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OSHA readies TB, ergonomics rules despite mounting opposition

Congressional foes won't derail standards, agency vows

Ignoring the grenades lobbed into their camp by congressional factions and politically savvy professional associations, officials of the Occupational Safety and Health Administration (OSHA) pledge to forge ahead and release two long-awaited, controversial regulations on time.

OSHA is in the final stages of drafting a proposed ergonomics standard that could be issued as soon as this fall and is putting the finishing touches on the final rule regulating occupational exposure to tuberculosis, which is scheduled to become law next year. Both regulations have met with significant political and professional opposition during their years of development.

Nevertheless, OSHA remains steadfast in its resolve to promulgate both standards. "Right now, this agency continues to go forward," says spokesman **Bill Wright**. "As of now, nothing has changed. This agency's intent is to issue a proposed ergonomics standard this fall, and a final TB rule is planned for spring 2000. That's the schedule. It's a priority of the agency."

Most recently, the TB standard, which was reopened this summer for public comment **(see related story, p. 124)**, has been threatened with a strategic attempt to block its release. The Association for Professionals in Infection Control and Epidemiology (APIC) is calling on Congress to withhold funding unless OSHA submits the TB rule to a scientific review by the Institute of Medicine (IOM) in Washington, DC.

A similar tactic could prove successful in delaying the ergonomics proposal. HR 987, the "Workplace Preservation Act," narrowly passed the House of Representatives this summer. It requires OSHA to wait for the Washington, DC-based National Academy of Sciences (NAS) — an organization affiliated with the IOM — to complete and submit to Congress a study on the cause-and-effect relationship between repetitive tasks in the workplace and repetitive stress injuries before issuing an ergonomics standard.

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Correction

On page 117 of the October issue of *Hospital Employee Health*, in a story about vaccinating health care workers against influenza, we incorrectly reported that the current influenza vaccine contains live, attenuated influenza virus. The influenza vaccine, administered by injection, is not capable of causing influenza because the vaccine is made from killed, noninfectious viruses. However, research trials have been conducted on a new intranasal flu vaccine that does contain live, attenuated influenza virus. ■

The Workplace Preservation Act was introduced in the House by Rep. Roy Blunt (R-MO) and passed 217-209, mostly on the strength of Republican support. Efforts to develop an ergonomics rule have been plagued by political opposition, largely along partisan lines. Proposed rulemaking for a standard was announced in 1992, with a proposal slated for release in 1994.

However, that plan crashed due to congressional actions that weakened OSHA's regulatory authority. A draft proposal released in 1995 encouraged employers not to wait for a standard to implement workplace ergonomics programs.[1] Again, that proposal was squelched, along with any other plans to issue a standard, this time by a rider attached to a federal appropriations bill adopted by Congress. The rider prohibited OSHA from developing a rule before Sept. 30, 1998.

Prescriptive approach scrapped

When the ban was lifted last fall, OSHA once again resumed work toward a standard, although town hall-type meetings on ergonomics had been held around the country during most of 1998 in preparation for a federal rule. Earlier versions of an ergonomics proposal generally viewed as too prescriptive were scrapped in favor of a more "programmatic, flexible" approach, says **David Cochran**, PhD, PE, CPE, a special assistant for ergonomics at OSHA and a lead author of the standard.

Earlier this year, Cochran told *Hospital Employee Health* that the chances of OSHA's proposed rule gaining the support of both employer and labor groups looked good, based on responses at recent stakeholder meetings.

"It was surprising how much agreement there was," he says. "They agreed that a good [ergonomics] program is necessary to deal with these problems, and they agreed on the components of a good program. The key is trying to get the right amount of information [in a standard] without overdoing it."

OSHA head defends need for rule

Nevertheless, the working draft proposal released on OSHA's Internet Web site earlier this year did nothing to placate critics. In a speech last spring to the National Coalition on Ergonomics — a group of 200 diverse organizations including truckers, farmers, and convenience store owners who are the main opposition to a federal law and the main supporters of Blunt's legislation — **Charles N. Jeffress**, OSHA's assistant secretary of labor for occupational safety and health, defended the standard.

Noting that a 1998 NAS study found "substantial sound scientific evidence" linking back injuries and other musculoskeletal disorders (MSDs) to work activities **(see *Hospital Employee Health,* January 1999, pp. 1-3)**,[2] Jeffress denounced the coalition's support for another NAS review of the same subject.

"What different conclusions do you expect from yet another literature review by the academy? What will you say if the findings are identical to the last review? More research is always welcome, but we already know enough to begin addressing these problems," Jeffress stated.

Dan Wadlington, a spokesman for Rep. Blunt, argues that the 1998 NAS review was not a scientific study of the connection between MSDs and work, but just "some documents that hinted at it." The study called for in the legislation would be "the only scientific study of its kind," he says.

Having passed the House, the bill has been referred to the Senate for action there. President Clinton has said he will veto the measure if both sides of Congress approve it. Other supporters include the American Association of Occupational Health Nurses (AAOHN), the American Nurses Association (ANA), the Service Employees International Union (SEIU), and the American College of Occupational and Environmental Medicine (ACOEM).

Noting that ergonomics is "a very hot topic in Washington" now, Jeffress maintains that ergonomics programs have been shown to reduce the

risk of injury. More than 600,000 occupational MSDs occur annually, he says, costing businesses $15 billion to $20 billion each year in workers' compensation costs alone.

Following publication of the proposal this fall, OSHA will hold public hearings in early 2000 and will issue a final rule by the end of the year, Jeffress vows.

Some call proposal 'ambiguous'

While most critics fear being over-regulated by an ergonomics standard, others have the opposite concern. **Geoff Kelafant**, MD, MSPH, FACOEM, medical director of the occupational health department at Sarah Bush Lincoln Health Center in Mattoon, IL, says the draft proposal is too vague.

"From looking at this, I'm not really sure what a work-related musculoskeletal injury is," he observes. "I don't think companies do well when given a whole lot of latitude. I think they do better when beaten over the head."

Kelafant says an ergonomics standard should be more prescriptive, leaving less open to interpretation by employers.

"It's great that OSHA thinks it should have these [standards], but I'm not sure another ambiguous standard is going to clear things up," he states.

Guy Fragala, PhD, PE, CSP, a health care ergonomics expert and director of environmental health and safety at the University of Massachusetts Medical Center in Worcester, sees the standard as flexible rather than ambiguous. He says efforts to block the standard are "unfortunate."

"I don't know if the people who are voting on the issue really understand how effective ergonomics management can result in cost savings," Fragala says. "Many people think it would add a lot of cost, but it's changed quite a bit since the original proposal came out, so it's much less prescriptive. The program aspect of the standard is good — requiring a program but giving a lot of flexibility. Many health care providers have realized the value of reducing occupational injuries, especially those associated with patient lifting and handling."

