 I am the OSHA Specialist for SMART.
14 Actually by, the medical evaluations, let's just
15 start at the very beginning, you know.

16 During onboarding, when a contractor
17 needs to have their workers use respirators,
18 they literally find a PLHCP, which stands for
19 physician licensed and healthcare provider, and
20 the workers fill out the questionnaire. That is
21 the very beginning of how this all works.

22 And, by not doing that, you have a lot

1 of workers who, you know, they might have health
2 problems, health issues, because they want to be
3 on the job. And, they might find out that, hey,
4 they can't wear a respirator by filling out that
5 questionnaire, by that physician actually
6 checking in, going back and checking in with
7 them, but also the confidential of their health
8 does not go to the contractor, which will
9 protect them.

10 A lot of workers will also lie, I just
11 want to say they will lie just to be on that
12 job. So, this standard is not only protecting
13 the worker, but it is also protecting the
14 owner/contractor.

15 Due to time, I'm going to keep this
16 short and sweet. In construction, and hopefully
17 MK can share a story, there is also a thing of
18 asthma.

19 People could get asthma in the
20 construction field and they might not even know
21 it. By filling out a questionnaire, by actually
22 doing the testing, eventually they might pick up

1 on it and it could help not only them, but it
2 could also help the contractor.

3 At the end of the day, like I said,
4 there are many rules and regulations we can
5 discuss, but I believe we need to look at the
6 bigger picture.

7 The worker wants to provide for their
8 family and go home safely at the end of the day,
9 the owner wants to run a successful, profitable
10 business, but proper respiratory fit testing and
11 evaluations, it helps both sides.

12 When you fit test or you have an
13 evaluation for workers, you are not just
14 checking a box on requirements, you are helping
15 protect the worker, you are protecting the
16 company, and you're creating a situation where
17 everyone can win.

18 Like I said, due to time, I don't want
19 to take up a whole bunch of you all's time.
20 That is all I have to say. I want to pass it to
21 MK.

22 MS. FLETCHER: Hi, thank you so much.

1 I wish I was able to pass it to Blue Coble.
2 Unfortunately, she had a medical emergency she
3 had to manage this morning.

4 So, she was able to get me something
5 that she had pre-prepared. And so, this is what
6 it is.

7 But, I also, just to follow up from
8 what Dale said about asthma, is that also a lot
9 of construction exposures could create
10 conditions that the medical evaluation would
11 identify.

12 So, workers also might not know that
13 they have some of these conditions, but because
14 of their exposures that they've received in the
15 construction industry, they could have developed
16 it over time of being a construction worker.

17 Asthma is one of them. Isocyanates is
18 a known sensitizer and causes asthma within
19 individuals, and is also a common construction
20 component in the painting industry, just as an
21 example for one.

22 But, now I'm going to move onto Blue

1 Coble's comments. So, Blue Coble is a
2 journeyman ironworker from Local 75 in Arizona,
3 and a District Representative for the Safety and
4 Health Department of the International
5 Association of Bridge Structural, Ornamental,
6 and Reinforcing Ironworkers.

7 Thank you for the opportunity to
8 provide testimony regarding OSHA's proposal to
9 remove the medical evaluation requirement for
10 employees who are required to use filtering
11 facepiece respirators, including the N95 type
12 respirators and loose-fitting powered air
13 purifying respirators.

14 I appreciate OSHA's effort to examine
15 current requirements with the hope of increasing
16 efficiency and relieving administrative and
17 financial burden. However, I respectfully urge
18 OSHA to not finalize this proposal.

19 I believe the evidence presented does
20 not justify removing this preventative
21 safeguard, and I'd like to share some industry
22 experience and ask for reconsideration.

1 Ironwork is some of the most demanding
2 and brutal work a person can do. We help build
3 and maintain critical infrastructure by
4 performing high risk work, including steel
5 erection, welding, confined space, maintenance,
6 et cetera.

7 We climb ladders, carrying heavy loads,
8 working in hot or poorly ventilated areas, and
9 working in confined positions, performing
10 repetitive strenuous tasks for extended periods
11 of time, all 100 feet in the air, down in a
12 hole, or a hundred miles from the nearest town,
13 or even in the middle of a bustling city road,
14 because there's no place to land our iron.

15 And, sometimes we do all of this in the
16 same day while wearing a hard hat, glasses,
17 hearing protection, safety vest, a full body
18 harness, and a loaded tool belt. Needless to
19 say, it's not considered low to moderate
20 exercise, which was not considered in any of the
21 studies presented in the proposed rule.

22 Now, imagine you have to carry a heavy

1 load or climb a ladder while wearing a hard hat,
2 glasses, gloves, ear protection, safety vest,
3 harness, tool belt, and it's hot. And, now add
4 an N95 over your mouth and nose.

5 Can you safely tolerate wearing the
6 respirator while performing the job? Can you
7 trust that the person next to you can safely
8 tolerate wearing a respirator while performing
9 their duties?

10 The medical evaluation helps to answer
11 that question, because the N95 may be a
12 relatively light respirator, but it's an
13 additional physical demand placed on that
14 worker.

15 Many years ago, before I became a
16 journeyman, we had a contractor call and say, "I
17 need five ironworkers and three need to be
18 certified welders. The job site already had a
19 building in operations and there may be some
20 chemical exposure, or at the very least dust.
21 It is Arizona."

22 So, we were sent to get tested and

1 trained. My friend who I'll call Joe so he
2 doesn't get mad at me for using him as an
3 example at an OSHA hearing, he had been having
4 heart issues.

5 He didn't want to disclose that, he
6 wanted to work, because he wanted to provide for
7 his family. To illustrate some of the potential
8 risks, let's say there had not been a medical
9 evaluation and Joe is allowed to go to work
10 without medical clearance.

11 When you're in a precarious situation
12 up high or in a complicated structure like on a
13 bridge deck, your attention needs to be at 110
14 percent on the work in order for you, your
15 partner, and your crew to stay safe.

16 When your body begins to experience
17 pulmonary distress symptoms, they might not
18 always be obvious, but it is enough to
19 contribute to a serious injury like a fall.
20 That serious injury leads, for the contractor,
21 to insurance rates being adjusted.

22 The total recordable incident rate

1 number goes up, which is a metric that many
2 owners require you to be at a certain level for
3 you to even be allowed to bid on a project.

4 Halting work is necessary, but it comes
5 at cost and delays. And, with trade stacking
6 becoming too often on projects, the contractor's
7 not only causing project delays, but other
8 contractors can accuse you of holding them up.

9 If you need to replace the worker,
10 that's additional time and cost to hire and
11 train that person. It becomes more than just a
12 financial and administrative burden for the
13 contractor.

14 The costs not only outweigh the cost of
15 maintaining a simple medical screening process
16 for small businesses, this could be devastating
17 for them.

18 But, in good news, the medical
19 evaluation did flag Joe's medical condition and
20 he was given the time to properly follow up
21 before getting to work safely.

22 A successful medical screening program

1 prevents incidents. If a worker's screened and
2 determined to be at risk, that worker's
3 prevented from experiencing an event because
4 appropriate precautions are taken, and that
5 event does not appear in any database.

6 In the words of Carl Sagan, absence of
7 evidence is not evidence of absence. The
8 medical evaluation requirement is a preventative
9 measure.

10 Its purpose is to identify potential
11 problems before a worker experiences a medical
12 event. This also helps to clarify any concerns
13 or risks.

14 I have asthma and was originally told
15 that wearing an FFR could put me at risk. My
16 employer didn't want to put me in any risky
17 situation.

18 A medical evaluation helped prove that
19 I am able to wear any type of respirator and
20 allowed me to go to work. This reassurance to
21 the worker and the employer is critical in a
22 time where the industry is struggling to provide

1 a skilled workforce to populate the incredible
2 demand for data center and nuclear construction.

3 Therefore, OSHA's acknowledgement of
4 the existing medical evaluation remains a well-
5 accepted best practice and it should remain as
6 so.

7 In conclusion, I agree with OSHA's
8 advisory committee on Construction Safety and
9 Health's April 1 decision that said OSHA should
10 not proceed with the proposal to remove the
11 medical evaluation requirements and should
12 continue looking for best practices and provide
13 those to employers.

14 I'd also recommend OSHA conducts her
15 commission's construction-specific research on
16 respirator use during high exertion work. This
17 kind of data would be helpful in providing clear
18 criteria when a worker should receive
19 reevaluation based on changes in job duties,
20 physical demands, or environmental conditions.

21 Thank you. And, that is the remarks of
22 Blue Coble. She apologized for not being able

1 to be here with us today, but is also very happy
2 to answer any follow-up questions that we can
3 answer on her behalf.

4 And, I will turn it over to our last
5 panelist who we had scheduled to speak today,
6 Travis Parsons.

7 MR. PARSONS: Thank you, MK, and thank
8 you OSHA. I'll be brief because I already
9 testified earlier this morning. I'll be talking
10 a little bit about what Labor's work is over on
11 this NABTU Panel. Please see my previous
12 testimony for a description of the Laborers'
13 Health & Safety Fund of North America and LIUNA
14 members. I would also like to reiterate that
15 LIUNA members perform grueling physical labor,
16 such as demolition and remediation, and
17 tunnelling in extreme heat and wildfire smoke
18 operations, where respirators like N95 and
19 others are critical shields against hazards like
20 silica, asbestos, lead, and chemical fumes.

21 Combining respirators with heavy labor
22 creates a cardiovascular and respiratory stress,

1 and that is undeniable. OSHA's proposal to
2 eliminate mandatory baseline medical evaluations
3 for filtering facepieces and loose-fitting PAPRs
4 strips away these protective and proactive
5 preventive care measures that are in place
6 today. Without these screenings, laborers will
7 go undiagnosed through things like asthma, COPD,
8 heart disease, and at their hazardous zones,
9 blind to the risks.

10 Due to the fear of losing work and
11 shifts, workers rarely report breathing
12 difficulties and/or heart, for that matter, and
13 mandatory evaluations act as a non-negotiable
14 safeguard before anyone steps onto a job site
15 wearing a respirator. And while medical
16 evaluations are not an administrative burden,
17 they are an essential protection and essential
18 part of a comprehensive respiratory protection
19 program.

20 Those shifts should preserve mandatory
21 evaluations to safeguard these health workers'
22 health and lives. As safety and health

1 practitioners, we are taught to follow the
2 hierarchy of controls and eliminate or prevent
3 hazards before they occur versus managing
4 incidents after they unfold. That is my brief
5 comments to add to this panel. Thank you.

6 MS. CAIN: And that concludes our
7 prepared remarks.

8 JUDGE BELL: Mr. Levinson, questions
9 from OSHA?

10 MR. LEVINSON: Yes, Your Honor, thank
11 you. The first question is coming from Jonathan
12 Bearr.

13 DR. BEARR: Jonathan Bearr, OSHA. This
14 goes to the whole panel. In NABTU's written
15 comments, it stated that if OSHA removes the
16 medical evaluation requirement for FFRs and
17 loose-fitting PAPRs, employers must still be
18 responsible for preventing and addressing
19 adverse health effects that occur from
20 respirator use. Do any of you have suggestions
21 for how OSHA could remove the medical evaluation
22 requirement while still ensuring employer

1 responsibility?

2 MS. CAIN: Well, I would venture to say
3 don't remove it, because then you don't have to
4 figure out a creative way to ensure that workers
5 are safe in that regard. Is there anybody else
6 on the panel who wanted to respond? I know some
7 of our panelists are still in the other room, so
8 if anybody there wants to respond, just let me
9 know.

10 MS. FLETCHER: I'm happy to just quickly
11 respond. I think this is kind of one of those
12 situations of if it's not broke, don't fix it,
13 and that employers' liability is covered with
14 the current system. But I also think this would
15 be a great question to ask the employers on how
16 they would handle these situations?

17 DR. BEARR: Thank you. The other
18 question I have, so with voluntary use of N95s,
19 per se, no medical evaluation is required. So
20 do you know of any instances where employees who
21 voluntarily used a respirator like this wound up
22 having an adverse health outcome that would've

1 been discovered during a medical evaluation?

2 Also, referring to Brian Cavey's
3 testimony and Mr. Clark's testimony, it was
4 noted that workers will sometimes under-report
5 their medical conditions, and whether or not
6 there have been any instances that you all are
7 aware of where a worker who happened to under-
8 report their medical conditions wound up having
9 an adverse health outcome from wearing an FFR or
10 a PAPR?

11 MS. CAIN: Thanks. That's an
12 interesting couple of questions. It's not
13 something we discussed prior to the hearing, so
14 was there anybody on our panel who wanted to
15 respond to that? If any person -- then Glenn, I
16 think what you're looking for, Dr. Bearr, is
17 personal experience of workers who were using an
18 N95 as a voluntary -- a filtering facepiece N95
19 in a voluntary mode, and then experienced a
20 medical issue from that. That's one of your
21 questions, is --

22 DR. BEARR: That's correct. And the

1 other one had to do with Mr. Cavey and Mr. Clark
2 noting that workers will under-report their
3 conditions during the questionnaire, and that
4 these individuals may, perhaps, be wearing N95s
5 or PAPRs, and whether or not those individuals
6 who did not report having underlying conditions
7 -- or they may not even have known --

8 MS. CAIN: That's like, four questions
9 now. Can we go back --

10 DR. BEARR: Sorry.

11 MS. CAIN: Can we go back to the first
12 one?

13 DR. BEARR: Sure.

14 MS. CAIN: Glenn, that one you wanted to
15 respond to?

16 MR. MINYARD: Yeah. So I've been an OSHA
17 outreach instructor for 20 years, and I've
18 taught a lot of HAZWOPER classes.

19 MS. CAIN: Judge Bell, you're very
20 difficult to hear.

21 JUDGE BELL: Is anyone else having
22 difficulty hearing me? I was only asking the

1 witness to identify himself.

2 MR. MINYARD: Okay.

3 MS. CAIN: Go ahead, Glenn.

4 MR. MINYARD: My name is Glenn Minyard.

5 So I've been an OSHA outreach instructor for 20
6 years and taught a lot of HAZWOPER 40-hour
7 classes to prepare workers to be on hazardous
8 waste cleanup sites. So they did take these
9 classes voluntarily, and I've had multiple
10 people throughout the years that were all eager
11 to go on these projects, but once we would start
12 suiting them up and going through the fitting
13 process, we would go through the medical
14 questionnaire.

15 They were still eager to do it. Once
16 they put on the facepiece, one individual I'm
17 thinking of specifically right now, didn't
18 realize that when they breathe in to draw the
19 air through the facepiece that it would kind of
20 collapse on their face. The individual, with
21 every breath, said he felt like the entire room
22 -- because we were in the classroom at this time

1 -- felt like the entire room was collapsing in
2 on them, and they started panicking because they
3 were wearing the facepiece.

4 This was something that they wanted to
5 do, and did not know until I put the facepiece
6 on them and we were starting to go through the
7 fit testing that they were going to have this
8 claustrophobic reaction. We even had some get as
9 far as to be inside a fully encapsulated suit,
10 had the respirator on, everything was ready to
11 go, and when I got the zipper up to the top on
12 the encapsulated suit, they panicked and were
13 trying to rip themselves [sic] out of the suit,
14 and we had to unzip it and take these
15 individuals out.

16 So there are indications from the
17 classes that I've taught with the members who
18 were learning, where they did not know until we
19 were actually suiting up that they would react
20 in these ways.

21 MS. CAIN: This is Chris Cain. Thanks,
22 Glenn. Dr. Bearr, we're going to go back to the

1 transcript afterwards and make sure we
2 understand the questions you were asking, and
3 respond to them in post-hearing comments.

4 DR. BEARR: Thank you. Those are all
5 the questions from me.

6 MR. LEVINSON: Your Honor, the next
7 questions from the OSHA panel come from Dr.
8 Minda Nieblas.

9 DR. NIEBLAS: Thank you so much, and
10 thank you for your testimony. This question is
11 for all the panelists, but I believe Ms.
12 Fletcher and Mr. Kane specifically made
13 statements about this in their discussions with
14 us today. That is, I'm interested in
15 understanding more, or specifically knowing what
16 risks and liabilities they're hearing the small
17 business employers are stating that the
18 respirator questionnaire, medical questionnaire
19 protects them from.

20 So that was made several times and it
21 was a good argument. I'm just interested in
22 hearing a little bit more about specifically

1 what those risks are or liabilities might be,
2 and so yeah, that's kind of what I wanted to
3 expand on a little more. Specific instances
4 would be interesting, too, anecdotes are always
5 good.

6 MS. CAIN: Thank you, Dr. Nieblas. I
7 think that, while the panelists believe that the
8 risks would be then covered from the
9 contractors' perspective, we're not here to
10 testify in the legal obligations of the
11 contractor, though we'll take a look at the
12 question and see if we can provide some
13 reasonable comments in our post-hearing.

14 DR. NIEBLAS: Certainly understand,
15 thank you.

16 MS. CAIN: Thank you.

17 DR. NIEBLAS: And then, it was noted
18 that there is, as in the construction workforce,
19 a number of workers that have conditions that
20 may impact their ability to safely wear a
21 respirator. Do you have any information or data
22 about how many of these conditions have limited

1 the use of FFRs or PAPRs in the workplace?

2 Because we'd be interested in understanding a
3 little more about those situations.

4 MS. CAIN: I'm not hearing -- this is
5 Chris Cain. I'm not hearing anything from the
6 panelists on this one, so we will definitely try
7 to do our best in post-hearing on it. Thank
8 you.

9 DR. NIEBLAS: Thank you.

10 MR. LEVINSON: And Your Honor, the last
11 questions from the OSHA panel come from Tom
12 Mockler. Tom, you're muted.

13 MR. MOCKLER: Oh, I think I just
14 unmuted. Wait, hold on.

15 JUDGE BELL: You are now unmuted. Now
16 you're muted.

17 MR. MOCKLER: Okay, there's a slight lag
18 in the system. All right, can you hear me now?

19 JUDGE BELL: Yes.

20 MR. MOCKLER: Okay, all right. Yeah, I
21 have a few questions just to try to get a sense
22 if there's any data on the practices within your

1 union. The first question is does NABTU have
2 any survey data, or have there been any studies
3 within your membership on current practices with
4 regard to respirator usage, medical clearance
5 practices and procedures, and training on
6 respirator usage?

