

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 :
:

Thursday,
August 20, 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
ROBERT BLICKSILVER, 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

9:33 a.m.

JUDGE BELL: The hearing will now come to order. Today is the final day of 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. I'm 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 their oral testimony as well as other information pertinent to the proposed rule. After this hearing and the post hearing comment period have closed, OSHA will review the entire record in determining the content of the final rule. My

1 role as presiding judge is limited to conducting
2 the hearing, to assure that a complete and
3 accurate record is made, and that all interested
4 parties receive a fair hearing and have an
5 opportunity to submit their information.

6 The hearing schedule and OSHA's
7 procedures governing this hearing are available
8 on the de-regulatory rule-making page of OSHA's
9 website. These documents were sent to people in
10 organizations who filed a timely notice of
11 intention to appear at this hearing. A few
12 words about the nature of the hearing. Despite
13 the informal nature of the hearing, it is
14 governed by rules, both OSHA's rules governing
15 hearings, which can be found in 29 CFR, Part
16 1911, and the hearing procedures issued which
17 are specific to this rulemaking.

18 These rules are meant to assure that
19 everyone has a fair opportunity to speak and to
20 express an opinion about the proposed rule. To
21 that end, they allow me to hold witnesses to
22 their allotted times, limit undue repetition or

1 excessive argument, and to generally keep the
2 hearing on schedule. Any written comments you
3 have submitted to the docket are already a part
4 of the record of this rulemaking. In the rare
5 case where a witness wishes to provide any other
6 documents that have not already been entered
7 into the docket, they should provide them by
8 email to this address, oshaevents_dsg@dol.gov.
9 And that should be done before the witness
10 begins his or her testimony so that they can be
11 designated as exhibits in the record.

12 Because all pre-submitted documents are
13 already part of the record, we ask that your
14 oral testimony concentrate on presenting the
15 highlights of your written comments or
16 clarifying or expanding on your written
17 submission. Hearing participants may also
18 submit additional testimony or evidence for a
19 period following the end of the hearing and will
20 have an additional period of time after that to
21 submit any briefs based on the record as a
22 whole. I'll set deadlines for those two periods

1 at the end of the hearing. And at that point,
2 the hearing in this -- the record for this
3 hearing will close.

4 Today after each speaker or panel of
5 speakers completes giving their oral testimony,
6 OSHA representatives will have the opportunity
7 to speak or ask questions to that panel. When
8 OSHA has finished asking questions, there will
9 be an opportunity, as time permits, for persons
10 who filed a timely notice of intention to appear
11 to question the witness or panel. Participants
12 may only direct questions to witnesses with whom
13 they have no organizational affiliation. This
14 is intended to prevent the use of the question
15 period to extend testimony.

16 In general, this is the process I
17 intend to follow. After OSHA has finished
18 asking questions of a witness or a panel, I will
19 ask participants who wish to ask questions of
20 the witness or that panel to identify themselves
21 by pressing the raised hand button which you can
22 find at the bottom of the screen or by pressing

1 star nine on their telephone for those who have
2 called in.

3 Based on the hearing schedule, the
4 number of participants who wish to ask
5 questions, I will determine the order in which
6 participants will question a particular witness
7 or panel and any time restrictions that are
8 going to apply to that questioning. If there
9 are more questions than we have time for during
10 the scheduled period for questioning, it may be
11 possible to ask additional questions after the
12 conclusion of the final witness who has
13 testified today.

14 Further, if witnesses are unable to
15 answer a question during today's hearing, or
16 would like to expand on the answers provided,
17 they are welcome to use the post-hearing comment
18 period to submit such information. I'd like to
19 remind you that the proceeding today is being
20 recorded. And it's also being transcribed by a
21 court reporter. To ensure that the reporter is
22 able to provide an accurate record of the

1 testimony, please try to remember to provide
2 verbal responses to all questions, because the
3 court reporter has a difficult seeing if you
4 only nod or shake your head in response.

5 In addition, please remember to
6 identify yourself before the beginning of your
7 testimony or before asking or answering a
8 question. This is a forgotten rule, and I'll do
9 my best to try to help remind people to identify
10 themselves before speaking or before asking or
11 answering the question. The transcript of the
12 hearing will be uploaded to the hearing docket
13 on regulations.gov approximately two weeks
14 following the hearing. Mr. Levinson, I now ask
15 the OSHA panel to introduce themselves.

16 MR. LEVINSON: Thank you, Your Honor.
17 I am Andrew Levinson from OSHA's Directorate of
18 Standards and Guidance.

19 DR. BEARR: Dr. Jonathan Berr from
20 OSHA's Directorate of Standards and Guidance.

21 DR. NIEBLAS: Dr. Minda Nieblas from
22 OSHA's Directorate of Technical Support and

1 Emergency Management.

2 DR. BLICKSILVER: Dr. Bob Blicksilver,
3 OSHA Standards and Guidance, Office Of
4 Regulatory Analysis.

5 MR. LEVINSON: That's the OSHA panel,
6 Your Honor.

7 JUDGE BELL: Okay, thanks very much.
8 Mr. Berndt, I'd ask those from the Solicitor's
9 Office who are here today to introduce
10 themselves, please.

11 MR. BERNDT: Of course, Your Honor.
12 Joseph Berndt with the Office of the Solicitor,
13 Department of Labor.

14 MS. ZAVISLAN: Tessa Zavislan with the
15 Office of the Solicitor.

16 JUDGE BELL: Thank you all for being
17 here. Unless there are any other announcements
18 or housekeeping matters, I think it's time for
19 us to begin with the public testimony. The
20 expected speaking order will be displayed on the
21 screen. Our contractor will introduce each
22 speaker in turn and promote them to be

1 panelists. When you are called on to testify,
2 please state your name and affiliation for the
3 record. Speak slowly and clearly so that our
4 court reporter can make an accurate record. And
5 at this point, I think we're ready to begin.

6 MS. HARRISON: Thank you, Judge Bell.
7 Timothy Hannigan, I have promoted you to
8 panelist. You are welcome to unmute and turn
9 your camera on. And as a reminder, we have a
10 courtesy timer in the bottom right-hand corner
11 of your screen.

12 JUDGE BELL: Mr. Hannigan, welcome.
13 You may begin.

14 MR. HANNIGAN: Good morning, Judge
15 Bell, Timothy Hannigan, General Counsel for the
16 Firefighters Association of the state of New
17 York. Mr. Levinson, members of OSHA, and our
18 partners in the Department of Labor, good
19 morning. FASNY is the voice of New York state's
20 81,000 volunteer firefighters. Since 1872, we
21 have informed, educated, and trained the
22 volunteer fire service in our state, and we are

1 the largest state association of volunteer
2 firefighters in the United States.

3 Volunteer firefighters serve all
4 corners of New York in rural, suburban, and
5 urban areas. And as an interesting point, we
6 are the only state in the nation whose NFL
7 Stadium is served exclusively by volunteer
8 firefighters. Nearly all of our members, EMS
9 and Fire, including myself, are directly
10 affected by your respiratory protection
11 standard, whether through self-contained
12 breathing apparatus used in interior, structural
13 firefighting, or through the loose-fitting face
14 masks that many departments issue for wild land
15 smoke exposure and infection control duties on
16 medical related calls.

17 Accordingly, FASNY has a direct and
18 substantial interest in this de-regulatory
19 rulemaking and appreciates the opportunity from
20 you to offer comment. In terms of cost, our
21 volunteer fire departments administer the
22 respiratory protection standard with a fraction

1 of the administrative and medical resources
2 available to our career departments and private
3 industry. Every firefighter who may be required
4 to wear a respirator, whether that's an SCBA
5 facepiece for interior firefighting, or a loose
6 fitting mask during EMS response, must first be
7 medically evaluated by a physician or other
8 licensed healthcare professional.

9 For volunteer departments, particularly
10 those in rural areas of our state, scheduling
11 that evaluation means locating a physician who's
12 A, available, and B, willing to complete OSHA's
13 Appendix C questionnaire, coordinating the
14 physical around the volunteer's outside
15 employment, and absorbing a cost that is
16 frequently borne by the Department itself, or
17 the volunteer personally rather by an employer
18 with an occupational health program already in
19 place. Because volunteer rosters turn over
20 regularly, and physicals are performed annually,
21 this burden recurs continuously rather than as a
22 one-time on-boarding cost.

1 FASNY supports the proposed removal of
2 the mandatory medical evaluation requirement for
3 filtering facepiece respirators, and loose
4 fitting, powered air purifying respirators
5 subject to some clarification. As the proposal
6 indicates, and as we understand it, the proposal
7 does not reach SCBA, which remains the primary
8 respiratory protection used in IDLH atmospheres
9 and interior structural firefighting under
10 Paragraphs G3 and G4. FASNY'S members will
11 therefore continue to receive medical
12 evaluations before SCBA use, preserving
13 physician oversight where the physiological
14 burden of respirator use is highest.

15 The deregulatory proposal instituted by
16 OSHA instead targets the lower burden category
17 of filtering facepiece respirators and PAPRs
18 which OSHA has preliminarily determined impose a
19 materially different physiological demand than
20 tight-fitting, pressure-demand SCBA facepieces.
21 FASNY agrees. For our members the advantage of
22 the proposed rule is one that it could remove a

1 recurring administrative and financial obstacle
2 to equipping volunteer firefighters with
3 filtering face masks for the non-IDLH tasks
4 where departments currently require their use,
5 some after-action overhaul or salvage
6 operations, non-emergency HAZMAT support, wild
7 land and brush fire smoke exposure, and
8 infection control during EMS response.

9 New York's volunteer fire departments
10 bear the full cost of our annual physicals, and
11 fire departments that currently defer issuing
12 filtering facepiece respirators or that rely on
13 the voluntary use provisions with their intended
14 restrictions, would be able to equip members
15 more readily because of the removal of the cost
16 and scheduling burden under Paragraph E
17 evaluations.

18 This advances, in our view, rather than
19 undermines worker protection. Firefighters are
20 more likely to protect their communities and be
21 protected against particular exposure if the
22 administrative cost of doing so is reduced

1 without any corresponding reduction in the
2 medical oversight that continues to apply to
3 SCBA use in IDLH atmospheres. I referenced
4 earlier the point of clarification you're
5 looking for. FASNY requests that OSHA clarify,
6 either in the preamble, or to the final rule, or
7 in regulatory guidance, whether the proposed
8 amendment to Paragraph E has any effect on the
9 facepiece seal requirements of Paragraph
10 (g) (1) (i) .

11 I don't believe it does, but I think
12 it's a good point of clarification. As you
13 know, that paragraph prohibits an employer from
14 permitting a tight-fitting facepiece respirator
15 to be worn by an employee who has facial hair
16 that interferes with the sealing surface, or
17 valve function, or any other condition that
18 interferes with the face to facepiece seal or
19 valve function. These requirements govern fit
20 and use, not medical evaluation. And nothing in
21 the proposed rule, or text, or preamble, as
22 published, appears to amend them.

1 However, because Paragraph (g)(1)(i)
2 applies to tight-fitting facepiece respirators
3 generally, a category that includes the tight-
4 fighting filtering facepiece respirators and
5 tight-fighting PAPRs, not only SCBA, we're
6 asking for your confirmation that these fit-
7 related prohibitions will remain fully in effect
8 for filtering facepiece respirators and powered
9 air purifying respirators, even where that
10 medical evaluation under Paragraph E is no
11 longer required.

12 Our departments are asking for a clear
13 answer on this before they revise local policy.
14 Firefighters with facial hair or other seal-
15 interfering conditions, in our view, should
16 continue to be excluded from tight-fitting
17 respirator use under the current standard
18 regardless of whether they've undergone a
19 medical evaluation.

20 We want to ensure that the proposed
21 rule is properly interpreted at the local level
22 as not relaxing that independent fit-based

1 prohibition that has long been the law of the
2 land.

3 I note that there have been many
4 challenges in our state, and certainly in other
5 district courts in the Northeast, that think
6 that the facial hair rule compromises religious
7 or other legitimately held beliefs. And courts
8 have routinely deferred to OSHA and the express
9 language of the regulation and upheld the
10 requirements stated therein.

11 Again, FASNY appreciates the
12 opportunity to comment and supports the proposed
13 deregulatory action as a reasonable, targeted
14 reduction in administrative burden that leaves
15 undisturbed the medical evaluation requirement
16 for SCBA use in IDLH and interior structural
17 firefighting.

18 We respectfully request, as I just
19 discussed, that OSHA confirm and clarify in the
20 final rule that 1910-134 (g)(1)(i), and it's
21 subparagraphs A and B, are completely unaffected
22 by this rulemaking and that they will continue

1 to apply in full to all tight-fitting facepiece
2 respirators, including the filtering facepiece
3 respirators and PAPRs.

4 On behalf of New York's Volunteer
5 Firefighters, I appreciate your time and
6 attention and welcome any questions that the
7 panel may have. Thank you.

8 JUDGE BELL: Thank you, Mr. Hannigan.
9 Mr. Levinson, questions from OSHA for the
10 Witness?

11 MR. LEVINSON: Yes, Your Honor, OSHA's
12 first question comes from Dr. Jonathan Berr.

13 DR. BEARR: Jonathan Berr, OSHA. Mr.
14 Hannigan, thank you for your testimony.

15 Does your association have any data on
16 how often the medical questionnaire results in
17 workers finding out they have a medical issue
18 that they were previously not aware of?

19 MR. HANNIGAN: So I heard that concept
20 yesterday. And in my own experience, I've been
21 a volunteer firefighter for 22 years, and
22 counseled departments across the state, for

1 firehouses, it's not so much the appendix, it's
2 not the questionnaire, it's the blood work that
3 we have done, or the stress test, or some other
4 component of the annual physical other than the
5 questionnaire.

6 So, I mean, I've filled that
7 questionnaire out 21 times myself. And they
8 generally don't -- what we have found, got into
9 serious cardiac conditions or conditions that
10 our firefighters were unaware of, was blood
11 work, or the stress test, or some other
12 advanced testing that the questionnaire didn't
13 move the needle on one way or the other.

14 DR. BEARR: How often, when
15 firefighters are approved to wear their loose-
16 fitting PAPRs, how often, while they're working,
17 does the incident happen where they then have to
18 have another medical evaluation?

19 MR. HANNIGAN: I would say slim to
20 none. Generally speaking, for interior
21 firefighters we, even some of our exterior
22 firefighters get the full SCBA with the tight-

1 fitting seal.

2 I think employers now, generally in New
3 York, those being towns, villages, fire
4 districts in the rural areas, have those other -
5 - the PAPRs are generally not included in what
6 we do. There are some specialized HAZMAT teams
7 that would have that. But we are primarily
8 covered by that loose-fitting filtering
9 respirator.

10 Our departments have those available.
11 And I think if, you know, somebody had a
12 question about it, or was concerned about it,
13 they wouldn't be compelled to wear it or respond
14 with it. But generally, most use it now. And
15 they're already complying with the more
16 stringent components of the respiratory
17 protection standard.

18 In further explanation, I think that in
19 some of the comments I read about the
20 physiological concerns where -- when people wear
21 SCBAs, you could feel claustrophobic or
22 concerned. I have not experienced, or been

1 informed, any of those similar concerns were
2 shared with respect to the loose-fitting
3 respirators at all.

4 DR. BEARR: Thank you very much, those
5 are all my questions.

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

8 DR. NIEBLAS: Hello, Mr. Hannigan. I
9 just wanted to clarify, and I think I heard it
10 in the last answer, but it appears most of your
11 constituents are cleared for SCBA use. Are
12 there circumstances where they might just
13 require clearance for a powered air purifying
14 respirator as far as their volunteer duties?

15 MR. HANNIGAN: Yes, there could be for
16 specialized. I would expect to see that in
17 HAZMAT response. Many fire departments just
18 incorporate SCBA and put the full HAZMAT suit
19 over the air pack unit itself. I think it would
20 be a small component.

21 I don't know, there would be a cost
22 savings there, obviously, I don't know that it's

1 substantial, just because we have primarily SCBA
2 use. But there would be, for those departments
3 that do have that, they would certainly
4 experience a savings.

5 DR. NIEBLAS: Thank you. This is Dr.
6 Nieblas again, with a follow-on question. Would
7 you be concerned, given you discussed HAZMAT,
8 there may be high stress, high exertion, or a
9 high heat kind of scenario where they're wearing
10 these PAPRs. Are there any concerns around
11 that?

12 MR. HANNIGAN: Yes. I mean, I think on
13 there's a sticker on all our helmets that
14 firefighting is inherently dangerous and,
15 basically, why are you doing this? So we always
16 have concerns about our folks going into that.
17 The Tyvek suits can be warm, and I think that
18 part of that medical evaluation is good.

19 I have concerns, but generally those
20 teams train so often that when there's -- if
21 there was going to be an incident we would be
22 training. But there are so many test

1 simulations of that, that I think the rate of
2 injury with respect to use of PAPRs, or
3 certainly the loose-fitting facepiece
4 respirators, would be de minimis. And if there
5 was some issue, we'd be able to get that person
6 out of the zone and deconed appropriately.

7 DR. NIEBLAS: Thank you, no further
8 questions.

9 MR. LEVINSON: And, Your Honor, OSHA'S
10 last questions come from Dr. Bob Blicksilver.

11 DR. BLICKSILVER: Hi, Bob Blicksilver,
12 OSHA Standards and Guidance. Mr. Hannigan, does
13 your association have any survey data, or have
14 there been any studies within your membership on
15 current practices with regard to respirator
16 usage, medical clearance, practices, and
17 procedures, and training on respirator usage?

18 MR. HANNIGAN: I don't know that we
19 have data on it, we could likely find -- we
20 could provide data on the number of interior
21 firefighters in the state. So we're an OSHA
22 planned state, so all of our interior

1 firefighters, and many of our exterior
2 firefighters who were formerly interior,
3 continue to get the annual fit test under
4 1910.134.

5 With respect to the loose-fitting ones,
6 I think our EMS component, we'd see that.
7 During COVID, a lot of our firefighters were
8 also, you know, we wore masks more often, even
9 including on the apparatus that we generally
10 don't do.

11 The best estimation of that, sir, would
12 probably be the number of total firefighters,
13 just because we know interiors do that physical
14 process now.

15 DR. BLICKSILVER: Thank you, Bob
16 Blicksilver again. Well, if in post-hearing
17 comments you come across, or you're aware of any
18 compiled data that profiled the distribution of
19 just certain types of respirators that you've
20 described here, for certain activities among
21 firefighters, that would really be helpful to
22 us. Thank you.

1 MR. HANNIGAN: Okay. Thank you, Dr.
2 Blicksilver.

3 DR. BLICKSILVER: Thank you.

4 (Simultaneous speaking.)

5 DR. BLICKSILVER: So when you screen
6 new employees for health concerns in relation to
7 the use of respirators, do you rely exclusively
8 on the questionnaire in the appendix to the OSHA
9 standard, or have you developed other means of
10 identifying medical signs or symptoms? In post-
11 hearing comments, could you characterize and
12 quantify the range of costs involved with
13 medical screening procedures.

14 I think you touched on how you
15 identified, through blood work and other means,
16 signs and symptoms, and medical conditions that
17 your firefighters have. If you could elaborate
18 on those, if you have anymore information to
19 share on those areas and, as I mentioned, if you
20 can characterize and quantify the range of costs
21 involved with the medical screening procedures.

22 I think you mentioned administrative

1 costs in your testimony. So if you could,
2 again, please elaborate on that, that would be
3 helpful to us. Thank you very much.

4 MR. HANNIGAN: Absolutely, yes, thank
5 you.

6 Do you want me to respond now, or post
7 hearing on that?

8 DR. BLICKSILVER: If you have anything
9 to respond now, that would be fine, otherwise,
10 post-hearing would be fine too.

11 MR. HANNIGAN: Okay. Real quickly, all
12 departments in our state used the appendix --
13 the questionnaire. But with respect to
14 respirator use, I think that it would be the
15 other, the occupational health physician that's
16 performing the physical, or some departments are
17 certified in-house to do that.

18 Either the office are performing that
19 test or, in many cases, the medical
20 professionals are performing it. It's the eyes
21 on operation and use of that, particularly with
22 respect to SCBA's, that they will use in

1 determining whether we're qualified or not, or
2 if there's some problem.

3 I would note that many firefighters by
4 nature generally try to tough it out. You know,
5 like, I'm fine, everything's good. So I don't
6 know that the questionnaire really prompts the
7 types of responses that would otherwise cause,
8 you know, cause some concern from physicians.

9 Our volunteers tend to want to serve
10 until they're, you know, 130 years old, because
11 they love it, and they serve the communities
12 with pride. But it's generally the eyes on,
13 hands on, medical testing that catches stuff for
14 our members. And that's their statement across
15 the board.

16 But I can look into the cost of -- it
17 would be beyond just this deregulatory action
18 when you're talking the full physical. But we
19 could get a range of the costs on that to try to
20 estimate it.

21 DR. BLICKSILVER: Sure, thank you. Bob
22 Blicksilver again. Yes, however you wish to

1 characterize the cost, whatever you identify in
2 your records, any information that you're able
3 to gather on the different aspects of the
4 administrative costs, and other resource uses --

5 MR. HANNIGAN: Okay.

6 DR. BLICKSILVER: -- any other costs of
7 resources involved in the screening and
8 evaluation of your firefighters. Thank you.

9 MR. HANNIGAN: Absolutely, thank you.

10 MR. LEVINSON: Your Honor, that
11 concludes OSHA's questions for Mr. Hannigan.

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

14 MR. BERNDT: Joseph Berndt from the
15 Office of the Solicitor. I have no questions.
16 But, Mr. Hannigan, thank you for taking the time
17 to testify today, much appreciated.

18 MR. HANNIGAN: Absolutely, you're
19 welcome. Thank you all.

20 JUDGE BELL: And Mr. Hannigan, thanks
21 very much for your service and the service of
22 your members.

1 MR. HANNIGAN: Thank you, Judge Bell.

2 JUDGE BELL: All of us who live in
3 communities served by volunteer firefighters and
4 EMS really appreciate what you do. Thank you
5 very much.

6 MR. HANNIGAN: You're welcome, sir.

7 JUDGE BELL: Okay.

8 MR. HANNIGAN: Thank you.

9 JUDGE BELL: All right, we have next
10 the American Road and Transportation Builders
11 Association.

12 MS. HARRISON: Here we go. I am
13 promoting two panelists, Prianka Sharma and Brad
14 Sant.

15 Here we go, so you should have the
16 ability to turn on your camera and your
17 microphone. And as a reminder, we have a
18 courtesy timer in the bottom right-hand corner
19 of your screen.