Similar attempts to derail the TB standard have not gone as far yet, but APIC members hope their legislative strategy will be successful in delaying the rule's finalization. The TB standard proposed in 1997 met with an onslaught of criticism from the health care community over a number of controversial provisions, including the risk assessment and frequency of respirator fit-testing and employee skin-testing.[3] **(See *HEH*, January 1998, pp. 1-4; February 1998, pp. 13-17; June 1998, pp. 69-72; and February 1999, pp. 13-16.)**

Many critics, most prominently APIC, have argued for enforcement of the 1994 Centers for Disease Control and Prevention guidelines,[4] which they say have worked to control the risk of occupational TB infection. This would be preferable to an OSHA rule, they contend.

APIC has taken its case to Congress, where the organization's government affairs representatives have gained support from Rep. Roger Wicker (R-MS) and Rep. John Porter (R-IL) in introducing a bill that would require third-party review of the rule to determine whether there is a need for it, says **Jennifer Thomas**, APIC's government and public affairs director.

While APIC tried to stop the standard for several years, those efforts were unsuccessful, she says. Now the organization is taking a "compromise approach."

"When it came right down to it, we had to do something this year because the rule is due out next year, but we don't want it to be so political as the thwarting of a regulation," Thomas says. "We feel that the science can speak for itself, so by asking for an IOM review, we hope that it's a more objective approach to proving that there is no need for this rule."

Viewing TB as a public health issue

To prove its point, APIC says the rate of TB disease in health care workers is lower than that in the general population (5.3 per 100,000 vs. 8.0), "so that tells you it's a public health issue, not a health care worker issue," Thomas states.

The problem, she says, is that undiagnosed patients are "unwittingly" spreading TB to HCWs. "They are not symptomatic at all, which tells us that if 73% of transmissions come from undiagnosed patients, that's a public health issue."

The solution is to target populations in the community at risk for TB and to tailor TB prevention and treatment efforts to those groups before they enter health care facilities with undiagnosed TB.

"That's going to curb the problem for everybody, including health care workers," she says. **(See related story, p. 124.)**

That opinion is not shared by the American Nurses Association (ANA), which supports both the TB and ergonomics standards. **Susan Wilburn**, RN, MPH, occupational safety and health specialist for the Washington, DC-based organization, says the TB standard is a "long overdue" and necessary protection.

"Although the rates of TB in this country have declined over the last couple of years, the international rates have increased. We need to protect nurses and other health care workers from a completely preventable exposure and infection," she states.

Those protections are threatened even in hospitals that enforce the CDC's TB recommendations, Wilburn says.

A shield against the budgetary axe

"I've been told by employee health nurses and physicians over and over that [policies not based] on the requirements of a standard go on the cutting table when there's a budget crunch. I think APIC sees this as a resource allocation issue, that when resources are being spent on preventing TB, it means they're going to miss catching some new bug. I think the opposite is true," she states. "If there is an OSHA standard, they are going to be provided with the resources to do their job. If there's not a standard, they won't be."

APIC's position is an "extension of management," Wilburn says, whose aim is to cut costs, so "any regulation is a bad regulation," no matter how significant the risk.

"Hospitals may say in good faith they're going to do the right thing, but it's not true for TB and it's not true for ergonomics," she says.

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Critics get another crack at proposed TB standard

OSHA reopens record for limited comments

For nearly two months this summer, critics and supporters of the Occupational Safety and Health Administration's (OSHA) proposed tuberculosis standard had an unexpected opportunity to submit further comments on the document when the agency reopened the record.[1,2]

Some 41 additional comments were received during the limited reopening, but many of them contained nothing new, says **Amanda Edens**, OSHA project officer for the TB standard.

Edens cites two purposes for inviting more comments on OSHA's proposal for regulating occupational exposure to TB some eight months after the post-hearing comment period closed.

First, "several pertinent studies and reports became available to us after the close back in October '98," she says. They include four previously unavailable documents related to issues addressed during the public hearings, including costs of respiratory protection and fit-testing programs.[3]

Other newly acquired reports included information related to the risk of occupational exposure to TB in homeless shelters and medical waste treatment facilities. For the latter, OSHA is considering whether laboratories covered by the TB standard, which would include hospital labs, should be required to decontaminate their TB wastes before sending them off site for disposal.

Second, OSHA wanted to provide another opportunity to comment on the proposed standard's risk assessment provisions "to see if there were some new studies we needed to look at or some issues we needed to include in terms of preparing our final risk assessment for the TB standard," Edens explains.

While many of the comments received during the summer were similar to those previously submitted, Edens says "nothing is carved in stone. We're evaluating the different sides of the stories from all the groups [that commented] and will make the changes that seem reasonable where we can."

The American Hospital Association (AHA) in Chicago was among those taking the opportunity to comment on new developments. Focusing on

More education needed to stop nosocomial TB

Physicians in training should be targeted

A new study of health care worker compliance with the Centers for Disease Control and Prevention's (CDC) guidelines for preventing tuberculosis transmission in health care facilities shows that educational efforts need improvement, particularly among physicians in training.[1,2]

The observational study was conducted at the University of California-San Diego (UCSD) Medical Center, an urban teaching hospital that admits 25 to 30 cases of active TB per year. The institution has been successful in rapidly identifying and isolating potentially infectious TB cases.[3]

Over a 14-week period, a trained research assistant observed occupied adult respiratory isolation rooms for one- to two-hour periods. The observer did not reveal the observation's purpose and tried to remain inconspicuous.

Most observations took place on the day shift. Information was recorded for each HCW observed, including job title, whether a mask was worn entering and leaving the room, the type of mask worn (N95 masks are the only type permitted at UCSD), whether it was worn properly, and whether the door was closed immediately after entering and leaving the room.

A total of 541 HCW observations in 115 observation sessions involving 52 patients in isolation took place during the study period. Some HCWs were observed more than once. Most of the HCWs were aides or transports (166), followed by registered or licensed practical nurses (135), dietary workers (49), residents or fellows (47), medical students (46), phlebotomists (42), attending physicians (12), jail guards (10), skin-test technicians (9), housekeepers (8), nursing students (4), social workers (3), respiratory therapists (3), EKG technicians (3), security (3), and an X-ray technician (1).

Sixty-four total violations were observed, with 36 involving failing to maintain respiratory isolation (such as leaving the door open upon entry or exit) and 28 involving failure to use masks properly (masks not worn, masks worn improperly, or wrong type of mask worn).