7 MS. CAIN: Chris Cain. Can you specify
8 the type of data that you're looking for?

9 MR. MOCKLER: Well, the ideal would be
10 like, a statistically valid survey, but to be
11 honest, if you had any, that would be good, so.

12 MS. CAIN: Chris Cain. I guess I'm
13 asking for more clarity on the type of data
14 you're looking for. We can seek data on
15 training patterns, training topics, activities
16 around training, on usage -- we can look for
17 data, but I'm not sure what types of data you're
18 asking for.

19 MR. MOCKLER: I guess I would
20 essentially say whatever you have would be
21 appreciated, so.

22 MS. CAIN: We'll definitely look and

1 provide what we can.

2 MR. MOCKLER: Okay, thanks. And I had a
3 second question, which is more specific to
4 medical evaluation. The question is -- and it's
5 a sort of variation on that question -- so are
6 you aware of any data on the number of, or
7 percentage of workers at NABTU worksites who
8 receive a medical evaluation from a physician?

9 Or alternatively, are you aware of any
10 data on the number or percentage of workers at
11 NABTU worksites who indicated on the screening
12 survey that they have a condition warranting a
13 medical evaluation? For example, does NABTU
14 have data on the prevalence of medical
15 evaluation among members whose use of certain
16 respirators may elevate the risk to employee
17 health?

18 MS. CAIN: You asked for the percentage
19 is of members who've had medical evaluation by a
20 physician, was one of your questions?

21 MR. MOCKLER: Yes, that was the first
22 question, yeah.

1 MS. CAIN: Was it medical evaluation --

2 MR. MOCKLER: Yeah, and it --

3 MS. CAIN: -- by the employer and
4 examination by a physician or licensed
5 healthcare practitioner, is what you're looking
6 for? Like, those two stages of the medical
7 evaluation?

8 MR. MOCKLER: Well, again, I think
9 whatever you have. Yeah, right, but sure.
10 Yeah, it wouldn't -- whatever would essentially
11 pass muster would be existing standard.

12 MS. CAIN: I think some of that data
13 we've provided in our written comments --

14 MR. MOCKLER: Okay.

15 MS. CAIN: -- and testimony, but it
16 would be anecdotal. We will look at the --

17 MR. MOCKLER: Okay.

18 MS. CAIN: -- systemic data --

19 MR. MOCKLER: Right.

20 MS. CAIN: -- and provide it in post-
21 hearing comments.

22 MR. MOCKLER: Yeah, okay, that would be

1 appreciated.

2 MR. LEVINSON: Your Honor, that
3 concludes the remarks or the questions from
4 OSHA.

5 JUDGE BELL: Thank you. Mr. Berndt,
6 questions from the solicitor?

7 MR. BERNDT: Joseph Berndt from the
8 solicitor's office. No follow-up questions.
9 Thank you to the members of the NABTU panel for
10 their testimony today.

11 JUDGE BELL: Do we have questions from
12 the public?

13 MS. BURKE: No public questions, Your
14 Honor.

15 JUDGE BELL: All right, to the panel,
16 thank you very much for your testimony. We very
17 much appreciate it. I think at this time we'll
18 take our lunch break. Be back at 1:00 p.m.
19 Eastern time.

20 (Whereupon, the above-entitled matter
21 went off the record at 11:56 a.m. and resumed at
22 1:03 p.m.)

1 JUDGE BELL: I don't have any opening
2 statement to give in the afternoon session.
3 It's just a little after 1:03, and I think we're
4 ready for the next panel, please. You can go
5 ahead with your testimony.

6 MS. HARRISON: We will start promoting
7 our speakers for this session now. Let's see.
8 Do we have American Federation of Government
9 Employees on the line? Perfect, thank you. All
10 right, Ellie Barbarash, I have just promoted you
11 to panelist.

12 MS. BARBARASH: There we go. Hello, can
13 you all hear me, please?

14 JUDGE BELL: We can. Thank you very
15 much for being with us. Go ahead and begin your
16 testimony, please.

17 MS. BARBARASH: Thank you for presiding
18 on this and for the honor of addressing you. My
19 name is Ellie Barbarash. I'm a Certified
20 Professional Environmental Auditor with a
21 specialty in occupational safety. I've been in
22 the field for more than 40 years. I serve as a

1 Senior Health & Safety Advocate for AFSCME, the
2 American Federation of State, County & Municipal
3 Employees. AFSCME is a labor union representing
4 1.4 million members.

5 We build and maintain infrastructure,
6 provide healthcare, emergency medical and rescue
7 service, generate and deliver power, handle
8 municipal waste, and provide clean drinking
9 water. AFSCME represents countless workers
10 using respiratory protection to stay safe on the
11 job, including those using disposable air-
12 purifying FFRs like N95s and loose-fitting
13 PAPRs.

14 In our written comments, we described
15 how workers would be injured if proposed
16 revisions to the Respiratory Protection Program
17 standard, the RPP, should become law. We wrote
18 about how removing initial medical evaluation
19 requirements would strip workers of their right
20 to be medically assessed for health conditions
21 that either already exist, or that could be
22 worsened by using a tight-fitting respirator.

1 OSHA has not provided science-based
2 evidence to support any of these proposals.
3 Confidential screening evaluations should be
4 provided before any required respirator use,
5 even before fit testing. In the years before
6 the 1998 version of 1910.134, the Respiratory
7 Protection Standard, I personally observed
8 workers suffer illness and cardiac injury in the
9 middle of fit testing when fit testing was
10 carried out before the requirements for medical
11 evaluation and clearance had been implemented or
12 acquired.

13 Before workers are ordered to use any
14 tight-fitting negative-pressure respirator in a
15 contaminated environment, employers must assess
16 through a PLHP, a physician or licensed
17 healthcare professional, whether each worker is
18 medically capable of using the respiratory
19 protective equipment necessary for their safety.

20 As many people here have reminded us, the
21 purpose of the OSH Act is to assure safety and
22 healthful working conditions for working men and

1 women.

2 Providing medical evaluations prior to
3 respirator use delivers that assurance. As
4 OSHA's RPP is written, Appendix C establishes
5 key mandatory medical screening questions to
6 evaluate worker capacity to safely wear a
7 respirator. Negative answers to any one of the
8 first eight questions in Part A, Section 2
9 requires a more thorough diagnostic assessment
10 by the PLHP reviewing the screening
11 questionnaire. Follow-up diagnostic evaluations
12 must have their costs covered by the employer.

13 Key screening questions inquire about
14 histories of smoking, seizures, diabetes,
15 allergies, claustrophobia, pulmonary or
16 cardiovascular problems, medication or previous
17 adverse reactions to respirator use. The ninth
18 question asks workers, would you like to talk to
19 a healthcare professional who will review this
20 questionnaire with your answers?

21 Under the RPP, when it is actually
22 followed by employers, every worker assigned to

1 wear a tight-fitting respirator is granted a
2 potential opportunity to discuss their personal,
3 confidential medical situation with PLHP before
4 having to don respiratory protection for their
5 employer. Workers' right to medical evaluation
6 can provide access to further follow-up and
7 testing.

8 Health practitioners' professional
9 judgment may lead to workers being assigned more
10 protective or more comfortable respirators, or
11 could lead to workers' hours of respirator use
12 being restricted. The employer must respect and
13 cannot retaliate these changes, even if they
14 cost a little more money. OSHA's proposed
15 amendment would strip this protection from
16 workers and thus, endanger their health and
17 safety.

18 If employers are no longer required to
19 provide medical evaluations for workers assigned
20 to use FFRs or loose PAPRs, then the burden of
21 that safety and medical clearance -- can I do
22 this safely -- will be shifted to workers

1 instead of to the employers. Workers will lose
2 the right and the capacity to confidentially
3 request the need for and receive additional
4 medical screening paid for by the employer.

5 Workers will lose the right to be
6 accommodated for their health issues or partial
7 disability. They will lose the right to be
8 reevaluated by the employer's third party when
9 their health status changes or they experience
10 adverse signs or symptoms associated with
11 respirator use. For workers required to use
12 FFRs and loose-fitting PAPRs in hazardous
13 atmospheres, losing the right to confidential
14 paid-for medical evaluation will place workers
15 and AFSCME members' health at risk.

16 I would like to tell a story about a
17 healthcare worker, a union member, and my
18 personal friend, to illustrate the importance of
19 maintaining the Respiratory Protection Standard
20 as it is currently written. In 2020, my friend,
21 B, an advanced practice nurse, an APN, she had
22 decades of nursing experience. She was working

1 infection control in a large metropolitan
2 hospital in OSHA's Region 2.

3 She was experienced working shifts in
4 intensive cardiac and critical care. As the
5 COVID epidemic raged, she went from using PPE
6 and surgical masks to using FFRs, and when fresh
7 respirators ran out in her facility, she had to
8 reuse recycled, reeking N95s at the bedside of
9 one prone or intubated COVID patient after
10 another.

11 Like many colleagues, after long shifts
12 she came home through her garage, doffing
13 clothing and showering before greeting anyone at
14 home. Her family was likewise vigilant in
15 trying to stay safe and COVID-free, masking out
16 doors, vaccinating early, and self-testing along
17 with B. B was also responsible for teaching
18 infection control to new nurses. However, she
19 found the CDC's direction on COVID inconsistent.

20 CDC stated that respirators were not
21 necessary for exposures less than 15 minutes or
22 beyond six feet from a COVID-infected patient,

1 but B recognized that COVID transmission was
2 probably airborne, and she knew that airborne
3 transmission is never limited by 15 minutes of
4 exposure or to a six-foot spread, even though
5 OSHA adopted CDC's recommendations on this.

6 Hospital staff lounges and lunchrooms
7 did not require masking at her hospital. B was
8 vaccinated as soon as vaccines were available,
9 but she still got COVID. Her work exposures
10 were just too high. She was out sick for the
11 first time for five weeks. When she returned,
12 she was assigned to use even more sterilized,
13 smelly, reused N95s.

14 After about four months back on the
15 wards, B got COVID a second time. She was
16 sicker this time and was home for several
17 months, despite being vaccinated. When she
18 returned to work, it was really hard for her to
19 breathe through her N95s. Other nurses
20 recommended a different kind of filtered N95
21 respirator that was more comfortable, an Envo
22 Mask, which was NIOSH approved, with easily

1 replaceable flap filters, and reusable and
2 cleanable.

3 She purchased one herself and asked her
4 employer to fit test her, and she passed her fit
5 test. B also purchased all her own replacement
6 filters so she could change them as frequently
7 as she needed. She maintained strict infection
8 control protocols and her COVID vaccination
9 schedule. She still worked with the sickest,
10 most acute patients, and then she got COVID for
11 a third time.

12 This time, B was out for more than four
13 and a half months. She developed long COVID.
14 When she finally returned to work, she could not
15 comfortably breathe through any FFR, and even
16 the Envo Mask was really hard to work in, even
17 changing filters every 20 minutes if she could.

18 COVID had caused pulmonary damage. Her local
19 union backed her request.

20 She requested of her employer, under
21 the FFR, a new medical evaluation, and the union
22 assured her she would be protected from

1 retaliation. Her employer did allow B to be
2 reevaluated by a PLHP, and her medical details
3 remained private from her employer. As a
4 result, she was assigned a loose-fitting PAPR
5 with daily hours of respirator use restricted.
6 Her employer could not and did not retaliate. B
7 worked out an assignment change and took a
8 position in hospice.

9 My friend is still working in that
10 hospital as a skilled APN. Her continued
11 employment was only possible because the RPP let
12 her request a fit test, and then let her request
13 a new confidential medical screening when it was
14 obvious that her health status had changed, a
15 sequence of events that forced her employer to
16 eventually provide B with a more appropriate
17 respiratory protection, providing her with a
18 loose-fitting PAPR that she could use safely.

19 Had 1910.134 been amended in 2021 as
20 OSHA's current revision proposes, my friend B, a
21 skilled APN with decades of experience, would
22 have been forced to give up her career for the

1 sake of her health, adding to her employer and
2 the industry's chronic short-staffing crisis.
3 On behalf of all workers who use N95s, FFRs and
4 loose-fitting PAPRs in healthcare, construction,
5 research, engineering, emergency service and
6 more, AFSCME strongly opposes OSHA's proposed
7 changes to the Respiratory Protection Standard.

8 Thank you.

9 JUDGE BELL: Thank you. Mr. Levinson,
10 questions from the OSHA room?

11 MR. LEVINSON: Yes, Your Honor. Dr.
12 Jonathan Bearr has the first question from OSHA.

13 DR. BEARR: Thank you. Jonathan Bearr,
14 OSHA. I was wondering, especially in light of
15 the difficult story you shared with B, how often
16 do employees have conditions that show up after
17 their initial questionnaire and evaluation that
18 then require another medical evaluation to
19 determine how fit they are to wear their
20 mask/respirator?

21 MS. BARBARASH: I don't believe I have
22 data on that, but like other speakers here, we

1 can see what we can find and get back to you in
2 the post comment period.

3 DR. BEARR: Thank you.

4 MS. BARBARASH: I do know that it is
5 available as an option. In my friend's case,
6 there was a period of time between one and the
7 other, and that period was marked by her third
8 illness with COVID.

9 DR. BEARR: And I have one other
10 question. By any chance do you, in your
11 experience or the experience of your membership,
12 are you aware of how often, when a medical
13 questionnaire does flag someone for an
14 examination, how often that the employee is
15 actually learning for the first time that they
16 may have a condition, something that wasn't
17 diagnosed before?

18 MS. BARBARASH: I only know it
19 anecdotally. I don't have data on it, and I
20 certainly -- the story that I told about the
21 person having cardiac injury in 1998, that was
22 me fit testing in 1998, so I've been doing this

1 a while. I certainly have seen it happen. I
2 have fit tested people where screening has
3 revealed it after the fact. But aside from
4 personal knowledge, I wouldn't be able to give
5 you data.

6 DR. BEARR: All right, thank you very
7 much. Those are all the questions from me.

8 MR. LEVINSON: Your Honor, the next
9 question from OSHA comes from Dr. Minda Nieblas.

10 DR. NIEBLAS: Thank you, hello. As I
11 was listening to your testimony -- thank you --
12 I understand you mentioned the specifically
13 tight-fitting respirators. Could you elaborate
14 on why a PAPR, despite being easier to breathe
15 in, would still warrant a medical evaluation
16 before use?

17 MS. BARBARASH: Yes, I can. Yes, I can.
18 So if you wear hearing aids, it is really hard
19 to hear from the PAPR's motor. If you have a
20 neck injury, it can trigger neck injury or can
21 trigger shoulder injury. Very often the PAPR is
22 tight in certain ways that trigger migraine

1 headaches because of how they're holding onto
2 the head. I am a PAPR user, and those are some
3 personal answers I can give you. Those are
4 directly experienced issues.

5 Issues I've found with other members
6 might, in some cases it's that the airflow isn't
7 enough. In some cases, it's that -- well, I'm
8 thinking ahead because there are other OSHA
9 things that I'll probably testify about. But
10 it's really an issue about weight, balance,
11 pressure on the head, sound and communication,
12 would be how I would bundle them in my personal
13 experience as an occupational safety person.
14 There might be more, but that's what comes to
15 mind.

16 DR. NIEBLAS: Thank you.

17 MR. LEVINSON: Your Honor, the last
18 questions from OSHA come from Tom Mockler.

19 MR. MOCKLER: Hi. Yeah, I've asked a
20 series of questions just trying to find out what
21 kind of data various groups have, and I think
22 particularly valuable, since we actually

1 historically have had the least information
2 about government employees. So let me ask a few
3 questions here.

4 Does your union have any survey data,
5 or have there been any studies within your
6 membership on current practices with regard to
7 respirator usage, medical clearance practices
8 and procedures, and training on respirator
9 usage?

10 MS. BARBARASH: I would have to check
11 and get back to you. I wouldn't have it in
12 front of me, sorry.

13 MR. MOCKLER: Okay, that would be great.
14 And sort of a follow-up, are you aware of any
15 data on the number or percentage of workers at
16 AFSCME worksites who received a medical
17 evaluation from a physician, or are you aware of
18 any data on the number or percentage of workers
19 at government worksites who indicate on the
20 screening survey that they have a condition
21 warranting a medical evaluation.

22 For example, does AFSCME have data on

1 the prevalence of medical evaluation among
2 members whose use of certain respirators may
3 elevate risk to employee health?

4 MS. BARBARASH: Would you run those
5 questions by me one more time? I'm so sorry.
6 My answer may not change, but it would be
7 helpful if I could hear them again. Thank you.

8 MR. MOCKLER: Right. This may be a
9 matter of just getting on the record and then
10 you could -- if you're looking for stuff that
11 you can put in post-hearing comments, but I'll
12 run it by you again. This is all part of like,
13 the same question.

14 Are you aware of any data on the number
15 or percentage of workers at AFSCME worksites who
16 receive a medical evaluation from a physician,
17 or are you aware of any data on the number or
18 percentage of workers at AFSCME worksites who
19 indicated on the screening survey that they have
20 a condition warranting a medical evaluation?
21 More specifically, does AFSCME have data on the
22 prevalence of medical evaluation among members

1 whose use of certain respirators may elevate
2 risks to employee health.

3 MS. BARBARASH: Again, I'd have to check
4 and get back to you. I only have personal
5 anecdotal information from my experience as a
6 professional at the moment.

7 MR. MOCKLER: Right, yeah. We're just
8 trying to find out what's out there, so that
9 would be helpful. All right, thanks.

10 MR. LEVINSON: And Your Honor, that
11 concludes the questions from the OSHA panel.

12 JUDGE BELL: Thank you. Mr. Berndt,
13 questions from the solicitor?

14 MR. BERNDT: Yes, Joseph Berndt from the
15 Office of the Solicitor. No questions from me.
16 Thank you, Ms. Barbarash.

17 MS. BARBARASH: Thank you.

18 JUDGE BELL: Any questions from the
19 public?

20 MS. BURKE: There are no questions from
21 the public, Your Honor.

22 JUDGE BELL: All right, thank you very

1 much for your testimony. We really appreciate
2 it.