20 MS. SHARMA: Great, thank you. Good
21 morning. My name is Prianka Sharma with the
22 American Road and Transportation Builders

1 Association. And I believe my colleague, Brad
2 Sant, is here as well.

3 MR. SANT: Yes, good morning. Brad
4 Sant, and I serve as the senior vice president
5 of Safety and Education for ARTBA.

6 JUDGE BELL: Thanks very much. You all
7 can begin your testimony when you're ready.

8 MR. SANT: Thank you. So just by way
9 of introduction, the American Road and
10 Transportation Builder's Association, or ARTBA,
11 is a national association of over 8,000 members
12 in transportation and construction industry.

13 Our members represent the spectrum of
14 project delivery construction, including
15 contractors, material suppliers, planning and
16 design firms, safety and equipment
17 manufacturers, public officials, and
18 transportation research institutions. So we
19 represent a broad swath of the industry.

20 And just to begin, ARTBA strongly
21 supports OSHA and its mission to protect
22 America's workforce. Since our inception nearly

1 125 years ago, the safety of workers and roadway
2 users have been an essential component of our
3 core mission and values.

4 And we regularly reach out to partner
5 with OSHA through alliances, and training
6 programs, through the Federal Highway
7 Administration as well, because we view this
8 partnership between our entire industry and
9 government as very beneficial and important.

10 And so we support OSHA's efforts to
11 ensure its regulations are appropriate to
12 protect workers in the roadway construction
13 industry while at the same time ensuring that
14 they make sense for the employers to comply with
15 them. So we appreciate OSHA's constant kind of
16 looking out to make sure what they've done in
17 the past continues to make sense today.

18 So today we wish to express measured
19 support for OSHA's proposed amendments to the
20 medical evaluation requirements and their
21 respiratory protection standard for certain
22 types of respirators.

1 And we consider the medical evaluations
2 and the use of questionnaires, where
3 appropriate, to be a best practice for filtering
4 facepiece respirators and loose-fitting powered
5 air-purifying respirators, PAPRs.

6 While we strongly support the use of
7 appropriate PPE for the protection of workers,
8 the use of respiratory protection may cause a
9 physiological or psychological burden on
10 particular employees. And the existing medical
11 evaluation process can help identify underlying
12 conditions that could result in adverse effects
13 while they're wearing those types of respiratory
14 protection. And this includes the face
15 filtering respirators and the loose-fitting
16 power air purifying respirators.

17 So as this proposal came out, we spoke
18 with our members. And based on that, the
19 language is probably more anecdotal than a
20 scientific type survey. But we think OSHA could
21 consider adding this questionnaire as a best
22 practice, as a new non-mandatory appendix for

1 each type of respirator.

2 The strategy would provide our members
3 with guidance on whether a medical evaluation
4 might be beneficial while adding flexibility in
5 situations where the process simply may be
6 unnecessary.

7 We also respectfully request that
8 OSHA identify medical evaluation as a best
9 practice in the preamble of the final rule and
10 as an underlying regulatory test.

11 ARTBA takes the safety of our members
12 very seriously. And as such, we evaluate any
13 deregulatory proposal promotion with caution.
14 And we support the proposed rule as it gives
15 flexibility in cases where OSHA has
16 preliminarily determined that a mandatory
17 evaluation may not be necessary but continues to
18 provide information for situations like one may
19 suspect or may have information that shows that
20 this employee may need to go through that
21 questionnaire, and to have that available to
22 them with regard to these types of respirators.

1 So I will turn the time over to Prianka
2 to follow-up.

3 MS. SHARMA: Thanks, Brian. I don't
4 have too much to add. I just wanted to say,
5 first, just we support your effort to provide
6 review of these existing regulations.

7 I think one of the unique things about
8 the transportation construction industry is
9 that it's constantly evolving based on changes
10 in technology, the equipment, work practices,
11 available materials, given the scope of the
12 project.

13 And so I guess the only other thing we
14 would ask is for periodic review of these
15 standards and that this not be the sort of one
16 off review and stop gap. And then it's not
17 looked again for another several years,
18 especially just given the fact that we do have
19 equipment manufacturers and safety equipment
20 manufacturers who are constantly trying to
21 change and evolve new technologies.

22 We're hopeful that this will be an

1 ongoing and evolving effort on OSHA's part to
2 just make sure that the regulations are keeping
3 up with these new technologies as the come
4 online. And so with that, we're happy to answer
5 any questions. And again, we appreciate the
6 opportunity.

7 JUDGE BELL: Thank you very much. Mr.
8 Levinson, questions from OSHA?

9 MR. LEVINSON: Yes, Your Honor. First
10 questions from OSHA come from Jonathan Bearr.

11 DR. BEARR: Jonathan Bearr, OSHA. I
12 was wondering how often do workers require a
13 medical evaluation after using a respirator on
14 the job? Does your organization have any
15 information on that?

16 MR. SANT: Yes, we have not surveyed
17 our membership for information on that. So I
18 couldn't answer you specifically, but I'm not
19 aware of that being a very common practice at
20 all during follow-up.

21 DR. BEARR: All right. And if you are
22 aware of those incidents occurring, how are the

1 employers aware that a follow-up is needed?
2 Would that be through an actual medical incident
3 happening, or an employee requesting another
4 medical evaluation? How would that take place?

5 MR. SANT: You know, without having,
6 you know, direct feedback from the members of --
7 really, I suspect it would be a combination of
8 both of those. There may be a number of
9 circumstances that come up that would require
10 that type of followup. And maybe it's something
11 that's observed by the employer. Maybe an
12 employee himself reports something. I mean, as
13 you mentioned, there could be a variety of
14 things.

15 And we'd be glad to ask more specific
16 questions to the membership to provide you that
17 information. But simply, you know, we did not
18 survey for that.

19 DR. BEARR: All right. You know, that
20 would be excellent if you could provide that in
21 post-hearing comments, as well as asking your
22 membership how effective they think the

1 questionnaire is in identifying issues where
2 there would be a requirement for a limitation of
3 usage for these respirators?

4 Thank you, those are all of my
5 questions.

6 MR. LEVINSON: Your Honor, the next
7 questions come from Bob Blicksilver.

8 DR. BLICKSILVER: Hi, Bob Blicksilver,
9 OSHA Standards and Guidance. Mr. Sant, does
10 ARTBA or the coalition of trade associations
11 have any data on the prevalence of medical
12 conditions that would lead to respirator
13 changes of other job assignment accommodations
14 among your employees?

15 MR. SANT: And I assume you're talking
16 about the other coalition when we filed
17 comments. That was done as a group.

18 DR. BLICKSILVER: Yes.

19 MR. SANT: And again, we did not ask
20 that question, you know, of all the group as we
21 came together to do that. But, you know, we
22 simply could ask again, as we mentioned, ask

1 that question, and similarly, as the coalition
2 that signed that, see if they would be available
3 to answer those questions as well. But again,
4 that was not in our survey that we did as we
5 reached those comments.

6 DR. BLICKSILVER: Yes, that would be
7 helpful to us, Bob Blicksilver, again. That
8 would be helpful to us just to identify sort of
9 what the baseline practices are. What are the
10 current practices with regard to identifying
11 medical conditions and then accommodating for
12 those conditions through job assignments, or
13 altering the respirator assignment, or whatever
14 accommodations would be given to the employees.
15 So thank you.

16 MR. SANT: Thank you.

17 DR. BLICKSILVER: I think that's all
18 that I have, Andy.

19 MR. LEVINSON: Your Honor, the last
20 question from OSHA comes from me, Andy Levinson.

21 I'm curious. I don't know if Ms.
22 Sharma or Mr. Sant was available yesterday and

1 watched any of the proceeding. But one of the
2 issues that came up, and what I'm trying to get
3 at is this concept of best practices and some of
4 the things you said about moving things, maybe
5 into a non-mandatory appendix.

6 But the OSHA standards are really
7 primarily concerned with minimum required
8 practices. And one of the issues that was
9 floated yesterday was the possibility of
10 allowing employees to request medical
11 evaluation, either following training or
12 following fit testing, where sometimes medical
13 issues might be discovered during those
14 scenarios.

15 And I wanted to know if ARTBA had any
16 thoughts on those issues from yesterday or that
17 approach?

18 MR. SANT: Yes, thank you. So, I was
19 able to listen to the testimony yesterday
20 morning, particularly from those people who
21 represent the construction industry. And, you
22 know, I think that would be a very advisable

1 thing to do. You know, if an employee raises
2 some concerns, of if there's, you know, training
3 that goes on about the use of respirators, there
4 certainly should be mentioned in that training
5 that there is a questionnaire available, you
6 know, for these respirators if people have some
7 concerns, if they have some breathing concerns.
8 And then that should be made available should
9 the employee raise that in those situations.

10 So we would be definitely supportive of
11 that any time an employee may have a concern
12 about wearing a respirator and any kind of
13 functionality that they might have physically or
14 psychologically, then that would be the perfect
15 time to say, hey, this is an appropriate time to
16 use the questionnaire just to make sure they're
17 in the best shape to do so. So we would
18 certainly be supportive of that.

19 MR. LEVINSON: Thank you. The only
20 thing that I wanted to also offer -- I recognize
21 you offered comments, pre-hearing comments, as
22 part of a coalition. To the extent that any of

1 the stakeholders in that coalition may have
2 evolved their positions, any thoughts that you
3 have in post-hearing comments, where we can
4 really, clearly understand what ARTBA's position
5 is on any of these issues if they are, in fact,
6 evolved since the pre-hearing comments, that
7 would be very helpful and welcome in post-
8 hearing comments.

9 MR. SANT: Okay, thank you. Yes, we
10 will certainly do that.

11 MR. LEVINSON: Your Honor, that
12 concludes the questions from OSHA.

13 JUDGE BELL: Thank you. Mr. Berndt,
14 questions from the Solicitor?

15 MR. BERNDT: Joseph Berndt from the
16 Officer of the Solicitor. No questions for me,
17 but thank you for your time and testimony.

18 MR. SANT: Thank you.

19 JUDGE BELL: Are there questions for
20 this panel from the public?

21 MS. BURKE: No, Your Honor, there are
22 no questions from -- oh, we just got two raised

1 hands. Kathy Fagan, I have enabled your mic.

2 DR. FAGAN: Thank you, this is Dr.
3 Kathleen Fagan. Actually, I had a question for
4 the previous speaker, but it doesn't appear to
5 be an option.

6 JUDGE BELL: He'll be coming back, so
7 hold your question until --

8 DR. FAGAN: Oh, okay. Should I put my
9 hand down now or --

10 JUDGE BELL: You can put your hand
11 down, and I'll come back to you in 30 seconds, I
12 hope.

13 DR. FAGAN: Got it, okay.

14 MS. BURKE: And then I see a question
15 from Ellie Barbarash. Ellie, I have enabled
16 your mic as well.

17 MS. BARBARASH: Good morning, this is
18 Ellie Barbarash from AFSCME. And my question is
19 also for the prior speaker, so perhaps I should
20 wait. Thank you.

21 JUDGE BELL: Thank you.

22 MR. SANT: That makes it easy.

1 JUDGE BELL: Okay, Ms. Sharma, Mr.
2 Sant, thank you very much for your testimony.
3 We really appreciate it.

4 And if it's possible for us to bring
5 Mr. Hannigan back, we could pose the two public
6 questions to him that got overlooked a minute
7 ago.

8 MS. BURKE: Yes, Mr. Hannigan, I have
9 promoted you to panelist.

10 MR. HANNIGAN: Good morning.

11 JUDGE BELL: Thank you for coming back.

12 MR. HANNIGAN: You're welcome.

13 JUDGE BELL: All right, questions for
14 Mr. Hannigan that I overlooked, please.

15 MS. BURKE: I am going to enable Dan
16 Glucksman's mic since I saw he raised his hand
17 before. And your mic should be enabled.

18 JUDGE BELL: Go ahead, Mr. Glucksman,

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

22 Mr. Hannigan, in your comments -- and

1 granted this is a little bit of a divergence
2 from the contesting part, but you had mentioned
3 that the volunteer firefighters that you work
4 with, that their job is inherently dangerous.

5 MR. HANNIGAN: Yes.

6 MR. GLUCKSMAN: And a question on that:
7 do you feel that OSHA protections help to make
8 work safer for these individuals and help to
9 mitigate the inherent dangers in their job?

10 MR. HANNIGAN: Yes, I think the current
11 standards do. Yeah, I mean, we're an OSHA plan
12 state, so everything that OSHA comes out with
13 applies to us. I think certainly the
14 respiratory protection standard, as presently
15 written, is good. But I also think that there
16 is room for deregulation there.

17 And I think FASNY's position is where -
18 - on this particular deregulatory action, I
19 think it's appropriate. I think if they were --
20 for example, Mr. Glucksman, if OSHA was going to
21 say, you know, all firefighters can have full
22 beards now, we didn't mean what we said, we'd

1 probably have some response to that. But, on
2 this particular topic, I think they correctly
3 hit the nail on the head.

4 MR. GLUCKSMAN: Right. Then the other
5 one, not as weighty: what stadium is it that's
6 covered by the volunteers?

7 MR. HANNIGAN: It's the only New York
8 team: the Buffalo Bills.

9 MR. GLUCKSMAN: Excellent, thank you.

10 MR. HANNIGAN: You got it.

11 JUDGE BELL: Next question from the
12 public, please?

13 MS. BURKE: Okay, I am going to ask
14 Kathy Fagan to unmute.

15 DR. FAGAN: Thank you. This is Dr.
16 Kathleen Fagan. Thanks for your comments, Mr.
17 Hannigan. I wondered if you have an idea of the
18 age range or the average age of your volunteer
19 firefighters and what percent are in kind of an
20 older category, say, 50 years of age or above?

21 MR. HANNIGAN: Sure. So, Dr. Fagan, as
22 I age, the older range gets farther and farther

1 out. I've been in for 22 years, and I remember
2 feeling young. And I still feel young, and I'm
3 no longer 18.

4 So, we definitely accept anybody who's
5 physically fit. I could tell you, in my own
6 department, we have an exterior firefighter who
7 is administrative capacity only who is 88 years
8 old. So, he doesn't respond to emergencies; he
9 reports to the firehouse and basically handles
10 things there and coordinates the crews going out
11 for calls.

12 We, in New York, have had success with,
13 like, Explorer posts, or younger programs with
14 high school age, say, age 16 and up. That's a
15 category that's thankfully growing in our state,
16 which is good.

17 I'd say the smallest category is
18 generally people in my age bracket or just
19 slightly younger. So, college age, like 20 to
20 35, is where we really need to grow. And we're
21 in a tough spot because of housing affordability
22 and people having young children and starting

1 careers. It's a tough time to also pick up a
2 volunteer job to serve the community.

3 We do very well in, I think, the 40 to
4 55 bracket. And I think we do, just tracking
5 with the Baby Boomer generation, have a
6 disproportionately outsized age range there. But
7 our 60-plus members, age 60-plus members still
8 perform. We have some interior firefighters
9 that are into their mid-60s, some of them in
10 better shape than some of the guys my age. It
11 really does -- it really is individual-specific.

12 But in the volunteer fire service, you
13 generally transition from youth member with
14 probationary restrictions, to full active
15 interior, to exterior, to driver. We have
16 another subcategory of exterior firefighters
17 called fire police. And they generally
18 regulate, you know, scene traffic, scene safety,
19 shutting down the road as necessary.

20 It's a profession that you can really
21 age into and age well into, as long as you're
22 physically fit and healthy. But, yeah, we

1 basically cover 16 to, what did I say, 88.

2 DR. FAGAN: That's fine.

3 MR. HANNIGAN: 80s is high, it's rare
4 that we have people in their 80s, but we do.

5 DR. FAGAN: Thank you. And expanding
6 on that question, particularly for that kind of
7 40, 50, and above, do you know what percentage
8 of them have underlying chronic medical
9 conditions, like high blood pressure, or lung
10 disease, or heart disease?

11 MR. HANNIGAN: I don't have specific
12 numbers on that. I do know that, based on the
13 nature of the work that we do, that cardiac
14 events are generally the number one killer of
15 paid and volunteer, just because of the stress
16 of the job. There's a, you know, reason why the
17 career departments age people out after 20
18 years.

19 But they also, in the career
20 departments, lack the -- kind of the age-in-
21 place abilities that we have where there's light
22 duty roles later on in the support capacity.

1 So, as far as individual or -- and I
2 think the higher incidence of cardiac death is
3 related to the stress of the job. From the time
4 the tones go out, there's actually data or
5 studies on that, that show from the time that
6 the dispatch occurs, elevated heart rate.

7 I have no data myself, other than I
8 could tell you, when we do get toned out for
9 calls, I feel there is an adrenaline -- there is
10 a physiological change that occurs. In my
11 department, we had a chief die in response to --
12 after the call. He had other aggravating, you
13 know, factors going on there, but just the tones
14 cause a physiological response.

15 DR. FAGAN: Thanks. I have one last
16 question, kind of, that I think you answered
17 some of it, but I was a little confused, which
18 is: what percent of your volunteer firefighters
19 do duties that only require a filtering
20 facepiece, respirator, or loose-fitting PAPR?

21 MR. HANNIGAN: Sure. As far as the
22 PAPRs, I would say probably less than five

1 percent. The loose-fitting facepiece, I think
2 you could see a little more often. We would see
3 those with certain chiefs in jurisdictions that
4 have fire investigator responsibilities where
5 they'd wear that instead of full SCBA.

6 Again, this it would be days after the
7 incident. We're generally full SCBA even in
8 salvage and overhaul. But if we're called to
9 return to the scene, you'd have that loose-
10 fitting respirator.

11 For EMS response, certain EMS response,
12 they'll have loose-fitting respirators on. Some
13 volunteer fire departments provide a hybrid EMS
14 and fire response function. Other just provide
15 fire response. But those loose-fitting
16 respirator are there for -- it could be if
17 you're in, like, the cold zone in a HAZMAT
18 situation, respirator use could be indicated
19 there. We probably see -- did you ask for a
20 percentage for the loose-fitting ones?

21 DR. FAGAN: If you have it.

22 MR. HANNIGAN: Yeah. I don't have

1 numbers. I'm just kind of going off our
2 experience of what know ---

3 DR. FAGAN: Sure.

4 MR. HANNIGAN: -- other departments do.
5 I'd say that the likelihood of the loose-fitting
6 is probably, like, the 35 to 45 percent range,
7 at least on an ongoing basis. I think,
8 obviously, in the pandemic, it would be greater
9 but --

10 DR. FAGAN: Sure.

11 MR. HANNIGAN: -- on an ongoing basis,
12 the EMS response, I'd say about close to half or
13 just under.

14 DR. FAGAN: Okay. That's really
15 helpful. Thank you so much.

16 MR. HANNIGAN: You're welcome, Dr.
17 Fagan. Thank you for the question.

18 JUDGE BELL: Other questions from the
19 public?

20 MS. BURKE: Yes. Ellie Barbarash, I'm
21 going to ask you to unmute to ask your question.

22 MS. BARBARASH: Thank you. Mr.

1 Hannigan, thank you for your testimony. And I
2 really want to thank you for your service,
3 especially as someone who spent many, many, many
4 decades in New York State.

5 MR. HANNIGAN: Thank you.

6 MS. BARBARASH: I have a couple of
7 questions. One is, in AFSCME, a lot of our
8 members in other states are folks who repair
9 fire equipment, whether SCBA equipment,
10 helicopters, firefighting trucks, et cetera.
11 And we know that there's such a high level for
12 you and our members of cancer because of the
13 carcinogens in smoke.

14 And we also know that there really is
15 a dose response relationship where there is no
16 safe level for an exposure to a carcinogen.
17 Probability, any exposure of it heightens your
18 range for cancer, so much so that if you get,
19 God forbid, you get or someone gets cancer,
20 there's no challenge from worker's comp that
21 it's work related.

22 So I guess my first question is: do you

1 have any sense if your statistics on inhalation-
2 based and -- or just, you know, what your cancer
3 levels are that are fire-related? I guess that
4 would be a first question for your folks.

5 MR. HANNIGAN: Yes. So, thank you for
6 the question. So, in New York State, volunteer
7 firefighters have a presumptive --

8 MS. BARBARASH: Right.

9 MR. HANNIGAN: - cancer only for lung.
10 For other cancers which we know have a causal
11 relationship, there's a separate statutory
12 scheme under New York law where authorities
13 having jurisdiction have to buy an insurance
14 product that provides either a diagnosis benefit
15 or, sadly, in all those cases, a death benefit,
16 upon the death of the volunteer firefighters.
17 So we have less protection in New York than our
18 career counterparts with respect to all cancers.

19 But I know there's a similar program in
20 the State of Georgia that ours was modeled
21 after. I know that, again, as our population
22 ages, particularly with the Baby Boomers, we've

1 had more claims under that program. The data
2 for that is held by the insurance carriers.
3 Hartford would be one; VFIS, which is based in
4 Pennsylvania, would be another, that would have
5 the -- those carriers would have the raw data
6 immediately at their hands to know the total
7 number of claims. But we don't know that
8 exactly now.

9 I do agree, though, that your members,
10 to the extent they're performing work on the
11 apparatus, particularly on the inside, we've
12 come a long way as far as clean cab concept and
13 washing gear. I mean, just since the time that
14 I've joined, there's been a total
15 transformation. Dirty gear used to be a badge
16 of honor. Now people are telling you to get off
17 the truck and don't get inside.

18 But I think, for your members there,
19 outside the vehicle, I think, you know, the rate
20 -- I think it would be reduced risk. Inside the
21 vehicle could potentially be higher.

22 MS. BARBARASH: Okay. So thank you so

1 much for that answer and for your work on it.
2 But my second question is just for clarification
3 for something you answered before, which was --
4 and just because I thought I heard a
5 contradiction, so I just imagine you could clear
6 it up.

7 So, you shared that, for the volunteers
8 who may be getting up in age, or just have such
9 a profound commitment to the work as volunteers,
10 that they may not always be forthright on that
11 questionnaire, right?

