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Mr. Douglas Parker  
Assistant Secretary of Labor for OSHA  
Occupational Safety and Health Administration  
U.S. Department of Labor - OSHA  
200 Constitution Avenue, N.W.  
Washington, DC 20210

**Re: Comments on Occupational Exposure to COVID-19 in Healthcare Settings;  
Occupational Safety and Health Administration; Docket No. OSHA-2020-0004**

Dear Assistant Secretary Parker,

I am pleased to submit the following comments on the Occupational Safety and Health Administration's ("OSHA")'s "Occupational Exposure to COVID-19; Emergency Temporary Standard" ("Healthcare ETS" or "ETS"), Docket No. OSHA-2020-0004, published in the Federal Register of June 21, 2021, on behalf of the a coalition of companies that have medical clinics embedded within their operations and/or contract with or employ medical personnel, such as nurses or emergency response personnel at their facilities.<sup>1</sup>

These companies' medical clinics and operations were exempt from OSHA's Healthcare ETS for COVID-19 under the express exemption at 29 C.F.R. Section 1910.502(a)(2)(iii) for "[n]on-hospital ambulatory care settings where all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not permitted to enter those settings" ("screening exemption").

The Coalition is composed of a diverse group of national employers and trade associations, representing many industries, including manufacturing, petroleum refining and chemical manufacturing, aerospace defense, shipping/logistics, media and entertainment, and many more, with millions of employees across thousands of workplaces in every state in the Nation. The common thread among our coalition members is that they are responsible employers who care deeply about their employees' health and safety.

We understand that OSHA has reopened the comment period in part to solicit comments on the removal of scope exemptions, including the screening exemption. *See* 87 FR 16426, 16427

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<sup>1</sup> The Coalition notes that, while there are many different kinds of clinics for purposes of the Healthcare ETS, the Coalition's comments provided herein are narrowly tailored to clinics and emergency services that service employees.

(March 23, 2022). Under its “Removal of Scope Exemptions (e.g., ambulatory care facilities where COVID-19 patients are screened out; home healthcare)” section, OSHA states:

A final standard will be adopted under Section 6(b) of the OSH Act, which requires a finding of significant risk from exposure to COVID-19, rather than the finding of grave danger OSHA made in issuing the Healthcare ETS under Section 6(c) of the OSH Act. Section 6(b) requires that the standard substantially reduce or eliminate significant risk of material impairment of health to the extent feasible. In view of this different risk finding, OSHA is considering whether the scope of the final standard should cover employers regardless of screening procedures for non-employees and/or vaccination status of employees to ensure that all workers are protected to the extent there is a significant risk. OSHA seeks comment on this approach.

*See id.* As set forth below, the Coalition strongly urges OSHA to preserve the screening exemption.

As a fundamental backdrop to these comments, we wish OSHA to recognize and focus on the critical distinction between the universe of “patients” serviced by healthcare personnel working in embedded clinics from those serviced by healthcare personnel working in hospitals. While nurses, doctors, emergency technicians, etc. working in manufacturing facilities, refineries, on entertainment sets, in warehouses or distribution centers or the myriad of locations where employers provide medical clinics to their employees, may be professionally equivalent to their hospital counterparts, ***there is a fundamental difference between the clientele treated.*** Hospitals are designed to accept COVID-19 patients; embedded clinics are precisely the opposite. Employers have had systems in place for over two years now to prevent COVID-19 employees from reporting to work if they have or are suspected of being infectious with the coronavirus. Thus, the healthcare personnel at embedded clinics are providing care to a universe of employees who already have been identified as not having COVID-19.<sup>2</sup>

Beyond this, even when COVID-19 sneaks into the workplace, the services provided at embedded medical clinics are fundamentally different than those provided at hospitals – embedded clinic healthcare personnel simply do not treat COVID-19; healthcare workers in hospitals do.

For these reasons, and as further addressed below, we urge OSHA to maintain the screening exemption included in the ETS in any permanent COVID-19 standard developed.

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<sup>2</sup> This, of course, does not mean that these employees who are infectious with coronavirus do not ever enter the workplace. We recognize that workplace policies designed to keep infectious employees from entering are not 100 percent effective, particularly because asymptomatic or presymptomatic employees can be unaware of their COVID-19 positive status. However, this situation remains profoundly different from hospital settings that ***draw*** people with COVID-19 in.