3 MS. BARBARASH: Thank you.

4 JUDGE BELL: We ready with the next
5 panel, please?

6 MS. HARRISON: Yes, I am promoting Jamie
7 Brown, Jane Thomason, and Rocelyn de Leon-Minch.

8 JUDGE BELL: Thank you all. Welcome.
9 You may begin your testimony when you like.

10 MS. BROWN: My name is Jamie Brown. I
11 am President of National Nurses United, the
12 largest union and professional association for
13 registered nurses in the United States. NNU
14 represents more than 225,000 nurses across the
15 country. Our members work in acute care
16 hospitals and other healthcare settings in both
17 the private and public sectors.

18 I work in the surgical trauma critical
19 care unit, and I have been a registered nurse
20 for over 20 years. We are here in opposition to
21 OSHA's proposal to eliminate medical evaluation
22 requirements for filtering facepiece

1 respirators, FFRs, and loose-fitting powered air
2 purifying respirators, PAPRs. As frontline
3 healthcare workers, nurses provide hands-on
4 lifesaving care to our patients.

5 Our work environment contains
6 significant hazards, many of which can be
7 airborne, including infectious diseases,
8 cleaning and disinfectant chemicals,
9 pharmaceuticals and hazardous drugs, and
10 surgical plume and anesthetic gases. Multiple
11 measures, including engineering and
12 administrative controls and PPE, are vital to
13 protect us from these hazards, but even with
14 other controls in place, PPE is often a key
15 layer because of our proximity to our patients.

16 This is to say nurses are among the
17 millions of workers who rely on respirators
18 every day to protect our health while we do our
19 jobs, but a respirator doesn't just protect us
20 out of the box. A comprehensive program is
21 necessary to make sure that respirators
22 effectively protect workers, including ensuring

1 that respirators fit properly, can be worn
2 safely, and are sufficiently protective, and
3 that workers are trained appropriately.

4 For nearly 30 years, OSHA's Respiratory
5 Protection Standard has been in place with
6 responsibility for this comprehensive program
7 where it belongs, with employers. Yet
8 healthcare employers often fail to meet these
9 program requirements. A 2014 assessment found
10 that most of the evaluated hospitals had
11 respiratory protection programs that lacked one
12 or more requirement elements.

13 NNU's nationwide survey found that
14 nearly 20 percent of nurses had not been not
15 been fit tested in the previous year, despite
16 fit testing being required at least annually for
17 workers who may need to use a respirator. We
18 also found that healthcare employers failed to
19 select an appropriate level of respiratory
20 protection for major airborne pathogens. Only
21 about two-thirds of the nurses reported N95 or
22 higher level respirator use for tuberculosis and

1 COVID, and about one-third for measles.

2 When healthcare employers fail to
3 implement the necessary elements of a
4 respiratory protection program, healthcare
5 workers are left exposed to airborne hazards
6 that can lead to illness, severe disease, death
7 and other long-term healthcare impacts. The
8 bottom line is that healthcare workers need
9 stronger workplace protection enforcement, and
10 not weaker standards. That is why NNU opposes
11 OSHA's proposal to eliminate the medical
12 evaluation requirements for FFRs and loose-
13 fitting PAPRs.

14 OSHA's proposal would weaken
15 respiratory protection programs, removing
16 protections for all workers who need to use a
17 respirator, especially those with certain health
18 conditions. The current Respiratory Protection
19 Standard requires all workers to complete a
20 medical questionnaire prior to respirator use.

21 If certain conditions are noted, like
22 seizures, asthma, or cardiovascular or pulmonary

1 problems, the worker is referred to a physician
2 or other licensed healthcare provider for a
3 medical exam and a written recommendation.
4 Medical evaluations should also occur when a
5 worker's health condition has changed, even
6 temporarily, and may impact respirator use, such
7 as pregnancy or cancer.

8 Through this straightforward and simple
9 process, a worker may access safer respirator
10 alternatives, such as a loose-fitting PAPR or
11 alternative work assignments, if needed. OSHA's
12 proposal to remove medical evaluations for some
13 of the most commonly used types of respirators
14 means it is unclear how or whether employees
15 with medical conditions impacting the respirator
16 use can get access to alternative respirator
17 types or alternative work assignments, if
18 needed.

19 Removing medical evaluation
20 requirements for FFRs and loose-fitting PAPRs
21 places workers, especially those with health
22 conditions that could be impacted by respirator

1 use, at an undue risk of harm that could be
2 easily prevented by improving enforcement of
3 current standards. OSHA proposes to remove
4 those protections at a time when healthcare
5 employers have already created some of the most
6 dangerous working conditions in the country.

7 Every day, nurses witness how hospital
8 employers prioritize profits at the expense of
9 health and safety for us and our patients. Our
10 employers intentionally understaff our units to
11 cut labor costs, forcing nurses to take
12 dangerously high patient loads. Extensive
13 research shows that understaffing nurses
14 endangers patients and increases the risk of
15 occupational injury and illness for workers.

16 Our employers then neglect safety and
17 health protections, leaving us exposed to
18 hazardous conditions, including high rates of
19 workplace violence, ergonomic hazards,
20 infectious disease, hazardous chemicals and
21 other harmful exposures, leading to high rates
22 of injuries and illness on the job. As a

1 result, nurses are leaving the bedside.

2 Data shows that there are about 1.15
3 million registered nurses with active licenses
4 who are not currently working as nurses. There
5 is no nursing shortage, but a staffing crisis
6 brought on by years of industry neglect and
7 driven by healthcare employers' refusal to
8 create good nursing jobs where nurses are
9 respected, protected, and able to provide the
10 safe, therapeutic care our patients deserve.

11 In this moment, OSHA is spending time
12 removing existing protections that have worked
13 instead of making forward progress in addressing
14 hazards impacting nurses. Congress created OSHA
15 to protect workers' rights to be safe and
16 healthy at work, but under the Trump
17 Administration, OSHA is moving policies that
18 help corporations profit at the expense of
19 worker health and safety. OSHA's proposal to
20 remove medical evaluations for FFRs and loose-
21 fitting PAPRs inappropriately shifts the burden
22 of care away from employers to workers.

1 Combined with OSHA's reduced
2 enforcement activities and proposals to weaken
3 other standards, it is clear that OSHA is moving
4 away from its mission. This is part of the
5 Trump Administration's fascist plan to rig the
6 economy for billionaires at the expense of
7 working people. If OSHA makes changes like the
8 current proposals permanent in addition to
9 reducing enforcement, more workers will get
10 sick, injured and die.

11 NNU calls on OSHA to remain focused on
12 the mission that Congress created to protect
13 workers, not corporate profits. Especially in
14 the context of this hearing, NNU urges OSHA to
15 rescind or at least stall this proposal to
16 remove medical evaluations for FFRs and loose-
17 fitting PAPRs. NNU urges OSHA to maintain
18 current medical evaluation requirements and to
19 enhance enforcement of the Respiratory
20 Protection Standard to protect nurses and other
21 workers.

22 I will now turn it over to NNU's

1 Assistant Director of Health & Safety, Jane
2 Thomason, and NNU's Industrial Hygienist,
3 Rocelyn de Leon-Minch, to add additional details
4 to our presentation.

5 MS. THOMASON: Thank you, President
6 Brown. My name is Jane Thomason. I am the
7 Assistant Director of Health & Safety for NNU.
8 I'm also a Certified Industrial Hygienist with
9 over 10 years of experience and specialization
10 in healthcare.

11 Following up on President Brown's
12 remarks, we would like to provide three main
13 rebuttals to the arguments used by OSHA to
14 justify the elimination of the medical
15 evaluation requirements for workers who wear
16 FFRs and loose-fitting PAPRs. We do not believe
17 that OSHA has effectively made the case for this
18 proposal.

19 Rebuttal #1: OSHA's comparison to
20 voluntary respirator use during the COVID
21 pandemic is faulty. OSHA's proposal claims that
22 despite the sudden increase in and widespread

1 use of respirators and other face coverings
2 during the COVID pandemic, no evidence surfaced
3 identifying adverse outcomes in individuals with
4 underlying medical conditions.

5 But OSHA fails to cite surveillance
6 data or studies that even attempted to capture
7 this information, indicating that OSHA is
8 falling into a logical fallacy. The absence of
9 evidence is not the evidence of absence. OSHA's
10 argument also fails to recognize important
11 factors, including people who experience adverse
12 health outcomes related to using respirators due
13 to a specific medical condition may have chosen
14 not to voluntarily wear respirators.

15 Surgical and cloth masks were
16 frequently used. Workers with specific medical
17 conditions who opted for surgical or cloth masks
18 would not experience the same impacts as a
19 tight-fitting respirator, because surgical and
20 cloth masks are loose-fitting and have
21 significantly lower breathing resistance. The
22 lack of evidence that OSHA cites is not a

1 motivating reason to remove existing protections
2 that maintain employer responsibility for worker
3 health and safety.

4 Rebuttal #2: OSHA's assumption that
5 employees can simply take off respirators when
6 they need a break is erroneous and could lead to
7 dangerous workplace exposures. So in its
8 proposal, OSHA seeks to remove the medical
9 evaluation requirement for FFRs and loose-
10 fitting PAPRs on the basis of, if an employee
11 with a health condition experiences symptoms of
12 physical harm, they can simply remove the
13 respirator to take a break.

14 OSHA reasons that that worker likely
15 won't die because they won't be in an
16 immediately dangerous to life or health (IDLH)
17 situation since FFRs and PAPRs are not allowed
18 to be used in such conditions. This is a truly
19 absurd claim. OSHA's argument ignores the risks
20 posed by even short-term exposures to hazards
21 that are commonly present in healthcare
22 settings, like infectious diseases and hazardous

1 chemicals, where any amount of exposure can
2 contribute to health harm, especially when
3 cumulative.

4 There is very clear evidence that
5 short-term repeat exposures can increase the
6 risk of infection. For example, there is ample
7 evidence that indicates that SARS-CoV-2
8 infection can occur with fleeting exposures
9 occurring multiple times over a work shift.
10 Other pathogens have very low infectious doses,
11 like Ebola, where transmission can occur after
12 exposure to only one or a very few number of
13 viral particles.

14 OSHA also assumes that workers can just
15 leave their job tasks if they need a break from
16 the respirator due to a medical condition. This
17 is an assumption completely ignorant of the
18 daily realities faced by nurses and other
19 healthcare workers. When caring for a patient
20 with an infectious disease, nurses must wear
21 extensive PPE ensembles that can make it
22 difficult to leave the patient's room quickly.

1 Time is required to properly doff PPE to prevent
2 self-contamination.

3 Patient care often requires a nurse's
4 constant attention. They can't just leave their
5 patient's room if their patient is in crisis.
6 The employer-created healthcare staffing crisis,
7 which President Brown described, often means
8 that nurses are already unable to safely take
9 their meal and rest breaks.

10 OSHA's proposal would leave nurses less
11 protected, at higher risk of acquiring
12 infections and other harmful exposures at work,
13 like antineoplastic drugs, chemotherapy agents,
14 all to save employers money on medical
15 evaluations.

16 Rebuttal #3: OSHA's assumption that
17 high-exertion work likely self-selects for
18 individuals who would be medically fit to wear a
19 respirator is irrelevant and also unsupported.
20 In the proposal, OSHA assumes that high-exertion
21 work self-selects for individuals who would be
22 medically fit to wear an FFR or a PAPR. This is

1 an issue that is unfounded for two reasons.

2 One, there is no clear connection
3 between high-exertion work and work that
4 requires an FFR or PAPR. OSHA offers no
5 supporting evidence for making this claim, and
6 in fact, healthcare workers performed tasks with
7 mixed exertion levels. Speaking to patients,
8 charting, or administering medication may be low
9 to medium-exertion work, while moving and
10 handling patients, transporting patients,
11 responding to call lights, and performing CPR
12 may be medium to high-exertion work.

13 To imply that work with a respirator is
14 always high-exertion is completely wrong, and to
15 claim that high-exertion work self-selects
16 healthy individuals is a hasty generalization
17 that is just not true, which brings me to the
18 second reason OSHA should not be making these
19 assumptions. OSHA is also falsely assuming that
20 a worker's health status and risk level will not
21 change over time.

22 OSHA offers no supporting evidence for

1 this assumption, and the reality is that
2 occupational exposures can and do impact health,
3 and can cause an employee to develop a work-
4 related health condition over time that could
5 limit the use of a respirator. Just to provide
6 one example, COPD, chronic obstructive pulmonary
7 disease, and asthma are both specific medical
8 conditions that can limit a worker's ability to
9 use a tight-fitting negative-pressure
10 respirator, and which might require an
11 accommodation.

12 Both COPD and asthma can be caused
13 and/or exacerbated by common workplace exposures
14 in healthcare settings, like disinfectants and
15 cleaning chemicals. We have provided a lot more
16 supporting detail in our written comments
17 submitted to the docket last year. I would now
18 like to turn it over to Rocelyn to briefly
19 discuss one additional concern that we have
20 regarding OSHA's proposal.

21 MS. DE LEON-MINCH: Thanks very much.
22 Thank you, President Brown. Thank you,

1 Assistant Director Jane Thomason. My name is
2 Rocelyn de Leon-Minch, and I am an Industrial
3 Hygienist with National Nurses United. So in
4 the proposal, OSHA inaccurately represents
5 several studies by omitting key findings,
6 implications, or conclusions.

7 For example, OSHA cites the 2020 paper
8 by Epstein, et al., titled Returning to Training
9 in the COVID-19 Era: The physiological effects
10 of face masks during exercise. While the
11 findings are reported correctly, OSHA
12 inappropriately employs the study to aid its
13 argument that medical evaluations are not
14 necessary.

15 OSHA ignores the author's own
16 acknowledgement that, "subjects with obstructive
17 lung diseases like asthma or COPD, heart
18 diseases, should undergo meticulous evaluation
19 before attempting physical activity with a
20 mask." OSHA also references Harber and
21 Beckett's 2023 paper titled, Health Effects of
22 Filtering Facepiece Respirators: Research and

1 clinical implications of comfort, thermal, skin,
2 psychologic, and workplace effects.

3 When discussing the idea that
4 claustrophobia in large numbers of workers
5 wearing respirators is unfounded. The
6 application of this study in opposition to
7 medical evaluations is again problematic, as one
8 of the purposes of this study was to identify
9 research gaps to facilitate and better inform
10 future medical evaluations.

11 The researchers conclude that symptoms
12 are frequent and often exacerbate existing
13 problems, and that their analysis "suggests
14 several specific recommendations for respirator
15 research to inform both medical evaluation of
16 individual users and regulatory standards."

17 Lastly, OSHA summarizes the findings in
18 Harber, et al.'s 2025 paper titled, Respirator
19 Medical Examinations: Current practices and
20 future needs, stating that, "nearly all workers
21 were approved without restrictions, and it was
22 considered very unusual to decline approval."

1 This statement not only cherry-picks
2 the study's findings, but is categorially
3 untrue. Harber, et al.'s 2025 paper
4 demonstrates that evaluations rarely prevent
5 individuals from respirator use, but
6 significantly impact accommodation by adjusting
7 respirator type or use conditions. Sixty-six
8 percent of clinics reported that restrictions
9 were unusual, but 22 percent of clinics
10 indicated more frequent use of restrictions.

11 The study openly advocates for
12 expanding medical evaluations, as their
13 analysis, "supports the value of initial
14 evaluations and indicates that a broader set of
15 considerations should supplant the traditional
16 emphasis on pulmonary and cardiac issues.

17 OSHA's incomplete presentation of
18 findings and inappropriate reliance on studies
19 that support medical evaluations demonstrate
20 that there is not substantial evidence
21 indicating medical evaluations should no longer
22 be performed for FFRs and loose-fitting PAPRs.

1 In conclusion, nurses, healthcare and
2 other workers that depend on respiratory
3 protection need stronger workplace protection
4 and enforcement, not less. Amending the
5 respirator medical evaluation requirements would
6 materially weaken OSHA's Respiratory Protection
7 Standard and remove life-saving protections for
8 millions of workers across the country.

9 NNU urges OSHA to fulfill its
10 obligation to protect the health and safety of
11 workers and rescind this proposal immediately.
12 Thank you.

13 JUDGE BELL: All right, Mr. Levinson,
14 questions from the OSHA room?

15 MR. LEVINSON: Yes, Your Honor. The
16 first question comes from Jonathan Berr.

17 DR. BEARR: Hi, Jonathan Berr, OSHA. I
18 was wondering -- and this goes to the entire
19 panel -- if you all have collected any
20 information or if you have any information on
21 the percentage of workers who are identified
22 through the questionnaire as having an

1 underlying condition that could pose a risk to
2 wearing an FFR or PAPR?

3 MS. BROWN: I am not aware of any data
4 right now, but we will look and get back to you.

5 DR. BEARR: And I guess sort of building
6 on that, and again, I imagine you'll get back to
7 us -- what percentage of those individuals who
8 wind up having use limitations on their usage of
9 these respirators?

10 MS. BROWN: Again, I'll have to get back
11 to you.

12 DR. BEARR: And one last, and again, I
13 imagine you have to get back to me, which is
14 perfectly fine, in your post-hearing comments.
15 What percentage of these individuals that are
16 identified in the questionnaire actually learn
17 that they have a condition based on the
18 questionnaire, as in they did not know they had
19 a condition prior to filling out the
20 questionnaire?

21 MS. BROWN: We'll get back to you.

22 DR. BEARR: Thank you very much.

1 MS. BROWN: You're welcome.

2 MR. LEVINSON: Your Honor, the next
3 questions from OSHA come from Dr. Minda Nieblas.

4 DR. NIEBLAS: Thank you all for your
5 testimony. This is in general to the panel.
6 Anyone who chooses to answer, that's fine. In
7 your comments, you had noticed that employers
8 provided surgical masks and not FFRs when
9 workers were exposed to diseases. Did your
10 members express why they thought that happened,
11 why FFRs weren't permitted?