12 MR. HANNIGAN: Yeah.

13 MS. BARBARASH: They may not always be
14 forthright on that questionnaire, because they
15 don't want to not have the opportunity to
16 provide this service. But you also said that
17 your statistics show that it's not very -- you
18 know, like, one of your reasons for saying it's
19 not helpful is because you don't get much
20 response to it.

21 But I guess that doesn't -- I guess my
22 conclusion would be, if anything, that screening

1 questionnaire needs to be enforced and
2 implemented with more vigor as opposed to just
3 disregarded. Because it, kind of, what I hear -
4 - and I don't think you meant this -- is you're
5 saying, well, it doesn't work, because people
6 lie because they want to do the work. I mean, I
7 just wonder if you could expand on that.

8 MR. HANNIGAN: Sure, yeah. So, that
9 was anecdotal. I think all volunteer
10 firefighters in New York state fill that out,
11 including some exterior ones that are fit-tested
12 but will never serve the interior function.

13 I think my comments, to the extent I
14 didn't convey that correctly, I'll do so now, it
15 is other components of our annual physicals that
16 catch the conditions that I think were addressed
17 yesterday. It's not the questionnaire. It's
18 not because people aren't forthright on it. I
19 think they are. I think that some of the older
20 ones, again, it's more of a -- everybody fills
21 it out, but in our practice it's not, oh, this
22 questionnaire caused someone to get additional

1 testing.

2 No, the other components of the annual
3 physical program that we built in, whether it's
4 a cardiac stress test or advanced blood work,
5 it's the blood work and the stress test, in our
6 experience, we have found -- either find a
7 condition or discover that a condition's been
8 exacerbated such that we have to take that
9 volunteer offline or reduce their capacities
10 with respect to firefighting.

11 So, I think the questionnaire is nice;
12 I do think we get general compliance on it. I
13 mean, I think it would be easy enough for
14 somebody to not. But the questionnaire, even
15 when properly filled out, is not the thing
16 that's catching unknown conditions with
17 firefighters. It's other components that are
18 more invasive. It's the blood work, it's the
19 actual eyes-on, hands-on testing of firefighters
20 where those conditions are discovered, in our
21 experience.

22 MS. BARBARASH: Thank you so much,

1 again, for you work.

2 MR. HANNIGAN: You're welcome.

3 MS. BARBARASH: And for your work
4 protecting your members. Thank you.

5 MR. HANNIGAN: Thank you.

6 JUDGE BELL: Any other public questions
7 for Mr. Hannigan?

8 MS. BURKE: No other questions at this
9 time, Your Honor.

10 JUDGE BELL: All right. Mr. Hannigan,
11 thanks very much for coming back. It's my fault
12 --

13 MR. HANNIGAN: You're welcome. Thank
14 you, Judge.

15 JUDGE BELL: My fault that I overlooked
16 public questions earlier. So thanks for your
17 help.

18 MR. HANNIGAN: Judge's can make
19 mistakes, sir. You're all right. Thank you.

20 JUDGE BELL: That's why we have
21 appellate courts.

22 (Laughter.)

1 JUDGE BELL: All right, Society of
2 Chemical Manufacturers and Affiliates.

3 (Pause.)

4 MS. HARRISON: Yes, I am promoting
5 Sedra Beckman. There we go. And Javier Barajas
6 Martinez.

7 I've promoted you both to panelists.
8 You should receive an invite and should be able
9 to unmute and turn your cameras on when you're
10 ready.

11 MR. MARTINEZ: Good morning.

12 JUDGE BELL: Good morning, welcome.

13 MR. MARTINEZ: Thank you. My name is
14 Javier Barajas Martinez, and I serve as Vice
15 President of Government Relations for the
16 Society of Chemical Manufacturers and
17 Affiliates, often known as SOCMA. Joining me
18 today is Sendra Beckman, Health, Safety, and
19 Environmental manager for CJB Industries and
20 chair of SOCMA's Health and Safety Committee.
21 SOCMA represents approximately 150
22 companies across the specialty chemical

1 industry. Our members operate sophisticated
2 manufacturing facilities where protecting
3 employees is a core responsibility.

4 Through SOCMA's ChemStewards program,
5 manufacturer members implement environmental,
6 health, safety, and security management systems
7 focused on continuous improvement and risk-based
8 control.

9 SOCMA supports OSHA's proposed
10 amendment because it provides targeted
11 flexibility while maintaining strong worker
12 protections. We believe regulatory requirements
13 should reflect the type of respirator being used
14 and circumstances of its use. Rather than speak
15 about the principle only in abstract, we wanted
16 OSHA to hear directly from one of our member
17 companies about how the existing requirement
18 operates in practice.

19 I will not turn it over to Sedra.

20 MS. BECKMAN: Javier, thank you. And
21 thank you, OSHA, for the opportunity to share.
22 I'm Sedra Beckman, Health, Safety and

1 Environmental Manager for CJB Industries in
2 Valdosta, Georgia. CJB Industries is a family-
3 owned specialty and agricultural chemical
4 contract manufacturer that relies on a well-
5 trained workforce to safely manufacture and
6 formulate chemical products for customers.

7 Safety is an important part of how we
8 operate. CJB participates in SOCMA's
9 ChemStewards environmental health, safety and
10 security program and our facilities have been
11 recognized for proactive safety practices.

12 It is from that perspective that we
13 support OSHA's proposal to omit the medical
14 evaluation questionnaire requirement for
15 employees who only use filtering facepiece
16 respirators, including M95, R95s, (audio
17 interference) air-powered purifying respirators.

18 This is not about reducing worker
19 protection. Indeed, we fully support
20 maintaining hazard assessments, respirator
21 training, do testing where required, proper
22 respirator selection, and comprehensive

1 respirator protection programs. Those are
2 important controls that directly protect our
3 employees.

4 For CJB, however, the proposed change
5 would have a significant practical impact. We
6 estimate this change would remove the medical
7 evaluation requirement for approximately 82
8 percent of our employees, or about 164 of our
9 approximately 200-person workforce, who
10 otherwise undergo the process because at some
11 point in time they may wear a N95 or similar
12 respirator.

13 At approximately \$65 per evaluation,
14 that represents roughly \$10,660 in direct
15 savings. Beyond those direct savings, the change
16 would also eliminate at least 320 hours of
17 employee administrative time per evaluation
18 cycle if we were to go through all of our
19 employees, resources that could be directed
20 toward a higher value safety activity, including
21 employee training, hazard assessments, and
22 (audio interference).

1 We recognize concerns about employees
2 with underlying cardiovascular, respiratory,
3 and other medical conditions. Supporting this
4 proposal does not disregard their stress or mean
5 medical evaluations have no value, but the
6 requirement should reflect the type of
7 respirator and circumstances. Medical
8 evaluations can remain an important tool where
9 appropriate. At the same time, employers should
10 have greater flexibility for the respirators
11 covered by the proposal and continue meeting the
12 core requirement of an effective respiratory
13 protection program.

14 Based on our experience, this targeted
15 and practical update will remove an unnecessary
16 administrative burden for a substantial portion
17 of our workforce while preserving respiratory
18 protection measures with the greatest impact on
19 employee safety and health. We encourage OSHA
20 to move forward with this proposal. Thank you.

21 JUDGE BELL: Thank you. Questions for
22 this panel, Mr. Levinson, from OSHA?

1 MR. LEVINSON: Yes, Your Honor, the
2 first questions come from Jonathan Berr.

3 DR. BEARR: Jonathan Berr, OSHA. This
4 is a question, I believe, for Ms. Beckman.

5 Do you or your association have any
6 data on how often medical questionnaires result
7 in workers finding out that they have a medical
8 issue that they previously were not aware are?

9 MS. BECKMAN: We can put a poll out to
10 our Health and Safety Committee to ask that
11 question. I can speak from my own experience.
12 I've been at CJB for 15 years in my role. We
13 have not have somebody come through who, through
14 the medical questionnaire, found that they have
15 an issue. So we also do post-hire physicals for
16 our employees. And so if we were to have
17 something pop up, it's usually in that post-hire
18 physical that (audio interference).

19 DR. BEARR: And I had one other
20 question. Do your workers face any hazards or
21 perform any tasks when wearing an FFR or loose-
22 fitting PAPR that would prevent them from being

1 able to momentarily take their respirator off
2 safely? For instance, if they were feeling any
3 symptoms, like shortness of breath, or any sort
4 of discomfort?

5 MS. BECKMAN: So, we are a batch
6 manufacturer. So a lot of what we do -- and I
7 can only speak for our company, not members when
8 asked that same question. But our employees are
9 doing some manual tasks where they are possibly
10 exposed to powders. It's our biggest issue that
11 we wear respirators for. So they could
12 definitely step back and step away from that
13 process for a moment, take a breath, when they
14 need to, if they feel overcome.

15 We find that our employees that are
16 actually wearing the PAPRs enjoy those,
17 especially here in South Georgia. So, summer
18 months, having a little bit of air blowing, and
19 getting (audio interference) cooler on there
20 helps cool them down. And they tend to enjoy
21 wearing those loose-fitting respirators.

22 DR. BEARR: Thank you. Those are all

1 my questions.

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

4 DR. NIEBLAS: Yes, this is Dr. Minda
5 Nieblas. This question is for both panelists,
6 or whoever would like to step in.

7 I'd like to hear a little bit more
8 about the type of workload, or exposures that
9 workers are exposed to while wearing either
10 filtering facepiece respirators, or PAPRs; you
11 mentioned powders.

12 Are they wearing them all day? I'm
13 asking because we understand more from
14 yesterday's testimony about what health care
15 workers are using these for. I'm interested in
16 your employees.

17 MS. BECKMAN: We can also ask this of
18 our membership as far as the health and safety
19 committee. As far as my company, it's not
20 constant.

21 So we, maybe an hour. They'll step
22 away and do different tasks. Our PPE is based

1 on the hazard so the chemical hazard at the
2 moment, and so different parts of the batch
3 require different PPE.

4 At some point, they might only have on
5 an apron and slippers. They might not need to
6 have a respirator on, depending on what's going
7 --

8 DR. NIEBLAS: Thank you. I have a
9 follow-on question. This is again Dr. Nieblas.

10 Do you have any information about how
11 often a worker may require going back for a
12 medical evaluation, after using their respirator
13 on the job?

14 MS. BECKMAN: We can pose that question
15 to membership again. I can only speak from my
16 company, and we have not sent anybody back.

17 DR. NIEBLAS: Okay, thank you very
18 much. And, I have one more question. You
19 mentioned both FFRs and powered air purifying
20 respirators.

21 Is the use of the powered air purifying
22 respirator due to a recommendation from the

1 questionnaire, or is the use of the powered air
2 purifying respirator due to the hazard?

3 I just wanted to know a little bit more
4 about the context of using the powered air
5 purifying respirators.

6 MS. BECKMAN: So, it's based on the
7 hazard assessment.

8 DR. NIEBLAS: Thank you.

9 MS. BECKMAN: You're welcome.

10 MR. LEVINSON: Your Honor, the next
11 questions from OSHA come from Bob Blicksilver.

12 DR. BLICKSILVER: Hi, Bob Blicksilver,
13 OSHA Standards and Guidance. It sounds like
14 you're going to be having some time to survey
15 your membership during the post-hearing comment
16 time.

17 And, I wonder if I could suggest a few
18 other questions to include in that survey.

19 You mentioned operational efficiencies.
20 You describe that broadly in your written
21 comments, operational efficiencies.

22 From streamlining the questionnaire

1 process, to identify medical conditions.

2 Do you have any anecdotal testimonials
3 or survey data on potential cost savings
4 identified by your members, from reducing those
5 administrative expenses?

6 So, that's sort of a part A of my
7 request. I'll just pause here and see if you
8 have a response.

9 MS. BECKMAN: So, Javier, I guess I can
10 jump in again and just --

11 MR. MARTINEZ: Yes.

12 MS. BECKMAN: -- say that we can put
13 that out there to our membership.

14 MR. MARTINEZ: Yes, that's definitely
15 on our radar. We heard from the previous
16 discussion earlier today and yesterday, and we
17 will follow up with post-hearing testimony.

18 DR. BLICKSILVER: Okay, and thank you.
19 Bob Blicksilver again. I wonder if you can ask
20 also if your members identify, have identified
21 any, or could potentially identify any hidden
22 costs from eliminating the medical

1 questionnaire, and then medical conditions
2 arise, they discover them.

3 And that leads to workers' compensation
4 issues, and disruptions in production. And, the
5 reassignment of employees, and decisions about
6 respirators.

7 All of these administrative and
8 resource expenses that employers may incur, as a
9 result of not identifying a medical condition
10 through the questionnaire.

11 I wonder if you can include those types
12 of questions in your survey of your membership.

13 MR. MARTINEZ: Certainly will do.

14 DR. BLICKSILVER: Thank you very much.
15 That's all I have. Thank you.

16 MR. LEVINSON: Your Honor, the last
17 questions from OSHA come from me, Andy Levinson.
18 And my question, it centers on the phrase that
19 you used, Ms. Beckman, that you support medical
20 evaluations where appropriate.

21 And so, what I wanted to explore, and
22 see if you have thoughts either now or post-

1 hearing comments.

2 Some folks yesterday raised the issue
3 of potentially adding back in a medical
4 evaluation either after training, or after fit
5 testing where the employee or the supervisor had
6 perhaps identified a need for medical
7 evaluation.

8 And so, if you have any thoughts on
9 that, that would be very much appreciated.
10 And/or what, you know, in the context of loose
11 fitting PAPRs and filtering facepieces, medical
12 evaluations where appropriate, what you think
13 that, that means.

14 MS. BECKMAN: So, yes, going back to
15 some of the comments and even the comments said
16 for today about maybe being a best practice.

17 Or if it is during fit test that an --
18 is there something that's not quite right.
19 Having that available as an appendix for them to
20 use, and actually take back to the medical
21 department.

22 MR. LEVINSON: Thank you very much.

1 Your Honor, that concludes the questions from
2 OSHA.

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

5 MR. BERNDT: Yes, Your Honor, Joseph
6 Berndt from the Office of the Solicitor.

7 I guess this question kind of goes to
8 both of you, and may be employer-specific or to
9 your membership generally either now, or in
10 post-hearing comment.

11 Do you, or other members have any
12 information about how often medical
13 questionnaires for FFRs and loose fitting PAPRs
14 are currently resulting in further medical
15 evaluations, or subsequent limitations on
16 respirator use?

17 (No audible response.)

18 MR. BERNDT: I don't know, Ms. Beckman,
19 do you have thoughts on that anecdotally, or
20 just in your experience, or otherwise I
21 perfectly understand if it's better for post-
22 hearing.

1 MS. BECKMAN: Definitely better for us
2 to get some information from our members, but
3 also we haven't had any in the 15 years that --

4 (Simultaneous speaking.)

5 MR. BERNDT: You haven't had any?
6 Okay. And, one thing that was kind of came up
7 with some of the witnesses yesterday, and in
8 your experience, I think you just kind of said
9 something about this.

10 Do you find the fit testing procedure
11 ends up being -- some people said that they
12 thought the fit testing process was actually a
13 better place to sort of identify some of these
14 issues.

15 And, that's where they were more likely
16 to find an issue with the respirator use. Has
17 that been your experience?

18 MS. BECKMAN: So we haven't found any
19 type of cardiovascular, or respiratory issues
20 with the fit testing.

21 We have found claustrophobia and we
22 have found some PTSD actually, during that

1 process, which has been interesting.

2 MR. BERNDT: Okay. And then, what type
3 of professional is conducting the fit testing?
4 Is it a medical professional?

5 Is it, I guess I'm just curious as to
6 who you have conducting fit testing procedures.

7 MS. BECKMAN: So we do use medical
8 professionals.

9 MR. BERNDT: Okay. I have no further
10 questions, Your Honor. Thank you for your time.

11 JUDGE BELL: Are there questions from
12 the public for this panel?

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

15 JUDGE BELL: All right, thank you very
16 much for your testimony. We appreciate you
17 being here and answering all of the questions,
18 and providing your testimony. Very much
19 appreciated.

20 PARTICIPANT: Thank you.

21 JUDGE BELL: All right, Dr. Harber
22 seems to be our next presenter.

1 MS. HARRISON: All right, Dr. Harber, I
2 have promoted you to panelist. You can unmute
3 and turn your camera on when you're ready.

4 DR. HARBER: Now can you hear me and
5 see me?

6 JUDGE BELL: We can hear you, I can't
7 see you quite yet.

8 MS. HARRISON: Do you have a cover over
9 your camera by any chance?

10 DR. HARBER: No, I --

11 JUDGE BELL: There we are.

12 DR. HARBER: Ah, there we are, thank
13 you very much. That's been very helpful.

14 JUDGE BELL: Okay, thank you, you can
15 begin when you like.

16 DR. HARBER: Thank you, it's a pleasure
17 to be here and I appreciate the opportunity to
18 speak.

19 My name is Philip Harber, I'm currently
20 at the University of Arizona. I previously was
21 at UCLA where I was Chief of Occupational and
22 Environmental Medicine, in the College of, in

1 the School of Medicine.

2 I got interested in respiratory
3 protection when I was doing my fellowships in
4 occupational medicine and pulmonary medicine, at
5 Hopkins.

6 I saw three patients one afternoon in
7 clinic, who worked in heavy industries; said
8 they can't stand their respirator.

9 I did very extensive testing. That was
10 in the days when we could do that. Could not
11 find a good reason.

12 And since then, for probably 40 years,
13 I have been interested and done many research
14 studies both in laboratory, and in field
15 settings, for respirator work.

16 Much of the work has been summarized,
17 including by Dr. McLellan yesterday. I've
18 included several recent publications in the
19 materials that have been submitted.

20 Next slide, please.

21 Now, I hope you will consider these
22 items. First of all, do not eliminate the

1 medical evaluation requirement, but rather, make
2 it better.

3 Many testifiers already starting with
4 Ms. Reindel, number one yesterday, and going
5 through have said there are serious problems
6 with the current system.

7 This is an opportunity to fix some
8 problems. So, I would eliminate the need to do
9 an evaluation on every single FFR user.

10 But rather, make it stronger that those
11 who need it, get it. That includes giving the
12 mandatory written notice to worker that an
13 evaluation is available with no prejudice, and
14 no cost.

15 And specifying the process. Do this on
16 initial assignment, and at least annually at the
17 fit test.

18 This will have the advantage of
19 increasing access. Currently, many people view
20 the questionnaire-based evaluation as a one and
21 done. That's the reality. And, that's not a
22 very good idea.

1 I do think for reasons I'll discuss,
2 that PAPR users should be required to have a
3 medical evaluation.

4 As Bob McLellan, Dr. McLellan mentioned
5 and I discuss in detail and in the paper based
6 on the study, there is a lot in the
7 questionnaire that needs to be fixed.

8 But most importantly, we should be
9 careful about believing that the questionnaire
10 somehow has great predictive ability.

11 We need to do research. I don't think
12 however, it's advisable to say let's do research
13 and do nothing until that's done.

14 For those who work with large studies,
15 I have a little bit of experience with that,
16 you're talking about a 5-year delay.

17 I think we should do studies, but I
18 don't think we should delay changes.

19 Now, there is very limited or almost no
20 data that the current medical evaluation is done
21 routinely. Not for cause, not for symptoms, are
22 useful.

1 In addition to that, the concepts
2 underlying them are 50 years old, and were
3 developed at a time that there were no N95s.

4 Respirators were big, bulky and high-
5 resistance. That's not the way they are now.

6 In addition, much of the original work
7 that the Standard and the Procedures were based
8 on, is based on studies of Navy scuba divers,
9 maximal exertion levels, et cetera.

10 They are not particularly relevant or
11 accurate, at the current time.

12 The fundamental basis for, to the
13 current system for the FFR users, goes on the
14 hypothesis, is predicated on the hypothesis that
15 if you know the disease, you know whether they
16 can use a respirator.

17 On the other hand as Dr. Beckett and I
18 discuss in one of the papers, you have to
19 carefully consider the worksite, and the
20 individual's adjustment to it, as well as the
21 respirator.

22 Not just the list of diseases, which is

1 where it came from. Starting a list provided by
2 ANSI.

3 So that I think it's time for a change.
4 And we have to recognize as has been pointed out
5 by others, and we found in our survey that's in
6 the materials submitted, that the problem is not
7 just pulmonary limitation breathing through a
8 resistance anymore.

9 It's heat. Particularly with longer
10 use. Skin problems. Acceptability, not
11 physiologic limitation, is a significant factor.
12 And that needs to be assessed carefully.

13 Psychological problems were also
14 prominent in the survey we did. Now I must say,
15 the survey has significant limitations, and
16 needs to be extended.

17 There are reasons to make a change now.
18 Many of the speakers, testifiers, have presented
19 information that there are serious problems with
20 access.

21 And there are problems with quality of
22 the evaluations.

1 When the Standard was changed in 1999,
2 NIOSH actually formally opposed certain of the
3 changes, relying on a broad array of -- fees and
4 a questionnaire.

5 The current system is not working, and
6 as I said, I don't think we should say let's
7 keep it in place, do research, and 5 years from
8 now, consider it again.

9 Let's also focus on why we do these.
10 We do them to predict the future. Now, this is
11 a screening examination, not a diagnostic
12 evaluation.

13 That means that by usual criteria for
14 is screening useful, the goal is to find a
15 problem before it would become important
16 otherwise.

17 I think in this situation, there
18 definitely will be problems identified when
19 workers or fit testers report potential
20 problems.

21 The question is, is that way too late?
22 Now going further, we have to ask and this is

1 really a policy question.

2 I know that Dr. McLellan and I,
3 actually raised this in a technical question to
4 the Directorate several years ago.

5 Whether the exam, the evaluation should
6 focus on the ability to use a respirator, or
7 whether it's appropriate or necessary to look at
8 other things.

9 Now absolutely, it's a good idea to do
10 examinations to find hypertension and diabetes.
11 Ask about cigarette smoking for health
12 promotion.

13 The question is, not whether that's
14 useful. Not whether contact with an
15 occupational health professional is useful. But
16 rather, is it contributory for every person
17 using an FFR.

18 Now, moving ahead to PAPRs. Unlike
19 FFRs, I think PAPR users should be more
20 carefully evaluated.

21 Why? Too main reasons. First of all,
22 there's usually a problem. You use a PAPR

1 because there's a health condition, or an
2 exposure condition.