### ***I. The Screening Exemption is Effective in Excluding Suspected and Confirmed COVID-19 Persons from Embedded Medical Clinics***

Even where infectious employees enter the workplace (which tends to happen when the local geographical area is experiencing a surge in cases), OSHA's screening exemption remains an effective tool in excluding suspected and confirmed COVID-19 persons from embedded medical clinics. Screening and barring data reviewed by coalition members show that far fewer employees in the medical clinics contracted COVID-19 than employees outside the medical clinics. This is also true of emergency medical personnel. Screening methods included, but were not limited to, self-assessment checklists, no-touch temperature screenings, COVID-19 testing, screening signage, and/or paper/electronic questionnaires.

For example, one employer reported that, for one of its sectors, which has about 25,000 employees (of which, there are about 15 total staff in health services), from March 2020 to April 2022, it had approximately 4,000 total positive COVID-19 employee cases (confirmed by test or health care provider), with **zero** total medical personnel who contracted COVID-19 from the workplace.<sup>3</sup> This is despite almost 7,000 total number of visits to the medical clinics during this time period. The employer has been screening and barring using a questionnaire that includes questions about COVID-19 symptoms and exposure and has refused entry due to a failed screenings almost twenty times. Outside of this sector, at another site, the site reported that it had between four to seven employees/contractors during the pandemic, with **zero** exposure to a COVID-19 case or any positive cases amongst the medical staff.

Additionally, in speaking with one doctor who is a contractor for one of the largest sites of a major manufacturer, the doctor reported that there have been **zero** work-related COVID-19 cases among his medical staff in 4,310 encounters at his two embedded medical facilities since OSHA issued the Healthcare ETS in June 2021.<sup>4</sup> Indeed, the doctor reported that he has "stacks and stacks" of completed screening checklists, and that, despite many employee clinical visits, he believes no COVID-19 cases came through his clinic. The site has not had **any** health professional have a positive case due to a workplace exposure.

Another employer reported that, at one site, in the last seven months, it too has had **zero** work-related cases of COVID-19 among the staff in its medical unit.<sup>5</sup> The employer reports that the rate of COVID-19 cases across its sites has typically been about 25 percent lower than that of the community, with some sites as much as 75 percent lower. Thus, even though some portion of employees were contracting COVID-19, especially during local area surges (albeit at a substantially lower rate than the local community generally), the medical personnel in the facility's clinics were not contracting COVID-19.

In looking plainly at rate of transmission, without regard to work-relatedness, another employer's data reveals that at one of its locations, the rate of transmission among clinic staff

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<sup>3</sup> Only two medical team members contracted COVID-19 and both cases were due to personal travel.

<sup>4</sup> Only one employee of the doctor's staff contracted COVID-19, and that employee contracted the virus from the employee's son at home.

<sup>5</sup> Only two medical unit staff members contracted COVID-19, and both had children who contracted the virus first.

was much lower than that of non-clinic employees. Additionally, the rate of transmission among clinic staff at four other locations was **zero** percent.

Moreover, one employer who conducted second-level screening (i.e., screening at the door to the clinic, after screening at the door of the facility) via COVID-19 testing found that screening correctly identified and allowed the employer to screen out those employees who were asymptomatic or presymptomatic.

This experience is corroborated across the board by coalition members, regardless of the geographic region in the country or the type of industry. One employer stated that its medicine and occupational health units were simply not affected – **at all** – by COVID-19, even when their manufacturing sites experienced waves of COVID-19 driven by local area surges. The numbers truly speak for themselves as to the effectiveness of OSHA’s screening exemption.

The Coalition recognizes that OSHA may be concerned about the potential “pencil-whipping” nature of screening – that is, that **employees** are no longer taking screening seriously and may be mindlessly completing their screening questionnaires (or even deliberately lying because they know they cannot get into a clinic if they fail their screening), resulting in false statements and lowering the utility of screening in detecting COVID-19 risks. To the extent OSHA is concerned about false statements/records provided by employees, the Coalition suggests that, rather than remove the screening exemption, OSHA include a requirement that employers provide information to their employees on the importance of honestly and accurately completing the screening. This requirement most efficiently could be done in the form of additional language added to employer screening questionnaires and/or signage stating that employees can be subject to discipline, up to and including termination, if knowingly falsely completing their screening questionnaire or misrepresenting their COVID-19 status.

Alternatively, or in addition, OSHA could require employer screening materials to include a statement similar to that required on vaccination self-attestations in the Vaccination and Testing ETS. *See* 29 C.F.R. Section 1910.501(e)(2)(vi)(C) (withdrawn). The Vaccination and Testing ETS required self-attestations of vaccine status to include the following language:

I declare (or certify, verify, or state) that this statement about my vaccination status is true and accurate. I understand that knowingly providing false information regarding my vaccination status on this form may subject me to criminal penalties.