12 MS. BROWN: Jane, do you want to take
13 that one?

14 MS. THOMASON: Sure. Are you talking
15 about COVID specifically?

16 DR. NIEBLAS: Yes, I believe this was in
17 the context of COVID.

18 MS. THOMASON: Okay, so I believe
19 another panelist also addressed this earlier
20 today. The CDC's guidance during the early
21 parts of the COVID pandemic emergency waffled
22 back and forth, and then ultimately, the CDC

1 created the -- what did they call it? Basically
2 it was a menu of options for employers to race
3 to the bottom. They called it like, emergency
4 strategies or conservation strategies.

5 So in healthcare, we often see
6 employers race to the lowest possible standard
7 that they can get away with. And with COVID,
8 because the CDC muddled the waters and OSHA
9 didn't -- honestly didn't stand up to the CDC on
10 respirators being needed, we saw a lot of
11 healthcare employers race to the lowest standard
12 that they could possibly get away with.

13 We, of course, had nurses organizing
14 around that and fighting back, and winning
15 respirator use policies at their facilities,
16 ending policies to reuse respirators, because
17 the reality that a lot of our members faced was
18 that there was never a true shortage, or there
19 was never evidence of a true shortage. What
20 employers were doing was that they had lots of
21 N95 respirators locked up in their offices or in
22 the supply closet, and they would not allow

1 nurses to use them.

2 So we had to counter a lot of those
3 moves from management to restrict nurses' access
4 to the PPE that they needed to survive, to be
5 able to care for their patients and go home to
6 their families safely. So really it was in the
7 context of healthcare employers prioritizing
8 their pockets and their bottom lines over the
9 health and safety of our members.

10 DR. NIEBLAS: Thank you. In the
11 comments, I believe the written comments, but
12 also in these discussions, it was mentioned that
13 discussion regarding follow-up of medical
14 evaluations when situations change with a
15 respirator, or an individual had a change in
16 their underlying medical condition.

17 Would a requirement that employers must
18 stop the use of respirators and remove the
19 employee from those exposures and until a
20 medical evaluation was completed, would that
21 assuage some of your concerns if there was not a
22 requirement for an initial medical evaluation

1 requirement for FFRs or PAPRs?

2 MS. DE LEON-MINCH: No. I can take that
3 one. Obviously, Jane if you want to add to this
4 -- but no, it would not. I think that pushes
5 the burden and responsibility onto workers to
6 self-identify as opposed to a more structured
7 process of medical evaluation. And I think the
8 bottom line here is that it is the employers'
9 responsibility to proactively address workplace
10 health and safety hazards, including making sure
11 that respirators can protect employees.

12 It's also important to keep in mind
13 that many workers, especially those that belong
14 in non-union facilities, often cannot speak up
15 about their health and safety concerns without
16 fear of retaliation. I also want to add that
17 for many people, many workers, they may not be
18 aware of their medical conditions. Speaking to,
19 just for example, long COVID, many nurses and
20 other healthcare workers, still to this day,
21 they are exposed to SARS-CoV-2.

22 They can be exposed to SARS-CoV-2 even

1 at work, even after a mild exposure, they can
2 develop long COVID. And because long COVID, the
3 symptoms, it's so heterogenous in its
4 manifestations, from fatigue to really, really
5 disabling conditions, it's difficult to
6 ascertain the true scale and the prevalence of
7 long COVID.

8 And so there are many people that may
9 not be aware that they have long COVID, as just
10 one example of a health condition, that could
11 impact their ability to wear respirators safely.

12 DR. NIEBLAS: Thank you.

13 MR. LEVINSON: And Your Honor, the last
14 questions from OSHA come from Tom Mockler.

15 MR. MOCKLER: Hi. In your comments you
16 submitted to the Agency, you indicated that you
17 had done a survey in 2024. Has NNU released a
18 final version of your 2024 survey results? And
19 have there been any follow-up analyses on the
20 results pertaining to medical evaluation and
21 respirator usage?

22 MS. BROWN: You can find the survey

1 results on the NNU's website, and we can also
2 submit it in our post comments.

3 MR. MOCKLER: Okay, that would be great.
4 Thanks.

5 MS. BROWN: You're welcome.

6 MR. LEVINSON: Your Honor, that
7 concludes OSHA's questions.

8 JUDGE BELL: Thank you. Mr. Berndt, any
9 questions from the solicitor?

10 MR. BERNDT: Yes, Your Honor. This is
11 Joseph Berndt from the Office of the Solicitor.

12 My first question goes to something Ms. Brown
13 said, and this may actually be related to what
14 you just said you'll put in the docket, but I'll
15 ask it anyway. You noted that 20 percent of
16 nurses are not fit tested.

17 I was wondering if you had similar data
18 for how frequently nurses are not being
19 administered a medical questionnaire or medical
20 evaluations like, initially. Is that part of
21 that same survey that you have? I guess you
22 have that information somewhere.

1 MS. BROWN: Jane, is that in the survey?

2 MS. THOMASON: No, we did not ask that
3 specific question in that survey. We can look
4 through our files and see if there's anything
5 additional that we might be able to offer on
6 that particular point, but that was not part of
7 that one specific survey.

8 MR. BERNDT: Okay, great, yes. If you
9 are able to find anything and submit it with
10 your post-hearing comments, that would be great.

11 And relatedly, if you have any information
12 related to outcomes associated with those who
13 were not given that initial evaluation. My
14 other two questions are related to things Ms.
15 Thomason said, but anyone feel free to answer.

16 I think this was in the context of
17 voluntary use during COVID, you noted that
18 workers may have selected cloth masks instead of
19 respirators, that they would have chosen to do
20 that even though they could use a respirator.
21 Do you have any information about how frequently
22 that happened?

1 MS. THOMASON: No. Again, we can look
2 at the literature and see if there is anything
3 available.

4 MR. BERNDT: Great, thank you. And my
5 last question is just a clarifying question. I
6 just want to make sure I understood. I believe
7 one of the concerns that you expressed with
8 OSHA's proposal is that it ignores that worker
9 health changes over time, or that health
10 conditions can change over time. I just want to
11 make sure, in that context you're talking about
12 the kinds of things that we would catch via
13 additional medical examinations under E7, not
14 the initial questionnaire, right? Because these
15 are changes over time?

16 MS. THOMASON: We can go back and
17 double-check to make sure that we understand
18 that question correctly, as well.

19 MR. BERNDT: I'm sorry. If it wasn't
20 clear, I just meant that I think the concern was
21 that you believe that the proposal ignored that
22 a worker's health conditions could change over

1 time. I just wanted to make sure that those are
2 the type of conditions -- to make sure I
3 understand, those are not the types of
4 conditions we'd be catching in the initial
5 questionnaire.

6 They are things that would be kind of
7 discovered through subsequent medical
8 evaluations, and those are under E7 of the
9 current standard.

10 MS. THOMASON: Okay, thanks for
11 clarifying. Yeah, I think it's a mix.

12 MR. BERNDT: Okay.

13 MS. THOMASON: I think it's mixed. I
14 think some of those health conditions would
15 evolve over time. So if a nurse started her job
16 with pre-existing asthma, but then was exposed
17 to certain types of disinfectant chemicals on
18 the job, that asthma could become worsened over
19 time. So the medical evaluation might have
20 caught it or it might not, depending on how
21 compliant the employer was, which is why we are
22 pushing for better enforcement rather than

1 removing the requirement to begin with.

2 But then there are other nurses where
3 it is new-onset asthma that would happen, where
4 there is no asthma when the nurse starts the
5 job, but then exposure on the job leads to new
6 work onset asthma that would not be caught by
7 the initial medical evaluation. So I think it
8 is a heterogenous situation.

9 MR. BERNDT: Okay. Thank you for
10 clarifying. I appreciate that. That is it from
11 me.

12 JUDGE BELL: Do we have any questions
13 from the public?

14 MS. BURKE: No questions from the
15 public, Your Honor.

16 JUDGE BELL: All right. Thanks very
17 much to the members of this panel. We very much
18 appreciate your testimony. All right, our next
19 group, you may start when you're ready to go.

20 MS. HARRISON: And Sara Markle-Elder,
21 I've promoted you to panelist if you'd like to
22 unmute and turn your camera on.

1 MS. MARKLE-ELDER: Can you hear me?

2 JUDGE BELL: Yes.

3 MS. HARRISON: Yes.

4 MS. MARKLE-ELDER: Thank you, thank you.

5 Thank you for the opportunity to speak on
6 behalf of AFT's 250,000 nurses, physicians,
7 technicians and other healthcare workers in
8 opposition to the proposed changes to medical
9 evaluation under the Respiratory Protection
10 Standard. OSHA must consider workers' health,
11 age, and actual working conditions.

12 The Respiratory Protection Standard is
13 meant to protect all covered workers, not just
14 those who are young, fit, and have an
15 understanding employer. It must be maintained
16 to protect workers unable to use FFRs and PAPRs
17 safely. First, the healthcare workforce is
18 aging. Over half of registered nurses, the
19 largest occupational group, are 45 or older.

20 Healthcare workers are already at
21 higher risk for asthma and cardiovascular
22 disease from multiple hazards, as my colleagues

1 have mentioned, including disinfectants,
2 hazardous drugs, surgical smoke, and shift work.

3 And while PAPRs can help workers with heart or
4 lung problems, they are not an option for
5 everyone. The rate of back injuries in hospital
6 workers is more than double that of the rest of
7 the private labor force.

8 Moreover, working conditions in
9 healthcare are physically and mentally
10 demanding, particularly in hospitals. Lean
11 staffing has been the industry standard for
12 decades, and hospital workers report that
13 staffing has not returned to pre-pandemic
14 levels. Registered nurses typically work 12-
15 hour shifts, frequently without breaks for meals
16 or the restroom, and can be required to work
17 mandatory overtime in 32 states.

18 We're not in the pandemic now, but
19 healthcare workers do experience extended
20 respirator use while caring for measles and TB
21 patients, and they will again in future
22 pandemics. The standard must be protective. It

1 must protect workers now and in the future.
2 Medical evaluation ensures that nurses who can't
3 wear FFRs and PAPRs safely are not assigned to
4 patients whose care requires a respirator.

5 Nurse licenses are regulated under
6 state Nurse Practice Acts. They cannot simply
7 walk away from a patient without risking their
8 job and license. In an ideal world, a nurse
9 would ask management for a new assignment, but
10 chronic under-staffing means nurses regularly
11 work through exhaustion and illness. OSHA must
12 also recognize that infectious disease and
13 hazardous drug exposures are not trivial
14 hazards, even if they do not reach the high
15 threshold of immediately hazardous to life or
16 health.

17 OSHA should not put workers in a
18 position to decide between an exposure and
19 unsafe respirator use. Medical evaluation is an
20 important component of a complete respiratory
21 program, to be conducted even before fit testing
22 to screen and evaluate any workers who could

1 face material impairment from required
2 respirator use. In 1998, OSHA made a clear
3 distinction between respirator use under the
4 program and voluntary use. The distinction
5 rests on a hazard assessment and fit testing of
6 FFRs to ensure a tight fit.

7 If a worker is not required to wear a
8 respirator, the employer is not obliged to
9 provide medical evaluation and fit testing.

10 There is no assurance that the respirator does
11 fit tightly, and the user can remove it at will
12 if experiencing discomfort. Lastly, this change
13 to the standard effectively shifts the burden of
14 protecting workers' health onto the worker, and
15 eliminates an opportunity to educate workers.

16 As noted previously, healthcare workers
17 have higher rates of asthma and heart disease,
18 higher than the general population, but
19 individuals may not have been diagnosed.

20 Workers may assume that everyone experiences the
21 same level of discomfort, or may be afraid to
22 say no to an assignment. Again, OSHA should not

1 put workers in the position of having to
2 advocate for themselves.

3 The responsibility to ensure a working
4 environment safe from recognized hazards is the
5 employers' obligation under the OSH Act. OSHA
6 must maintain the standard as it is. Medical
7 evaluation is a critical protection for workers
8 within a complete respiratory protection
9 program. Thank you.

10 JUDGE BELL: Thank you. Are we going to
11 save questions until the end of this panel?

12 MR. LEVINSON: I think we could do that,
13 Your Honor. That would be fine with us.

14 JUDGE BELL: Okay, so Ms. Hurst, why
15 don't you go ahead with your presentation then,
16 please? Ms. Hurst, if you're talking, you might
17 be muted.

18 MS. HURST: Okay. I am a Certified
19 Occupational Health Nurse Specialist and have
20 been nursing for over 40 years. I am
21 representing the Association of Occupational
22 Health Professionals. The use of an N95

1 respirator or a powered-air purified respirator
2 currently does require a medical questionnaire.

3 There is limited evidence demonstrating that in
4 itself it prevents medical conditions associated
5 with respirator use.

6 In our experience, concerns related to
7 wearing an N95 respirator or a PAPR are often
8 more identified and addressed during the fit
9 testing process. The fit testing process,
10 whether it's either qualitative or quantitative,
11 does require discussion with the employee. You
12 have to teach them how -- you have to educate
13 them on fit-checking, how does the respirator
14 fit, and all of that other information. That is
15 a great opportunity to ask them medical
16 questions or ask them if they have any medical
17 concerns.

18 You do also need to identify any
19 allergens if you're going to be using the
20 qualitative fit testing process. The direct
21 assessment is more valuable than a questionnaire
22 because it allows the individuals to discuss

1 concerns, ask questions, and also address
2 concerns such as claustrophobia or discomfort by
3 wearing a respirator. The fit testing encounter
4 provides real-time feedback regarding the user's
5 ability to tolerate and correctly to wear the
6 device.

7 There is inconsistency regarding who is
8 qualified to review and evaluate the medical
9 questionnaire. We find that among our members,
10 some of them are having advanced practitioners
11 and physicians review them, while others are
12 having technical staff or nurses review them.
13 It was found that 80 percent of individuals
14 responsible for evaluating respirator
15 questionnaires reported that they have never
16 referred an employee for further evaluation.

17 The most commonly reported
18 complications associated with the N95
19 respirators, when we did a questionnaire and 207
20 employers responded, were a facial rash to the
21 mask and allergies. These issues can be often
22 identified through fit testing process, and then

1 they can be referred for medical evaluation as
2 needed. The use of PAPRs also provides an
3 effective alternative for individuals who cannot
4 achieve an adequate fit test or cannot tolerate
5 wearing those.

6 That can also be done during that
7 evaluation. This way, the air is actively
8 delivered and provides a nice, fresh airflow to
9 the individuals. Many of the PAPRs are
10 lightweight and comfortable now, so it depends
11 on what type of PAPR you're using, and it's
12 almost a person-to-person evaluation. The
13 medical questionnaire can be lengthy, and I have
14 found that individuals don't always complete it
15 properly when they're filling them out.

16 So I do think that there is an
17 alternative to filling out the medical
18 questionnaire, and it would be helpful to use it
19 more so when they're being fit tested and
20 person-to-person than having just people fill
21 out the medical questionnaire. Also, the fit
22 testing has to be completed annually, which also

1 requires you to do that annual evaluation and
2 how they're tolerating it. That is the end of
3 my presentation.

4 JUDGE BELL: All right, well, thank you
5 very much. Please stay with us in case we have
6 questions at the end of this panel. Dr. Fagan,
7 you're up next. And if you're talking, you may
8 be muted.

9 DR. FAGAN: Okay, I think -- is this
10 working? Am I unmuted?

11 JUDGE BELL: Yes, yes.

12 DR. FAGAN: Okay, great, thank you. My
13 name is Kathleen Fagan. I'm a board-certified
14 physician in occupational and environmental
15 medicine, and I'm speaking on behalf of AOEC.
16 Please note that we will be submitting more
17 detailed comments with our references. AOEC
18 opposes OSHA's proposed elimination of medical
19 evaluations for workers using filtering
20 facepiece respirators and loose-fitting PAPRs.
21 We disagree with OSHA's conclusion that
22 there is no evidence that wearing FFRs cause

1 significant health effects. We identified 10
2 studies OSHA did not cite, including studies
3 done during COVID, and systematic reviews of
4 between 14 and 55 studies. All 10 reported some
5 adverse health effects, including abnormal
6 physiologic effects in healthy individuals,
7 particularly at high exercise levels and workers
8 with symptoms while wearing FFRs.

9 We are concerned that workers with
10 underlying medical conditions, such as
11 allergies, asthma, immunologic disorders, lung
12 and heart disease, may be at increased risk of
13 adverse health effects while wearing FFRs.
14 Medical examinations allow clinicians to assess
15 workers' risks, recommend accommodations, and
16 discuss their findings with workers. Workers
17 can then better protect themselves from
18 hazardous workplace exposures. OSHA lists five
19 reasons for the proposed rule.

20 Reason 1 was lack of large-scale
21 epidemiologic studies, and to put this bluntly,
22 OSHA's evidence is lack of evidence. As

1 healthcare professionals, we believe that a
2 significant change to medical practice should be
3 made only when there is good evidence, not lack
4 of evidence, that such a change will not harm
5 our patients. OSHA's second reason is that they
6 found no evidence illustrating the need for
7 medical evaluations during the COVID pandemic.
8 We disagree.

9 Studies show that healthcare workers
10 contracted COVID during the pandemic in part
11 because of the lack of, or improper use of,
12 FFRs. Reason 3 is that few workers are refused
13 respirators. OSHA estimated that only two
14 percent of workers fail a medical evaluation,
15 but two percent of the estimated three million
16 medical examinations per year is a very large
17 number of at-risk workers who would not receive
18 needed medical evaluations and accommodations.

19 OSHA's fourth reason is that FFRs are
20 not generally used in IDLH situations. However,
21 there are situations that may not be categorized
22 as IDLH, but where a medical evaluation would

1 identify workers in greater need of respiratory
2 protection or accommodations. Exposures to
3 infectious disease is an obvious example;
4 exposures to allergens or sensitizers is
5 another, and these exposures can lead to serious
6 illnesses and even death.

7 OSHA's Reason 5 is that available data
8 on effects largely show minimal impacts on
9 health. Workers who experience headaches,
10 difficulty breathing, chest tightness, nasal
11 obstruction, eye and skin irritation, and sleep
12 disorders and fatigue, among other symptoms,
13 would not call these symptoms minimal.
14 Potential aggravation of migraine headaches,
15 asthma, COPD, heart disease, are not minimal
16 impacts.