Most importantly, the number of violations per observation differed significantly by employee job category. The highest rates were among physicians in training (residents, fellows, and medical students), housekeepers, and jail guards, with physicians in training by far the highest. They committed 45% of all violations but accounted for only 17.2% of total observations made.

While noting that the 29 violations committed by this group included at least eight technical violations that were not considered clinically important (orders to discontinue isolation were written either just before or after the observation), the study authors emphasize that educational efforts directed at physicians in training need improvement.

Although compliance with the CDC's guidelines seems "reasonably good," the researchers advocate continued and improved education of all HCWs regarding the importance of TB protection and complying with control measures.

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the controversial issue of respirator fit-testing, with its associated costs that many hospitals and professional organizations have contended would be prohibitive, the AHA supports flexible fit-testing programs that allow employees who use respirators to be evaluated annually for the need to be fit-tested.

"Maintaining flexibility in the standard regarding the use of annual fit-testing would support good management and promote a cost-effective respiratory protection and fit-testing program," says **Rick Pollack**, AHA executive vice president, in comments to OSHA.

Specifically, the AHA asserts that OSHA should

adhere to the approach outlined in the proposed standard, which accepts medical surveillance criteria in lieu of requiring annual fit tests. After an initial fit test, employees would be evaluated during their annual TB assessments to determine if significant facial changes or changes in respirator type or design warrant another fit test.[4]

Major costs are labor-related

Roslyne Schulman, senior associate director for policy development at the AHA, explains that while the N95 respirators now considered standard for TB protection are less expensive than the high-efficiency particulate air respirators that have been required in the past, the major costs for fit-testing programs are labor-related.

"Overall, hospital budgets are finite, and many other employee safety initiatives have to be budgeted, so there is a need to use resources wisely and effectively for employee health," Schulman says. "Requiring employees to go through annual fit-testing when it's not necessary is not a wise use of resources."

The AHA's comments credit hospital occupational/employee health services as a resource that allows a more flexible approach to respirator fit-testing.

"Occupational health services have the opportunity to assess individuals each year at a minimum, and are in a unique position to assess health care workers for TB," the AHA states. "Thus, hospitals have an opportunity to ensure employees are questioned systematically and carefully for the very changes that help determine whether or not further fit-testing is needed."

Edens says OSHA has no plans to reopen the standard again. Release of the final rule is still planned for spring 2000, "but I can't predict those kinds of things," she says.

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Hundreds of lawsuits filed against latex glove makers

Sensitized HCWs sue in federal and state courts

Health care workers have filed more than 300 lawsuits in federal court against at least seven major latex glove manufacturers and a handful of smaller companies, alleging that exposure to natural rubber latex gloves at work has caused the HCWs to suffer from Type 1 latex hypersensitivity.

The latex allergy lawsuits have been combined into multi-district litigation (MDL), a procedure that allows similar cases to be consolidated for pretrial discovery and motions. Lawsuits pending in federal courts in different parts of the country were transferred to a Philadelphia federal court. After the pretrial process, the cases will be transferred back to the courts where they originated for further proceedings, including trials, explains **David Shrager**, plaintiffs' lead counsel and senior partner of Shrager, McDaid, Loftus, Flum and Spivey law firm in Philadelphia.

Shrager chairs the plaintiffs' steering committee, which includes 12 law firms. Hundreds of additional cases pending in state courts are being handled in conjunction with the MDL cases.

Many of the HCWs suing glove manufacturers are disabled by latex allergy, and all have been sensitized to latex from glove use, Shrager says. Plaintiffs contend that the defendants have manufactured gloves that were high in natural rubber latex proteins.

"As a consequence of that, when an explosion in the use of gloves occurred in association with the CDC's universal precautions relative to AIDS in the 1980s, the [glove manufacturing] industry took shortcuts. There was a concomitant increase and risk of harm to what you would predict would be a high-risk group, namely health care providers who would repeatedly don gloves and would be exposed with frequency to dipped latex-containing products as opposed to vulcanized products such as tires," he says.

While most of the cases will probably be settled out of court, Shrager expects at least some to be heard by a jury. Last year, a radiologist was awarded $1 million in the first major latex product liability case to go to trial. Legal experts said the verdict could set a precedent for similar outcomes in the hundreds of pending lawsuits. **(See**

***Hospital Employee Health,* September 1998, pp. 107-109.)**

At the time, attorneys for defendant Smith & Nephew PLC, a British medical device firm that also is a defendant in the MDL, said the outcome was affected by the court's failure to instruct the jury properly. They maintain that the latex gloves they manufactured were not unreasonably dangerous or defective, as the plaintiff charged. The case is on appeal.

Statutes of limitations could block action

Shrager says the MDL defendants are using two main defense strategies: waiting for the statute of limitations to run out and claiming that product identification — proving which manufacturer's gloves were responsible for a HCW's latex sensitization — is impossible.

Statutes of limitation vary from state to state, but usually are between one and six years. A California case scheduled for trial in state court this month may not get there. The plaintiff, a registered nurse, suspected in 1992 that the allergy symptoms she was experiencing were caused by the latex gloves she wore at work, but she waited until 1996 to file her complaint. The judge agreed with the glove manufacturer — Baxter International, now known as Allegiance Healthcare Corp. in McGaw Park, IL — that the nurse's claims were barred by California's one-year statute of limitation.

"Their defense is the clock and which gloves did it," says Shrager. "Instead of facing up to the situation and settling it, they're toughing it out. I think it will take a few trials to straighten things out."

Hospital Employee Health contacted several defendants in the MDL lawsuits, but all refused to discuss the charges because they are in litigation.

Becton-Dickinson Corp., in Franklin Lakes, NJ, is a defendant in more than 200 federal and state product liability lawsuits relating to latex gloves, but spokeswoman **Camilla Jenkins** says the company sold its latex gloves division in 1995. Becton-Dickinson is suing insurers for refusing to cover the company in those lawsuits.

When asked if Allegiance, a major manufacturer of powdered and powder-free latex as well as synthetic gloves, might modify its product lines depending on the outcomes of some 400 state and federal latex-related lawsuits against the company, spokesman **Geoffrey Fenton** replied, "Allegiance offers the broadest line of products and we intend to continue to do so."

Nevertheless, Shrager says the litigation will have a positive effect on the glove manufacturing industry.

"Once they feel comfortable facing up to their responsibility for what happened, they will in retrospect realize that the threat of litigation and the reality of litigation have given them the economic encouragement to produce safer gloves," he states. "This will also improve the quality and safety of medical care, encouraging industry to think of alternative products and to improve latex gloves without sacrificing what they believe to be the qualities of barrier protection offered by latex and the tactile sensation important to a lot of health care providers."