*See id.* Either by warning employees of the possibility of discipline and/or of the potential criminal liability they could face for misrepresentation related to COVID-19, that surely would be a strong reminder to employees that they must take screening seriously, and would be a far fairer approach to address any concerns OSHA may have regarding “pencil-pushing” by employees than to impose an onerous set of compliance obligations on employers.

## ***II. There is No Scientific Basis for Removal of the Screening Exemption***

There is no scientific basis for elimination of the screening exemption. We understand that OSHA may be considering eliminating the screening exemption based on a concern that

screening does not detect the entire universe of potential infectious persons because it may not identify asymptomatic or pre-symptomatic individuals who are unaware of any recent close contacts. This is a subset of people who likely will be missed by screening. However, when OSHA issued its Healthcare ETS in June 2021, it was already well aware of this risk. For example, in the preamble to the Healthcare ETS, OSHA states, “Regular health screening for possible indications of COVID-19 is a first step in detecting employees who might be COVID-19-positive so those employees can seek medical care or testing, or inform the employer if they have certain symptoms. **While pre-symptomatic and asymptomatic infections and the non-specificity of COVID-19 symptoms make it difficult to quantify the accuracy of symptom screening in predicting COVID-19**, health screening is a strategy supported by the CDC and the American College of Occupational and Environmental Medicine (ACOEM).” See 86 FR 32376, 32452 (June 21, 2021) (emphasis added).

OSHA goes on to state, “ACOEM recommends that employers implement a medical surveillance program that includes educating and training employees on how to recognize when they may have COVID-19, in order to prevent employees with infections from entering the workplace. The CDC recommends that employers conduct screening at the worksite, or train employees to be aware of and recognize the signs and symptoms of COVID-19 and to follow CDC recommendations to self-screen for symptoms before coming to work. Screening for employee symptoms, particularly when combined with their recent activities (e.g., the likelihood they have had a recent exposure to COVID-19), can help determine if the employee is suspected to have COVID-19 or should be tested.” See 86 FR at 32452 (internal citations omitted).

Additional language from the preamble goes on to show that OSHA recognized the potential shortcomings associated with screening, but decided to support it not only as an overall mitigation strategy, but also as a mechanism for employers with medical clinics and/or onsite emergency medical personnel to be exempt from the standard, as long as these employers did not allow those who failed screening to enter their medical clinics:

- “Limited contact with potentially infectious persons is a cornerstone of COVID-19 pandemic management. For example, **screening** and triage of everyone entering a healthcare setting **is an essential means of identifying those individuals who have symptoms that could indicate infection with the SARS-CoV-2 virus**. Persons with such symptoms can then be triaged appropriately to minimize exposure risk to employees.” See 86 FR at 32430 (internal citations omitted) (emphasis added).
- “Symptoms-based screening is a standard component of infection control. This approach was recommended during the 2003 SARS epidemic (caused by SARS-CoV-1, a different strain of SARS) and is routinely recommended for airborne infections such as M. tuberculosis and measles, and as a general practice in infection control programs. **Because SARS-CoV-2 can be transmitted by individuals who are infected but do not have symptoms (asymptomatic and presymptomatic transmission), symptom-based screening will not identify all infectious individuals. However, persons with symptoms early in their SARS-CoV-2 infection are among the most infectious. Therefore, symptom-based screening will identify some of the highest-risk**

***individuals for SARSCoV-2 transmission and thereby reduce the risk to workers.***  
See 86 FR at 32430 (internal citations omitted) (emphasis added).