3 You use a -- thank you -- you use a
4 PAPR because you think the person is at greater
5 risk.

6 They're immunosuppressed. They have an
7 allergy, or they're having symptoms. Now
8 symptoms need to be evaluated. It's not enough
9 to say I'm uncomfortable, but you want to find
10 the cause.

11 Again, we discuss this in one of our
12 papers. Or they have a greater exposure, just
13 as the prior testifier pointed out.

14 It's exposure-driven; it's driven by
15 higher exposures such as aerosol generating
16 procedures, high heat, and things like that.

17 Another concern, particularly in health
18 care, and that's the business that I'm in as a
19 clinician.

20 You go in and out of rooms pretty
21 quickly. Not just doctors, but dieticians,
22 dietary staff, et cetera.

1 It's a lot easier to grab an FFR
2 outside a room, don it properly, spend your 2
3 minutes in the room, and get out, than go down
4 the hall, find a PAPR, put it on, et cetera.

5 I strongly suspect, without strong
6 data, frankly, that protection will actually be
7 decreased if it's required when you have to rely
8 on a PAPR.

9 So for these reasons, both the personal
10 health risks or the exposure risks, I think PAPR
11 users need to be evaluated.

12 So in summary, I think we need to make
13 the changes now. I think we need to improve the
14 quality of examinations by focusing them.

15 It will help to improve the quality
16 because the examiners, the evaluators, will have
17 to focus on the specific workplace conditions.

18 I also think there are objections.
19 What I'm suggesting is not deregulation per se,
20 but it's better regulation.

21 And I think it may have reduced costs,
22 but that's not the purpose. The purpose is

1 improving.

2 Now many people say well, the FFR user
3 might get a breath or two of something bad.

4 Well, the fact is if FFRs get dislodged pretty
5 easily, you sweat, they move around.

6 If that's the highest risk, then an FFR
7 is inappropriate.

8 So in summary, I would like to thank
9 you for the opportunity to speak and go to the
10 last slide.

11 There are -- on the last slide, please,
12 there we are. There are several references that
13 I've included.

14 They are papers that I've written
15 because they reflect my thoughts. They're not
16 necessarily the most profound, but they are ones
17 that I work with.

18 I'd like to thank Dr. Bill Beckett, who
19 contributed and worked with me on three of them.

20 And Dr. McLellan and other members of
21 the ACOM team, who worked on the survey study,
22 and our OSHA questionnaire critique. Thank you.

1 JUDGE BELL: Thank you, Dr. Harber.
2 And, I want to make sure that the slide deck
3 that we saw excerpts from, is part of the
4 record.

5 Mr. Berndt, do you know the answer to
6 that?

7 MR. ANTHONY: Hello, Your Honor, yes, I
8 was going to do that before my questions, but we
9 could do it right now.

10 Sorry, this is Joseph Anthony, Office
11 of the Solicitor. I would like to move to
12 designate the PowerPoint presentation used
13 during this witness's testimony, as Exhibit 5.

14 (Whereupon, the above-referred to
15 document was marked as Exhibit No. 5 for
16 identification.)

17 JUDGE BELL: Without objection, Dr.
18 Harber's PowerPoint deck is designated as
19 Exhibit 5. Thanks very much.

20 MR. ANTHONY: Thank you, Your Honor.

21 JUDGE BELL: Mr. Levinson, questions
22 from OSHA for Dr. Harber?

1 MR. LEVINSON: Yes, Your Honor. The
2 first questions come from Dr. Minda Nieblas.

3 DR. NIEBLAS: Yes, this is Dr. Minda
4 Nieblas. Thank you Dr. Harber, for your
5 presentation.

6 I had a follow-on question, wondering
7 based on your clinical experience or anecdotes,
8 or any studies that you've reviewed.

9 Are you aware of, or have you ever
10 treated, any adverse medical events or
11 conditions caused or exacerbated by either an
12 FFR, or a PAPR's use?

13 DR. HARBER: Yes. I would say that
14 there are a limited number of published studies
15 that are largely anecdotal. But the literature
16 is, frankly needs to be supplemented.

17 I must say that we submitted an RO1
18 grant application a decade ago to NIOSH to do
19 it, but it unfortunately wasn't funded.

20 Now, so I'm speaking from clinical
21 experience. There are a lot of people who find
22 FFRs to be uncomfortable.

1 We studied in the laboratory people
2 with asthma, with chronic bronchitis, with upper
3 airway disorders.

4 And most of them tolerated it well.
5 However, in clinical experience you find some
6 people who say it's a real problem.

7 Sometimes there is a physiologic basis.
8 Sometimes, particularly for prolonged use with
9 an FFR, the heat itself at the face, not total
10 body heat exposure, is a problem.

11 In one of our laboratory studies, we
12 compared FFRs to dual-cartridge half-masks, et
13 cetera.

14 And the FFRs were much better
15 tolerated, including in the people with disease.
16 The only thing of the many, the multi domains we
17 looked at, was heat was worse with the FFR,
18 which is probably no surprise from anybody who's
19 used one.

20 Occasionally, you find somebody who
21 actually has psychologic concerns with it. The
22 arbitrary 10 percent of people have

1 claustrophobia belief.

2 If you read the literature going back
3 to when that started, that was intentionally an
4 arbitrary number.

5 They said well, 10 percent of people
6 have psychologic problems, so 10 percent must be
7 here.

8 I haven't found that to be that often,
9 but there are some people have trouble.

10 In addition, Bill Beckett, Dr. Beckett
11 and I, looked at anecdotally, why people say
12 they have poor tolerability.

13 And we sub-classified it. Sometimes
14 there's increased sensation. Sometimes it has
15 to do with if you consider it acceptable.

16 Dr. Stella Hines, who until recently
17 was at NIOSH, did an important study. Small,
18 but relevant, where she asked nurses which kind
19 of respirator would you like?

20 And if it's just they well, it might be
21 TB, they don't want a -- one. But they're
22 willing to tolerate a lot more when she asked

1 them, what if it's I think multi-resistant
2 tuberculosis, et cetera?

3 So your acceptability becomes
4 important. Now, the whole context becomes
5 important.

6 Back 50 years ago in a forgotten paper,
7 Dr. Mary K. White looked at spray painters.
8 Now, these were not FFR users.

9 But whether your co-workers used them,
10 and the social pressure changed your
11 acceptability, or whether you're -- just like
12 firefighters, you weren't a real firefighter if
13 you had to use an SCBA during clean up.

14 Whereas now, you're not a real
15 firefighter if you don't use it.

16 So, you need to find out the reasons.
17 So yes, I found problems. But I believe that
18 the problems should be diagnosed.

19 Many of them are treatable. My only
20 question is, have I ever found anybody who put
21 it on, immediately fell over dead? No.

22 My understanding that the cases where

1 that have occurred, again, OSHA I believe
2 collects reports, was where supplied air
3 respirators with a cross-connect supplying
4 nitrogen instead of air, et cetera.

5 So, yes, there are reasons but I think
6 that asking somebody to report symptoms would be
7 a good way to do it.

8 DR. NIEBLAS: Thank you. I'd also like
9 to know, are there questions in the current
10 questionnaire, that you think are useful in
11 predicting health outcomes for workers who would
12 be wearing an FFR, or a PAPR?

13 DR. HARBER: Yes. In the published
14 paper, again not profound, but we actually, I
15 set this up with a working group.

16 And, we asked the working group to rate
17 whether you think it's useful, and whether you
18 think it is well worded.

19 Some were worded poorly, but were
20 useful. It's clearly useful to ask have you had
21 problems.

22 That unfortunately, doesn't apply to

1 new users, because they have no experience.

2 Other things that are clinically
3 useful, are whether or not you've got
4 significant skin problems.

5 Now advanced cardiopulmonary disease is
6 going to be important. But usually you don't
7 need a questionnaire to identify it.

8 Now again, I personally think that
9 asthma may be, of the respiratory diseases, the
10 one of most concern.

11 And you don't find that on routine
12 exams because asthma, people with asthma, tend
13 to have intermittent symptoms.

14 So, just if they're triggering an
15 attack, that's the person who may take the mask
16 off while they're exposed to something.

17 That's a particular concern with half-
18 mask, full mask, et cetera. If you have bad
19 asthma, you probably shouldn't be using a FFR,
20 even if it's dust, per se, low levels of a non-
21 specific dust.

22 So yes, I think there are a few

1 questions that are useful. But I think it
2 should be determined empirically.

3 DR. NIEBLAS: Thank you.

4 DR. HARBER: And not rely just on
5 somebody's opinion. Thank you.

6 DR. NIEBLAS: Thank you. That's all I
7 have.

8 DR. HARBER: Thank you.

9 MR. LEVINSON: Your Honor, the next
10 questions from OSHA come from Dr. Jonathan
11 Bearr.

12 DR. BEARR: Jonathan Bearr, OSHA. I
13 guess sort of building off of what was
14 previously asked.

15 How often do you think workers find out
16 that they have conditions that they didn't know
17 about, just through the questionnaire? Or do
18 they already know what conditions they already
19 have?

20 DR. HARBER: Well, if you don't know
21 you have something, you're not going to check it
22 on the questionnaire.

1 So if you've got hypertension, high
2 blood pressure, but you don't know it, you're
3 probably not going to check the box on the
4 questionnaire.

5 So occasionally, somebody will have
6 something where it seemed like a minor symptom
7 to them, but it might be important for their
8 general medical care.

9 Not specifically for respirator use,
10 but I imagine that's pretty, that's pretty
11 unusual.

12 Much of the literature on when you're
13 going to find things, really is covered by the
14 USPTF. U.S. Preventive Task Force that looks at
15 screening general populations, and NIOSH has
16 done a lot of work recently through Total Worker
17 Health, looking at, looking at things other than
18 work-related things.

19 But the answer to your question is,
20 probably not very often, per se.

21 DR. BEARR: And, I had one other
22 question. You were mentioning how medical

1 evaluations should be required for all loose-
2 fitting PAPR users.

3 And, I was wondering outside of
4 situations where we know there's medical
5 conditions that result in that selection, are
6 there other considerations and particularly what
7 I'm interested in, if you look at Germany's G26,
8 they have a threshold of 3 kilograms.

9 Whereas they require medical
10 examinations if the PAPR is more than 3
11 kilograms, but do not require that if it's
12 under, if it's less than 3 kilograms.

13 Do you have any thoughts on that?

14 DR. HARBER: Yes, well that's looking
15 at one specific problem, can you carry the
16 weight of the PAPR.

17 And I'm not, I don't know the German in
18 detail. Obviously, PAPRs are constructed
19 differently.

20 Some put a lot of the weight on the top
21 of the head; some are on the belt, et cetera.
22 But that's only one consideration.

1 I think there is a lot more than the
2 PAPR. And as I said, with the exception of
3 people who use the PAPR for religious or
4 personal belief exemptions because of facial
5 hair, et cetera, there's usually a reason.

6 It's usually because somebody's
7 immunosuppressed, or has an allergy, or is
8 perceived to.

9 Or because, as the prior testifier from
10 the Southern Chemical Company reports, there is
11 concern about exposure.

12 Certainly aerosol-generating procedures
13 are well known to generally warrant a PAPR.

14 DR. BEARR: Thank you, those are all my
15 questions.

16 DR. HARBER: Thank you.

17 MR. LEVINSON: And, Your Honor, the
18 last question from OSHA comes from Dr. Bob
19 Blicksilver.

20 DR. BLICKSILVER: Hi, Bob Blicksilver,
21 OSHA Standards and Guidance. Dr. Harber, do you
22 or your colleagues, your teams of researchers,

1 have any data that would help OSHA refine its
2 profile of respiratory uses, usage, specifically
3 the profile of filtered respirators and PAPRs,
4 filtered facepiece respirators, excuse me, and
5 PAPRs?

6 It sounds like you've done a
7 considerable amount of research in health care
8 and social services, for example.

9 So, I do, have you conducted any
10 studies to profile the usage of these types of
11 respirators, or are you aware of any other
12 studies?

13 We're just trying to be sure that we've
14 collected all the relevant and up-to-date
15 studies, survey data, on profile of respirators.

16 DR. HARBER: Sure. We did a,
17 essentially a pilot study that's published. The
18 results, however, are limited and should not be
19 over-interpreted because we only got results on
20 essentially a convenient sample.

21 We're not, that's overweighted with
22 health care, and overweighted with health care

1 systems where the medical officers agreed to
2 participate.

3 More importantly, about 20 years ago
4 NIOSH, working with the Bureau of Labor
5 Statistics, did an industry, a wide study.

6 It's outdated; it missed a lot of
7 things, but it provided a lot of information
8 about the fact that only a very, and I'm sure
9 you're more knowledgeable about it than me, only
10 a limited number of people were having any
11 evaluation.

12 Of course, that's ancient history. Now
13 about 4 or 5 years ago, NIOSH embarked on a
14 smaller version of that.

15 Again, I believe it was again this time
16 not with BLS, but I believe they contracted this
17 with another contractor. I believe it may have
18 been Westat.

19 Again, but I don't have expertise in
20 this. To my knowledge, that repeat of the mini
21 version of the old BLS study, has not been
22 completed.

1 But that's probably the best place for
2 you to look at this time.

3 DR. BLICKSILVER: Great, thank you. We
4 will search it out. Bob Blicksilver, thank you
5 very much, Dr. Harber.

6 DR. HARBER: Thank you.

7 MR. LEVINSON: Your Honor, this is Andy
8 Levinson for OSHA. I actually have one more
9 follow up question for Dr. Harber.

10 I wanted to probe this issue of loose-
11 fitting PAPRs a little bit more. So, you had
12 stated that kind of the two primary categories
13 for why people would be in a PAPR, would be some
14 sort of medical accommodation, or a higher
15 exposure scenario where they need a higher
16 assigned protection factor.

17 And there's kind of this third category
18 that you did not spend a lot of time on, but
19 OSHA is aware that there are some people who
20 wear PAPRs simply for the comfort.

21 It is the cooling air of a loose-
22 fitting PAPR. It is less physiologically

1 burdensome, et cetera.

2 In those scenarios where somebody
3 either has kind of facial hair and/or religious
4 reason where there's no kind of underlying
5 medical condition or exposure scenario, but
6 they're doing it for kind of comfort and/or ease
7 of compliance.

8 Is there a physiologic need for some
9 higher level of screening for those folks? The
10 medical screening questionnaire, in those
11 scenarios?

12 DR. HARBER: Well, I think there's a
13 good reason to consider it. If PAPR use was
14 totally benign, and had absolutely no problems,
15 the answer would be no, choose what you like.

16 However, besides the cost, I really do
17 think as somebody who frequently goes in and out
18 of a patient room for a 2-minute how are you
19 doing, let me listen to your lungs visit,
20 they're not going to get used that much, I
21 believe.

22 Now Bob, Dr. Harrison, who is speaking

1 this afternoon, did a survey of, an old survey,
2 of quality of protection against multiple drug-
3 resistant organisms, and protective procedures.

4 And as he points out in his paper, they
5 don't, even the hospitals that volunteered,
6 which were probably disproportionately good, had
7 really serious problems.

8 So, I suspect that PAPR use probably
9 has a lot of not being used all the time in
10 health care settings.

11 Certainly if you're doing an hour and a
12 half bronchoscopy, you'll put it on. But if
13 you're doing a 1 minute visit, I wonder how
14 often this is going to happen.

15 As to why this should be looked at if
16 it's just comfort, the reason is that you need
17 to make a diagnosis of why do you feel you need
18 it.

19 Again, Dr. Beckett and I, in the paper
20 on a suggested updated approach to the medical
21 aspects, identify various causes of why you
22 might want it.

1 Some of it may be that you have
2 increased sensation of breathing. Some of it
3 may be that you're -- may be contextual.

4 You don't, you have a lot of fear about
5 the job and worker counseling may be helpful.

6 So you need to make a, I think you need
7 to make a diagnosis of why it's used. If it's
8 purely for comfort and there is no adverse, no
9 adverse effect of using a PAPR, sure, why not?

10 But I do think there are potentially
11 adverse effects whether from the weight, whether
12 from not using it enough, et cetera.

13 Some people actually if it's only used
14 occasionally, the battery may be run down. So
15 there are a lot of reasons to consider it
16 carefully.

17 And that's one of the reasons why I
18 suggest don't just write them off and say well,
19 they have lower air flow resistance. Because
20 that's not the usual problem nowadays anyway.

21 MR. LEVINSON: Sure, just to anchor
22 this in a more concrete non-health care setting.

1 For example, OSHA has been asked repeatedly by
2 the asbestos abatement industry, where people
3 are doing asbestos abatement all day long, in
4 construction settings that for tolerability,
5 comfort, et cetera, right?

6 That in those scenarios, people would
7 like to be able to wear loose-fitting PAPRs, or
8 other sorts of manufacturing environments where
9 it's not kind of the in and out of hospital room
10 scenarios.

11 So there are some other work settings
12 that OSHA is considering.

13 That is all the questions, Your Honor,
14 from OSHA.

15 JUDGE BELL: Thank you. Questions from
16 the solicitor?

17 MR. BERNDT: Joseph Berndt, from the
18 Office of the Solicitor. No questions for me.
19 Thank you, Dr. Harber.

20 DR. HARBER: Thank you.

21 JUDGE BELL: Do we have questions from
22 the public?

1 MS. BURKE: Yes, Judge Bell, we have
2 two so far. Ellie Barbarash, I have enabled
3 your mic.

4 MS. BARBARASH: Thank you very much.
5 And, Dr. Harber, thank you for your work, and
6 for your testimony.

7 I think I heard you say that, that
8 instead of, my understanding of the 1910-134 as
9 it is now, is if your average worker goes to
10 their employer and says they are un, they want
11 more screening, and if they actually say I want
12 a PAPR, I am uncomfortable working and breathing
13 in an FFR, they have the right to have one.

14 And certainly in AFSCME, our members
15 have used that, as I testified about yesterday.
16 But I heard, I think I heard you say that you
17 would want to remove the right of workers to get
18 a PAPR upon request.

19 And rather, they would have to justify
20 by a medical threshold, permission to use a
21 PAPR.

22 And, you did talk about lots of valid

1 medical things that would justify that, but I
2 just wonder if you could address the concern of
3 who would be doing that justification. Are they
4 actually a third party?

5 I'm thinking of all the workers' comp
6 denials in the world. I just really --

7 (Simultaneous speaking.)

8 DR. HARBER: I --

9 MS. BARBARASH: -- I'm really concerned
10 about that as something that would be used to
11 disempower workers to protect themselves in
12 situations where they are already dealing with a
13 lot of precarity. Thank you.

14 DR. HARBER: I agree. We absolutely
15 must assure that a worker has access to a PAPR,
16 or other accommodation such as work schedule
17 adjustment, or various other approaches when it
18 is necessary.

19 I think that I would further, and I
20 would suggest further enshrining the right to be
21 evaluated by requiring written notice on a
22 regular basis, as discussed.

1 And do it in a way that you probably
2 don't need to go through your employer and say,
3 I'm sick and B.S., what's wrong with you.

4 I think it's absolutely essential to
5 provide that, that access.

6 Now, whether it should be a choice to
7 use a PAPR on a totally arbitrary basis, that is
8 I think I want one, I think should also take
9 into account some of the industrial hygiene
10 expertise, and some health expertise.

11 It may be the industrial hygienists
12 feel that it's not the best thing, based upon
13 the exposure.

14 There are times when PAPRs really may
15 not be as good as, as an FFR. But I agree that
16 the person should have the right to ask for it.

17 And if the health, and if the evaluator
18 says yes, what you, it makes a lot of sense that
19 you have significant discomfort that puts you at
20 risk of not using the device, or not performing
21 well in the job to work efficiently, or protect
22 yourself, then by all means, you should continue

1 it.

2 So we do need qualified and objective,
3 and independent evaluators. But I don't think
4 it's always advisable to say well, I want it and
5 therefore, I get it.

6 But I think you should have a low
7 threshold, but not automatic. Because it may
8 not be the best thing sometimes.

9 MS. BARBARASH: Thank you. I have one
10 follow-on question that kind of synthesizes a
11 lot of things said.

12 And I will just say for the record, I
13 strongly hope that workers still have the right
14 to get a PAPR upon request.

15 From what I understand of the
16 difference of a loose-fitting PAPR and a tight-
17 fitting PAPR, and an N95 or NRP99, I have most
18 negative pressure respirators and most PAPRs
19 have a minimum of HEPA filtration, which are
20 screening out 99.97 percent of particles .3
21 microns or larger.

22 And an N95 is 95 percent, and quite a

1 lot more exposure for things like carcinogens.

2 The issue -- and PAPRs are appropriate
3 where you're not worried about someone having a
4 hugely hazardous exposure if their battery dies.

5 Because that's when you need a tight-
6 fitting PAPR, so that they have access to rescue
7 filtration when they get out of the space.

8 And, that's why a loose-fitting PAPR
9 and an FFR are totally inappropriate for
10 asbestos work for a carcinogen threat, which
11 there is cumulative exposure and no safe level.

12 I just wonder if you could address that
13 issue. You did address it when you said for
14 example, somebody intubating or doing something
15 generating high aerosols should not be in an
16 FFR; should be in something with better
17 protection.

18 Thank you. That's my last question.

19 DR. HARBER: Yes, I think you raise a
20 very important point. A PAPR is not a PAPR, is
21 not a PAPR.

22 There are different types. Even for

1 loose-fitting ones, there are different designs.
2 The manufacturers produce many different types.

3 Some have actually, a fairly low, a
4 fairly high end of the hood. Others have, go
5 down much further.

6 There is concern at very high exertion
7 rates. Dr. Ed Sinkule, at I believe he's at RHD
8 in NIOSH, but he may be in NPPTL, did a study in
9 the past showing that if you're doing very high
10 exertion, you can actually over-breathe it.

11 In other words, the device has to flow
12 air downward faster than you're sucking air up.
13 Well, if you're sucking air in at a higher flow
14 rate than, instantaneous flow rate than it's
15 blowing down, you're obviously going to be
16 potentially contaminated.

17 Now that of course, occurs at very high
18 levels. But I agree with you, there are many
19 different kinds of PAPRs.

20 And, there are many different kinds of
21 loose-fitting PAPRs, which again is why I think
22 somebody should evaluate is it the right thing.

1 I focus on a health evaluation but as
2 you point out, an IH evaluation may be
3 appropriate also, rather than simply picking one
4 and using it.