Shortcuts may have increased risk

The plaintiffs maintain that a warm-water wash of the latex would have removed most of the allergenic proteins from its surface, but this step of production was eliminated as one of the shortcuts taken by glove manufacturers to meet increased demand during the late 1980s, they allege.

This explanation also was offered by the Occupational Safety and Health Administration in a technical bulletin issued earlier this year,[1] as well as by the National Institute for Occupational Safety and Health in the latex hazard warning the agency published in 1997.[2]

Glove makers could have changed their manufacturing processes when the Food and Drug Administration (FDA) issued an alert in 1991,[3] says **Lise Borel**, DMD, a dentist disabled by occupational latex allergy who now is national president of the Education on Latex Allergy Support Team and Information Coalition.

"Given the nature of the warnings by the FDA and the notable increase in the number of cases reported right after universal precautions were implemented, there was an opportunity to make an immediate change that may have averted or reduced the amount of litigation that has come to be," says Borel, who became so ill from latex allergy and treatments that, at age 45, she has undergone five cardiac procedures and wears a pacemaker.

Borel is adamant that hospitals accept their share of the responsibility.

"They have to consider their glove and other [latex-containing] product purchases very carefully. Otherwise, they're just contributing to what their future patient care is going to be like. Hospitals have the responsibility to look at the safety features

Letter to the Editor

Editor:

The June 1999 issue of *Hospital Employee Health* reported on the recent congressional inquiry into the Occupational Safety and Health Administration's [OSHA] controversial technical information bulletin concerning latex allergies **["OSHA issues latex allergy warning amid intense storm of accusations," pp. 61-65]**. OSHA's bulletin advises health care workers to reduce their use of natural rubber latex gloves. While most of the reporting on the events surrounding the bulletin's issuance is balanced and fair, the article contains a serious inaccuracy.

The article correctly indicates I testified on behalf of Allegiance Healthcare Corp. The article also correctly indicates that Dr. Reed, an emeritus professor of medicine at the Mayo Medical School and retired head of the Division of Allergic Diseases and Internal Medicine at the Mayo Clinic, testified at the hearing and has acted as an advisor to Allegiance on this health issue. However, the article wrongly asserts that former U.S. Surgeon General C. Everett Koop, who also testified at the hearing, is a paid consultant to Allegiance. Allegiance did not and has not paid Dr. Koop in any capacity. The author's indication that Dr. Koop is a "paid consultant" does a disservice to the stellar reputation of Dr. Koop, who has worked tirelessly to educate the public about the risks of bloodborne pathogens and infectious diseases. It is also unfair to Allegiance, a provider of latex and non-latex gloves, who has been a leader in the effort to educate health care professionals about latex allergies.

Latex allergy is an important issue. Unfortunately, your June 1999 article suggests that the independent opinions of recognized health experts should be discounted if they consult for or simply agree with the position of a stakeholder in this debate. What we know today is that natural rubber latex medical gloves provide the best barrier protection against deadly bloodborne pathogens such as AIDS and hepatitis B and C. Scientific studies conducted by the government show that health care workers are at no greater risk for developing latex sensitivity than any other member of the general public. Powdered gloves are cost-effective and preserve the tactile sensitivity necessary to perform delicate medical procedures.

F. Samuel Eberts III
Associate General Counsel
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Editor's Note: Hospital Employee Health *apologizes for any misunderstandings about Dr. Koop's status with Allegiance Health Corp., but notes that Allegiance was given the opportunity to clarify the situation before publication. Despite a promise from a spokesperson to obtain the information about whether Dr. Koop is or ever was a paid consultant to Allegiance and four follow-up telephone calls from our editor, no one from the company responded until this letter was received.* ■

and risks associated with everything they use. They're as much responsible as the glove manufacturers are. They have the opportunity to be part of the process to stop the sensitization. It's the easier road to take when you look at the long-term effects," Borel says.

Some manufacturers have denied a correlation between natural rubber latex proteins and latex allergy in the pretrial process, Shrager notes.

"That's medical history revisionism of the worst sort," he asserts. "They don't concede anything. We hope they stay with that attitude because if they insist that the moon is made of green cheese, that will certainly compromise their real defenses. We think when the time comes, they'll be willing to deal fairly and appropriately with these cases. If their lawyers go sufficiently far and it becomes necessary to try a few cases, the price tag may go up for them."

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NEWS BRIEFS

Court denies challenge to respiratory standard

Occupational health nurses claim victory

The U.S. 11th Circuit Court of Appeals has denied a petition by the American College of Occupational and Environmental Medicine (ACOEM) challenging language in the Occupational Safety and Health Administration's (OSHA) respiratory protection standard that allowed nonphysicians to perform medical evaluations.

The Arlington Heights, IL-based ACOEM, which represents some 7,000 physicians, had requested a review of the standard's language that permits nonphysician licensed health care professionals to perform medical evaluations required by the rule. In April 1998, the American Association of Occupational Health Nurses (AAOHN) and the American Nurses Association (ANA) filed with the U.S. Court of Appeals to become intervening parties in the lawsuit. The registered nurses claimed that the ACOEM challenge would prevent them from being able to practice to the full extent of their licensed qualifications.

OSHA's respiratory standard requires surveillance activities that include determining if an employee is fit to wear a respirator and ensuring proper fit. Administering an employer's respirator program, which includes training and assessments, is also part of the standard.

The court ruled that the standard defers to state law on the question of who may provide required medical evaluation services.

"Our primary consideration is the health of workers," says **Robert J. McCunney**, MD, ACOEM president. "ACOEM is very concerned that the court ruling may result in someone other than a qualified physician making medical diagnoses and medical decisions."

AAOHN and ANA have long supported inclusion of broad-based language in OSHA standards for health surveillance requirements.

"This is a tremendous victory for registered nurses and other professionals trained to provide surveillance," says **Deborah V. DiBenedetto**, MBA, RN, COHN-S, ABDA, AAOHN president. "The court has recognized that nurses with the expertise, competencies, and training can provide safe, effective surveillance of occupational exposures. States hold the responsibility to regulate the scope in which nurses practice, and trained surveillance is well within our scope." ▼

NIOSH proposes study of needlestick alert

Goal is effective injury prevention tool

The National Institute for Occupational Safety and Health (NIOSH) plans to develop and evaluate an alert concerning the risk of needlestick injuries to health care workers.

In a proposed study, NIOSH will send the six- to 10-page alert to one of two individuals with formal responsibility for employee health and safety in hospitals: directors of health and safety, or directors of infection control.