- “In general, the presence of COVID-19 symptoms can alert employees that they may have COVID-19, which will allow them to take appropriate next steps. Thus, by monitoring for COVID-19 symptoms through regular health screening, employees can better address their personal health and avoid potentially infecting other people by seeking medical attention and getting tested for COVID-19 as appropriate; informing their employer if they are suspected or confirmed to have COVID-19, including concerning symptoms; and remaining away from the workplace where appropriate. Therefore, ***health screening is an effective strategy for preventing the transmission of COVID-19 in the workplace.***” See 86 FR at 32453 (emphasis added).
- “Paragraph (a)(2)(iii) provides that the ETS does not apply to non-hospital ambulatory care settings where all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not permitted to enter those settings. This exception is intended to exclude from the standard certain healthcare providers ***that do not treat, and instead exclude from their facilities, people with suspected or confirmed COVID-19***, either because such treatment is not related to the nature of their practice or because the provider chooses not to engage in such treatment as a matter of policy. The exception will apply so long as the employer meets the exception’s conditions: ***the employer must screen each non-employee prior to entry, make a determination based on that screen whether the non-employee has suspected or confirmed COVID-19, and bar entry to that non-employee if it is determined that the non-employee has suspected or confirmed COVID-19.***” See 86 FR at 32564 (emphasis added).
- “As defined in paragraph (b), screen means asking questions to determine whether a person is COVID-19 positive or has symptoms of COVID-19. ***Although it is not a perfect tool, screening is an important aspect of a multi-layered approach to minimizing workplace exposures to COVID-19.***” See 86 FR at 32571 (emphasis added).
- “The employer needs to be aware that ***screening will not identify some employees who have COVID-19. Some individuals with COVID-19 may be pre-symptomatic (i.e., have not developed symptoms yet) or asymptomatic (i.e., do not develop symptoms over the course of infection) but can still transmit the virus.*** Therefore, in settings covered by the standard, employers must continue to follow all requirements of the standard, using employee health screening as only one component of a multi-layered approach.” See 86 FR at 32589 (emphasis added).

There is no new, additional scientific evidence that was not available to OSHA at the time it promulgated the ETS to suggest that the screening exemption should be eliminated. While certainly the Omicron variant was shown to be more transmissible (though, thankfully, less virulent) than previous variants, there does not appear to be any evidence to suggest that it caused more asymptomatic or presymptomatic cases. Indeed, in describing the Omicron variant, as it was on the rise in December 2021, the CDC stated, “Preliminary information from

South Africa indicates that there are no unusual symptoms associated with Omicron variant infection, **and as with other variants, some patients are asymptomatic.** See CDC "[Science Brief: Omicron \(B.1.1.529\) Variant](#)" (updated December 2, 2021) (emphasis added). The use of CDC's "as with other variants" in describing asymptomatic Omicron cases goes to suggest that there is nothing particular or unique about Omicron in terms of the number of asymptomatic cases. Thus, the effectiveness of screening now is essentially the same as it was back in June 2021, when OSHA promulgated its Healthcare ETS. Therefore, there is no scientific basis for eliminating the screening exemption.

### ***III. There is No Significant Risk of COVID-19 Transmission in Embedded Medical Clinics***

We understand that OSHA also may be considering eliminating the screening exemption in part because the agency believes it can do so legally based on the less stringent legal standard for Section 6(b) rulemaking compared to emergency rulemaking conducted under Section 6(c) of the OSH Act. As OSHA explains, "[a] final standard will be adopted under Section 6(b) of the OSH Act, which requires a finding of **significant risk** from exposure to COVID-19, rather than the finding of **grave danger** OSHA made in issuing the Healthcare ETS under Section 6(c) of the OSH Act. Section 6(b) requires that the standard substantially reduce or eliminate significant risk of material impairment of health to the extent feasible." See 87 FR at 16427 (emphasis added).

Indeed, as OSHA set forth in its Healthcare ETS, "OSHA recognizes that the grave danger is most elevated in those healthcare settings where people with suspected or confirmed COVID-19 are expected to be treated, but it also acknowledges that there is a subset of healthcare providers who elect not to treat such people and instead screen them out to prevent them from entering their facilities. Paragraph (a)(2) of the ETS therefore includes several scope exclusions for such employers, which are addressed in more detail in the following summary and explanation. This is not the only exception – several other exceptions are identified and explained in the following paragraphs – but focusing the ETS on settings where COVID19 is reasonably expected to be present is particularly significant because it is intended to tailor the ETS to address the grave danger OSHA has identified and the need for the ETS to address that danger." See 86 FR at 32562.

However, it is not at all clear that OSHA would have legal authority under Section 6(b)'s significant risk standard to impose compliance with the permanent healthcare COVID-19 standard on embedded medical clinics in non-healthcare settings. A resounding common theme among many coalition members is that their embedded medical clinics are **not** traditional healthcare facilities where employees would be allowed to go to be seen for suspected COVID-19 or any similar-type virus.<sup>6</sup> The same is true of onsite emergency medical personnel.

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<sup>6</sup> To clarify the distinction between general concierge clinic service, and the limited occupational health and/or triage services provided by embedded "clinics," many employers reported that they do not even call their embedded medical clinics "clinics" – rather, they call them some version of "medical units."