17 Medical examinations allow clinicians
18 to inquire about potential exposures and provide
19 the education necessary to assure workers'
20 safety. Clinicians all have cases we call
21 medical saves, where a medical screening has
22 prevented a hazardous exposure or occupational

1 illness. We are also concerned that workers are
2 being placed in the position of potentially
3 discussing personal health information with
4 their employers. Many workers will choose not
5 to do this, and may place themselves in danger.

6 Further, employers are being placed in
7 the position of determining workers' medical
8 fitness to wear respirators, a position they are
9 not qualified for. Employers may, in fact,
10 occur liability for adverse consequences if a
11 worker becomes ill or dies because of inadequate
12 respiratory protection.

13 Finally, we believe that OSHA's
14 proposal sends the message that respiratory
15 protection is not important, that exposures are
16 not hazardous, and that employers and workers
17 should not be concerned. We believe that
18 failure to protect workers from these
19 respiratory hazards will lead to a large
20 increase in occupational exposures, illnesses,
21 and deaths.

22 We urge OSHA to withdraw this proposal

1 and support a more thorough review, including
2 requesting that NIOSH pursue the research that
3 is needed. Thank you for your attention. Happy
4 to answer questions.

5 JUDGE BELL: Thank you, Dr. Fagan.
6 Stick with us for a few minutes, please, before
7 we get to questions. Ms. Cleary, when you're
8 ready, you can unmute and begin your testimony.

9 Ms. Cleary, if you're talking, we're not able
10 to hear you.

11 MS. CLEARY: Hi, I think I'm here now.
12 Can you hear me?

13 JUDGE BELL: Yes, we can. Thank you.

14 MS. CLEARY: Okay, great, thank you.
15 Can you see me?

16 JUDGE BELL: I cannot, but maybe others
17 can.

18 MS. CLEARY: Okay, I will proceed. Good
19 afternoon, Honorable Judge Bell, OSHA, DOL
20 Leadership Team. I'm Helen Cleary, founder of
21 OSH Proterie. We are a regulatory intelligence
22 and member network for environmental health and

1 safety leaders. Our members work for large,
2 multi-site employers, utilities, high-tech
3 manufacturing, and some construction. We don't
4 speak for any individual company. What we bring
5 to this record is the collective experience and
6 voice of the safety leaders on the ground, the
7 people who run these programs.

8 We support this proposal, and we
9 appreciate OSHA's effort to modernize and
10 streamline requirements where the evidence
11 supports it. First, what actually changes --
12 because we think it's narrower than many are
13 describing -- for a required N95 user, one step
14 comes off the front end. Fit testing stays
15 annually, training stays annually, hazard
16 assessment, selection, cleaning, the written
17 program, nothing changes for elastomeric scuba
18 or supplied air. This removes a step, it
19 doesn't remove the program.

20 Second, the reframe that we'd ask the
21 Agency to consider, a questionnaire at hire is a
22 prediction. Everything else in this standard is

1 detection, and here's what that prediction is
2 built on. The worker circles yes or no to nine
3 questions about their medical history. The
4 employer supplies the rest under Paragraph E5,
5 Expected Work Effort, Expected Duration,
6 Expected Temperature, all projections.

7 Then a clinician reviews the two
8 together, usually without meeting with the
9 worker, because under Question 9, that
10 conversation is something the employer has to
11 ask for. This isn't a comment about the worker
12 or clinicians. It's about what a yes or no
13 form, completed before the job starts, can
14 actually do. It captures what a worker has
15 already been told about their health.

16 Some commentors in this record are
17 worried about workers with undiagnosed
18 conditions, but a medical history form cannot
19 find a condition that nobody has diagnosed.
20 There is one block of questions on that form
21 about what actually wearing a respirator, eye
22 irritation, skin problems, creates. The

1 instructions say that if you've never worn one,
2 you skip it.

3 So the new hire, the person this
4 evaluation helps to screen, skips the only
5 questions about the experience being evaluated.

6 That worker is on the floor for the next five,
7 10, 20 years. The healthcare professional is
8 not there when something happens. They are not
9 there the two hours into a shift in August. The
10 people who are there are the fit tester, the
11 trainer, the supervisor, and the worker.

12 That's why we ask the Agency to look at
13 where these concerns actually get caught --
14 claustrophobia as an example. The questionnaire
15 asks about it, but it gets found at the fit
16 test. A worker seals a respirator to their face
17 and does exercises for several minutes, someone
18 watching. Trouble breathing, issues come to
19 life at the fit test. The rule requires
20 evaluation, but observations made during fit
21 testing indicate a need.

22 That's an annual gate. It's hands-on.

1 The questionnaire is one time on paper at hire.

2 The referral trigger is broad. A yes to any of
3 questions one through eight sends someone for a
4 physical exam. Question 1 is whether you've
5 smoked in the last month. Question 5 includes
6 high blood pressure, roughly half of American
7 adults. But OSHA's own figures show that 23
8 percent are referred, and about one percent end
9 up with a limitation, and that's a gap in the
10 story.

11 A screen that refers a quarter of your
12 workforce and restricts only one percent isn't
13 sorting people, it's routing them. We'd also
14 note for most workers, this is a form filled out
15 online and reviewed remotely. The standard
16 permits that, it always has, which is worth
17 sitting with, because much of the opposition
18 here rests on the clinical judgement that in
19 practice is being applied to a document, not a
20 person.

21 Fourth, COVID, because it's in the
22 record and we think it's being looked at a bit

1 backwards. COVID changed what employers and
2 workers know about wearing these devices, and
3 that shouldn't be discounted. But much of what
4 people experienced came from duration and
5 conditions. Hours of continuous wear, heat,
6 exertion, not from an undetected condition that
7 a form at hire would have surfaced.

8 Many of the examples offered against
9 this proposal make the point, commenters
10 describe respirators worn under the nose, worn
11 intermittently, or first given surgical masks,
12 and KN95s aren't NIOSH approved, every one of
13 those, the failure of fit, wear or selection. A
14 medical questionnaire does not teach a worker
15 how to don a respirator. It does not seal it to
16 their face, it does not choose the device. Fit
17 testing, training, and selection do, and all
18 three are untouched by this proposal.

19 So here's what we ask the Agency to do.
20 Don't write this final rule as a deletion.
21 Write it as a shift from prediction to
22 detection, because that's what it is, and

1 detection is what's effective in a workplace,
2 which means being explicit about two of the
3 elements. One, Paragraph E7 still applies.
4 OSHA asked that question directly in the
5 proposal. Our answer is yes. When a worker
6 reports symptoms, when a supervisor or program
7 administrator flags someone, when something
8 turns up during that fit test, the employer
9 provides a medical evaluation.

10 Employers have raised this in the
11 record, that the mandate is removed, but the
12 responsibility isn't, and OSHA saying it plainly
13 would help resolve that. Two, an employer who
14 continues doing evaluations voluntarily isn't
15 creating a new obligation by doing so.
16 Otherwise, the extra step becomes a risky one,
17 and you'll see fewer employers make it. That's
18 the line we're asking for, not a limitation of
19 the rule or the element that makes it usable.

20 So thank you for your time today, and I
21 just want to say thank you to the OSHA team for
22 the commitment to supporting the health and

1 safety of workers. We realize it can come with
2 heavy criticism, as illustrated today, and we
3 appreciate what we believe are genuine
4 intentions, holding these hearings, listening to
5 commentators in an effort to make the right
6 decision, so thank you for that.

7 JUDGE BELL: Mr. Levinson, questions for
8 this panel from OSHA?

9 MR. LEVINSON: Yes, Your Honor. The
10 first questions come from Dr. Minda Nieblas.

11 DR. NIEBLAS: Thank you very much.
12 Thank you all to the panelists for coming to
13 talk with us today. My question, I believe,
14 would be directed at Dr. Fagan, but I'm also
15 interested if other panelists have anything to
16 add to this. Dr. Fagan mentioned the term of
17 medical saves.

18 Would you be able to, without, of
19 course, disclosing anything that's private or
20 personal medical information, be able to expand
21 on how the medical respirator questionnaire
22 initially, did it lead to any of these medical

1 saves and the circumstances?

2 DR. FAGAN: Yeah. These are anecdotal,
3 and from our AOEC clinicians. Many of them have
4 noted that they noted something on a
5 questionnaire, they had a worker come in for an
6 exam, and diagnosed things like hypertension,
7 heart disease, asthma, other lung diseases, and
8 were able to refer those workers to their
9 doctor. One clinician told me, and I'll quote
10 this one, "I had a company where they sent the
11 employee for a medical evaluation and found he
12 had extremely high blood pressure, even though
13 he was young. Wearing an N95 could've caused a
14 medical emergency for him."

15 Let's see. Well, and then this is more
16 getting at how these medical evaluations might
17 protect workers with underlying conditions.
18 Another clinician I talked to described a case
19 of a worker with COPD who had trouble wearing an
20 FFR for prolonged periods. The clinician
21 limited the time wearing an FFR to two hours per
22 shift, followed up with the worker, and the

1 worker was able to tolerate this quite well, and
2 was able to keep his job, which is a big deal.

3 In another case, a clinician reviewing
4 respiratory questionnaires over time identified
5 a worker who wasn't symptomatic, but then
6 developed symptoms. He had the worker come in,
7 and it turned out they had developed asthma,
8 maybe due to exposures at work. So there is
9 anecdotal information.

10 DR. NIEBLAS: Thank you, and I
11 appreciate that, because those are stories that
12 matter. I have one more follow-up question with
13 that. In your clinical experience, or it sounds
14 like in the experience of the members or clinics
15 and clinicians who are represented here today,
16 are there specific medical conditions or
17 symptoms that would preclude someone from going
18 on for fit testing, that would be identified in
19 that initial medical questionnaire?

20 DR. FAGAN: Hm. That's not something
21 I've thought about, so let me check and get back
22 to you on the post-hearing comments. That's a

1 good question.

2 DR. NIEBLAS: No, and thank you so much
3 for that, and just -- I was also wondering if
4 there is any sort of data that the clinics have
5 sort of gathered on the number of people on
6 initial respirator questionnaire that get
7 flagged and don't move forward for fit testing
8 or wear.

9 DR. FAGAN: Yeah, we would love to do
10 that study.

11 DR. NIEBLAS: I didn't know if you have
12 any of that.

13 DR. FAGAN: We'd love to do that study.
14 We'll ask NIOSH for some money to do that
15 study.

16 DR. NIEBLAS: Thank you.

17 DR. FAGAN: Then we can answer
18 Jonathan's question, too.

19 DR. NIEBLAS: Thank you so much.

20 DR. FAGAN: Right, okay.

21 MR. LEVINSON: Yes, and before we turn
22 it over to the next question, Dr. Fagan, thank

1 you very much for your testimony. I know that
2 you identified and referenced a number of
3 studies. It would be very helpful in post-
4 hearing comments if we have all of that
5 submitted to the docket so that it's in the
6 official record.

7 DR. FAGAN: Yes, we absolutely will do
8 that.

9 MR. LEVINSON: Great, thank you. The
10 next questions come from Dr. Jonathan Berr.

11 DR. BEARR: Jonathan Berr, OSHA. I
12 guess first off, Ms. Hurst, if you could provide
13 in your post-hearing comments the information
14 and data that it sounded like you have on fit
15 testing and medical questionnaire, that would be
16 appreciated.

17 MS. HURST: Yes, I can provide that.

18 DR. BEARR: Thank you. Second, this
19 panel is pretty interesting in how it was -- the
20 people here have made some comments about the
21 usefulness of fit testing, particularly in
22 getting a better understanding of underlying

1 conditions. One thing I wanted to bring up, in
2 most European countries, there is not a
3 mandatory medical evaluation. It's much more
4 foot-first with medical fitness -- not medical
5 fitness -- fitness of the respirator.

6 I was wondering what your thoughts were
7 on that approach that most European nations
8 have, if you know of any studies or reports that
9 evaluate the efficacy of that, if workers are
10 more or less at risk or at the same amount of
11 risk, and perhaps -- I know this is a long
12 question -- how do you think a European approach
13 would fit in the United States?

14 MS. HURST: Well, I haven't looked at
15 the European approach. I just know from a
16 personal approach that the individuals that I
17 assessed or that my staff assessed, it was much
18 -- we actually were able to obtain more
19 information from our employees during the fit
20 testing procedure than during the questionnaire.

21 The questionnaires, they just quickly filled
22 out, they didn't always mark everything. But if

1 we talked to them and we were in the process of
2 fit testing or seeing how they did, that's where
3 we gained most of the information.

4 DR. BEARR: Thank you. I think Sara has
5 a hand up.

6 MS. MARKLE-ELDER: Yes, can you hear me?

7 JUDGE BELL: Yes.

8 MS. MARKLE-ELDER: Okay. I appreciate
9 the perspectives that Ms. Hurst and Ms. Cleary
10 brought, but I do want to point out from
11 anecdotal information that we have from our
12 members, fit testing is not always done up to
13 the standard that OSHA would expect, and that
14 often it's done in sort of an assembly line
15 fashion. I'm not saying that all employers do
16 it like that, but I believe many do.

17 I understand the perspective that we
18 could be improving the questionnaire, we could
19 be updating questions and front-loading a better
20 kind of assessment. But I just want to caution
21 that fit testing is not a one-on-one time-
22 intensive interaction between the worker and the

1 fit tester. So if OSHA is prepared the
2 strengthen the existing fit testing
3 requirements, that is worth considering, but if
4 that is not on the table, then the medical
5 evaluation remains a critical component to
6 identifying people who are potentially at risk.

7 Thank you.

8 JUDGE BELL: Other questions from OSHA?

9 MR. LEVINSON: Yes, Your Honor, I think
10 there were some similarities in the testimony
11 between Ms. Hurst and Ms. Cleary, and I wanted
12 to know, Ms. Hurst, if you had thoughts on the
13 way that Ms. Cleary talked about what is
14 discovered during the respirator medical
15 evaluation questionnaire and what is discovered
16 during the fit testing process.

17 I think expanding this a little bit for
18 the other speakers, we've heard some other folks
19 testify earlier today about giving kind of
20 socially-desirable answers, where people can
21 kind of deem out what the right answer is to the
22 medical questionnaire if you don't want to

1 trigger an evaluation or you're concerned about
2 being sure that you get the job.

3 So we're trying to figure out how much
4 is actually being caught by the questionnaire
5 that is truly undetected, where somebody could,
6 upon questioning or self-identification, figure
7 out whether or not they have a condition where
8 they should talk to a doctor. Is that a
9 sufficient trigger to catch the people, or does
10 it have to be done through the questionnaire?

11 I'll start with Bobbi Jo Hurst, but if
12 anybody else on the panel wants to kind of get
13 into that issue, that would be very helpful.

14 MS. HURST: I think with the
15 questionnaire, we had used a paper form. One of
16 our other companies had used an electronic form.

17 I think people just check it, and it's just a
18 quick way to get through like it's a procedure,
19 that I'm just going to quick check and go down
20 through here.

21 Then actually when talking to the
22 people or knowing the people, they may have

1 other health conditions that will come up, or
2 they may have concerns when they're going
3 through the fit testing process. I'm just not
4 sure how well they do the paperwork or the
5 checklist, to rely on that.

6 MS. CLEARY: Yes, I'll add to that.
7 Thank you for the question. The conversations
8 that I've had with members are similar in that
9 the avenue they're going down is they fill this
10 questionnaire out online. It is a check in the
11 box type action.

12 Where the understanding and realization
13 comes from if they have conditions that the
14 respiratory would impact, respiratory issues,
15 breathing issues, or the claustrophobia issue
16 that I mentioned, those realizations from the
17 worker come out during training, during the fit
18 testing, and during those conversations, and
19 that the questionnaire has become just a get-
20 through, get to the next step process, which is
21 why we had recommended removing that because
22 it's not making the biggest impact, and put the

1 energy on the follow-up because you do have that
2 annual follow-up test, the fit testing, the
3 training, and the knowledge of when your system
4 changes, your body changes.

5 People realize after wearing it for
6 some time what the issues are, and it becomes a
7 progressive, more informative process for the
8 worker. But I can follow up with more detail on
9 actual examples or data from our members on what
10 they're hearing -- I'm sorry, what they're
11 receiving -- because what I was told yesterday
12 was I have never received a recommendation for a
13 medical follow-up following the questionnaire.

14 So we just get these automatic
15 approvals that come through from the review
16 process, and we have very few issues of people
17 that have problems during the fit testing, as
18 well.

19 JUDGE BELL: Ms. Cleary, can you lower
20 your hand, please? Dr. Fagan, we'll recognize
21 you, please.

22 DR. FAGAN: Thank you. Sure, there are

1 workers that will not accurately fill out a
2 questionnaire, but we also see lots of
3 questionnaires where there are positive answers.

4 So it's not that everybody writes negative
5 answers, so I don't think -- we still are able
6 to identify workers that need medical exams.

7 Then the question is well, how many?
8 What's the data? That's where we need more
9 research, so I get back to the point that we
10 need that research. All of this is anecdotal.
11 NIOSH is the place to do that.

12 MR. LEVINSON: Your Honor, that
13 concludes the questions from the OSHA panel.

14 JUDGE BELL: I think Ms. Markle-Elder
15 has her hand up.

16 MS. MARKLE-ELDER: Yes, just --

17 JUDGE BELL: Go ahead.

18 MS. MARKLE-ELDER: Yeah, just a quick
19 add-on on two points. Yes, we had in our
20 written comments advocated for NIOSH to do
21 research on this. OSHA does have the capacity
22 to request the employers' records, so the

1 potential is there to get this information.

2 Secondly, I want to emphasize something that my
3 colleagues at NNU said, that enforcement is
4 really a problem.

5 We were learning during COVID how
6 little our members knew about what their rights
7 were under the standard, and that fit testing
8 was not always annual. Again, I want to say in
9 so many cases it is really an assembly line
10 process. So if a version of this proposal goes
11 forward, it must be accompanied by strengthening
12 of the fit testing requirements. I'd also like
13 to point out that it's great to compare our
14 system to European systems, but they have
15 universal healthcare and we do not.