NIOSH then plans to follow up with a randomly selected sample of 450 hospitals at two points. The alert recipient will be interviewed two to six weeks after the alert was sent, and the other employee health official who did not receive the alert will be interviewed 10 to 14 weeks later. The reason for the second interview is to determine how well the alert information was communicated to all key personnel with responsibility for employee health, explains NIOSH spokesman **Fred Blosser**.

Goals of the study are to assess whether and under what circumstances the alert encourages hospitals to adopt control measures, and to ascertain whether the information in the alert assists hospitals in implementing control measures, according to a NIOSH spokesman.

Presently in development, the NIOSH needlestick alert will be released sometime this fall. The alert will provide information on the extent of risk and practical guidelines for prevention. **(See related story in *Hospital Employee Health*, March 1999, pp. 25-28.)** In planning the alert and study, NIOSH notes the estimate of approximately 800,000 needlestick injuries every year. Needlesticks can expose HCWs to HIV and hepatitis B and C, and account for most occupational transmissions of those pathogens to HCWs. ▼

Angry, depressed workers create serious problems

Violence and low productivity top the list

Recent surveys show that employees who are angry or depressed have become a prevalent problem in the workplace, resulting in low productivity and ever-increasing explosions of violence.

The National Foundation for Brain Research in Washington, DC, says a survey of more than 400 human resource professionals reveals that depression is a common problem among workers, with a significant negative effect on workplace productivity.

"Each year, the United States loses $44 billion to lost productivity and medical treatment related to this illness," says **Lawrence S. Hoffheimer**, executive director of the foundation.

Only 5% of respondents to the survey indicated that their companies had mental health screening programs, and 39% of the 56% who said workplace depression was severe enough to affect productivity indicated that their company had a mechanism for measuring depression.

In another study presented at a recent meeting of the Academy of Management in Chicago, nearly 25% of 1,000 working adults responding to a telephone survey said they were "generally at least somewhat angry at work." This may help explain recent outbursts of workplace violence, says **Donald Gibson**, a co-author of the study.

The most common cause of workplace anger is actions of supervisors or managers, he says. Other top causes cited in the study are heavy workloads, dealing with the public, unproductive co-workers, tight deadlines, and being treated badly.

"There has been a lot of downsizing," says Gibson. "A lot of companies are leaner and meaner, and many of the workers who are left feel overworked and underappreciated."

While outbursts of violence often have disastrous consequences, so too can suppressed workplace anger, which has been linked with high blood pressure, depression, anxiety, and heart disease. ■

Literature Review

Fahey BJ, Henderson DK. **Reducing occupational risks in the health care workplace.** *Infect Med* 1999; 16:269-270, 273-275, 278-279.

Noting that some current investigations find bloodborne exposures are "device- or product-mediated," authors from the National Institutes of Health in Bethesda, MD, say that improvements in device design should substantially reduce occupational exposures. Safer design characteristics, as well as safer phlebotomy equipment, intravenous (IV) catheter systems, surgical equipment, and sharps disposal containers, are presented in a series of tables.

Safer technology is becoming more available, but the authors warn that specific areas of use within the hospital, with their differences in work conditions, must be considered in device selection. For example, a device that is useful in a structured patient care area may not be appropriate in emergency care settings.

In addition, device failures or occupational exposures may result from inappropriate use of safer devices. One example is an IV catheter safety system containing a plastic sheath that slides over the contaminated needle to help protect the user's hands; however, the sheath makes the catheter so bulky that it often requires two hands for operation. The additional maneuver makes the device difficult to use with uncooperative patients and has resulted in skin exposure to blood, the authors point out.

Studies of new device evaluations show some promising results in the areas of efficacy and

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cost-effectiveness, but some data are "far from encouraging," they add.

A Centers for Disease Control and Prevention (CDC) study demonstrated efficacy of three phlebotomy devices, and another study showed shielded disposable syringes contributed to a 75% decrease in needlestick injuries. However, another study of safety syringes in an emergency department found no associated exposure reduction.

Studies of needleless IV systems also show mixed results. While four studies concluded that the technology lowered the incidence of device-specific injuries, another study found that needlestick injuries continued despite needleless devices, possibly due to incorrect product use, low user acceptance, and continued use of traditional needle-containing devices in study areas.

A 12-month, three-hospital study of IV catheters found injury rates associated with safety catheters much lower than those related to conventional device use. Investigators concluded that although other factors may have contributed to the lower rates, effective safety devices may produce far more injury reductions than those achieved through education, training, and good needle disposal systems.

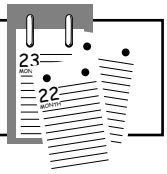
For occupational blood exposures in surgery, the authors discuss blunt suture needles. A randomized trial comparing glove punctures using a cutting needle and a blunt-tipped needle showed many fewer perforations with the latter. A CDC study found that blunt suture needles greatly reduced the incidence of needlestick injuries, had minimal adverse effects on patient care, and were well-accepted by surgeons.

The authors also mention puncture-resistant gloves, glove liners, and finger guards, but note that limited information is available to assess their efficacy in reducing blood exposures.

Needle disposal systems have been found to contribute to a rise in needlestick rates. OSHA and the CDC emphasize the importance of effective needle disposal systems, staff education, convenient disposal box location, and appropriate container placement.

The authors conclude that additional safety devices and studies are needed, as is staff education about the rationale and proper use of new technology. Health care facilities' product evaluation must be "consistent and rigorous," accompanied by "intensive education and training of the users of the technology and thoughtful integration into existing institutional policy and procedures." ■

CALENDAR



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After reading each issue of *Hospital Employee Health*, the nurse will be able to do the following:

- identify particular clinical, administrative, or regulatory issues related to the care of hospital employees;
- describe how those issues affect health care workers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on overall expert guidelines from the Centers for Disease Control and Prevention, the National Institute for Occupational Safety and Health, the U.S. Occupational Safety and Health Administration, or other authorities, or based on independent recommendations from clinicians at individual institutions. ■