Coalition members overwhelmingly indicated that their medical clinics provide essentially two types of services: (1) routine, regulatory compliance occupational health services (e.g., respirator fit testing, fitness for duty, annual hearing testing, etc.); and (2) triage of workplace emergencies. Employers report that the medical services provided do not include diagnoses or treatment for personal medical conditions (never, even before the pandemic), and that basic patient diagnostic (concierge-type) care is not provided as a service. The units serve as a location to provide transactional services without direct patient care and medical treatment, with the exception of infrequent work-related medical emergencies.

One employer reported that its units are staffed by registered nurses, not doctors, and the services provided are typically limited to first aid and emergencies in the workplace. Additionally, employee visits tend to be quick – employees are “in and out,” with the average visit being less than 20 minutes. No follow-up medical care or continuity of care is provided. If an employee cannot get back to work the same day, they are referred out.

Another employer described the services provided in its units/clinics as generally limited to work-related injuries and emergencies, occupational health, and new hire physicals. No treatment services are provided. Indeed, the employer reported that all services must be related to work. For example, the units/clinics would not give out strep medication. Quite simply, outside routine occupational health and new hire physicals, the main objective of the units/clinics generally is to triage and cut response time for emergencies – *not* to provide concierge treatment.

Beyond all this, there are several other distinguishing factors that make the risks associated with COVID-19 at embedded medical clinics significantly less than the same risks at traditional healthcare facilities. First and foremost, coalition members require their employees to report to them before coming to work by calling from home if they test positive or are diagnosed with COVID-19, which provides an initial filter for excluding any confirmed cases from entering the medical clinics. The same goes for employees who might have been exposed or are otherwise suspected of having COVID-19. Employers communicate applicable return-to-work criteria for employees who have had close contact with a COVID-19 case, for example, for purposes of quarantine. To ensure employees do not choose their paycheck over their health, and in compliance with applicable law, many employers have also implemented flexible sick leave policies for employees who must isolate or quarantine.

Second, unlike a hospital or urgent care center, the embedded medical clinics are not available for use by the general population. Rather, the clinics are on secured sites where access to any location on site is denied to those who are not employees and who do not have business to conduct on site – without first going through visitor control and being escorted the entire time they are on site. As pointed out at the outset, because the population served by the clinics is generally limited to employees, and the population around the clinics is limited to employees and select authorized visitors, the universe of suspected and confirmed COVID-19 cases to come through the door is already much smaller than that for traditional healthcare settings. The same can be said for onsite emergency medical personnel, who do not serve members of the public.

Third, as demonstrated by the examples above, employers' clinics generally do not deal with or broadly operate with the same health issues and concerns with which traditional healthcare settings deal. Such clinics that restrict themselves to dealing with only an employee's onsite occupational injury/illness do not expose their medical staff to the same broad health risks as those healthcare clinics. They, for example, will (since the pandemic, screen and) provide first aid care for a cut, sprain, fracture or related injury that occurs during the workday while performing a job task and send them on for further off-site medical care by a doctor. Or, they will treat a work-related illness (such as inhalation of some work-related generated gas), but they will not see and treat an employee who comes in on a Monday with an injury he received over the weekend or after hours while playing a game or working around the house. Accordingly, even before the COVID-19 pandemic, innate features of embedded medical clinics make them unlike traditional healthcare settings and thus, the risks presented in embedded medical clinics are unlike those at traditional healthcare settings.

Fourth, coalition members are prepared in case an employee fails a screening while onsite. One employer, as part of its screening mechanism, implements a rundown flow with instructions on how an employee should be isolated if they fail their screening. Specifically, employees are directed to isolate outside the medical unit in an outdoor tent. The employee is then given a courtesy escort through a specific exit door and directed to call the employer from their car/house for further instruction. This is similar to the protocols implemented by another employer, which directs employees to go to their cars and contact medical unit/clinic personnel via telephone (not in person) if they experience COVID-19 symptoms while onsite.

Fifth, the embedded medical clinics have been quick to adapt to ensure they are not unintentionally drawing employees unknowingly infected with the coronavirus to the clinic. For example, one employer stated that, although the clinics historically had provided over-the-counter medicine for employees who experienced headache or upset stomach in the workplace, those services were immediately stopped when the pandemic started and have not resumed. Rather, Advil/Tylenol is available **outside** the clinic, with some medicines and bandaids for minor cuts available now in a vending machine. All of this goes to show the efforts made by coalition members to keep their medical clinic employees safe from any potential COVID-19 hazards.