5 But thank you for bringing up the fact
6 that there are so many different types.

7 MS. BARBARASH: Thank you.

8 DR. HARBER: And that they are not
9 routinely protective.

10 MS. BARBARASH: Thank you.

11 JUDGE BELL: Other questions from the
12 public?

13 MS. BURKE: Yes, Judge Bell. There is
14 Kathy Fagan; I have enabled your mic.

15 DR. FAGAN: Thank you. This is Dr.
16 Kathleen Fagan, hi, Dr. Harber.

17 DR. HARBER: Hi, Kathy.

18 DR. FAGAN: So you're recommending I
19 believe, that there are better ways to do
20 medical screening, to prevent adverse health
21 effects from the use of FFRs and loose-fitting
22 PAPRs.

1 And that OSHA could, did not, does not
2 need to wait for long-term research studies, and
3 that there's things that can be done more
4 quickly.

5 But I also think you're not suggesting
6 that the present proposal fits that bill. So,
7 how would you recommend that OSHA proceed to go
8 about figuring out the best ways to do these
9 medical screenings?

10 DR. HARBER: Well, most everybody
11 agrees that something needs to change. And
12 frankly, to say let's do a quote/unquote large
13 epidemiological study, close quote, really
14 reflects a long delay.

15 In the survey paper, I put in a big
16 section about possible study designs. A
17 prospective cohort is probably not necessarily
18 the best way to do it.

19 But we probably shouldn't go off in
20 that direction right now. But again, I think
21 that the research should get started.

22 More importantly, what should we do

1 now? We should mandate and enforce the mandate,
2 that everybody be given written notice.

3 Preferably written notice that
4 specifies if you think you have a problem, this
5 is the health care provider you should call,
6 contact.

7 In other words, pre-specify the method,
8 not put the employer in the middle to say well,
9 you don't look so bad to me.

10 That's step number one. To really
11 improve things, I do think that by reducing the
12 overall number of people getting questionnaires,
13 those who do end up requiring evaluation will be
14 evaluated in more detail.

15 Preferably by somebody who has much,
16 has considerable expertise in knowing the
17 different types of FFRs.

18 I suspect that some evaluators may not
19 distinguish an N99 from an N95, for example. We
20 should remember that NIOSH was opposed to the
21 1999 change. The director specifically put
22 comments in a letter to OSHA.

1 So, I think those are the changes that
2 should be done soon. And of course, to help
3 that along, I think a working group, an advisory
4 group, should be established.

5 Whether through a group, whether
6 through OSHA itself, whether through an
7 organization like the American Thoracic Society.

8 I should say that my first committee I
9 chaired for the ATS, was establishing a
10 respirator policy a long time ago.

11 Or through ACOM, or AAOHN, but clearly
12 a working group should be established to provide
13 advice. Or perhaps, AEOEC.

14 There are a number of groups that could
15 facilitate this. But I think it needs a little
16 impetus from OSHA, and probably from NIOSH, to
17 get it going.

18 Dr. Fagan, does that address your
19 question?

20 DR. FAGAN: Yes, it does, thank you
21 very much.

22 DR. HARBER: Thank you.

1 JUDGE BELL: Other questions from the
2 public?

3 MS. BURKE: No other questions from the
4 public, Your Honor.

5 JUDGE BELL: All right, Dr. Harber,
6 thank you very much for your testimony. We
7 appreciate it.

8 DR. HARBER: Thank you.

9 JUDGE BELL: Can we promote Ms. Crisp,
10 please?

11 (Pause.)

12 MS. HARRISON: I do not see Ms. Crisp
13 online. If you are here, could you raise your
14 hand?

15 (Pause.)

16 JUDGE BELL: All right, I'm not seeing
17 a hand raised. Ms. Crisp, the hand raising is
18 at the bottom of your screen in the middle.

19 If you're here, please raise your hand
20 for us.

21 (Pause.)

22 JUDGE BELL: All right, if we hear from

1 Ms. Crisp, we can invite her back this
2 afternoon, but it appears that she is not here
3 now.

4 Okay, well I don't think she's going to
5 be joining us. It's 11:25 Eastern Time. We'll
6 take our lunch break now.

7 I don't think we have time for a 12-
8 course tasting lunch, but hopefully an hour and
9 a half break will be welcome.

10 We'll be back at 1:00 o'clock Eastern
11 Time.

12 (Whereupon, the above-entitled matter
13 went off the record at 11:24 a.m. and resumed at
14 1:00 p.m.)

15 JUDGE BELL: All right, we re back on
16 the record, it s 1:00 Eastern Time, and we are
17 ready for Dr. Markowitz.

18 MS. HARRISON: Here we go, Dr.
19 Markowitz, I have just promoted you to panelist.

20 DR. MCEVOY: Okay, good afternoon,
21 members of the OSHA panel. My name is Charlene
22 McEvoy and I m a pulmonary critical care

1 physician, Medical Director of Health Partners
2 Asthma Center, and an Associate Professor of
3 Medicine at University of Minnesota.

4 Throughout my career, I ve cared for
5 patients with asthma, COPD, pulmonary fibrosis,
6 pulmonary hypertension, heart failure, coronary
7 artery disease, and many other cardiopulmonary
8 conditions that affect a person s ability to
9 tolerate physical stress and respiratory
10 challenges.

11 I am here today to oppose a proposed
12 rule to amend the Respiratory Protection
13 Standard and support the continued requirement
14 for medical evaluation of employees who are
15 required to wear respirators, including N95
16 filtering facepiece respirators, full face
17 respirators, and powered air purified
18 respirators, or PAPRs.

19 My central message today is simple,
20 medical evaluations are not an administrative
21 burden, they are a worker safety measure.
22 Respirators are intended to protect workers from

1 harm. Medical evaluations help ensure that
2 every equipment intended to provide protection
3 does not inadvertently place a worker at risk
4 because of an underlying health condition.

5 This is not merely a requirement I
6 recommend and perform for others, as a physician
7 who uses respiratory protection in healthcare
8 settings, I am also required to undergo periodic
9 respirator medical evaluation to ensure that
10 respirator use remains safe and appropriate for
11 me.

12 I understand firsthand that this
13 process is straightforward, efficient, and
14 focused on safety. I do not view it as a
15 burden; I view it as a routine safeguard that
16 helps ensure the respirator will protect me
17 without creating unintended health risks.

18 If medical evaluations important
19 physicians, nurses, respiratory therapists, and
20 other healthcare professionals is equally
21 important for every worker who relies on
22 respiratory protection to perform their job

1 safely.

2 Respirators are essential tools in
3 healthcare, emergency response, manufacturing,
4 public safety, construction, and many industrial
5 settings. They save lives by protecting workers
6 from infectious diseases, dust, fumes, and toxic
7 airborne contaminants.

8 However, respiratory use is not
9 physiologically neutral. Even relatively
10 lightweight N95 respirators increase breathing
11 resistance and require greater effort to move
12 air in and out of the lungs. Respirator use can
13 increase worker breathing, increase perceived
14 exertion, contribute to heat stress, and worsen
15 symptoms of anxiety and claustrophobia in
16 susceptible individuals.

17 For healthy individuals, these effects
18 are generally modest and well tolerated, but not
19 every worker is healthy. For individuals with
20 asthma, COPD, pulmonary fibrosis, pulmonary
21 hypertension, heart failure, obesity, or
22 significant anxiety disorders, the additional

1 physiologic burden associated with respiratory
2 use can become clinically meaningful.

3 As physicians, we should never assume
4 that every patient responds to physiologic
5 stress in the same way. Workers should not be
6 treated differently.

7 One of the strongest arguments for
8 maintaining medical evaluations is a health
9 profile of the modern workforce. The reality is
10 that today s workforce is not uniformly healthy.
11 Nearly half of American adults have
12 cardiovascular disease or hypertension.
13 Approximately 25 million Americans live with
14 asthma. Millions more have chronic lung
15 disease, including COPD, many of whom are active
16 members of the workforce.

17 These conditions are often invisible.
18 A worker may appear completely healthy while
19 carrying out significant underlying
20 cardiopulmonary disease. Supervisors and safety
21 officers are not expected to diagnose medical
22 conditions, nor should they. Employers cannot

1 reliably identify these risks through
2 observation alone, nor should they.

3 Without formal medical review process,
4 employers may unknowingly place workers in
5 situations that increase the risk of respiratory
6 distress, cardiovascular symptoms, panic
7 reactions, heat related illness, or inability to
8 safely perform essential job functions.

9 Medically evaluations exists precisely to
10 identify these risks before harm occurs.

11 OSHA did not establish this requirement
12 arbitrarily. Medical evaluation is a core
13 component of the Respiratory Protection Standard
14 because respirators place demands on multiple
15 body systems. The OSHA medical screening
16 questionnaire evaluates respiratory disease,
17 cardiovascular disease, neurologic conditions,
18 psychological conditions, and other factors that
19 may affect a worker s ability to safely wear a
20 respirator.

21 The questionnaire screens for
22 conditions, including asthma, chronic

1 bronchitis, emphysema, heart disease, high blood
2 pressure, seizure disorders, diabetes, chest
3 pain, claustrophobia, and anxiety disorders.

4 This extensive screening exists because
5 these conditions can affect respirator tolerance
6 and respiratory safety.

7 More importantly, the purpose of the
8 evaluation is not regulatory compliance, the
9 purpose is individualized assessment and
10 prevention.

11 Some argue that, because most workers
12 are medically cleared, the evaluation process is
13 unnecessary. I would argue the opposite. The
14 fact that most workers are cleared demonstrate
15 the system is efficient. The process -- the
16 value of the process lies in identifying the
17 workers who require something more than a one-
18 size-fits-all approach.

19 In occupational health programs, the
20 majority of workers complete the questionnaire
21 and are cleared without restriction. However,
22 studies and occupational health experience

1 consistently show that Approximately 5 to 15
2 percent of workers require additional review
3 beyond the initial questionnaire, depending on
4 workforce age, job demands, underlying health
5 status.

6 Those individual evaluations often
7 identify workers who require further medical
8 assessment, temporary or permanent restrictions,
9 alternative respiratory types, workplace
10 accommodations, or ongoing follow up and
11 monitoring.

12 Many are ultimately cleared, some are
13 not. Others require a different respirator than
14 initially planned. Those are exactly the
15 workers that this process is designed to
16 identify.

17 Even if only one out of 20 workers
18 requires additional evaluation, that worker may
19 be someone with severe asthma, significant heart
20 disease, or another condition that could place
21 them at increased risk. Eliminating the
22 evaluation process would disproportionately

1 affect the employees who are most medically
2 vulnerable.

3 Furthermore, not all respirators are
4 the same and not all workers are the same. The
5 medical evaluation allows a physician or other
6 licensed healthcare professional to consider
7 existing medical conditions, physical demands of
8 the job, duration of respirator use,
9 environmental heat burden, workplace conditions,
10 type of respirator required, whether an
11 alternative respirator may be safer.

12 This individualized assessment by
13 qualified licensed medical professionals is
14 important because the safest respirator for one
15 worker may not be the safest one for another.

16 As clinicians, individualized
17 assessments is what we do every day. We would
18 never prescribe the same medication at the same
19 dose to every patient regardless of age,
20 diagnosis, or medical history. Respirator
21 selection should follow the same common sense
22 principle.

1 Some have suggested that workers who
2 cannot tolerate an N95 respirator can simply use
3 a PAPR instead. In practice, the situation is
4 often more complex. PAPRs can reduce breathing
5 resistance because they improve -- they provide
6 powered airflow.

7 For many workers, this is a significant
8 benefit. However, PAPRs also introduce other
9 considerations. They add weight, they may alter
10 visibility and communication, they can reduce
11 mobility, and create ergonomic challenges. They
12 may be difficult for workers with neck or back
13 problems or balance disorders, musculoskeletal
14 limitations, or certain cardiovascular
15 conditions.

16 For some workers, a PAPR is clearly a
17 better choice, for others, it may clearly -- may
18 create a whole set of different challenges. The
19 medical evaluation helps determine which
20 respirator protection strategy is the safest for
21 the individual worker, rather than relying on
22 assumptions.

1 In healthcare, emergency response,
2 public safety, manufacturing, and industrial
3 environments respirators are often worn during
4 prolonged shifts, in periods of significant
5 physical exertion, the stakes are high.

6 A worker who experiences respiratory
7 distress, cardiovascular symptoms and anxiety
8 related incapacitation, or other medical
9 complication while performing hazardous work
10 risk injury, not only to themselves, but also to
11 coworkers, patients, and the public.

12 Medical evaluations function as a
13 preventative safe measure -- safety measure.
14 They help identify workers who may benefit from
15 further evaluation, accommodations, alternative
16 respirators, work restrictions, or ongoing
17 monitoring before a serious event occurs. That
18 is exactly how good occupational safety programs
19 should function.

20 From a policy perspective, it is
21 important to consider what is actually being
22 proposed. The current process is already

1 streamlined in risk space. Most workers
2 complete a questionnaire that takes only a few
3 minutes. Only those with concerning responses
4 are referred for additional review, the burden
5 is minimal. Potential consequences of missing
6 significant cardiopulmonary disease are not.

7 Those consequences may include
8 preventable medical emergencies, workplace
9 injuries, lost work time, workers compensation
10 claims, increased healthcare costs, risks to
11 coworkers, and the public.

12 In the healthcare setting, a worker who
13 becomes medically compromised while using
14 respiratory protection, they also jeopardize
15 patient care.

16 The most effort required for medical
17 screening is far outweighed by the potential
18 benefits of preventing foreseeable harm.

19 In summary, respirators save lives. A
20 respiratory protection program should protect
21 the whole worker, not simply satisfy the
22 equipment requirement.

1 Medical evaluations are a practical,
2 evidence based safeguard that identifies workers
3 who may be at increased risk because of
4 underlying medical conditions.

5 They support individualized assessment,
6 appropriate respirator selection, accommodation
7 when necessary, and prevention of foreseeable
8 harm.

9 As a pulmonary and critical care
10 physician, and as someone who personally
11 undergoes periodic respirator medical
12 evaluation, I view this requirement not as a
13 regulatory obstacle, but as a common sense
14 worker safety measure.

15 Most workers will be cleared quickly
16 and without restriction, but for the minority
17 whose medical conditions place them at higher
18 risk, the brief evaluation may be the only
19 opportunity to prevent predictable and
20 potentially serious harm.

21 The goal should not be simply to place
22 a respirator on every worker, the goal should be

1 to ensure that every worker can safely use the
2 respirator required for the job.

3 Nearly one-half of American adults have
4 cardiovascular disease or hypertension and
5 millions more have asthma or chronic lung
6 disease. Removing medical evaluation means
7 removing the only systematic process designed to
8 identify workers who may be harmed by the very
9 respiratory equipment intended to protect them.

10 For those reasons, I urge you to
11 maintain the medical evaluation requirement
12 completed by a qualified licensed healthcare
13 provider as an essential component of every
14 respiratory protection program.

15 Thank you for the opportunity to
16 testify.

17 JUDGE BELL: Thank you, Dr. McEvoy.

18 Are there questions from the OSHA room,
19 please?

20 MR. LEVINSON: Yes, Your Honor. The
21 first question comes from Dr. Minda Nieblas.

22 DR. NIEBLAS: Thank you, Dr. McEvoy,

1 for your testimony. I was wondering if you
2 could state from your experience, particularly
3 with your expertise, have you ever restricted or
4 declined use of a filtering facepiece respirator
5 or PAPR based on information obtained from the
6 questionnaire?

7 DR. MCEVOY: I have not yet, no.

8 DR. NIEBLAS: Okay, thank you. We've
9 also heard from other people who've testified
10 that there are questions on the current
11 respirator questionnaire. Are there any that
12 are most beneficial in helping you make your
13 determinations or that address your concerns?

14 DR. MCEVOY: Well, the questionnaires
15 are really a screening tool, it's a very
16 sensitive screening tool to identify people who
17 may potentially have a problem.

18 Where the questions that I may answer
19 as, you know, being experienced in the areas, I
20 will be then, therefore, you know, you need it
21 tailored to the patient to understand what they
22 say, oh, I have asthma, I cough. Well, what --

1 how often do you cough? I mean, it s the
2 questions that I can ask to determine what kind
3 of difficulties they have or health problems
4 that they may have occur that could affect their
5 use of a particular respirator.

6 DR. NIEBLAS: All right, thank you,
7 thank you very much.

8 One more question, have you, in your
9 experience, found that issues were discovered or
10 brought to your attention or people were
11 referred to you after fit testing? Any people
12 who have challenges during the fit testing
13 process?

14 DR. MCEVOY: Yes, I have, and many of
15 them -- yes, I have. I ve had --

16 DR. NIEBLAS: You don t need to
17 disclose personal information.

18 DR. MCEVOY: Yes, yes, no, I have. And
19 I always -- I mean, to be -- there s some people
20 who, I get them through the right treatment and
21 such, I can get them to be able to use that
22 respirator, but they wouldn t be able to use it

1 unless I had them get the right treatment.

2 There s certain conditions that are
3 triggered by it. So, yes, I can -- so, the
4 value of me seeing them and getting them to be
5 able to use a respirator safely is really key.

6 DR. NIEBLAS: Thank you.

7 Thank you, no further questions, Your
8 Honor.

9 MR. LEVINSON: Your Honor, the last
10 question from OSHA comes from me, Andrew
11 Levinson.

12 Dr. McEvoy, I m trying to explore your
13 statement that it s only a minority of workers
14 that need follow up and need actual contact with
15 a physician. And I m trying to figure out the
16 most efficient and effective way to get those
17 workers identified.

18 One of the things that we heard in
19 earlier testimony yesterday and today was that
20 people -- some people thought that the questions
21 were actually not particularly sensitive and
22 that you could do away with many of them.

1 And that, if you -- if we simply asked
2 workers to self-identify who wants to talk to a
3 healthcare provider for follow up, either
4 following training or following fit testing,
5 that that might be a way to identify some
6 significant portion of those folks who need
7 follow up.

8 Do you have any thoughts on whether or
9 not that would be effective or not in addressing
10 the people where you are actually seeing them
11 for more direct medical follow up?

12 DR. MCEVOY: Well, one, I would say is
13 that they misunderstand what sensitivity means
14 and we talk about that. Sensitivity is really
15 broad and it is very sensitive, that s the one
16 thing that s been established with that
17 questionnaire.

18 Sensitive means that you re going to
19 probably have false, you know, false positives,
20 people that may have a problem with it. But you
21 don t want to miss anyone because it s a
22 screening program, that s how they work, and

1 they re not specific.

2 So, they may say that maybe the
3 questions aren t specific enough, that may be
4 what they are meaning. But that -- but they are
5 really quite sensitive.

6 And when we talk about a minority of
7 people involved, you know, minority, yes, but we
8 have got millions of workers, so it s a lot of
9 people potentially at harm.

10 So, I do think that the -- I mean,
11 that s what screening -- that s why we screen.
12 We screen to make sure we don t miss anyone and
13 then, have them evaluate before you would go to
14 a fit test.

15 I, having a fit test before, really may
16 miss it because I ve done these fit tests, it s
17 just like you sing, you talk while you re doing
18 it. That s going to miss problems that someone
19 may have do with heavy exertion, with their work
20 type, it really depends on what they do.

21 So, yes, so, I -- are all the questions
22 perfect? No, I can t say that, that s the case,

1 but the sensitivity of it and the flow and the
2 process, I think has been a very good process
3 for workers.

4 MR. LEVINSON: Thank you.

5 Your Honor, no further questions from
6 OSHA.

7 JUDGE BELL: Mr. Berndt, questions from
8 the solicitor?

9 MR. BERNDT: Joseph Berndt from the
10 Office of Solicitor.

11 No questions from me.

12 JUDGE BELL: Thank you.

13 Do we have questions from the public?

14 MS. BURKE: No questions from the
15 public, Your Honor.

16 JUDGE BELL: All right. Dr. McEvoy,
17 thanks very much for being here and for your
18 testimony, we very much appreciate it.

19 DR. MCEVOY: Thank you.

20 JUDGE BELL: Thanks.

21 DR. MCEVOY: Appreciate the
22 opportunity.

1 JUDGE BELL: Okay. All right, who are
2 we going to have next, please?

3 MS. HARRISON: Dr. Markowitz, are you
4 ready?

5 DR. MARKOWITZ: Oh, I am ready, can you
6 hear me?

7 MS. HARRISON: Yes.

8 JUDGE BELL: Yes, we can. Thanks very
9 much for being here. You can start when you
10 like.

11 DR. MARKOWITZ: Okay. Good afternoon,
12 or good morning, if you re on the West Coast.
13 Thank you for the opportunity to speak today.
14 My name is Steven Markowitz. I m an
15 occupational medicine physician. I direct the
16 Barry Commoner Center at the City University of
17 New York.

18 I ve also been given some time to
19 present comments later after I present my own
20 comments on behalf of Bob Harrison who couldn t
21 be here today. And I will delineate those
22 specifically.

1 We approached this at the beginning of
2 September, which is always a difficult time in
3 occupational health in New York City, especially
4 this year, the 25th anniversary of September
5 11th. We think of the 126,000 people who are
6 still alive and enrolled in the NIOSH World
7 Trade Center Health Program because they have
8 cancer, they have PTSD, they have chronic lung
9 disease or other WTC health conditions.

10 September 11th was obviously,
11 hopefully, a singular event. So, you may wonder
12 why it is that I mention it here at a hearing on
13 OSHA medical evaluations for requirements for
14 respirator use.

15 So, I was reminded of it when I read
16 the rule, actually, the proposed rule. Let me
17 quote what reminded me of this. Quote, OSHA
18 concludes that the data available for health
19 effects are lacking and insufficient to
20 establish that medical evaluations meaningfully
21 reduce material impairment caused by wearing an
22 FFR or a loose fitting PAPR, end of quote.

1 In other words, data are not available
2 for health effects associated with respirator
3 use or that medical evaluations make a
4 difference in altering impairment associated
5 with respiratory use. So, this issue of how we
6 act in the absence of good evidence is actually
7 central to occupational health. And the
8 principle that we should have used is September
9 11th, but we didn't.

10 It's quite simple, when uncertain,
11 protect. We didn't know, September 11th, how
12 and whether the dust and smoke were toxic at
13 Ground Zero, and we did not make every needed
14 effort to minimize human exposure at Ground Zero
15 and surrounding neighborhoods. We did not have
16 evidence in hand that World Trade Center
17 exposures could cause anything worse than throat
18 irritation. Some of you may recall we called it
19 WTC cough for a time.