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Hospital Employee Health®

Salaries remain flat as EHPs stay afloat in health care turmoil

Be prepared to meet the challenges ahead

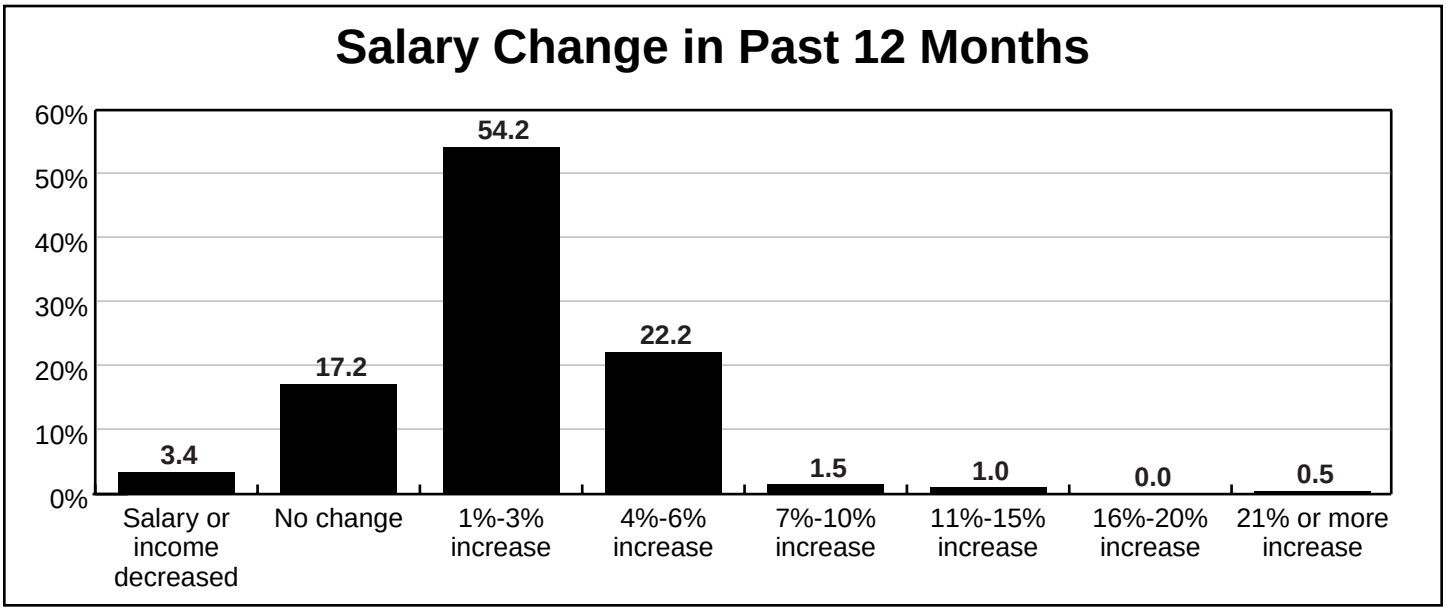
Salaries have largely remained flat over the past year for employee health practitioners, which is not surprising in the current climate of budget cutbacks and minimal raises in health care.

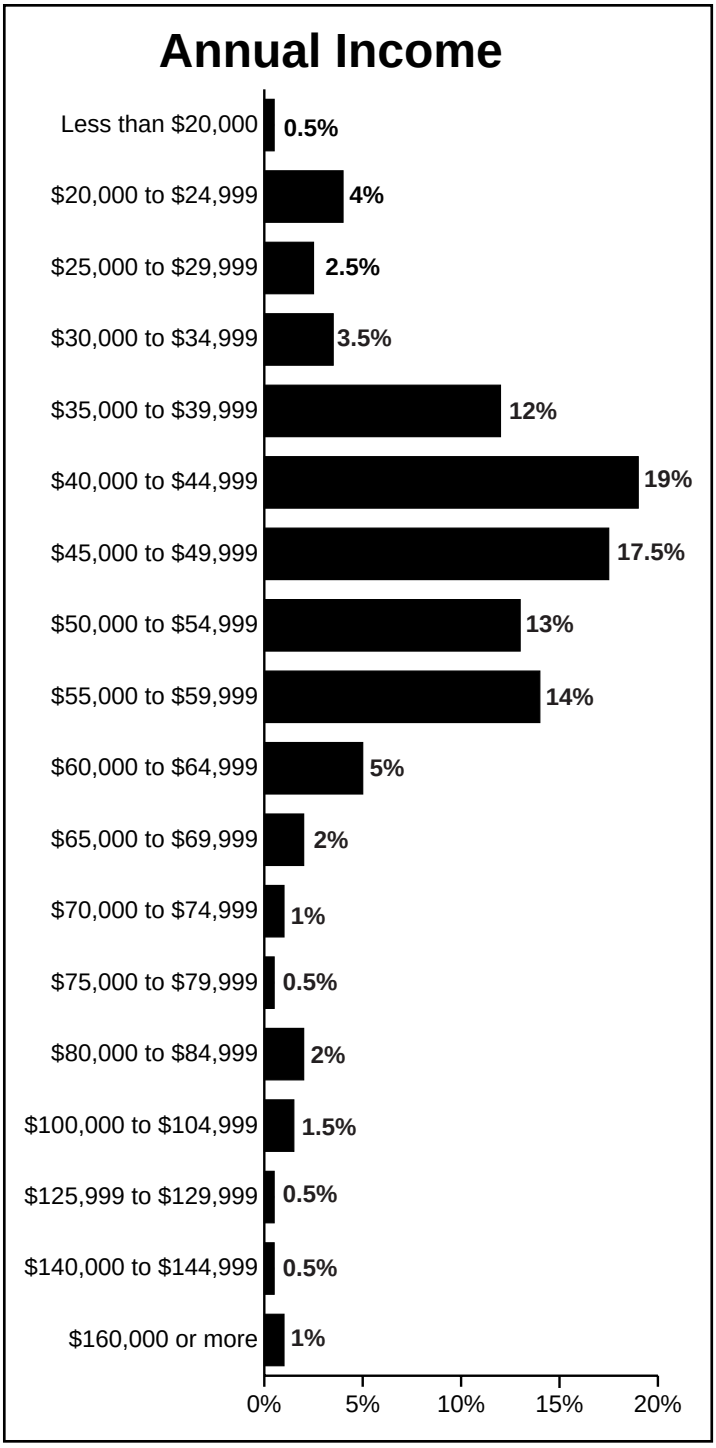
The numbers revealed in the exclusive 1999 *Hospital Employee Health* salary survey reflect the scene in health care today. Of those EHPs who received salary increases in the past year, the majority (54%) saw only between 1% and 3% more on their paychecks. For 17%, salary levels remained exactly the same in 1998-99 as in the previous year.