16 We have a very patchy situation, even
17 among healthcare workers. Many do not have
18 insurance themselves, particularly those at the
19 lower end of the spectrum in terms of
20 occupational skill. Thank you.

21 JUDGE BELL: Mr. Levinson, anything else
22 from OSHA?

1 MR. LEVINSON: No, Your Honor.

2 JUDGE BELL: Mr. Berndt, anything from
3 the solicitor?

4 MR. BERNDT: Joseph Berndt from the
5 Office of the Solicitor. No questions, thank
6 you.

7 JUDGE BELL: All right. Do we have
8 questions for this panel from the public?

9 MS. BURKE: Yes, Judge Bell. I'm going
10 to go ahead and go with the first raised hand,
11 MK Fletcher. Your mic should be enabled.

12 MS. FLETCHER: Great, thank you so much.

13 Hi, I'm MK Fletcher with North Americas
14 Building Trades Unions. My question is I think
15 for either Kathy or Sara, but anyone can answer,
16 as well. Is the fit test performed by a
17 healthcare provider or someone with medical
18 expertise that could kind of judge shortness of
19 breath or some of these other symptoms that
20 we're talking about of needing further medical
21 evaluation? Thanks.

22 DR. FAGAN: I bet the answer is it

1 depends, right, Sara?

2 MS. MARKLE-ELDER: I think you're better
3 qualified to answer this one.

4 DR. FAGAN: Oh no. I think it depends
5 on what employer is providing the fit testing.
6 In a healthcare situation, it may be someone
7 with healthcare background, but in non-
8 healthcare situations, it may not.

9 MS. MARKLE-ELDER: I would agree.
10 Within the hospital setting, it's likely to be
11 the occupational health nurse who is doing it,
12 but I can't speak to what happens outside of
13 hospital settings.

14 JUDGE BELL: All right, other questions
15 from the public?

16 MS. BURKE: Yes, Robert McClellan, I
17 have just enabled your microphone.

18 DR. McLELLAN: Great, thank you for
19 recognizing me. I'm Robert McClellan, and this
20 is a question for Ms. Hurst, and it's a follow-
21 up really on what we were just talking about.
22 That is, assuming for a moment that the fit

1 tester is not a physician or a licensed
2 healthcare provider, would you agree that HIPAA
3 would say it's not a good idea for you, as an
4 agent of the employer, to be inquiring about
5 their, and probing them about their medical
6 status?

7 MS. HURST: If it would not be somebody
8 from the employee health department, they would
9 be instructed by them on their fit testing, and
10 they would just be asking them in general, do
11 you have any problem, and then referring them to
12 employee health. So that's how it would be. We
13 would not be compromising the employee's medical
14 information. They would just be referred to the
15 employee health person if they were not doing
16 the fit testing, so it would be built into that
17 process.

18 DR. MCLELLAN: Thank you.

19 JUDGE BELL: Any other questions from
20 the public?

21 MS. BURKE: Yes, two more. Next one is
22 from Ellie Barbarash. Ellie, you should be able

1 to unmute.

2 MS. BARBARASH: Thank you so much. This
3 is Ellie Barbarash from the American Federation
4 of State, County & Municipal Employees. My
5 question is very similar to the last caller, the
6 last question. Between 1911 [sic] and 2022, I
7 worked in New Jersey and Pennsylvania with
8 nursing homes and hospitals, probably a total of
9 about 42 institutions, of which 22 are
10 hospitals, and often the smaller facilities did
11 not have health services.

12 So my question is -- and as I spoke in
13 my testimony today, I spoke a lot about workers'
14 right for confidential medical information so
15 that they don't experience shift retaliation.
16 That's just reality on the ground, that's what
17 happens.

18 My question to the panelists who have
19 said that it should be done during fit testing,
20 in my direct experience working with these
21 facilities during the COVID pandemic, often
22 because of the need to finally put so many

1 people in respirators because of the extent of
2 the COVID pandemic, management was just training
3 any supervisor to do the fit test.

4 So I would really like to know how
5 possibly workers' confidentiality for medical
6 information, as a thing about not having
7 retaliation, how would that possibly be
8 respected when you don't have your own health
9 service there? I don't understand how that's
10 practical, and I'd love to hear about that.

11 Thank you.

12 MS. HURST: Well, I think it would be
13 respected in the way that they would just tell
14 them that they have difficulty with it, or due
15 to a health condition, and then be referred to
16 somebody for a confidential evaluation.

17 JUDGE BELL: Ms. Hurst, can you identify
18 yourself as the one who just provided those
19 comments?

20 MS. HURST: Oh, I'm sorry. This is
21 Bobbi Jo Hurst who just said that.

22 JUDGE BELL: Thanks very much. Any

1 other questions from the public?

2 MS. BURKE: Yes, one more question.

3 Kayla Flowers, I've just enabled --

4 MR. LEVINSON: Your Honor, Dr. Fagan has
5 a hand up --

6 JUDGE BELL: Oh, I'm sorry.

7 MR. LEVINSON: -- to respond to that.

8 JUDGE BELL: Dr. Fagan, I didn't see
9 your hand.

10 DR. FAGAN: Thank you. That's okay,
11 thanks. I just want to say that I do not think
12 that medical confidentiality can occur in most
13 situations with fit testing, that that should be
14 during a medical examination with a healthcare
15 provider. I think workers are going to not tell
16 their employer or the fit tester about medical
17 problems because of their fear of losing their
18 job or they're not wanting to share personal
19 information.

20 JUDGE BELL: Thank you. Let's go back
21 to our last public question, please.

22 MS. BURKE: Kayla Flowers, your mic is

1 enabled.

2 MS. FLOWERS: Hello, Kayla Flowers with
3 the United Steel Workers. My question, I guess,
4 is probably more towards Ms. Hurst and Ms.
5 Cleary. In my experience, fit testing is often
6 conducted, like we've just heard, on-site by a
7 safety professional, a supervisor, someone with
8 no medical background. My question is, how is
9 someone with no medical background expected to
10 flag medical issues in an employee, as well as -
11 - and I guess this part is probably more towards
12 Ms. Cleary -- are the members of your
13 association, the companies that you represent,
14 willing to take on the liability of their
15 supervision, their supervisors stepping in to
16 make medical calls.

17 MS. CLEARY: Thank you, Helen Cleary.
18 I'm not going to speak to if they're willing to
19 take on the liability. But I can say that one
20 of the conversations we had about this change
21 was a question of liability, and that the
22 questionnaire is a piece of that. So I don't

1 believe that everybody is going to be willing to
2 get rid of it because it could provide a layer
3 of protection for the employer.

4 But in the context of the regulation
5 and the standard, and what the standard should
6 be doing and how to streamline it, we think that
7 this is an area that can be removed. I can't
8 speak to if they're willing to take on the
9 liability. As for the fit test process, that
10 would vary among different organizations and how
11 it's done. If they are not medical
12 professionals, they're not making medical
13 determinations, they're not sharing confidential
14 information. But if, through that test, there
15 are issues determined, they are passed on for
16 recommendations for a medical evaluation.

17 JUDGE BELL: All right, thank you. Any
18 other questions? Ms. Flowers, did you have
19 another question?

20 MS. FLOWERS: I just wanted to clarify
21 in the answer she just provided, you said if
22 there's medical issues, those medical issues

1 will be identified, but how will those medical
2 issues be identified if they're working with
3 someone with no medical background? I'm just
4 curious. Thank you.

5 MS. CLEARY: I'm sorry. I must have
6 misspoken then, but I was trying to say is that
7 if they're having any type of breathing issue,
8 or the fit testing identifies they can't wear it
9 because of the claustrophobia or a breathing
10 concern, then that would trigger a
11 recommendation further.

12 JUDGE BELL: And just to be clear, that
13 was Ms. Cleary who gave the last answer.

14 MS. CLEARY: Thank you.

15 MS. FLOWERS: Thank you.

16 JUDGE BELL: Ms. Markle-Elder, did you
17 have your hand up?

18 MS. MARKLE-ELDER: Yes, thank you. This
19 is Sara Markle-Elder from AFT. I just wanted to
20 go back to some of the points about retaliation
21 and confidentiality. Often my focus is on
22 registered nurses who are an educated workforce.

1 If they're unionized, they have somewhat of a
2 level of knowledge about their rights, not all
3 of them. But we're also talking about the
4 entire labor force that OSHA covers for those
5 who need to have respiratory protection.

6 During the pandemic, of course the
7 public was searching for information. I was
8 fielding phone calls from environmental service
9 workers who were not unionized, who had no
10 rights, and who were being told, you get in
11 there immediately. They were not even given the
12 option of a respirator. They were not being
13 given the option to allow the number of air
14 changes to happen.

15 So again, unless OSHA is prepared to
16 radically improve enforcement of 1910.134, and
17 in particular strengthen the existing fit
18 testing requirements to address these issues of
19 confidentiality, of providing a medical
20 professional to conduct fit testing, to conduct
21 fit testing in a way that people are not just
22 being quickly run through the process on an

1 annual basis and you're done, OSHA's obligation
2 is to ensure that people are protected. I'm
3 afraid that the proposal as currently written
4 simply strips workers of their rights. Thank
5 you.

6 JUDGE BELL: All right, I see no other
7 hands up. Any questions from the public that
8 have come in while we've been answering these?

9 MS. BURKE: No other questions from the
10 public, Your Honor.

11 JUDGE BELL: All right, to this panel,
12 thanks very much. You obviously had a lot to
13 say that was of interest to people, and we
14 appreciate it. Thanks all of you.

15 MS. MARKLE-ELDER: Thank you.

16 JUDGE BELL: All right, is our next
17 presenter ready to go?

18 MS. HARRISON: Yes, Rosemary, I have
19 promoted you to panelist. You should be able to
20 unmute and turn your camera on when you're
21 ready. Try that again. There we go, okay. She
22 should be on her way.

1 JUDGE BELL: Dr. Sokas, we're ready when
2 you are. And if you're talking, you're muted.

3 MS. HARRISON: Let's see, there we go.
4 Took a moment, little tech glitch.

5 JUDGE BELL: We're ready when you are,
6 Doctor.

7 DR. SOKAS: Thank you. Can you hear me
8 now?

9 JUDGE BELL: We can, yes, thank you very
10 much.

11 DR. SOKAS: Thank you so much. So --
12 here today, I -- thank you, my name is Rosemary
13 Sokas, I'm here today on behalf of the American
14 Public Health Association.

15 My background is as an occupational
16 medicine physician and emeritus professor from
17 Georgetown University, and I've served as Chief
18 Medical Officer at both OSHA and NIOSH.

19 The American Public Health Association,
20 for whom I'm speaking today, is a diverse
21 community of public health professionals who
22 champion the health of all people and

1 communities.

2 We strongly oppose OSHA's proposal to
3 eliminate the medical evaluation requirements
4 for workers using filtering facepiece
5 respirators and loose fitting power air
6 purifying respirators.

7 This change would weaken protections
8 for workers who may have conditions that are
9 worsened by the respirators themselves, unless
10 medical recommendations for safe work
11 modifications are implemented.

12 Failure to do this leads to the failure
13 to wear protection effectively and leaves the
14 workers exposed to air contaminants that cause
15 cancer and other diseases, including infectious
16 diseases that can be transmitted to others.

17 After all feasible engineering and
18 administrative controls are in place,
19 respiratory protection provides the last line of
20 defense against inhalational exposures.

21 These respirators are lifesaving but
22 impose some cost, not monetary, but human.

1 The filtering facepiece respirators add
2 a physiologic burden to breathing, increase heat
3 strain, and may cause skin irritation, headache,
4 and other outcomes.

5 Although loose fitting PAPRs may help
6 alleviate many of these concerns, at times, they
7 may also increase heat strain, claustrophobia,
8 and they do add noise and weight to the wearer.

9 The existing medical evaluation
10 requirements are already quite streamlined.

11 Workers complete a questionnaire under
12 the supervision and review of a physician or
13 other licensed healthcare professional, and
14 individuals who self-identify specific issues
15 then receive the face to face evaluation.

16 That's it.

17 These medical evaluations are an
18 essential safeguard for workers who wear
19 respirators, including well-fitted N95s and
20 loose fitting PAPRs.

21 Now, we could have an argument that
22 says maybe everybody, not just the self-

1 identified, should be evaluated, because that's
2 what I believe Ms. Cleary and Ms. Hurst are
3 suggesting.

4 OSHA provides two examples from the
5 last rulemaking record to conclude that only 2
6 percent of workers who were medically evaluated
7 for the use of these respirators are placed on
8 restrictions.

9 That's -- as Dr. Fagan pointed out,
10 that's still a lot of people.

11 By OSHA's estimate back then of 3
12 million workers using these types of
13 respirators, 60,000 workers would be jeopardized
14 if the medical evaluation requirement was
15 eliminated.

16 In the 30 years since those two
17 comments were submitted, the U.S. workforce has
18 aged.

19 Workers 55 or older made up 24 percent
20 of the workforce in 2022, up from 10 percent in
21 1994.

22 The proportion of U.S. adults who are

1 obese has also more than doubled during that
2 time, and both age and obesity increased the
3 physiologic burden of respirator and interact
4 with other concomitant exposures such as heat
5 and exertion.

6 There's substantial evidence, some of
7 which OSHA cited, about the potential material
8 impairment to health that may result from use of
9 these respirators.

10 One prospective case crossover
11 laboratory study of healthy male volunteers
12 explored the effect of wearing filtering
13 facepiece respirators compared to surgical masks
14 compared to no masks on pulmonary function and
15 cardiac capacity.

16 It demonstrated statistically
17 significant, I quote, highly impaired, unquote,
18 measurements for ventilation, cardiopulmonary
19 exercise capacity, and comfort among subjects
20 who, when they wore the filtering facepiece
21 respirators.

22 Here's just one example, the forced

1 expiratory volume in one second, the FEV1, is a
2 marker of airways obstruction that can be
3 decreased in people with asthma or chronic
4 obstructive lung disease.

5 Among the healthy, fit volunteers in
6 the study, the average FEV1 fell from 4.3 liters
7 to 3.7 liters, a difference that is both
8 statistically highly significant and clinically
9 meaningful.

10 Similar findings were reported in a
11 systematic review with meta-analysis of 14
12 studies, that's the one I believe Dr. Fagan
13 mentioned.

14 The pooled data confirmed the impact of
15 FFPs on reduced ventilation measures and
16 decreased oxygenation at high levels of
17 exertion.

18 All studies excluded anyone with
19 underlying conditions.

20 By contrast, 8.6 percent of the U.S.
21 adults have asthma, another 4.2 percent have
22 other chronic obstructive lung disease, and 5

1 percent have coronary artery disease.

2 Finally, the volunteers who wore the
3 respirators in the study did so for no longer
4 than 60 minutes compared to a whole work shift.

5 Another issue, new onset headaches, and
6 exacerbation of pre-existing headache disorders,
7 including migraines, have been reported
8 frequently among healthcare workers wearing N95s
9 for prolonged periods.

10 There are several likely mechanisms,
11 but one of these is the potential that increased
12 carbon dioxide from exhaled air in the breathing
13 zone may have a triggering effect.

14 And a study conducted by a team of
15 neurologists actually documented using non-
16 invasive transcranial dopplers that they had
17 changed coronary -- middle coronary artery blood
18 flow associated with the increased carbon
19 dioxide and tidal volume levels and headaches,
20 and that both of these were relieved when PAPRS
21 were used.

22 A 2023 review that's also been

1 published -- identified by OSHA identified a
2 large range of symptoms, including headache,
3 difficulty breathing, skin disorders, increased
4 discomfort from heat and humidity, all of which
5 could increase the concern that workers would
6 discontinue FFR use.

7 OSHA's assertion that this would not be
8 a problem because these respirators are not used
9 in immediately dangerous to life and health
10 situations, fails to recognize the immediate
11 harm from allergens that can trigger severe
12 asthmatic or anaphylactic responses or serious
13 infectious diseases.

14 And as others have said, rather than
15 citing the inadequate respiratory protection
16 documented during the COVID pandemic as showing
17 that medical evaluations don't matter, the
18 widespread absence of NIOSH certified
19 respirators, fit testing, and medical
20 evaluations resulted in healthcare workers
21 sustaining enormous morbidity and mortality,
22 along with other workers, including

1 agricultural, meat and poultry processing
2 workers, and retail workers.

3 In many areas of the country, these
4 infections contributed to community spread.

5 The healthcare workforce alone now
6 numbers 17 million people.

7 At times, N95s and loose fitting PAPRs
8 are necessary to protect safe -- to provide safe
9 patient care.

10 Meningococcal disease, tuberculosis,
11 and other severe infectious diseases remain
12 threats.

13 Zoonotic pandemics of highly pathogenic
14 avian influenza have infected scores of
15 agricultural workers in the recent past.

16 Eliminating medical evaluation as a
17 requirement places not only workers, but the
18 entire public, at risk.

19 OSHA's assertion that there is a lack
20 of evidence that material impairment can be
21 avoided by requiring medical evaluations is
22 incorrect.

1 If OSHA seriously requires confirmation
2 through rigorous controlled trials, it needs to
3 fund such trials as it has done in the past
4 through arrangements with NIOSH.

5 Otherwise, the indirect evidence is
6 ample and compelling.

7 OSHA's required medical evaluations
8 reduce the risk of exacerbating existing health
9 conditions such as asthma, chronic obstructive
10 lung disease, migraines, dermatitis,
11 claustrophobia, coronary artery disease,
12 congestive heart failure, and other conditions
13 that may either be severe in themselves or
14 prompt workers to remove protection.

15 Depending on working conditions and
16 health findings, a physician or other licensed
17 healthcare professional may recommend a variety
18 of work modifications or restrictions to permit
19 safe work.

20 When clinicians identify these issues
21 and provide protective work restrictions, they
22 are demonstrating material impairment avoided.

1 The best available evidence supports
2 the continued use of medical evaluations for
3 filtering facepiece respirators and loose
4 fitting PAPRs.

5 Finally, removing the requirement for
6 medical evaluations raises legal and ethical
7 concerns that you've already heard about.

8 Assessing a worker's fitness for
9 respiratory use is a medical decision.

10 Removing the healthcare professional
11 from that decision-making raises the possibility
12 of an improper respiratory assignment and
13 subsequent harm.