20 So, we presumed, as the EPA had said,
21 that the, quote, air was safe, end of quote.
22 So, workers were allowed to put in long hours

1 with variable respirator use, leading to undue
2 exposures and subsequent disease.

3 So, in fact, we did not have good
4 evidence in either direction soon after
5 September 11th, either that there was a
6 heightened risk or that the conditions permitted
7 safe work. So, we employed a default position
8 that permitted exposure in the absence of known
9 risk. We didn't know, so we permitted exposure.
10 And, in retrospect, this was a very costly
11 decision.

12 The default position should have been
13 to protect people, as in when uncertain,
14 protect. When we don't know, let's err on the
15 side of protecting people.

16 We face this challenge in occupational
17 health all the time. It's not just in
18 respirator clearance and considering --
19 consideration of what we should do about that.
20 The fact is, for most occupational exposures, we
21 really don't know much about their toxicity.

22 Now, EPA and their chemical inventory

1 has 86,000 chemicals, of which 42,000 are in
2 active use in American commerce. Let s compare
3 that to what OSHA has regulated in 50 years.
4 OSHA has promulgated 29 standards on specific
5 agents and another close to 500 in the Z table,
6 which is outdated. Compare that to the 42,000
7 that are in active use.

8 Or consider cancer; the International
9 Agency for Research on Cancer has evaluated a
10 thousand -- roughly, a thousand agents for
11 cancer out of the 42,000 in current use. So,
12 the fact is we conclude we don t know a lot in
13 occupational health, and most workplace agents
14 have not been properly evaluated and not
15 properly regulated either.

16 We routinely don t have good evidence.
17 Lack of evidence is actually the rule, not the
18 exception. So, we need to employ the
19 precautionary principle, I think, in respirator
20 clearance, just as we should elsewhere, which
21 is: when uncertain, protect.

22 I want to respond now to a different

1 issue that was -- been raised in the hearing and
2 I think was alluded to in the previous question
3 to the presenter.

4 Some people believe that, in the
5 absence of a respirator associated health
6 evaluation, that relevant worker health concerns
7 can be addressed during the fit testing process
8 or during respirator training, and thereby,
9 obviating the need for a routine health
10 evaluation.

11 Personally, I think this makes no sense
12 to rely on a random process where workers are
13 expected to volunteer their health concerns in
14 fit testing or training, which are non-private
15 settings, to people, fit testers or trainers,
16 who may or may not have health expertise to
17 understand those concerns. And, furthermore,
18 that there wouldn't be any systematic way to
19 follow up.

20 To try to uncover health concerns in
21 this fashion would violate workers' rights to
22 confidentiality and autonomy. To do it this way

1 would also send the message, frankly, that
2 potentially relevant health concerns are not
3 important enough to deserve specific evaluation.
4 Screening for relevant health issues and
5 respirator evaluation has to be intentional, it
6 has to be systematic, and it has to be
7 respectful.

8 So, now, I m going to move to Robert
9 Harrison s comments. Bob is a clinical
10 professor at University of California San
11 Francisco Medical School, also in state health
12 department work, longtime occupational medicine
13 physician. And he has a number of points, some
14 of which overlap with Dr. McEvoy, so I m trying
15 to expedite this.

16 Although, in fairness, he was given ten minutes,
17 so maybe I actually will use up those ten
18 minutes. We ll see.

19 In any event, point number one, a
20 medical evaluation determines whether a
21 particular worker can safely perform their work
22 while wearing a respirator.

1 The current OSHA standard explicitly
2 recognizes three elements relevant to respirator
3 use. The respirator itself, the anticipated
4 working conditions, and the employee s medical
5 status.

6 Current evidence that healthy subjects
7 generally tolerate N95s does not establish that
8 every worker, regardless of their health status,
9 can safely tolerate an N95 under actual
10 conditions of use in the workplace. Indeed, the
11 ability to wear an N95 or another FFR or PAPR
12 should not be considered in isolation.

13 I think Dr. McEvoy actually nicely
14 touched on this.

15 A workplace -- OSHA said that workplace
16 factors are relevant to determine whether an
17 employee can tolerate respirator use.

18 So, it s a consideration not just of
19 the respirator, but the respirator plus the
20 worker s health status, plus the tasks they are
21 being asked to do, plus the overall work
22 environment that must be considered in

1 respirator evaluation.

2 Point number two, a medical evaluation
3 actually is a low-cost screen for vulnerable
4 workers. The current standard does not require
5 that every N95 user undergo costly medical
6 testing and in the initial evaluation can
7 consist of an OSHA standardized confidential
8 questionnaire reviewed by physician or other
9 professional.

10 This questionnaire can identify -- and
11 it s quite detailed, in response to a question
12 that Dr. McEvoy -- in terms of looking at
13 symptoms and the like, identify workers who have
14 cardiopulmonary problems, respiratory symptoms,
15 claustrophobia, or other relevant conditions.

16 I would also hear comment, this comes
17 from me, not Dr. Harrison, that in response to a
18 question in the last session, is that many
19 workers are under diagnosed with chronic lung
20 disease, particularly blue collar workers. They
21 have COPD, but they have not -- it has not been
22 diagnosed by a physician. And so, they will not

1 readily come forward and say they have COPD.

2 They may have shortness of breath, they
3 may have exercise intolerance, and they will
4 have undiagnosed COPD. And unless you probe
5 with questions that are contained in the current
6 questionnaire, it s unlikely to be detected.

7 Point number three by Dr. Harrison: the
8 OSHA original evidentiary conclusion pointed,
9 actually, in the opposite direction of the
10 proposed rule. When OSHA adopted the current
11 standard in 1998, it concluded that adverse
12 health effects could occur, even with
13 respirators with low breathing resistance and
14 short-term use, particularly with workers who
15 have cardiopulmonary impairment.

16 OSHA previously explained that
17 respirator use can alter breathing patterns and
18 increase physiologic workload. OSHA, therefore,
19 concluded that respirator use warranted prior
20 medical evaluation.

21 So, given this reasoning and now 30
22 years, 30 years, of established policy, the OSHA

1 -- the onus is on OSHA to demonstrate that there
2 is now persuasive evidence that warrants a
3 proposed rule change eliminating health
4 evaluations for selective respirator use.

5 Point number four, lack of evidence of
6 harm is not necessarily evidence of no risk.

7 The OSHA 2025 -- June 2025 memorandum says that
8 the proposed exemption is based on, quote, lack
9 of data indicating adverse health effects, end
10 of quote, in relation to FFRs and PAPRs.

11 Two comments about that. Adverse
12 events among susceptible workers may be
13 difficult to detect through studies that are
14 primarily designed to assess average physiologic
15 response in healthy populations.

16 And, secondly, the current application
17 of the existing medical clearance requirement
18 itself may reduce adverse outcomes in higher
19 risk workers. And, therefore, it would be
20 difficult to detect in real world studies,
21 because, in fact, those workers have been
22 screened and accommodations have been made.

1 Point number five, medical evaluation
2 creates an important pathway to accommodation.
3 Under the existing rule, a medical evaluation
4 does not lead to a binary decision cleared or
5 not cleared. The clinician can recommend
6 imitation, additional evaluation, an alternative
7 respirator.

8 Removing the medical evaluation
9 eliminates a systematic mechanism for
10 identifying these workers before required
11 respirator use begins, not after at a time with
12 which workers develop symptoms.

13 Two more points. One -- number six is
14 actually the burden of the existing requirement
15 is relatively limited. OSHA does not require,
16 to our knowledge, an annual medical clearance,
17 rather medical clearance evaluation occurs
18 initially, and then, reevaluation is triggered
19 by a change in health or a change in work
20 requirements.

21 And I don t have data on this, but it s
22 likely that this periodic evaluation actually

1 only occurs in a minority of workers.

2 And then, finally, point number seven,
3 that healthcare actually presents an especially
4 important case for retaining the medical
5 evaluation requirement. In healthcare, required
6 N95 use occurs in a variety of different
7 settings and tasks.

8 When a person enters an isolation room,
9 when a healthcare worker is asked to prolong --
10 to wear a respirator on a prolonged basis during
11 outbreaks, during emergencies, during
12 procedures, or any changes that involve
13 substantial physical activity or use of other
14 PPE.

15 This heterogeneity of uses and
16 exposures is not addressed by a regulation that
17 is based on the proposition that the average N95
18 user imposes little physiologic burden.

19 A standardized medical evaluation gives
20 occupational health programs a mechanism to
21 identify a comparatively small population for
22 whom such heterogeneity of tasks really matter.

1 And I think Dr. McEvoy nicely addressed
2 this point.

3 So, in summary, eliminating a low
4 burden, confidential screening process will
5 leave a subset of medically susceptible workers
6 unidentified before they are required to wear a
7 negative pressure respirator under potentially
8 strenuous workplace conditions.

9 Thank you for the opportunity to appear
10 today.

11 JUDGE BELL: Thank you, Dr. Markowitz.

12 Questions from OSHA?

13 MR. LEVINSON: Yes, Your Honor, the
14 first questions come from Dr. Minda Nieblas.

15 DR. NIEBLAS: Good afternoon, Dr.
16 Markowitz.

17 DR. MARKOWITZ: Good afternoon.

18 DR. NIEBLAS: Thank you for your
19 testimony. One of the questions I have is one
20 that you ve been heard -- you ve probably heard
21 before, and I was asking, from your experience,
22 have you restricted or declined use of an FFR or

1 a PAPR based on the questionnaire?

2 DR. MARKOWITZ: Not based on the
3 questionnaire. I referred people for further
4 evaluation, but not strictly based on the
5 questionnaire.

6 DR. NIEBLAS: Do you -- could you state
7 -- sorry, this is Dr. Nieblas again. Could you
8 continue or clarify whether or not individuals
9 were diagnosed and, ultimately, could not wear a
10 respirator or had to have restrictions?

11 DR. MARKOWITZ: No, for the most part,
12 they could end up wearing a respirator and did
13 not require restrictions. I don't have -- I
14 mostly do research; I don't have the vast
15 experience in this setting. I don't operate,
16 for instance, an occupational health clinic or
17 the like. But my experience is that they are
18 permitted to wear a respirator and some number
19 of accommodations are required.

20 DR. NIEBLAS: Thank you. Thank you for
21 that. One more question. Are there, in your
22 experience or in your discussions with

1 colleagues, questions on the questionnaire that
2 are most beneficial in helping, you know, make
3 your determination on medical clearance?

4 DR. MARKOWITZ: Sure. I think the
5 questionnaire is reasonably comprehensive,
6 actually, and touches on most of the important
7 aspects.

8 For instance, what I referred to
9 before, you know, the question number four, I'm
10 looking at the questionnaire at the moment,
11 where it asks about pulmonary symptoms, where,
12 you know, there are a dozen different symptoms
13 which are asked. This is, I think, quite
14 comprehensive.

15 And I do think there are a lot of
16 workers in certain sectors, manufacturing,
17 construction, possibly others who do have
18 undiagnosed chronic lung disease. And I think
19 COPD, chronic obstructive pulmonary disease, is
20 the most common.

21 And so, if you ask them, do they have
22 COPD, they're going to say no. But then you

1 probe and ask them about specific symptoms, and
2 then you get concerned that they might and that
3 they need proper evaluation.

4 So, I find these, what appears
5 repetitive, questions actually quite useful in
6 probing for undiagnosed disease that requires a
7 closer look.

8 DR. NIEBLAS: Thank you. I don't have
9 any further questions.

10 MR. LEVINSON: Your Honor, there are no
11 further questions from OSHA.

12 JUDGE BELL: Thank you. Are there
13 questions from the Solicitor?

14 MR. BERNDT: Joseph Berndt from the
15 Office of the Solicitor, no questions from us.

16 Thank you, Dr. Markowitz.

17 JUDGE BELL: Are there questions from
18 the public?

19 MS. BURKE: There are questions from
20 the public.

21 Kayla Flowers, I have enabled your mic.

22 MS. FLOWERS: Thank you. Kayla Flowers

1 with the United Steelworkers. Hi, Dr.

2 Markowitz. I just have a quick question.

3 You spoke to something that has come up
4 in prior testimony and in -- also in questions
5 from OSHA. So, regarding the identification of
6 health issues that may affect respirator use
7 during the fit testing process, what is the
8 purpose of the fit testing process under OSHA's
9 Respiratory Protection Standard?

10 DR. MARKOWITZ: Sure. I mean, the
11 purpose is to -- kind of self-explanatory, which
12 is that there is an adequate fit to the
13 respirator that's going to be used. I think if,
14 relating to what I said before, whether health
15 concerns would come up in this in this setting,
16 I think is completely ad hoc. And when a person
17 undergoes fit testing for a very short period of
18 use of the respirator, it doesn't really
19 reflect.

20 It helps you in terms of achieving the
21 proper fit, but it doesn't reflect actual
22 conditions of use. But the idea that, in that

1 process, the fit tester would somehow be able to
2 detect health concerns that should trigger a
3 further look, further evaluation. It could
4 happen, but I wouldn't rely on it, not
5 systematically.

6 MS. FLOWERS: Okay, thank you.

7 JUDGE BELL: Other questions from the
8 public?

9 MS. BURKE: Yes, one other question.

10 Rebecca Reindel, I have enabled your
11 mic.

12 MS. REINDEL: Wonderful, thank you.

13 Thank you, Dr. Markowitz, for your
14 testimony. I had a question I was interested in
15 asking you, but I'm wondering, it may have been
16 covered a little bit here, both from the
17 previous questioner and some of your responses,
18 but let me ask it anyway for maybe for
19 clarification, and if there's anything else you
20 want to add.

21 You were talking about the usefulness,
22 as a medical professional, in probing workers

1 for information related to their conditions.

2 And then, would asking workers during a
3 fit test a general question if they have medical
4 concerns or if they want to speak to a medical
5 professional about respirator use serve the same
6 purpose as those probing or prompting that you
7 do get out of the questionnaire, even if, you
8 know, even if workers are sort of checking the
9 boxes and going through the questionnaire?

10 DR. MARKOWITZ: Yes, well, so let me
11 admit to a conflict of interest. I m a
12 physician, so I believe that health
13 professionals actually have an important role
14 here.

15 But, seriously, I wouldn t expect,
16 frankly, your average worker who goes for fit
17 testing to admit to health issues to a fit
18 tester. They wouldn t regard that as the proper
19 place to discuss those health issues, not just
20 on basis of privacy, but what s the point?
21 Because the fit tester isn t the qualified
22 health professional who s going to help you

1 figure out what s going on and what impact it
2 has on their use.

3 So, I just think it s the -- if you re
4 interested in the health status as it impacts
5 respirator use, the only way to approach that is
6 through an evaluation by a licensed health
7 professional, physician or the like, and not
8 rely on industrial hygiene, fit tester, a
9 trainer or the like, it just doesn t make any
10 sense.

11 MS. REINDEL: Thank you.

12 JUDGE BELL: Other questions from the
13 public?

14 MS. BURKE: No further questions from
15 the public, Your Honor.

16 JUDGE BELL: Dr. Markowitz, thank you
17 very much for your testimony and presenting that
18 of Dr. Harrison as well, we really appreciate
19 it.

20 All right, who do we have next, please?

21 MS. HARRISON: Next, we have Scott
22 Robertson.

1 Here we go, so, I have just promoted
2 you to panelist. You ll be able to unmute and
3 turn your camera on.

4 (Pause.)

5 MS. HARRISON: Hey, Scott, if you are
6 speaking you are still muted and your camera is
7 still off.

8 MR. ROBERTSON: Okay, I m there.

9 MS. HARRISON: Perfect.

10 JUDGE BELL: All right, Mr. Robertson,
11 are you able to hear us?

12 MR. ROBERTSON: Yes, sir, I am.

13 JUDGE BELL: All right, go ahead,
14 please.

15 MR. ROBERTSON: All right, good
16 afternoon, Judge and members of the panel. My
17 name is Scott Robertson. I m speaking and
18 testifying today in my capacity as an AFGE Union
19 representative on behalf of the MDAC, and not
20 the Department of Veterans Affairs. I am an
21 AFGE safety steward, and I represent
22 pipefitters, skilled trades, and employees

1 across a wide range of occupations here at the
2 Department of Veterans Affairs.

3 Thank you for the opportunity to
4 testify today on OSHA s proposal to amending the
5 medical evaluation requirements in the
6 Respiratory Protection Standard for certain
7 types of respirators.

8 The American Federation of Government
9 Employees, AFGE, is the nation s largest federal
10 employee union, representing more than 820,000
11 federal and D.C. government workers.

12 AFGE members work across the federal
13 government and include healthcare workers,
14 correctional officers, industrial hygienists,
15 environmental professionals, emergency
16 responders, skilled trades, and many others who
17 rely on respiratory protection to safely perform
18 their jobs.

19 I personally use a powered air
20 purifying respirator, or PAPR, as part of my
21 pipe fitter work. So, when I talk about
22 respiratory protection and medical evaluations,

1 I m not talking about something hypothetical,
2 I m speaking as a worker who actually relies on
3 this equipment to help protect me while doing my
4 job.

5 Our work can be physically demanding.
6 When I put on a respiratory protection, I need
7 to know two things, that it will protect me from
8 the hazard, and that I am medically able to
9 safely use it while doing my job. A respirator
10 is supposed to protect the worker, not create
11 another risk for the worker.

12 And this issue reaches far beyond
13 doctors and nurses. Morgue and autopsy
14 personnel may rely on N95s and PAPRs during
15 procedures that can generate infectious
16 aerosols. Housekeeping employees may enter
17 contaminated environments. Skilled trade
18 employees may encounter asbestos, chemicals,
19 dust, biological hazards, and other airborne
20 contaminants.

21 If we require these employees to wear
22 respiratory protection to keep them safe, we

1 should make sure they can safely use that
2 protection.

3 OSHA s mission is to assure America s
4 workers have safe and healthful working
5 conditions free from unlawful retaliation. VA s
6 mission is to fulfill President Lincoln s
7 promise to care for those who have served in our
8 nation s military and for their families,
9 caregivers, and survivors.

10 These two missions come together inside
11 every VA Medical Center. We cannot fulfill our
12 promise to care for our veterans if we fail to
13 protect the workers who make that care possible.

14 Under OSHA s current Respiratory
15 Protection Standard, 29 CFR 1910.134, Paragraph
16 E, employees must receive a medical evaluation
17 before they are fit tested or required to use a
18 respirator.

19 That protection is also consistent with
20 the broader federal commitment to worker safety
21 established by 29 USC 668, Executive Order
22 12196, and 29 CFR Part 1960, which requires

1 federal agencies to maintain effective
2 occupational safety and health programs. Within
3 VA, VHA safety and occupational health policies
4 further reinforce that responsibility.

5 These protections should work together
6 and not be weakened by removing a preventative,
7 sorry, safeguard for OSHA s Respiratory
8 Protection Standard. This is not unnecessary
9 paperwork; this is preventative worker
10 protection.

11 And that raises a very important
12 question. If OSHA removes the medical
13 evaluation requirement for N95s and other
14 filtering facepiece respirators, FFRs, what
15 systematic safeguard will identify an employee
16 who may not be medically able to safely use that
17 respirator before that employee is placed at
18 risk?

19 Waiting until a worker becomes short of
20 breath, dizzy, overheated, experiences chest
21 pain, or develops another medical problem while
22 performing hazardous work is not prevention.

1 That is intervention after the problem has
2 already occurred.

3 NVAC is also concerned that eliminating
4 mandatory medical evaluations could shift
5 responsibility away from the employer and
6 occupational health professionals and place that
7 burden on the individual employee.

8 Employees are not physicians, a worker
9 may not or may have no reason to know that a
10 medical condition could make the use of a
11 particular respirator unsafe.

12 They may not recognize the warning
13 signs until they are already performing
14 strenuous work, working in the heat, wearing
15 additional PPE, caring for an infectious
16 patient, or responding to an emergency.

17 Think about what that means in an
18 actual VA workplace. A VA employee caring for
19 an infectious patient entering an area with a
20 respiratory hazard, performing an autopsy, or
21 responding to an emergency should never be
22 placed in the position to having to choose

1 between removing the respiratory protection
2 required to protect them from the hazard or
3 continue working while experiencing medical
4 symptoms. That is exactly the situation
5 prevention is supposed to prevent.

6 The purpose of the medical evaluation
7 is to identify foreseeable problems before the
8 employee is placed in the situation, not after.
9 Some of the healthcare professionals caring for
10 our veterans themselves have served in our
11 military or continue to serve in the Reserve or
12 National Guard.

13 When our service members took their
14 oath, they promised to support and defend the
15 Constitution of the United States against all
16 enemies foreign and domestic. Today, some of
17 the same men and women continue serving our
18 country in another way by being at a bedside,
19 caring for their fellow veterans.

20 We have a responsibility to protect
21 them while they do it, because if we fail to
22 protect our nurses, caregivers, housekeeping

1 employees, skilled trades, morgue and autopsy
2 personnel, and other day workers, we jeopardize
3 their ability to continue serving our Veterans.

4 And that veteran isn't just a patient
5 on a chart; that veteran is someone's fellow
6 service member, husband or wife, father or
7 mother, brother or sister. Ultimately, that
8 veteran is someone's loved one.

9 Medical evaluations are part of that
10 protection. They help identify workers who may
11 be at increased medical risk from respirator
12 use. OSHA's own standard recognizes this under
13 29 CFR 1910.134, Paragraph E, 6 Roman Numeral
14 II, when a medical condition may place an
15 employee at increased risk while using a
16 negative pressure respirator, the employer must
17 provide a PAPR if the medical evaluation finds
18 that employee can safely use one.

19 But if we eliminate the medical
20 evaluation, how do we identify the worker who
21 needs that additional protection before
22 something happens?

1 AFGE s position is simple: if you re
2 telling us we need a respirator to do our job
3 safely, then make sure we can safely wear it.
4 Protect the skilled trades who keep our facility
5 operating. Protect the housekeeping employees
6 who keep them clean and safe. Protect the
7 morgue and autopsy staff performing difficult
8 and potentially hazardous work. And protect the
9 nurses and healthcare professionals caring for
10 our nation s Veterans. Because protecting the
11 workers protects the caregiver, and protecting
12 the caregiver protects our veterans.