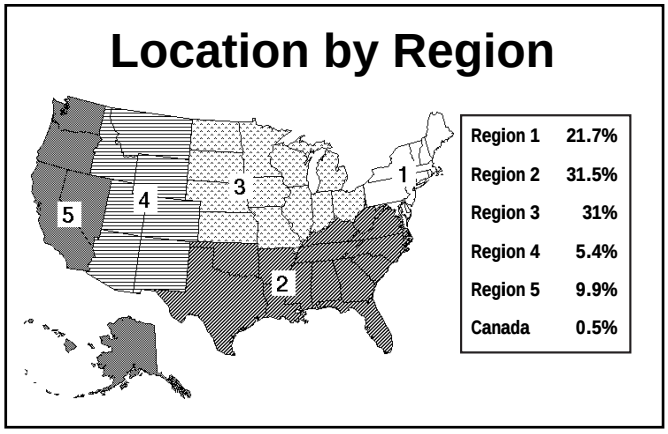
Each year, *HEH* sends subscribers a confidential salary survey form to complete and return. This year's results show that most annual earnings hover in the $35,000 to $50,000 range, the same as last year. An examination of the numbers by job title — employee health nurse, coordinator / manager, and director / administrator — indicate that most of those who earn salaries of $60,000 or more are employee health directors / administrators.

Most survey respondents work between 41 and 45 hours per week, supervise between one and three people, have worked in employee health between one and six years, and have earned a bachelor's degree. The highest proportion work in medium-sized nonprofit hospitals.

"Nobody's job is secure in health care today," says **Kathleen VanDoren**, RN, BSN, COHN-S,







former executive president of the Association of Occupational Health Professionals in Healthcare (AOHP) in Reston, VA. "The health care system is in such turmoil that hospitals are trying to operate with the bottom line in mind. There will be more major changes in health care in the coming years, and nobody's seat is secure."

In the 21st century, employee health departments will continue to be caught up in "cost-crunching," she adds, unless they can start proving their worth. On the other hand, the need for surveillance programs and immunizations will not decrease.

"In fact, I just attended a conference at which an employee health physician suggested that hepatitis A vaccine be part of routine immunizations for hospital plumbers and food handlers," she notes. "It is something I can see coming, and something I have recommended myself."

If employee health professionals feel overwhelmed by responsibility, VanDoren suggests prioritizing.

"We're nurses; ideally we like to do everything for everybody, but we may not be able to continue to offer some of the nice things, such as doing blood pressure checks for volunteers. We might have to look for what we can eliminate. When OSHA comes up with an ergonomics standard, you will have to fit that into your schedule. If you can't add on to your own staff, you'll have to look for help by bringing other departments onto your team," she says.

During the latter years of the 20th century, VanDoren has seen greater employee appreciation for the services of the employee health department. She hopes that hospital administrators will adopt the same viewpoint as the new millennium unfolds. Many administrators see EH departments as "a necessary evil," she says, because they don't understand the department's value.

While administrators often recognize that the department helps keep them from OSHA citations, they tend to be unaware of other aspects of the employee health service's value. However, with more OSHA regulations due to be issued in the next year or two and with the Joint Commission on the Accreditation of Healthcare Organizations taking a closer look at employee health functions, that could change. **(See *Hospital Employee Health*, October 1999, pp. 115-117.)**

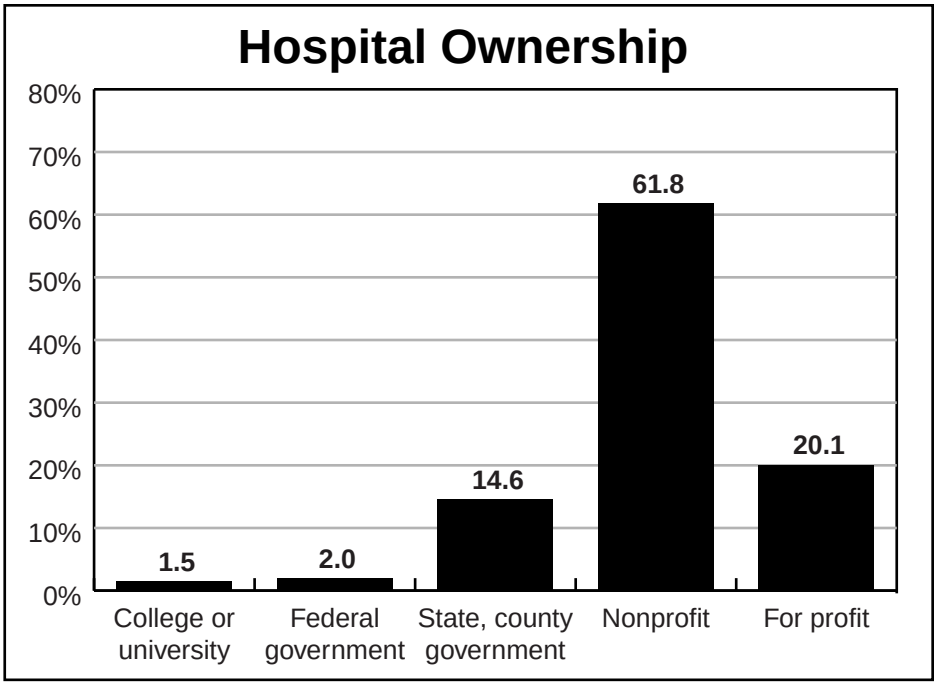
"If the Joint Commission would really scrutinize employee health — either by separate standards or more employee health applications of

existing standards — and focus on employee health when they do their surveys, that would be a terrific asset in showing the value of what employee health is doing," VanDoren says. "It would wake up administration and show them they need this department, what an advantage it is, and how much money they're saving the hospital, for example, in bringing employees back to work from injuries in modified duty positions."

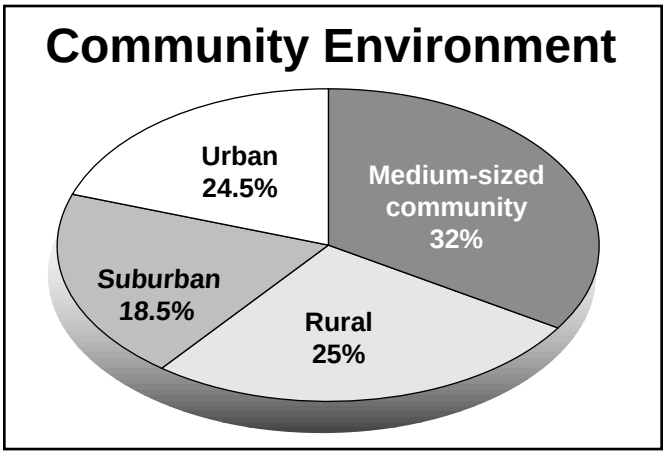
MaryAnn Gruden, MSN, CRNP, NP-C, COHN-S, newly installed executive president of the AOHP, agrees that the Joint Commission, OSHA, and the CDC are all becoming more aware of the EHS's role.