14 Workers must not be required to reveal
15 personal health information to their employer,
16 an unethical breach of confidentiality that
17 appropriate medical evaluations protect.

18 In closing, APHA urges OSHA to withdraw
19 this proposed rule and retain the requirement
20 for medical evaluations for workers using FFRs
21 and loose fitting PAPRs.

22 We thank you for your attention and for

1 your efforts to ensure that every worker returns
2 home safely at the end of their workday.

3 I thank you.

4 JUDGE BELL: Thank you.

5 Mr. Robinson, questions from OSHA?

6 MR. LEVINSON: Your Honor, we thought
7 perhaps we could have Dr. McLellan testify and
8 then take the questions for both as a panel.

9 JUDGE BELL: Okay, I don't have a --

10 Dr. Sokas, are you able to stick around
11 for a few more minutes for questions?

12 DR. SOKAS: Sure, yes.

13 JUDGE BELL: All right, well, why don't
14 we get Dr. McLellan up and get his testimony and
15 then, we'll have questions for both.

16 MS. HARRISON: All right, I have just
17 promoted Dr. McLellan to panelists.

18 JUDGE BELL: Dr. McLellan, welcome
19 back.

20 DR. MCLELLAN: Can you hear me now?

21 JUDGE BELL: We can hear you now,
22 thanks very much.

1 Welcome back.

2 DR. MCLELLAN: Thank you for this
3 opportunity to testify.

4 I'm Robert McLellan, an occupational
5 and environmental physician, a professor
6 emeritus at the Geisel School of Medicine at
7 Dartmouth, and a past president of the American
8 College of Occupational Environmental Medicine,
9 or ACOEM.

10 Today, on behalf of ACOEM, I am
11 testifying in opposition to OSHA's proposed rule
12 changes that would relax medical evaluation
13 requirements for workers using filtering
14 facepieces, or FFRs, and loose fitting powered
15 air-purifying respirators, or PAPRs.

16 ACOEM is the national medical society
17 representing more than 3,000 occupational
18 medicine physicians and other health
19 professionals dedicated to worker health,
20 safety, and environmental protection.

21 Our members have decades of experience
22 performing medical evaluations for respirator

1 use, including FFRs and PAPRs, and several have
2 conducted foundational research on respirator
3 tolerance, physiologic effects, and
4 psychological impacts.

5 And two ACOEM members have just
6 published the widely used Guide to the Medical
7 Evaluation for Respirator Use, now in its second
8 edition.

9 Note that except for this book, I have
10 already submitted copies of the research that I
11 cite during this testimony and will be
12 forwarding the book shortly.

13 Today I'll explain why ACOEM disagrees
14 with OSHA's scientific rationale for eliminating
15 medical evaluations.

16 I'll be emphasizing existing medical
17 evidence of intolerance to these respirators and
18 the risks posed to vulnerable workers, which
19 require medical accommodations or sometimes
20 outright denial.

21 I'll also outline ACOEM's
22 recommendations for convening a panel of experts

1 and relevant stakeholders to refine the medical
2 evaluation process with targeted modifications
3 supported by research.

4 And ACOEM, as other speakers have, also
5 recommends strengthening enforcement in 1910-
6 134.

7 So, let me now provide ACOEM's comments
8 on the key points listed in OSHA's review of
9 current science.

10 First, OSHA cites a lack of large-scale
11 epidemiologic evidence.

12 With many other speakers, we agree with
13 OSHA, there's an absence of large epidemiologic
14 studies on adverse effects of FFRs and PAPRS.

15 In fact, we have repeatedly called for
16 them.

17 However, major changes to occupational
18 health practice should be guided by the
19 presence, not the absence of evidence, and
20 relaxing protections while awaiting large-scale
21 data risks preventable harm.

22 Secondly, workers -- OSHA cites the

1 fact that workers are already using these
2 respirators without medical evaluation.

3 OSHA states it's unaware of adverse
4 effects among workers who use FFRs and PAPRs
5 without required medical evaluations.

6 However, I'll point out that violations
7 of 1910-134 are consistently among OSHA's top
8 ten citations.

9 And these citations often include
10 multiple deficiencies in respiratory protection
11 programs, including missing medical evaluations.

12 Workers in poorly functioning programs
13 are less likely to report adverse effects due to
14 inadequate training, pressure not to report, or
15 lack of awareness.

16 The fact that many workers use
17 respirators without required evaluations
18 reflects enforcement gaps, not evidence that
19 evaluations are unnecessary.

20 We are deeply concerned that
21 eliminating aspects of the medical evaluation
22 rule may, in fact, create a broader failure of

1 respiratory protection.

2 Thirdly, OSHA states that they note a
3 dramatic increase in the number of people not
4 covered by OSHA using FFRs and PAPRs.

5 OSHA cites widespread public use of
6 these respirators without medical evaluations as
7 evidence of safety.

8 However, public use was unregulated,
9 not formally reviewed, often incorrect, and
10 highly variable.

11 Media images showed respirators worn
12 upside down, inside out, or on the chin.

13 And mixed messaging about N95
14 effectiveness likely led many people
15 experiencing discomfort to stop using them or
16 switch to less protective masks.

17 No large scale epidemiologic studies
18 have examined the adverse effects among the
19 general public.

20 Studies of some historical examples of
21 widespread lay use of respirators, such as gas
22 mask distribution during World Wars or Israel's

1 civilian respirator program did show good recall
2 of basic mask skills training, but were not
3 designed to find evidence of the absence of
4 adverse health effects.

5 In fact, some deaths have been reported
6 in community settings due to incorrect
7 respirator selection.

8 Eliminating medical evaluations may
9 incentivize some employers to provide FFRs or
10 PAPRs even when inappropriate for the hazard,
11 all for the purpose of avoiding a medical
12 evaluation.

13 OSHA also cites evidence of physiologic
14 -- about the physiologic burden of FFRs and
15 PAPRs.

16 Now, we agree with OSHA that some
17 studies have demonstrated minimal physiologic
18 burden of these respirators under certain
19 working conditions.

20 However, in addition to the fact that
21 high heat and high exertion creates an
22 additional physiologic burden where, in fact,

1 these respirators can become an issue.

2 Physiologic burdens should be
3 interpreted more broadly to include symptoms
4 impacting comfort that are likely to drive many
5 workers to be intolerant of FFRs and thereby
6 threaten their health through noncompliance with
7 the FFR.

8 Symptoms without a formal diagnosis,
9 such as heat, thermal pressure, or anxiety can
10 drive intolerance.

11 Discomfort, communication, or visual
12 limitations, and underlying disease status, such
13 as asthma or preexisting dermatologic
14 conditions, can significantly affect tolerance
15 and compliance.

16 Field evidence shows many healthcare
17 workers could not tolerate FFRs for extended
18 periods, even with breaks, and we've heard how
19 rare it is for many nurses to get breaks
20 whatsoever during long shifts.

21 Reductions of visual field and impaired
22 communication create safety hazards that require

1 training to mitigate.

2 Even short duration use of FFRs
3 commonly results in dermatologic conditions that
4 can reduce compliance.

5 Systematic reviews and meta-analyses of
6 healthcare workers using FFRs demonstrated
7 associations with occupational dermatoses, as
8 well as many other symptoms that can drive FFR
9 intolerance.

10 Medical evaluations can address these
11 many considerations.

12 Fifthly, OSHA states that workers can
13 remove respirators if symptoms arise without
14 risk of adverse effects.

15 Hazard evaluations that demonstrate the
16 need for FFRs or PAPRs indicate significant
17 respiratory exposure risks.

18 Brief lapses in protection may be
19 acceptable for some hazards, such as chronic
20 effects of wildfires and smoke.

21 However, some workers, for example,
22 persons with asthma, in some use settings, such

1 as protection from mycobacteria, aerosol, and
2 patient care can cause serious adverse effects,
3 even with brief exposures.

4 As well, vulnerable workers, including
5 those with pulmonary or cardiovascular disease,
6 anxiety disorders, pregnancy, or
7 immunosuppression may experience significant
8 harm even from short exposures.

9 Relying on workers' judgment shifts
10 this risk from employers to individuals.

11 And finally, OSHA points out that few
12 workers are denied respirator use for medical
13 reasons.

14 While few workers are denied respirator
15 clearance, this did not diminish the value of
16 evaluations.

17 Even a 2 percent denial rate across --
18 applied across millions of evaluations represent
19 a large number of workers who would otherwise
20 face preventable harm.

21 And recent studies show that, although
22 examiners rarely deny all respirator use, they

1 often recommend accommodations, such as PAPRs
2 instead of N95s, limits on duration of use, or
3 restrictions from certain environments.

4 Employers often rely on these medical
5 recommendations to provide PAPRs or adjust
6 duties appropriately.

7 Medical evaluations identify risks and
8 guide safe accommodations, even when clearance
9 is granted.

10 So, I'll now outline our
11 recommendations.

12 As follows, ACOEM supports modifying,
13 but not eliminating, the medical evaluation
14 requirement.

15 We recommend for now, maintain the
16 existing medical evaluation requirement covering
17 FFRs and PAPRs.

18 Given persistent widespread
19 noncompliance with 1910-134, eliminating medical
20 evaluations risks further erosion of respiratory
21 protection programs.

22 Secondly, maintain and emphasize

1 employers' obligation to refer workers for
2 evaluation for existing OSHA triggers in 1910-
3 134.

4 Thirdly, given widespread noncompliance
5 with the standard, OSHA should implement a
6 national emphasis program to increase compliance
7 with the standard.

8 Fourthly, continue strong support of
9 the National Personal Protective Technology
10 Laboratory, NPPTL.

11 This NIOSH lab ensures that respirators
12 meet strict quality and performance standards,
13 and funding should support research to improve
14 comfort, safety, and long-duration acceptance,
15 which has been repeatedly shown to be an issue
16 that drives noncompliance.

17 Fifthly, expand the use of online and
18 automated questionnaire review.

19 Automated systems can reduce the burden
20 and costs for employers and workers while
21 maintaining safety.

22 Sixth, support the funding of large-

1 scale epidemiologic studies.

2 Recent research by ACOEM members has
3 proposed improved questionnaires and study
4 designs.

5 We certainly agree and have published
6 papers that says the current OSHA questionnaire
7 is inadequate.

8 It is outdated and needs to be updated.

9 And we suggest that, to do this and to
10 make any modifications of the medical evaluation
11 process, that OSHA convenes a panel to assemble
12 researchers, clinicians, and other relevant
13 stakeholders to develop targeted evidence-based
14 modifications.

15 I'll provide a few examples of targeted
16 modifications, not to say this is exactly what
17 should be done, but just as some examples that,
18 if we pulled together a panel and looked at the
19 existing evidence, it might be helpful in
20 modernizing the medical evaluation process.

21 One example of a targeted modification
22 would account for conditions and symptoms that

1 have been already demonstrated to drive
2 intolerance, that is skin trauma, anxiety,
3 communication difficulties, sensory problems,
4 and perceptual hazards, work environment
5 conditions, intensity of effort, and other PPE,
6 as well as underlying medical conditions that
7 increased risk.

8 Another example of the modification
9 would be to require medical evaluations for
10 working -- for workers using FFRs or PAPRs when
11 use is extended, other PPE is worn concurrently,
12 environmental conditions could increase
13 symptoms, or brief removal could cause serious
14 harm.

15 Alternatively, and this gets to the
16 potential role that fit testing could play in
17 triggering medical evaluations, with all of the
18 provisos that we've just been through in the
19 recent testimony about medical confidentiality
20 and how the -- who is performing those fit
21 testing, it is possible that OSHA could expand
22 its current expectation that respiratory

1 symptoms during fit testing trigger medical
2 evaluation.

3 An abbreviated questionnaire could also
4 be used at initial and annual fit testing with
5 positive responses prompting medical evaluation.

6 Example trigger questions which would
7 not involve a fit tester probing for protected
8 health information include, do you have any
9 medical problems or symptoms that may limit
10 respirator use?

11 Have you been told you should be
12 medically evaluated?

13 Are you concerned that work conditions
14 will impair safe respirator use?

15 Have you previously had problems
16 wearing an N95 or PAPR?

17 Do you want to speak with a health
18 professional about respirator use?

19 Which, by the way, we feel is the
20 single most useful current question in the
21 existing OSHA questionnaire.

22 So, in conclusion, ACOEM agrees that it

1 is time to update and modernize the medical
2 evaluation process, this is warranted.

3 But eliminating medical evaluations
4 without further input would place vulnerable
5 workers at increased risk and undermine
6 respiratory protection programs.

7 We urge OSHA to adopt target evidence-
8 based modifications, support needed research in
9 collaboration with NIOSH, and strengthen
10 enforcement to ensure workers remain protected.

11 And for all of the research that I've
12 cited, I provided those references and the
13 actual documents themselves to OSHA.

14 So, I'm anticipating some of those
15 questions, it's in the docket now.

16 JUDGE BELL: Thank you. Mr. Levinson,
17 the documents --

18 MR. LEVINSON: Your Honor, your speech
19 was a little bit garbled, I'm assuming you
20 called on me.

21 JUDGE BELL: I did call on you.

22 Can you hear me better now?

1 MR. LEVINSON: I can.

2 JUDGE BELL: Okay.

3 MR. LEVINSON: Thank you.

4 Your Honor, the first questions for the
5 panel come from Dr. Minda Nieblas.

6 DR. NIEBLAS: Thank you.

7 Sorry, it takes me a minute to unmute.

8 Thank you both for your testimony.

9 My question has to do with your
10 extensive occupational medicine expertise,
11 especially particularly at ACOEM with the
12 evidence-based emphasis they have, both in our
13 guidelines, as well as in the book that you just
14 referenced and mentioned.

15 Are you aware or can you provide in --
16 or is it already in the provided documents,
17 information about injuries or illnesses that
18 have been caused by or significantly exacerbated
19 by the use of these N95 filtering facepieces or
20 powered air purifying respirator use?

21 And where the questionnaire might have
22 prevented that outcome or, conversely, I guess

1 if they did the questionnaire, why didn't it
2 prevent that outcome?

3 DR. MCLELLAN: Right.

4 Well, yes, there is evidence in the
5 literature right now of problems that have
6 occurred as a result of the use, particularly of
7 FFRs.

8 In particular, occupational dermatoses
9 is very common.

10 I will also point out a couple of
11 things.

12 First of all, the existing
13 questionnaire is inadequate to potentially
14 identify this because, for example, it says,
15 have you ever experienced skin problems?

16 Or if you've ever worn a respirator
17 before, have you experienced skin problems?

18 Well, there are plenty of people who
19 haven't worn respirators before who, if given an
20 opportunity in a questionnaire might say, yes, I
21 have skin problems.

22 And those people with skin problems are

1 documented to be at higher risk of additional
2 skin problems on wearing a respirator due to its
3 irritation, or actually, allergic reactions to
4 some of the respirator components.

5 There is extensive, actually, a
6 systematic review.

7 And by the way, that is in the docket,
8 one paper to that effect.

9 And there is a -- I've also put in the
10 docket a systematic review of the prevalence,
11 it's called The Prevalence of Physical and
12 Psychological Impacts of Wearing PPE,
13 specifically, FFRs with other healthcare worker
14 type PPE during the COVID-19.

15 And if you look at that, just look at
16 the abstract, it's actually frightening to see
17 how common the prevalence of symptoms are.

18 I mean, we're talking in the range of
19 50 percent of people experience one of a variety
20 of symptoms that might not necessarily be
21 considered a diagnosable disease, but that
22 certainly could drive non-compliance.

1 And I will point out, that particular
2 paper, because there was some comment about
3 differences in other countries use of fit
4 testing versus medical evaluation.

5 So, this particular study looked
6 actually at some European countries, including
7 the UK.

8 And I'm not aware of this, but someone
9 mentioned this, that they do not do medical eval
10 first, they go right to fit testing.

11 So, there's a lot of evidence that
12 these kinds of things cause problems, which gets
13 to another point of our recommendation.

14 I mean, it is crucial given -- and I
15 would say, the number of people wearing these
16 was vastly underestimated in the OSHA evidence
17 in the NPR, and that is that it's probably
18 millions and millions and millions and millions.

19 I mean, there are 12 million, as Dr.
20 Sokas said, 12 million healthcare workers.

21 There is a recent publication that I
22 think came out of NIOSH, again, I can provide

1 that if you're interested.

2 But non-essential workers during the
3 pandemic, as many as 80 million people expected
4 to wear these kind of respirators.

5 DR. NIEBLAS: Thank you.

6 I have no further questions, but thank
7 you again for your testimony.

8 MR. LEVINSON: Your Honor, the next
9 question comes from Tom Mockler.

10 DR. MOCKLER: Hello.

11 Yes, thanks for your testimony.

12 Actually, as an immediate follow up,
13 you would indicate we -- the analysis had
14 significantly underestimated the number of, you
15 know, N95 users.

16 And that was actually my question is
17 whether you had any information that you could
18 add to the record in terms of updating our
19 understanding of how many people are using them
20 as of -- what year is it, 2026.

21 We know there was a surge during the
22 pandemic, it may have dropped off some since

1 then.

2 But in any case, we could really use
3 some updated information, both on the numbers of
4 various types of respirators being used, as well
5 as some of the practices going with them in
6 terms of, you know, medical clearance practices
7 and training on respirator use.

8 So, whatever you can provide to the
9 record would be helpful.

10 DR. MCLELLAN: Sure, I'm happy to
11 provide that.

12 And I also will point out, and
13 actually, there's a chapter in the book that
14 I'll be sending that actually gets to currently
15 non-OSHA workforces that are not covered by the
16 Respiratory Protection Standard.

17 And so, for example, I mean, whether it
18 be postal workers or firefighter, excuse me,
19 wildfire workers, there's a number of -- lots of
20 people who are not currently -- had not
21 traditionally been expected to wear respirators.

22 And so, they have not traditionally

1 been covered by Respiratory Protection Standard.

2 DR. SOKAS: And I'm just going to
3 answer.

4 So, from the American Public Health
5 Association perspective, we do not have that
6 kind of data.

7 But as a former OSHA employee, I would
8 mention that the Directorate of Standards and
9 Guidance has a wonderful history.