13 Thank you.

14 JUDGE BELL: Mr. Robertson, thank you
15 and thank you for your work on behalf of
16 Veterans.

17 Questions from the OSHA room?

18 MR. LEVINSON: Yes, Your Honor, first
19 question comes from Minda Nieblas.

20 DR. NIEBLAS: Thank you, Mr. Robertson,
21 this is Minda Nieblas.

22 Based on your experiences or what

1 you've heard from the membership, do you know of
2 a situation where a medical evaluation was not
3 provided and there was an adverse health outcome
4 from use of a respirator?

5 MR. ROBERTSON: Not that I'm aware, but
6 we can address those questions in our post-
7 hearing comments.

8 DR. NIEBLAS: Understand, thank you.
9 This is Dr. Nieblas again. Do you know, have
10 you had anybody or your members who may have
11 been cleared at some point to wear a respirator,
12 medically cleared and are wearing a respirator
13 on the job, like you yourself said you did, but
14 wind up having to return for a re-medical
15 evaluation?

16 MR. ROBERTSON: No, I mean, all -- the
17 agency does all of that stuff, so that would
18 have to be, you know, contacted through the
19 agency to get that information.

20 DR. NIEBLAS: All right. Oh, thank you
21 so much, I appreciate your testimony very much.
22 This is -- no further questions from Minda

1 Nieblas.

2 MR. LEVINSON: Your Honor, the next
3 questions from OSHA come from Bob Blicksilver.

4 DR. BLICKSILVER: Hi, Bob Blicksilver,
5 OSHA Standards and Guidance.

6 Does AFGE or the Department of Veteran
7 Affairs have any survey data or have there been
8 any studies within your membership or DVA on
9 current practices with regard to respirator
10 usage, medical clearance practices and
11 procedures, and training on respirator usage?

12 Are you aware of any survey data, sir?

13 MR. ROBERTSON: Mr. Blicksilver, we can
14 address that in our post comments if you would
15 like.

16 DR. BLICKSILVER: Excellent, thank you.
17 And if you want to add any personal observations
18 as well, that would be welcome, those would be
19 welcome.

20 Bob Blicksilver, again. Are you aware
21 of any data on the number or percentage of
22 workers at AFGE work sites who receive a medical

1 evaluation from a physician? Or, alternatively,
2 are you aware of any data on the number or
3 percentage of workers at AFGE work sites who
4 indicated on the screening survey that they have
5 a condition warranting a medical evaluation?

6 MR. ROBERTSON: I ll defer that to our
7 post-hearing comments as well so we can collect
8 all that data for you.

9 DR. BLICKSILVER: Okay. Any data that
10 you -- Bob Blicksilver again -- any data that
11 you have on the prevalence of medical evaluation
12 among members whose use of respirators may
13 elevate the risk to employee health, if you have
14 any data on prevalence of that type, that would
15 also be useful to us.

16 Thank you, that s all I have.

17 Thank you, thank you, Josh.

18 MR. LEVINSON: Your Honor, no further
19 questions from OSHA.

20 JUDGE BELL: Questions from the
21 Solicitor?

22 MS. ZAVISLAN: This is Tessa Zavislan

1 from the Solicitor s Office, I have no
2 questions.

3 Thank you for your testimony, Mr.
4 Robertson.

5 MR. ROBERTSON: Thank you.

6 JUDGE BELL: Do we have questions from
7 the public?

8 MS. BURKE: No questions from the
9 public, Judge Bell.

10 JUDGE BELL: All right.

11 Mr. Robertson, thanks very much for
12 your testimony, we very much appreciate it.

13 MR. ROBERTSON: Thank you very much,
14 have a good day.

15 JUDGE BELL: Thank you.

16 Who do we have next, please?

17 MS. HARRISON: Next, we have Dr. Bruce
18 Lippy.

19 And I ve just promoted Dr. Lippy to
20 panelist now.

21 It s taking a moment.

22 JUDGE BELL: Dr. Lippy, if by chance

1 you re speaking, we re not able to hear you.

2 MS. HARRISON: There we go.

3 Okay, so you should be able to unmute
4 and turn your webcam on when you re ready.

5 DR. LIPPY: Yes.

6 JUDGE BELL: Welcome, Dr. Lippy, go
7 ahead, please.

8 DR. LIPPY: Thank you.

9 I greatly appreciate this opportunity,
10 not just to speak, but to be with such a
11 distinguished panel.

12 Again, my name is Bruce Lippy, I am a
13 certified industrial hygienist and a certified
14 safety professional, and I have my own
15 consulting firm.

16 I began my career as an industrial
17 hygienist working at Maryland OSHA back in 1978.
18 And really, I ve worked as a practitioner most
19 of the time.

20 During my career, I ve worn air
21 purifying half face, full face respirators for
22 hundreds of hours in asbestos removal projects,

1 and for two months during the cleanup of the
2 World Trade Center destruction as a member of
3 the IUE s HAZMAT unit.

4 And Steve, I am one of the 126,000 in
5 the program, the WTC program, and it is an
6 excellent service, so I was very appreciative of
7 that.

8 I ve also worn a full face tight
9 fitting PAPR on the cleanup of the anthrax
10 attack in the AMI Building in Boca Raton,
11 Florida.

12 I d like to emphasize that a powered
13 air purifying respirator switches from positive
14 pressure to negative pressure when the battery
15 dies. And that was a regular issue working long
16 hours in the hot AMI Building.

17 So, I was able to attend the entire
18 hearing yesterday, and I found it quite
19 valuable. But I would like to amplify three key
20 points that I heard yesterday.

21 One is the hierarchy of controls was
22 raised several times, and I consider it

1 personally an absolutely critical concept for
2 proper management of worker protection.

3 And again, it was repeated a number of
4 times yesterday, but respiratory protection is
5 at the absolute bottom of this hierarchy.

6 And OSHA has made that abundantly clear
7 that, you know, employers need to show that
8 engineering and administrative controls aren't
9 practicable before turning to respirators.

10 And I think that's an important point,
11 I do not want to denigrate respirators. I have
12 trusted my health to NIOSH-certified respirators
13 throughout my entire career. But as pointed out
14 yesterday, they are the last line of defense.

15 And so, I find the idea of decreasing
16 protections that are currently in place very
17 misguided and potentially harmful to workers.

18 My second point is this, there was
19 considerable discussion yesterday about the
20 mandatory questionnaire with some indicating it
21 was antiquated and could be replaced by having
22 the same questions asked during fit testing or

1 training. I agree with Steve Markowitz, this is
2 really misguided.

3 You know, I've done lots of
4 quantitative fit testing and rarely asked
5 medical questions because I am not qualified to
6 do so. And so, I needed to focus on what I was
7 there for, and that's properly conducting a
8 quantitative fit test to make sure no one was
9 entering a contaminated work area with a poorly
10 fitting respirator. That was my job, and I
11 think that would be the way most folks doing fit
12 testing would feel.

13 I spent a lot of time with peer
14 trainers in the NIEHS worker training program.
15 And I have always admired their credibility with
16 workers, which I have never had as an IH geek,
17 they, you know, they trust peer workers.

18 But these people don't have the medical
19 or scientific background to handle the
20 application of questionnaires to a class of 15
21 or 20 or more workers.

22 First off, the logistics would be

1 overwhelming. I have taught OSHA Institute
2 courses with peer trainers, and really, the
3 paperwork is quite time consuming.

4 Not to mention, now, asking these
5 trainers to handle confidentiality issues,
6 possible violations of HIPAA, and most
7 important, the lack of a licensed medical
8 profession to ask questions to when unsure. I
9 would routinely get calls from trainers with
10 industrial hygiene questions, and I was happy to
11 help them.

12 I agree that the questionnaire could
13 use some updating. According to the OSHA
14 docket, the questionnaire was adapted from an
15 ANSI Z88.6 standard from 1984, that s 42 years
16 ago.

17 You know, I liked Dr. McLellan s idea
18 yesterday of bringing together stakeholders and
19 respirator experts to redesign the
20 questionnaire.

21 But it s important to keep in mind that
22 the questionnaire currently is quite

1 comprehensive and it was a compromise to avoid
2 incurring medical professional costs if the
3 questionnaire didn't show any untoward health
4 issues. So, I am against getting rid of it.

5 I work in construction where a majority
6 of firms have less than 20 employees. And so, a
7 contact the worker has with a licensed
8 healthcare professional may be the only time he
9 or she has that before working.

10 My third point is this, I have no
11 interest in trying to rebut the argument that
12 most healthy individuals will suffer no harm
13 from wearing a filtering facepiece respirator
14 without a previous medical evaluation.

15 I think that's generally correct, but
16 that totally misses the point that 1910.134
17 wasn't written to cover only healthy workers,
18 which, unfortunately, is what predominates in
19 the literature.

20 Medical evaluation, as you've heard
21 quite often, I'm sure, is intended to identify
22 workers with conditions that could predispose

1 them to adverse reactions, particularly when
2 respirators are worn for long periods.

3 Again, this is rare in the literature,
4 but it s very common in many workplaces. We
5 heard about hospital settings, and I can tell
6 you from construction, if the weather s good,
7 you keep working.

8 Finally, I ve worked with OSHA on
9 projects like creating the Disaster Site Worker
10 courses and VPP inspections, and I found their
11 efforts at Ground Zero to be exemplary.

12 But building this proposed elimination
13 of medical evaluations on, quote, a lack of data
14 about medical evaluation efficacy really speaks
15 to the need for further NIOSH research funding,
16 not cuts.

17 You know, it s important to note,
18 unfortunately, that this administration, rather
19 than better funding NIOSH, nearly eliminated it
20 until the uproar from health professionals and
21 others forced the reinstatement of most of the
22 staff. I ve relied on NIOSH all my career, I m

1 glad to see it back.

2 Consequently, I strongly urge OSHA to
3 not go forward with these proposed changes. And
4 I thank you for your time.

5 JUDGE BELL: Dr. Lippy, thank you very
6 much for your testimony.

7 Questions from OSHA, please?

8 MR. LEVINSON: Yes, Your Honor, first
9 questions from OSHA come from Dr. Minda Nieblas.

10 DR. NIEBLAS: Hello, Dr. Lippy, this is
11 Dr. Minda Nieblas.

12 Based on your experience, does the need
13 for further medical evaluation to determine if
14 there should be limitations on respirator use,
15 does that become most apparent or is that more
16 likely to become apparent when the worker is
17 answering the medical questionnaire, when the
18 worker is being fit tested, or after using the
19 respirator for a while in the workplace?

20 DR. LIPPY: Well, I would say the
21 questionnaire, because people just complain
22 about respirator wearing, it s not like it s a

1 specific health issue other than it s
2 uncomfortable.

3 When I taught the folks at the business
4 school in Maryland where I am, I made someone
5 wear a respirator for the whole class and asked
6 them what they thought about the cost of that
7 versus the uncomfortable nature.

8 And usually, they were very concerned
9 about how much -- the pain of wearing a
10 respirator. So, I would say the medical
11 questionnaire is where you probably get at that
12 the best.

13 DR. NIEBLAS: Thank you.

14 No further questions.

15 MR. LEVINSON: Your Honor, next
16 questions from OSHA come from Dr. Bob
17 Blicksilver.

18 DR. BLICKSILVER: Hi, Bob Blicksilver,
19 OSHA Standards and Guidance.

20 Dr. Lippy, do you have any experience
21 advising clients on the choice of filtered
22 facepiece respirators and powered air purifying

1 respirators in relation to medical evaluation?

2 And if so, what do you find to be the
3 typical time length, the typical time length for
4 modifying respirator usage, and achieving
5 satisfactory fit, or any other measures of
6 accommodation when you are consulting, providing
7 consultation and instructions on remedying
8 exposure, and any elevation of a medical
9 condition?

10 What measures of accommodation and any
11 unit cost measures that you can identify in
12 relation to accommodating the relocation and
13 reassignment of workers?

14 DR. LIPPY: Yes, one of the numbers
15 that jumps out at me immediately is the
16 difference between, you know, a filtering
17 facepiece respirator and a PAPR.

18 The latter, a lot of times runs a
19 thousand dollars, and then you have to buy
20 cartridges. So, it s much easier to put people
21 in filtering facepiece respirators.

22 I have worn PAPRs and they can provide

1 more comfort, you know, as far as the
2 temperature, the air is blowing across your
3 face, but they are expensive. And, you know,
4 I've not found a lot of employers that want to
5 shell out that kind of money.

6 DR. BLICKSILVER: Right, thank you.
7 Bob Blicksilver again.

8 If you have any thoughts on the time
9 involved in examining the worker, considering
10 the conditions and advising, the actual time of
11 a consultant such as yourself or any other
12 physician or a licensed healthcare professional
13 or any, you know, anyone who would be brought
14 in, that would be helpful to us.

15 A range of time estimates, depending on
16 the conditions that you've observed in your
17 career, any thoughts that you might have on, you
18 know, assigning the expenses, administrative and
19 resources expenses, involved in accommodating
20 workers for certain medical conditions?

21 DR. LIPPY: Well, I don't know about
22 the specific conditions, but I'll tell you, if

1 I m called in to advise on respiratory
2 protection, I want to see the work area.

3 I want to know if they re wearing other
4 PPE, because, you know, it s been stated, but
5 you really need to look at the entire package.

6 So, you know, it s usually at least a
7 half a day for me to get out and look at what
8 they re doing and look at the production.

9 And I ve worked a half mile underground
10 where they re storing nuclear waste for the
11 Department of Energy. It s a very different
12 operation than healthcare.

13 So, you really need to look at where
14 they re doing the work, how many workers are
15 involved, how many are going to be wearing
16 respirators, because not all of them have to.

17 I m working out west at a nuclear
18 weapon cleanup in Hanford, and there s just a
19 limited number of workers who are in self-
20 contained breathing apparatus, the rest are in
21 full face air purifying. The costs are
22 dramatically different, so it really takes a

1 focus on what s going on.

2 And also, are there engineering
3 controls that can alleviate even wearing
4 respirators? And they re doing that on this
5 project at Hanford. They re putting in stacks
6 to take care of the exhaust.

7 Does that help?

8 DR. BLICKSILVER: Yes, thank you very
9 much for those observations.

10 If you have any further thoughts and
11 post-hearing comments, we would really welcome -
12 -

13 DR. LIPPY: I m happy to do it.

14 DR. BLICKSILVER: -- getting those from
15 you, thank you.

16 Bob Blicksilver, again, thank you very
17 much, Dr. Lippy.

18 DR. LIPPY: Yes.

19 MR. LEVINSON: All right.

20 And Your Honor, the last question comes
21 from Dr. Jonathan Berr.

22 DR. BEARR: Jonathan Berr, OSHA.

1 DR. LIPPY: Yes.

2 DR. BEARR: I was wondering, Dr. Lippy,
3 you know, based on your experience within the
4 construction industry, do you workers face any
5 hazards or perform work tasks while wearing an
6 FFR or loose fitting PAPR that would prevent
7 them from being able to take their respirator
8 safely off for a few moments?

9 You know, this is either for, you know,
10 removal because of a medical reason or removal
11 for comfort or to readjust the fit?

12 Are there things they re being exposed
13 to that would present adverse health outcomes
14 rather immediately?

15 DR. LIPPY: There s a situation in
16 construction that s quite different than other
17 work environments, whereas we call it bystander
18 exposure.

19 So, there are situations where you may
20 be doing okay, but there s dust or vapors coming
21 from somebody else s operation.

22 So, it s tricky to say that it s okay

1 at any one point to take it off, other than when
2 you re going into a break room or, you know,
3 having lunch.

4 So, I really caution folks to be
5 careful about everything that s going on around
6 them before they take off a respirator.

7 The other thing with construction is, a
8 lot of the places they work, it becomes tough to
9 get into the spaces they do, you know, I m
10 thinking of pipe fitters and plumbers, while
11 wearing particularly a PAPR.

12 It s a piece of equipment that can get
13 caught in all kinds of things. So, and that can
14 jerk it off your face while you re working. And
15 some of the exposures in construction are quite
16 significant.

17 So, I would be very hesitant about
18 saying, if you feel a little -- just pull your -
19 - pull the respirator off. The only time I
20 would say that I would reverse that is when we
21 taught about heat stress and inside containment
22 for asbestos work.

1 I taught workers that, if somebody goes
2 down, looks like they have heat stroke, cut the
3 damn plastic and get them out of there because
4 the risks from the asbestos is not nearly what
5 it s going to be for somebody who may be
6 suffering from heat stroke.

7 I don t know if that helps, I m just
8 giving you some examples.

9 DR. BEARR: Thank you.

10 That s the only question I have.

11 MR. LEVINSON: Your Honor, no further
12 questions from OSHA.

13 JUDGE BELL: Thank you.

14 Questions from the Solicitor?

15 MR. BERNDT: No questions.

16 Sorry, this is Joseph Berndt from the
17 Office of the Solicitor, no questions from us.

18 Thank you, Dr. Lippy.

19 JUDGE BELL: Do we have questions from
20 the public?

21 MS. BURKE: Yes, we do.

22 First person, Rebecca Reindel, I have

1 enabled your mic.

2 MS. REINDEL: Wonderful, thank you.

3 Thank you, Dr. Lippy, this is Rebecca
4 Reindel with the AFL-CIO. I think I have two
5 questions for you.

6 The first is that it sounds like your
7 professional opinion is that medical evaluations
8 must be done prior to fit testing, but please
9 correct me if I ve misstated that?

10 And then, so as part of that, OSHA
11 requirements aside, current OSHA requirements
12 aside, would you feel comfortable fit testing
13 someone on a respirator that they haven t been
14 medically cleared for already?

15 DR. LIPPY: No, I think medical
16 clearance should come first.

17 And really, the questionnaire
18 facilitates that, you don t have to have a
19 doctor involved right up front.

20 MS. REINDEL: Right, okay, yes, thank
21 you.

22 And then, my second question is,

1 confidentiality aside, like removing that from
2 this picture during fit testing, which is your
3 experience, do you think that, during fit
4 testing, workers would answer a general question
5 about volunteering to talk to a medical
6 professional if they re given no other medical
7 information because it s not a medical
8 professional asking it?

9 In other words, the confidential
10 information would follow up that -- after the --
11 I m sorry, with the medical professional would
12 follow if they were referred.

13 Do you think workers would still
14 volunteer for that after they ve been fit tested
15 (audio interference)?

16 DR. LIPPY: No, no.

17 My experience has been that workers can
18 be quite reticent about discussing medical
19 issues unless it s somebody they truly trust.

20 And you know, quite often, you can end
21 up getting into trouble by talking about your
22 medical condition if the boss finds out.

1 MS. REINDEL: Okay, thank you very
2 much.

3 DR. LIPPY: Yes, my pleasure.

4 JUDGE BELL: Other questions from the
5 public?

6 MS. BURKE: Yes, there are four others
7 in the queue right now.

8 MK Fletcher, I have enabled your mic.

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

10 I m MK Fletcher with North America s
11 Building Trade Unions.

12 My question was actually very similar
13 to Rebecca Reindel s second question.

14 But Dr. Lippy, I was just wondering if
15 you could kind of further expand on what you
16 said?

17 You -- particularly about how workers
18 feel the ability to speak up or not speak up,
19 even if just the question during a fit test or a
20 training was to -- would you like to speak with
21 a medical professional?

22 You mentioned just earlier that they

1 could feel that they might have -- experience
2 trouble if they do speak up and I was just
3 wondering if you could expand on that?

4 DR. LIPPY: Well, again, I work in
5 construction and most firms are small, so
6 everybody knows each other. There is turnover,
7 but, you know, they tend to be very reticent
8 about speaking.

9 And there s also this, it s most --
10 it s almost a male profession, unfortunately,
11 MK, and the bravado is part of that.

12 At the World Trade Center, we couldn t
13 get people to admit they were having mental
14 issues or any kind of health problems. And so,
15 we, you know, we had this ten thousand mile
16 stare coming out of workers. So, you know, I
17 think that s really a problem, particularly,
18 again, in a male-dominated profession, to just
19 not say anything.

20 And what would you know to say if you
21 haven t even been checked for some of the
22 issues? A lot of folks have health issues, and

1 they just live with them.

2 MS. FLETCHER: Thank you so much.

3 DR. LIPPY: Sure.

4 JUDGE BELL: Next question from the
5 public, please?

6 MS. BURKE: Dan Glucksman, I have
7 enabled your mic.

8 MR. GLUCKSMAN: Hi, Dan Glucksman.

9 DR. LIPPY: Yes, how are you, Dan?

10 MR. GLUCKSMAN: Good.

11 Two questions, one, earlier in your
12 comments, I think, and maybe it was some -- in
13 discussion with one of the OSHA panelists, there
14 was a question about why would an employer
15 choose a filtering facepiece respirator versus a
16 powered air purifying respirator?

17 And one thing I didn't hear was
18 assigned protection factor and that sometimes
19 the exposure is such that a worker needs that
20 higher level protection.

21 But that's one of the key factors,
22 right, in terms of --

1 DR. LIPPY: Absolutely, Dan, you re
2 right, it is.

3 Powered air purifying respirator, of
4 course, gives you a much higher protection
5 factor than a filtering facepiece.

6 MR. GLUCKSMAN: Right.

7 It may be just a note that I haven t
8 heard that much discussion on APFs in some of
9 the testimony, I guess maybe I thought I would
10 have heard some discussion of that.

11 But one other question, how often, in
12 your experience, are insurers kind of directing
13 the type of personal protective equipment, or I
14 guess in this case, respirators, whether it s an
15 FFR, half face mask, you know, say with a N95 or
16 P100 particulate filter?

17 DR. LIPPY: Yes, Dan, I don t think
18 I ve had much experience at all with the
19 insurers being a driving force for choice of
20 respirators.

21 MR. GLUCKSMAN: Okay.

22 DR. LIPPY: That s not been my

1 experience.

2 MR. GLUCKSMAN: Okay, great, thank you.

3 DR. LIPPY: Oh, sure.

4 JUDGE BELL: Next question from the
5 public, please?

6 MS. BURKE: Ellie Barbarash, I ve
7 enabled your mic.

8 MS. BARBARASH: Thank you so much.

9 This is Ellie Barbarash, I m from
10 AFSCME. And Dr. Lippy, it s a pleasure to hear
11 your testimony and to meet you. I m another
12 9/11 first responder, so thank you for your
13 service.

14 I have two quick questions, one of them
15 thinking about the APF, my first question was,
16 the last thing you had shared in your testimony
17 was about someone getting heat stress in
18 asbestos containment.