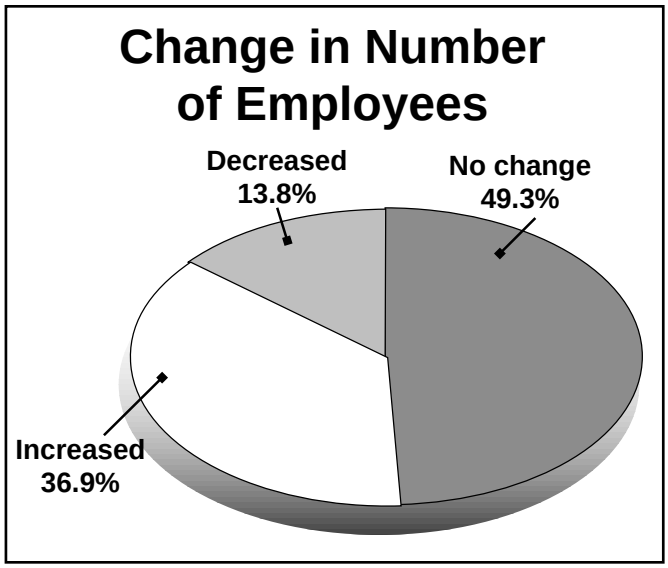
"There will be continuing opportunities for employee health as we go forward into the 21st century," says Gruden, who also is an employee health nurse practitioner at Sewickley Valley Hospital in Sewickley, PA. "We've begun to develop a national presence with the government and regulatory agencies that we need to comply with. There are challenges, too. In some areas of the country, employee health departments are closing due to downsizing, but in other areas, [employee health practitioners] are gaining more responsibility."

EHPs need to become more visible within the organization, she advises. This can be accomplished by participating on safety and infection control committees, joining professional associations, becoming certified, and staying current with developments in the field.



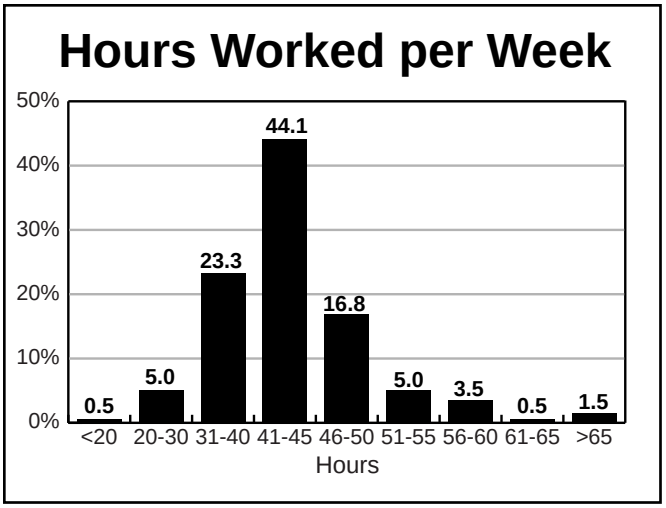
"We must demonstrate our ability to be cost-effective and productive in what we do," Gruden says. "That's a challenge, because we don't have clear-cut measures for that. How do you show how productive you are when you're trying to juggle clinical and administrative duties?"





In the past, employee health nurses tended to be in that position simply because they were close to retirement or were placed there for lack of another assignment in the hospital, but that isn't true for the majority anymore, she notes.

"Especially since the bloodborne pathogens standard, there is a need for professionals to have more knowledge and experience. People are going back to school to learn more about occupational health and to get advanced degrees. There are more opportunities now for that than there were 20 years ago," she states.



If organizations such as the Joint Commission start scrutinizing employee health functions within hospitals, they will be looking for a "competency-based practice," says **Jeanne Culver**, RN, COHN-S, clinical manager of employee occupational health services at Emory University Hospital in Atlanta.

However, this does not mean that only a separate occupational health department can provide employee health services. In many hospitals, infection control departments do a good job with those responsibilities, as long as they employ nurses with appropriate experience and expertise, she says.

"If a hospital has the resources and a large number of employees, it certainly behooves them to have specialists who are evaluating employees' fitness to do a job and monitoring their health. It does take specialists to be able to do that," Culver states. "The reality of it is that we're not living in an ideal world. It requires well-educated practitioners, no matter what department they're affiliated with. The only factor they're going to be judged by is whether the people who have the responsibility for employee health are qualified and competent."

EHPs of today and the future must be familiar not only with OSHA standards but also with the various state health department regulations, she adds.

"Hospitals are not just going to be able to put a nurse [in charge of employee health] who's close to retirement, who has no idea about occupational health hazards in a hospital environment. They wouldn't recognize an adverse event if they saw one," she says.

For employee health departments to continue to exist, they must become "collaborative," Culver asserts. "They must team up with other people who make their jobs easier. Their value will be found in being able to assume some responsibilities for things that are tangentially associated with the health and safety of employees. Cost containment is absolutely a priority for non-revenue-generating departments in hospitals. They have to demonstrate in concrete terms what their contributions are to the bottom line or they're not going to survive."

What does the future hold for employee health departments? "My hope is that we will be alive and well," Gruden says. "There's a lot of potential, but it will take a lot of work as well. In health care today, there are many external issues we have no control over, so that's why it's important to focus on the areas where we can really help the organization." ■

Salary Levels by Title

Annual Gross Income	Employee Health Nurse	Coordinator/ Manager	Director/ Administrator
less than $20,000	0%	1%	0%
$20,000 to $24,999	9%	1%	0%
$25,000 to $29,999	2%	4%	0%
$30,000 to $34,999	5%	4%	0%
$35,000 to $39,999	11%	13%	13%
$40,000 to $44,999	20%	20%	9%
$45,000 to $49,999	23%	15%	6%
$50,000 to $54,999	10%	20%	4%
$55,000 to $59,999	16%	13%	13%
$60,000 to $64,999	3%	6%	7%
$65,000 to $69,999	1%	1%	9%
$70,000 to $74,999	0%	0%	7%
$75,000 to $79,999	0%	0%	4%
$80,000 to $84,999	0%	2%	9%
$85,000 to $89,999	0%	0%	0%
$90,000 to $94,999	0%	0%	0%
$95,000 to $99,999	0%	0%	0%
$100,000 to $104,999	0%	0%	0%
$105,000 to $109,999	0%	0%	9%
$110,000 to $114,999	0%	0%	0%
$115,000 to $119,999	0%	0%	0%
$120,000 to $124,999	0%	0%	0%
$125,000 to $129,999	0%	0%	0%
$130,000 to $134,999	0%	0%	0%
$135,000 to $139,999	0%	0%	0%
$140,000 to $144,999	0%	0%	4%
$145,000 to $149,999	0%	0%	0%
$150,000 to $154,999	0%	0%	0%
$155,000 to $159,999	0%	0%	0%
$160,000 or more	0%	0%	6%