10 I refer you back to Liz Grossman and
11 John Martonik and Carolyn Freeman of very smart
12 epidemiologists who would find data, either
13 through available sources or through the
14 enforcement information.

15 And I'm curious, this is really a
16 question back at Dr. Nieblas as well as the DSG
17 folks about whether some of this information
18 that's been requested might even be available
19 through the mandatory screening that takes place
20 for the compliance, safety, and health officers
21 every year.

22 Not that they're restricted to the

1 filtering facepiece or PAPRs, but that, you
2 know, some of these questions about how often do
3 the questionnaires identify information, if
4 that's applicable, some of that might be within
5 OSHA's ability to identify.

6 So, I think those are excellent
7 questions, if it's a little tight in the budget
8 to be funding NIOSH to do these extensive
9 studies.

10 And one of the ways OSHA used to get
11 NIOSH funded was to have settlement agreements
12 with some of the large compliance cases that
13 they would make.

14 They would then get the settlement
15 funding, not to be paid as a fine, but to
16 support the kind of research that you've been
17 requesting throughout the day today.

18 Thank you.

19 MR. LEVINSON: Thank you for that, Dr.
20 Sokas.

21 If I could just remark, Dr. Sokas, the
22 APHA testimony was prepared by Kerri Wizner.

1 If you could please just review that
2 testimony and make sure that it comports with
3 anything that you said today and that if you
4 file post-hearing comments, if there are any
5 additional studies or points that you made today
6 that you want to make sure is in the record, if
7 you could please address that?

8 DR. SOKAS: So, even though Kerri
9 Wizner signed off, in fact, Dr. Fagan had a
10 great deal to do with collecting that, the
11 references are all in there.

12 The references are all in there for
13 those studies.

14 The first three studies were publicly
15 available through COVID, I don't think they've
16 been uploaded, but I'll double check, but
17 they're freely available, so there's no pay
18 wall.

19 And then, the fourth study is the one
20 that OSHA already cited.

21 So, there's a bunch of other references
22 to the public health statistics, you know, on

1 asthma, and age, and all that stuff, but you
2 pretty much have all of that.

3 So, I don't think there'll be anything
4 additional unless we come up with, you know,
5 somebody who's done some study that none of us
6 know about.

7 And if we do, we'll definitely make
8 sure to get that into post-hearing comments.

9 JUDGE BELL: Just a point of order,
10 please.

11 DR. SOKAS: Rosemary Sokas, sorry.

12 JUDGE BELL: I know, yes, it's late in
13 the day, let's all remember to identify
14 ourselves when we speak, please.

15 Thank you.

16 DR. SOKAS: Thank you.

17 MR. LEVINSON: Right.

18 And I think that may have been me,
19 Andrew Levinson, for OSHA.

20 One additional question for either Dr.
21 Sokas or Dr. McLellan.

22 OSHA's intent is to try and reduce

1 unnecessary cost on employers.

2 And so, what we're trying to figure out
3 is, how often do you think the questionnaire is
4 identifying information that is actually useful
5 and protective of workers and/or could a
6 modification, where -- as Dr. McLellan pointed
7 out, the single most useful question is the, do
8 you want to talk to somebody about a health
9 issue, right?

10 Would that either, separately and/or
11 part of training and/or part of fit testing, be
12 something that would address the vast majority
13 of situations that are -- that the questionnaire
14 is currently intended to try and identify?

15 DR. MCLELLAN: So, I'll take a crack at
16 it first.

17 For just a couple of points, first of
18 all, some of us have done some research and
19 published a paper which is included in the
20 docket, which did survey clinicians at many
21 different occupational medicine clinics, heavily
22 represented by medical centers, although some

1 outside of that, and do have some of the
2 statistics that some of you have been hungry
3 for, recognizing all the limitations of this
4 particular study.

5 But we did find, indeed, a relatively
6 few would screen -- would be denied a
7 respirator.

8 But many, and I think someone quoted it
9 before, up to 60 percent or so of those denied
10 were not denied altogether, excuse me, they were
11 provided restrictions, which might have been a
12 shorter duration or PAPR versus an FFR, as an
13 example.

14 So, that's one point.

15 I think -- now I'm losing my other
16 point, could you just ask that question one more
17 time because I had another more important point
18 I just lost? Sorry.

19 MR. LEVINSON: Sure, Dr. McLellan.

20 We were trying to tease out the how
21 much is actually gained from the respirator
22 survey or question rather, medical question

1 versus taking, for example, the question that
2 you posed, do you want to talk to somebody and
3 inserting that as part of the training after
4 somebody had been trained on signs and symptoms
5 and/or after fit testing when somebody might
6 have discovered something through the fit
7 testing process?

8 DR. MCLELLAN: Right.

9 So, there is no question that the
10 current OSHA respirator questionnaire is
11 desperately in need of improvement.

12 There are many questions that are --
13 and by the way, we also published, and it's in
14 the docket, a paper regarding this, there are
15 many questions that are either unclear or are
16 irrelevant.

17 We did talk about the skin condition
18 one as one example.

19 There's a lot of -- there are several
20 questions about, have you ever, for example, had
21 pneumonia or a seizure?

22 I might have had a febrile seizure when

1 I was 2, but I'm now, well, now 75. But I
2 haven't had a seizure since and I can wear an
3 N95.

4 So, there are many questions that are
5 either unclear or actually irrelevant.

6 You know, so, the cigarette smoking
7 question is actually a pretty dumb question and
8 is one which, if you follow OSHA protocol
9 exactly, would then require some kind of a
10 follow up, at least a telephone call.

11 So, there's examples of questions that
12 should be removed, but there's -- or that need
13 to be clarified, but there's also many questions
14 that aren't there that should be there.

15 So, there's another document in the
16 docket that I've uploaded that describes domains
17 other than health conditions that should be
18 looked at.

19 So, when this questionnaire was first
20 put together, you know, 20 odd years ago, it was
21 based on, basically, kind of some science, but
22 also misunderstanding and lack of foresight in

1 terms of progress, in terms of the types of
2 respirators that people would wear, et cetera.

3 There are domains that should be on the
4 questionnaire that are not.

5 This could be related to, for example,
6 neurologic conditions that might impact the
7 doffing and donning because of musculoskeletal
8 issues being able to put on a respirator
9 correctly.

10 There's not questions about the, you
11 know, that would get at whether or not an
12 individual may have intermittent and episodic
13 sudden cardiac events or pulmonary events or
14 neurologic events or metabolic events, like
15 hypoglycemia that could create someone -- could
16 disable someone perhaps in a hazardous
17 environment.

18 And I will tell you that the book that
19 we put together goes through the existing OSHA
20 questionnaire, not just the first nine, but the
21 rest of the questions as well, and provides
22 detailed guidance about how a -- I call it a

1 PLCP, physician or licensed healthcare provider,
2 should proceed if they identify a positive
3 answer to a particular question.

4 And based on further interview,
5 potentially physical examination or even
6 potentially testing, to then make decisions
7 about respirator use, either the type of
8 respirator or other work-related conditions.

9 DR. SOKAS: And from the American
10 Public Health Association perspective, this is
11 not going to help you, unfortunately, the real
12 concern is that there are people who may not be
13 able -- who either, as we've heard, just want to
14 power through.

15 We've heard mostly from people who are
16 affiliated with unions today.

17 We haven't heard from the vast number
18 of people who are desperate to keep their jobs
19 and who really are just trying to tick off as
20 much as they can and not really pay attention.

21 So, I think that's, in many ways, a
22 bigger concern that the questionnaire itself,

1 not that it's useless, but that by being too
2 much relied upon that there needs to be some
3 other --

4 We would agree, certainly, with ACOEM
5 that there needs to be improvement in the
6 questionnaire itself, but that the improvements
7 need to be in a way that allows people to very
8 easily at least ask for someone affiliated with
9 the overseeing, you know, physician or the
10 licensed healthcare professional, to have
11 someone do a verbal interaction with the
12 individual, make it easy for that to happen.

13 Because the concern is more that people
14 are going to be afraid to have that happen and
15 that they're trying to get through without
16 identifying themselves.

17 This is an example, not from respirator
18 fit testing, but I honest to goodness had a
19 patient once who denied all kinds of stuff
20 because he wanted to keep his job and then, went
21 and the physical had a throat to abdomen scar
22 from his last coronary artery bypass graft.

1 So, the issue of people not wanting to
2 self-identify in a tight economy is a really
3 important one.

4 JUDGE BELL: That was Dr. Sokas.

5 DR. SOKAS: I'm sorry, yes.

6 JUDGE BELL: That's okay.

7 MR. LEVINSON: Your Honor, the last
8 question from OSHA is a late breaking one from
9 Dr. Minda Nieblas.

10 DR. NIEBLAS: Thank you so much.

11 And again, I thank the panelists and
12 everyone for their patience.

13 Dr. McLellan, many of the members of
14 ACOEM are actually -- work with employers,
15 they're corporate physicians.

16 And so, they may advise employers on
17 risk assessments or risk management issues like
18 this.

19 Today in various testimonies, we heard
20 questions such as, is the employer willing to
21 take on this liability?

22 Or is the employer willing to take on

1 this risk?

2 In the context of removing the
3 respirator questionnaire from, you know, before
4 fit testing for filtering facepieces and powered
5 air purifying respirators.

6 So, my question is, and is there --
7 could there be a concern or would employers be
8 somewhat concerned about assuming more liability
9 in the event these medical respirator
10 questionnaires are not completed?

11 Also goes to Dr. Sokas' statement in
12 which an employee may not be completely
13 forthright.

14 And if someone did have something, they
15 would have medical respirator questionnaire to
16 reach back to, to say we've done our job here.

17 So, I was just wondering what your
18 thoughts might be around that?

19 DR. MCLELLAN: Well, I think as
20 certainly OSHA is well aware, and certainly
21 Rosemary Sokas is very aware, there's a huge
22 spectrum of the amount of attention that

1 employers of various sizes, including big ones
2 or small ones, pay attention to safety and the
3 health and well being of their workers.

4 And so, I guarantee you there's some
5 that would throw whatever caution they might
6 have to the wind with any relaxation of this
7 standard.

8 Absolutely no question, as you know, as
9 I already testified and you should know, you
10 have the data.

11 You know, apparently as many as 50
12 percent of workers, when audited, are not
13 providing any medical evaluation anyway.

14 And so, they are unlikely to -- they're
15 probably, if anything, will applaud any
16 relaxation of the standard.

17 There are other workers -- there are
18 other employers that, regardless of what OSHA
19 does, which is going to want to have, and as you
20 know, the standard currently says you have to do
21 it -- it's just the bottom, right?

22 You have to at least give this

1 questionnaire, but many employers insist on more
2 for many reasons.

3 First of all, it may be combined with
4 other medical surveillance activities.

5 It may be because they have recognized
6 some of the problems that have been discussed.

7 Sometimes people just, you know, fill
8 them out without really attention to their
9 personal health in order to get the job, et
10 cetera, et cetera.

11 So, there's some employers who will
12 absolutely, no matter what OSHA does, will try
13 to use the best available evidence, which
14 currently would, first of all, include questions
15 that are not on the current OSHA questionnaire
16 and may well insist on some type of a personal
17 at least interview or perhaps a targeted
18 examination.

19 JUDGE BELL: And that was an answer
20 from Dr. McLellan.

21 DR. MCLELLAN: Yes.

22 JUDGE BELL: Other questions from OSHA?

1 MR. LEVINSON: Your Honor, OSHA has no
2 further questions.

3 JUDGE BELL: Questions from the
4 Solicitor?

5 MS. ZAVISLAN: Thank you, Your Honor.

6 This is Tessa Zavislan from the
7 Solicitor's Office.

8 We have three questions for Dr.
9 McLellan.

10 We would welcome your responses either
11 now or in a post-hearing comment.

12 You stated that some employees could
13 not safely remove their respirators.

14 Could you please elaborate on the range
15 of circumstances where employees could and could
16 not safely remove their respirators?

17 DR. MCLELLAN: Sure.

18 Well, I think there have been some
19 other examples of that given during this day-
20 long hearing.

21 One of the issues where there is
22 currently not sufficient OSHA regulation has to

1 do with infectious disease.

2 And there are infectious diseases such
3 as measles or mycobacteria where very brief
4 exposures can result in devastating and
5 potentially life-threatening illnesses.

6 We've also -- and also, nurses,
7 chemotherapy -- work with chemotherapy agents.

8 There's certainly been some
9 epidemiology published that shows that these
10 nurses are at higher risk of reproductive harm
11 and even cancer.

12 And so, brief exposures to these
13 potentially carcinogenic, teratogenic, et
14 cetera, agents could, in fact, cause harm.

15 And then, we heard that the very nature
16 of healthcare work and certainly, other jobs,
17 mean that you would be derelict, and most
18 providers put their patient first no matter
19 what.

20 And oftentimes, their job is dependent
21 upon that, and they would be derelict to leave a
22 situation where they're giving -- actively

1 giving CPR or other life-saving care to take a
2 break.

3 As we heard from the nurses
4 organization, the fact of the matter is, nurses
5 oftentimes don't get a break all day even to use
6 the restroom, let alone take a break because
7 they need to take a breath.

8 MS. ZAVISLAN: Thank you.

9 My second question is about your
10 comments, recommendation that requiring medical
11 evaluations for workers using face -- filtering
12 facepiece respirators or loose fitting powered
13 air purifying respirators when use is extended,
14 other PPE is worn concurrently, or environmental
15 conditions could increase the symptoms, or brief
16 removal could cause serious harm.

17 Could you please elaborate on what
18 triggers medical evaluations?

19 For example, what do you consider to be
20 extended use or types of concurrent PPE?

21 DR. MCLELLAN: Well, so, this is meant
22 to be some things to look at as we try -- as you

1 try to update the medical evaluation process.

2 And there's plenty of evidence that
3 concurrent use of other PPE, work conditions
4 such as heat, extended duration of use increase
5 the likelihood of adverse effects, either de
6 novo or that aggravate, you know, already pre-
7 existing conditions.

8 MS. ZAVISLAN: Thank you.

9 And then, my final question for you is
10 if you could please explain more about your
11 recommendation for expanding OSHA's current
12 expectation that respiratory symptoms during fit
13 testing trigger medical evaluations?

14 DR. MCLELLAN: Could you just say that
15 one more time, please?

16 MS. ZAVISLAN: Of course.

17 Could you please explain more about
18 your recommendation for expanding OSHA's current
19 expectation that respiratory symptoms during fit
20 testing trigger medical evaluations?

21 DR. MCLELLAN: So, you know, as we
22 heard one of the prior testifiers mention, fit

1 testing does provide a more face to face, person
2 to person, in person opportunity to evaluate,
3 first of all, someone's concerns about wearing a
4 respirator in the first place.

5 Secondly, their ability to doff and don
6 a respirator.

7 Thirdly, about any apparent distress
8 that they have, whether it be respiratory or
9 other types of distress that a layperson could
10 identify without necessarily probing what's your
11 medical problem that's causing this.

12 I'm not recommending that whatsoever,
13 but rather that this is another opportunity,
14 especially when only the questionnaire has been
15 used as a screening to potentially identify
16 problems that a person is having.

17 And the annual fit testing requirement
18 is yet another opportunity when this could be
19 identified.

20 Although, you know, our, you know, as
21 we -- some of the papers we've published suggest
22 that one of the best approaches is actually a

1 very quick re-eval after an initial approval of
2 a respirator use, not a year later, but a few
3 weeks later, maybe a couple weeks later, simple
4 questions that actually could be provided by a
5 non-medical person to simply identify whether
6 the person has had a problem that should be
7 further medically evaluated.

8 And that -- it is, as we've heard right
9 now, there simply is no prospective
10 epidemiologic research to answer any of the
11 questions that we all have.

12 How good is this, whether it be the
13 questionnaire or full-scale medical eval, at
14 predicting a future problem?

15 And there's, you know, some face
16 validity to some of the things that we can do
17 based on what we know about the job, et cetera,
18 et cetera.

19 But one of the best things that any
20 occupational medicine can use to determine
21 whether or not someone can do a job safely and
22 do it capably is whether they've already done

1 it.

2 And so, the idea would be to,
3 potentially, this is another potential, you
4 know, way we could modify it, is a quick re-eval
5 shortly after the person has been put out on the
6 field wearing a respirator.

7 MS. ZAVISLAN: Thank you both for your
8 testimony.

9 That's all from the Solicitor.

10 DR. MCLELLAN: And that was Robert
11 McLellan saying all those things, by the way.

12 JUDGE BELL: Thank you very much.

13 Do we have questions from the public?

14 MS. BURKE: No questions from the
15 public, Your Honor.

16 JUDGE BELL: Okay.

17 Well, that was an instructive hour.

18 Thank you very much to our last
19 witnesses, really appreciate your testimony.

20 We're at the end of all of our
21 scheduled witnesses for today.

22 Hearing participants -- I'm sorry?

1 Hearing participants may submit
2 additional evidence or statements for a period
3 following the end of the hearing.

4 And we'll have an additional period of
5 time after that to submit any briefs based on
6 the record as a whole.

7 I'll set those deadlines for those two
8 periods at the end of the hearing tomorrow.

9 At that point, the record for this
10 hearing will close.

11 On behalf of the Department of Labor, I
12 wish to publicly thank all of those who gave
13 their time and testimony to contribute to the
14 hearing today.

15 To all the participants, thank you for
16 your interest in this important matter.

17 The hearing is hereby adjourned for
18 today and we'll reconvene at 9:30 a.m. Eastern
19 time tomorrow and we're off the record.

20 (Whereupon, the above-entitled matter
21 went off the record at 3:38 p.m.)
22

1 C E R T I F I C A T E

2 This is to certify that the foregoing transcript
3 was duly recorded and accurately transcribed
4 under my direction; further, that said
5 transcript is a true and accurate record of the
6 proceedings; and that I am neither counsel for,
7 related to, nor employed by any of the parties
8 to this action in which this matter was taken;
9 and further that I am not a relative nor an
10 employee of any of the parties nor counsel
11 employed by the parties, and I am not
12 financially or otherwise interested in the
13 outcome of the action.

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19 _____

20 James Cordes
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