19 So, I just -- and what I d like to
20 highlight, and perhaps you can expand upon what
21 I m going to suggest, is that the deregulation
22 proposal suggests that, because we re not in an

1 IDLH situation, if we re overwhelmed wearing an
2 FFR, we can just take it off for a minute and
3 then leave the work site as if that won t really
4 kill us. But and so, there s taking it off for
5 comfort.

6 But then, if somebody is overwhelmed by
7 heat stress, we know that, if the temperature
8 goes beyond a certain threshold, I think you re
9 dead in four minutes, so, time is of the
10 essence. So, taking it off in that situation is
11 a matter of life and death, right?

12 DR. LIPPY: Sure.

13 MS. BARBARASH: Yet, asbestos is also a
14 carcinogen that you don t want to be
15 cumulatively having to -- breathing in or
16 whatever else you re in, especially in a
17 hazardous waste site.

18 I was just wondering if you could
19 address those differences in the proposal that
20 it s not a big deal to take your respirator off
21 in a hazardous situation versus the exposure to
22 you when you do versus when you have no choice

1 because you re going to be dead in four minutes,
2 you better get it off of you?

3 DR. LIPPY: It s prioritizing risk.

4 And heat stroke, again, is just an
5 absolutely major event that you have to take
6 care of or they will, in the case that I dealt
7 with in MOSH, two folks died at Bethlehem Steel
8 from heat stroke and, you know, they weren t
9 handled well. So, that s number one.

10 After that, it really becomes a
11 question of where are you working, if you re
12 outside, and I know a lot of filtering facepiece
13 respiratory protection folks do get outside and
14 can take them off as opposed to being, you know,
15 in a medical clinic.

16 But, you know, generally, we really
17 frown on taking respirators off until you re
18 completely done with the work and out of the
19 area.

20 In fact, in asbestos, we routinely
21 fired people who took off the respirator inside
22 containment, so, you know, it s serious

1 business.

2 MR. BARBARASH: Dr. Lippy at 9/11, I
3 was helping out at the decontamination chambers
4 at John and William Streets, and I was helping
5 utility workers with their decontamination.

6 And my instructions to them, as I was
7 instructed, was to tell them to take their
8 respirator off only in the shower after they had
9 completely ungarbed so that they would have
10 water capture for any contaminant there.

11 The other thing I just wanted to ask
12 about was about protection factors.

13 So, an FFR is a protection factor of 10
14 or at least an N95 or something.

15 DR. LIPPY: Yes.

16 MS. BARBARASH: Loose fitting PAPR, I
17 think of 25, right?

18 DR. LIPPY: I believe that s correct.

19 MR. BARBARASH: But what about when I m
20 in containment and my battery goes, do I have
21 any protection factor at that point?

22 DR. LIPPY: You know, I ve never worked

1 with a loose fitting PAPR, they scare me a bit,
2 so, I ve always -- a tight face seal.

3 In that case, you revert to a -- the --
4 whatever the -- and we always fit test that in
5 the negative mode to make sure you ve got a good
6 fit.

7 So, I really can t comment on loose
8 fitting PAPRs, and I know they re very common in
9 the medical profession.

10 MR. BARBARASH: Yes, I would say that
11 they re -- I don t know that there is a
12 protection faction there because they -- they re
13 not negative pressure and they re not tight
14 fitting. And without a battery, there is no
15 filtration.

16 That s all my questions, I thank you so
17 much.

18 DR. LIPPY: Sure, thank you.

19 JUDGE BELL: Do we have other questions
20 from the public?

21 MS. BURKE: No further questions from
22 the public, Your Honor.

1 JUDGE BELL: All right.

2 Dr. Lippy, thank you very much for your
3 testimony.

4 DR. LIPPY: My pleasure.

5 JUDGE BELL: We greatly appreciate it.

6 DR. LIPPY: You re welcome.

7 JUDGE BELL: Who do we have up next,
8 please?

9 MS. HARRISON: Next we have Kelly
10 Taylor, who I ve just promoted to panelist.

11 So, you should be able to unmute and
12 turn your camera on when you re ready.

13 JUDGE BELL: Ms. Taylor, I hope you re
14 not talking because we re not able to hear.

15 MS. TAYLOR: Can you hear me now?

16 JUDGE BELL: Yes, I can, thank you very
17 much. Go ahead, please.

18 MS. TAYLOR: Great. Can you see me?

19 JUDGE BELL: Not yet.

20 MS. TAYLOR: Okay, let me see if I can
21 fix that.

22 My camera does not want to participate.

1 JUDGE BELL: Well, we can hear you
2 fine.

3 MS. TAYLOR: Okay, great.

4 JUDGE BELL: So, if you re okay to go
5 without video, go ahead, please.

6 MS. TAYLOR: I sure am, sorry about
7 that.

8 So, thank you for the opportunity to
9 participate in this public hearing.

10 My name is Kelly Taylor. My career
11 began 35 years ago as a physical therapist
12 caring for people recovering from injuries and
13 illnesses, including work-related injuries.

14 I then worked for the Minnesota
15 Department of Labor and Industry, first in the
16 Workers Compensation Division as a policy
17 analyst, and later at Minnesota OSHA as a
18 program analyst, where I developed and
19 implemented policy, and reviewed investigator
20 case files before a citation issuance.

21 In my more than ten years at Minnesota
22 OSHA, I read thousands of case files filled with

1 documentation of workplace hazards, hazards that
2 put lives at risk.

3 My coworkers at Minnesota OSHA and the
4 employees working in OSHA state plants and
5 federal offices across the country work every
6 day to save the lives of America s workers.

7 Currently, I work in a leadership role
8 at Damarco Solutions. Damarco partners with 3M
9 to provide Respexam, an online respirator
10 medical evaluation system developed and
11 physician reviewed by board certified
12 occupational medicine physicians.

13 Damarco has provided Respexam
14 respirator medical evaluations for more than 20
15 years and has processed more than 2 million
16 evaluations.

17 That gives me, through my role at
18 Damarco, a practical view of how the current
19 medical evaluation requirement works for
20 employers and employees. It also gave me access
21 to data that, with its limitations, is real
22 world, real worker data.

1 I am testifying today because I cared
2 about injured workers as a physical therapist.
3 I cared about injured workers as a workers
4 compensation policy analyst. I cared about
5 preventing workplace injuries and illnesses as a
6 Minnesota OSHA employee. And I continue to care
7 about the American worker.

8 In 1998, OSHA promulgated the
9 comprehensive Respiratory Protection Standard
10 that established the current medical evaluation
11 requirement.

12 In the preamble to that final rule,
13 OSHA stated that the purpose of the medical
14 evaluation requirement is to ensure that an
15 employee who is required to use a respirator can
16 tolerate the physiological burden of respirator
17 use.

18 OSHA identified multiple conditions
19 that may compromise an employee s ability to
20 tolerate respirator use, including but not
21 limited to cardiovascular disease, respiratory
22 disease, and reduced pulmonary function.

1 OSHA stated that these conditions may
2 place workers at increased risk of illness,
3 injury, or death. OSHA described the medical
4 evaluation requirements as minimal requirements
5 necessary to protect respirator users.

6 OSHA also rejected an approach that
7 would have exempted employees using respirators
8 for fewer than five hours per week because a
9 short use threshold could miss workers with
10 preexisting medical problems and leave workers
11 at risk.

12 That is the foundation of the current
13 rule. So, the question is, what has changed?

14 How respirators work and the
15 physiological burden they create have not
16 changed.

17 FFRs are still tight fitting, require a
18 face seal, and rely on the wearer s own
19 respiratory effort to draw air through the
20 filter.

21 Workers still vary in their
22 cardiovascular and respiratory health, their

1 physical capacity, and their ability to tolerate
2 respirator use.

3 Required respirator use still occurs
4 under actual working conditions, including heat,
5 exertion, protective clothing, and prolonged
6 duration.

7 The physiological burden OSHA
8 identified in 1998 remains relevant today.
9 Studies conducted since the 1998 rulemaking and
10 cited in my original comment continue to support
11 OSHA s original concern that respirator use,
12 including N95 or comparable FFR use, can affect
13 breathing, cardiovascular demand, and exercise
14 tolerance.

15 Some of those studies specifically
16 noted that the effects may be more significant
17 for people with pulmonary disease,
18 cardiovascular disease, or other medical
19 conditions.

20 OSHA s own proposal cites recent
21 studies of healthy volunteers to argue FFRs have
22 minimal physiological impact.

1 That caveat is important because OSHA s
2 medical evaluation requirement is designed for
3 the actual workforce, not for healthy volunteers
4 in controlled studies.

5 A review of two recent years of
6 Respexam data shows that among referred FFR
7 users with follow-up received, 15.4 percent were
8 restricted and 11.6 percent were determined
9 unable to wear an FFR. Of note, roughly two-
10 thirds of both groups had been referred for
11 pulmonary or cardiac symptoms.

12 Those are not theoretical workers,
13 those are workers who were screened because
14 their employers were complying with OSHA s
15 current standard.

16 Those are workers whose medical
17 evaluation identified a need for restriction or
18 disqualification before they were required to
19 wear an FFR, indeed, before they were fit
20 tested.

21 I want to be candid about this data s
22 limitations. It comes from Respexam customers,

1 not a nationwide sample. While employers are
2 encouraged to provide follow-up documentation
3 for every referred employee so we can update the
4 employee record, in most cases, they do not.

5 I do know, from my experience assisting
6 employers, that some use the screening as the
7 final determination as to whether the employee
8 is given tasks that require respirator use. So,
9 there are many referred employees whose final
10 outcome is not entered into the Respexam system.

11 Additionally, Respexam was designed to
12 assist the employer in complying with the
13 medical evaluation requirement efficiently and
14 cost effectively.

15 To that end, most workers are evaluated
16 for several respirator types at once, and
17 isolating evaluations for FFR and PAPR use only
18 is difficult and necessarily narrows the set.

19 With those limitations, the Respexam
20 data still aligns with OSHA s own data.

21 In its proposed amendment, OSHA points
22 to low refusal and limitation rates after

1 medical evaluation, asserting figures around 1
2 to 2 percent, and appears to treat those low
3 rates as evidence that the screening process has
4 limited impact.

5 Applying that 1 to 2 percent to OSHA s
6 estimate of 2.6 million private sector non-
7 mining FFR users represents 26,000 to 52,000
8 workers who, if OSHA statistics are correct, are
9 medically unable to wear an FFR or require
10 restrictions or limitations to do so safely.

11 And it has been asserted in previous
12 testimony, as well as OSHA s proposal, that the
13 total number of FFR users is likely understated.

14 A low denial or limitation rate does
15 not mean medical screening lacks value. It
16 means most workers are cleared efficiently while
17 the screening process identifies the workers who
18 need follow-up, restriction, limitation, or
19 disqualification to protect their health. That
20 is how screening is supposed to work.

21 OSHA s proposal is internally
22 inconsistent. The proposal would remove the

1 medical evaluation requirement for FFRs and keep
2 it for tight-fitting PAPRs.

3 But FFRs are also tight-fitting
4 respirators that require a face seal, and unlike
5 a PAPR, which uses a blower to deliver air to
6 the wearer, an FFR requires the wearer s own
7 respiratory effort to draw every breath through
8 the filter.

9 I m not raising this because OSHA
10 should also exempt tight-fitting PAPRs, it
11 should not. I raise it because the
12 inconsistency shows OSHA has not adequately
13 analyzed the health basis for removing medical
14 evaluations for required FFR use.

15 This exemption is broader than the way
16 it has been described, including in OSHA s
17 presentation to its Construction Advisory
18 Committee which framed the proposal around N95
19 dust masks.

20 The proposal is not limited to N95s, it
21 applies to required FFR use across all nine
22 NIOSH particulate filter classes, including

1 P100s, which have higher filter efficiency and
2 higher flow resistance than N95s.

3 It is also worth noting that, after
4 considering OSHA s presentation, the
5 Construction Advisory Committee recommended that
6 OSHA not proceed with this proposal.

7 OSHA has proposed this amendment as a
8 cost-saving measure. By OSHA s own accounting,
9 roughly two-thirds of the projected savings is a
10 single line, the \$193.75 cost of each follow-up
11 medical exam.

12 OSHA assumes 23 percent of screened
13 workers are referred for follow-up exams, while
14 acknowledging in its own proposal that the rate
15 may be much smaller for these respirators. The
16 Respexam referral rate for FFR and PAPR-only
17 evaluations for the data I reviewed was 3.5
18 percent.

19 Cost savings should not be treated as
20 net benefits without considering what the
21 medical evaluation requirement does.
22 Eliminating medical evaluations does not

1 eliminate medical risk.

2 If workers who would have been
3 restricted or determined unable to wear an FFR
4 are instead required to use one, financial costs
5 may be shifted to employers, insurers, and the
6 workers compensation system.

7 But the most important cost is not
8 financial, it is the risk imposed on the worker
9 who may be required to wear a respirator that a
10 medical evaluation would have shown they could
11 not safely tolerate.

12 The current requirement is being met
13 through questionnaire-based screening at modest
14 cost, and America s workers are worth it.

15 Listening to previous testimony, I
16 noticed that the panel returning repeatedly to
17 the same request for data and studies. It is
18 apparent that the data OSHA seeks to properly
19 analyze this proposal is not readily available.

20 It will take time, money, and perhaps
21 administrative burden in the form of mandatory
22 reporting by employers to obtain comprehensive

1 data to fully analyze this proposal, the very
2 things deregulation attempts to avoid.

3 In the meantime, the lives and
4 livelihoods of America s workers hang in the
5 balance. OSHA should not finalize the proposed
6 amendment.

7 I also want to speak to a question Dr.
8 Nieblas has asked several previous hearing
9 participants, whether retaining paragraph E7,
10 reevaluation when symptoms arise, would address
11 the concerns raised.

12 Paragraph E7 should be retained, but it
13 is not a substitute for the initial medical
14 evaluation. Under E7 alone, a sometimes
15 nondescript symptom arises, and we hope the
16 worker recognizes it, understands it, and
17 reports it.

18 Appendix C currently instructs the
19 employee, in OSHA s own mandatory language, that
20 to maintain your confidentiality, your employer
21 or supervisor must not look at or review your
22 answers.

1 Under E7 alone, the only path to a
2 medical evaluation is by disclosing symptoms to
3 the employer or supervisor, and OSHA trusts that
4 the employer will act on the employee s report.

5 Additionally, if the adverse reaction
6 arrives as an event rather than a symptom, the
7 employer bears the cost, the recordable injury,
8 the workers compensation claim, the lost time.

9 Thank you for the opportunity to
10 testify.

11 JUDGE BELL: Thank you.

12 Questions from OSHA?

13 MR. LEVINSON: Yes, Your Honor, the
14 first question comes from Jonathan Bearr.

15 DR. BEARR: Jonathan Bearr, OSHA.

16 Thank you, Ms. Taylor, for your
17 testimony.

18 I was wondering, in your post-hearing
19 comments, to the extent that you can, can you
20 provide the data to which you were discussing in
21 your testimony?

22 MS. TAYLOR: So, yes, I ve already

1 provided the data that I've found relevant. And
2 I just want to acknowledge that I really do want
3 to be helpful to OSHA, I want to help provide
4 data.

5 We have pledged to our customers that
6 the information that they provide will not be
7 sold or shared with anyone, so I can't provide
8 any raw data.

9 The system was designed to help
10 employers comply with the current requirement
11 and to manage that information securely, it was
12 not designed to mine data. So, what can be, you
13 know, compiled has real limits.

14 I can certainly provide the same
15 statistics that I've provided, I do believe they
16 are already in my comment.

17 DR. BEARR: Thank you.

18 A couple more questions.

19 The data to which you have are through
20 personal experience. Have you -- are you aware
21 of how often workers discover they have a
22 condition solely through the questionnaire?

1 MS. TAYLOR: I m really glad you asked
2 that question, I was hoping you would because
3 I ve heard you ask several others. I don t have
4 data, I do have anecdotal experience.

5 As we run this online respirator
6 medical evaluation system day in and day out for
7 literally hundreds of thousands of employees,
8 those that are referred often contact us after
9 their referral. And some of them are --
10 strongly believe they should not be referred, I
11 don t think I should be referred.

12 And so, in that situation, what we do
13 is, we go through their evaluation, the answers
14 they provided to make sure that they didn t
15 accidentally provide the wrong answer.

16 And in many cases, they have provided
17 yes answers to symptoms that, you know, should
18 be concerning, and yet they don t think they
19 should be referred.

20 And in those cases, we re like, you
21 know, when they re confirming the answers they
22 provided were correct, and we inform them that,

1 no, you really do need to go see a doctor.

2 In addition to that, many of those
3 employees express reticence at the fact that do
4 they have to tell their employer why they were
5 referred?

6 And once we tell them that no, they
7 don t, they do not have to tell their employer
8 why they were referred, they feel much better
9 about that referral and they re willing to go
10 see that doctor.

11 DR. BEARR: Do you know by chance how
12 frequently that occurs?

13 MS. TAYLOR: So, we don t track that
14 and I would say it s less than once a week, but
15 more than once a month.

16 DR. BEARR: Thank you.

17 And my other question is, does the data
18 that you have or your personal experiences, how
19 often do workers who are cleared for using an
20 FFR or a loose fitting PAPR, do they have an
21 incident while working and request a
22 reevaluation?

1 MS. TAYLOR: We don t have that data.

2 Our, you know, our system is limited to
3 the scope of providing a service for the
4 employer to easily and cost effectively meet the
5 requirement.

6 So, we don t have contact with
7 employees in that respect.

8 DR. BEARR: Thank you.

9 Those are all my questions.

10 MR. LEVINSON: Your Honor, the next
11 question comes from Bob Blicksilver.

12 DR. BLICKSILVER: Hi, Bob Blicksilver,
13 OSHA Standards and Guidance.

14 Ms. Taylor, you described scenarios
15 where if a worker who would have been restricted
16 or determined unable to wear an FFR after
17 medical evaluation, if they re instead required
18 to use one, costs may be shifted downstream
19 through workers compensation claims, lost time,
20 restricted duty, replacement labor, and higher
21 experience rated premiums, I m quoting from your
22 written testimony.

1 Do you have any empirical data of you,
2 yourself or Damarco or any other -- are you
3 aware of any other studies with empirical data
4 on those or related costs of removing medical
5 screenings from FFR and PAPR fit testing?

6 And also, could you share your thoughts
7 in post-hearing comments in relation to that
8 area of shifted costs from the failure, really,
9 to reduce the likelihood of the enhancement of
10 these medical conditions?

11 Thank you.

12 MS. TAYLOR: Yes, I do not have
13 empirical data, I would be happy to share my
14 thoughts in post-hearing comment.

15 DR. BLICKSILVER: Bob Blicksilver,
16 thank you very much, Ms. Taylor.

17 That s all I have.

18 MR. LEVINSON: Your Honor, we actually
19 have one final late-breaking question from Dr.
20 Minda Nieblas.

21 DR. NIEBLAS: Thank you, Dr. Minda
22 Nieblas.

1 Thank you, Ms. Taylor. I was wondering
2 if, from your data, you re able to determine
3 which questions from the questionnaire are most
4 commonly associated with the request for
5 referrals and inability to clear the employee?

6 MS. TAYLOR: I haven t thought of that,
7 it s certainly something I can try to think
8 about and go back and look at and provide in
9 post-hearing comment.

10 DR. NIEBLAS: Thank you so much, I
11 appreciate it.

12 MS. TAYLOR: Mm-hmm.

13 MR. LEVINSON: Your Honor, no further
14 questions from OSHA.

15 JUDGE BELL: Questions from the
16 Solicitor?

17 MR. BERNDT: Joseph Berndt from the
18 Office of the Solicitor, no questions from us.

19 Thank you, Ms. Taylor.

20 JUDGE BELL: Do we have questions from
21 the public?

22 MS. BURKE: There are no questions from

1 the public, Your Honor.

2 JUDGE BELL: All right, Ms. Taylor,
3 thank you so much for being here, we really
4 appreciate it.

5 MS. TAYLOR: Thank you.

6 JUDGE BELL: Do we have any other
7 witnesses to appear before us?

8 MS. HARRISON: No.

9 JUDGE BELL: All right, we re now at
10 the end of all scheduled witnesses for today.

11 Following the hearing, there will be
12 two separate periods for submitting additional
13 information. Hearing participants may submit
14 additional evidence or data relevant to the
15 proceedings within 30 days of the end of the
16 hearing. Participants then will have 45 days
17 after the end of the hearing to file briefs
18 based on the record as a whole.

19 The purpose of having these two periods
20 is to allow for the submission of new data and
21 evidence, and to include additional responses to
22 questions posed at the hearing, and then to have

1 a period that allows participants to respond to
2 that new evidence.

3 Therefore, new data, studies, or
4 similar evidence may not be added during the
5 second period, and commenters should reference
6 the docket ID number for any evidence they rely
7 on in their briefs.

8 Today is August 20th, 2026, so the
9 deadline for submitting additional evidence or
10 data is September 19th, 2026, and the deadline
11 for submitting briefs will be October 4th, 2026.
12 At that point, the record for this hearing will
13 close.

14 The public hearing on the proposed rule
15 amending the medical evaluation requirements in
16 the Respiratory Protection Standard for certain
17 types of respirators is concluded.

18 Let the record show that all persons
19 and organizations who filed a timely Notice of
20 Intention to Appear have been extended an
21 opportunity to do so.

22 Let the record also show that in every

1 instance, following the presentation of oral
2 comments and testimony, an opportunity has been
3 extended for questioning of the witnesses by
4 those who had Filed Notices of Intention to
5 Appear and by members of OSHA s panel.

6 On behalf of the Department of Labor, I
7 wish to publicly thank all those persons who
8 gave of their effort and time and testimony and
9 expertise to contribute to this hearing today.

10 To all participants, thank you for your
11 interest and your important contributions to
12 this matter.

13 The hearing is hereby adjourned.

14 (Whereupon, the above-entitled matter
15 went off the record at 2:37 p.m.)
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C E R T I F I C A T E

This is to certify that the foregoing transcript was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings; and that I am neither counsel for, related to, nor employed by any of the parties to this action in which this matter was taken; and further that I am not a relative nor an employee of any of the parties nor counsel employed by the parties, and I am not financially or otherwise interested in the outcome of the action.



James Cordes

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