Additionally, the coalition would like to note that, despite the fact that screening cannot always identify asymptomatic or pre-symptomatic cases, from a risk perspective, screening does keep out those who are likely to be the most infectious. OSHA states in the preamble to its Healthcare ETS that "persons with symptoms early in their SARS-CoV-2 infection are among the **most infectious**. Therefore, symptom-based screening will identify some of the highest-risk individuals for SARS-CoV-2 transmission and thereby reduce the risk to workers." See 86 FR at 32430 (internal citations omitted) (emphasis added). Indeed, for purposes of quarantine (not isolation), current CDC guidelines do not even require individuals who are up to date with their COVID-19 vaccinations and have had close contact with someone who has COVID-19 to quarantine, unless they experience symptoms. See CDC, "[Quarantine and Isolation](#)" (updated March 30, 2022). Accordingly, the fact that screening targets those who are most likely to transmit the virus means that barring those individuals if they fail a screening – which is the

criteria set forth under the screening exemption – is an effective method to keep employees in embedded medical clinics safe.

Finally, the Coalition shares one more resounding common theme among many coalition members, as a reminder to OSHA. Many facilities in general industry implement “double screening” – that is, **all** employees are subject to a first screening before they enter the building, and a second screening if they wish to visit the embedded medical clinic. This means that, except for the rare circumstance when someone starts feeling symptomatic while already onsite or is notified of a close contact while at work, the population in and around the medical clinic should be free of all suspected and confirmed COVID-19 cases. Importantly, some employers also implement different screening mechanisms for first v. secondary screening, making it more likely to catch suspected or confirmed cases. For example, one employer conducts heat mapping (i.e., no-touch temperature checks), in addition to normal screening for symptoms and close contacts, for all employees in its first screening. It then also conducts secondary screening for anyone who wants to enter its medical units.

Based on these factors, even without screening, it is arguable that there is no “significant risk” of COVID-19 hazards to embedded medical clinics or onsite emergency medical personnel.<sup>7</sup>

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<sup>7</sup> While the landmark decision by the Supreme Court in *Industrial Union Department, AFL-CIO v. American Petroleum Institute*, 448 U.S. 607 (1980), commonly known as the “Benzene” decision, relates to carcinogenicity risks, it may be useful to apply the principles set forth in this decision to the current situation. In the Benzene decision, the Court observed that “the requirement that a ‘significant’ risk be identified is not a mathematical straitjacket” and that the Secretary’s obligation was to “make a **rational judgment** about the **relative significance** of the risks associated with exposure to a particular carcinogen.” See 448 U.S. at 655, 656-57 (emphasis added). The Court offered the following illustration:

“If, for example, the odds are **one in a billion** that a person will die from cancer by taking a drink of chlorinated water, the risk clearly could not be considered significant. On the other hand, if the odds are **one in a thousand** that regular inhalation of gasoline vapors that are two percent benzene will be fatal, a reasonable person might well consider the risk significant and take appropriate steps to decrease or eliminate it. Although the Agency has no duty to calculate the exact probability of harm, it does have an obligation to find that a significant risk is present before it can characterize a place of employment as ‘unsafe.’”

See *id.* at 655 (emphasis added). As of April 16, 2022, the case rate in the United States is 11 per 100,000, or .011%. See The New York Times “Coronavirus in the U.S.: Latest Map and Case Count” (April 16, 2022). While clearly this is more than one in a billion, it is significantly less than one in a thousand, or .1%. And, what’s more, 11 per 100,000 is a rate that would never be experienced in a general industry medical clinic setting for the reasons outlined herein, including specifically the fact that embedded medical clinics are not open to the general public, typically only provide work-related and emergency services, and, importantly, exist in facilities that often already screen for COVID-19 at the building entrance. Given these factors, the risk of COVID-19 exposure to employees in embedded medical clinics is likely much closer to one in a billion than one in a thousand. Indeed, unlike hospital or urgent care settings, which draw those with COVID-19 in (i.e., persons suspected or confirmed to have COVID-19 should typically either stay home or go to the hospital or urgent care), embedded medical clinics that screen and bar actually **turn away** suspected and confirmed cases. Accordingly, based on

Regardless, the Coalition is not interested in a legal debate over whether the “significant risk” threshold would be met if OSHA were to apply the permanent healthcare standard to medical clinics and onsite emergency personnel. Rather, it provides these comments to urge OSHA to avoid that debate and preserve the screening exemption it included in the Healthcare ETS. Screening, as well as a myriad of other controls coalition members have implemented, have effectively protected healthcare workers at these general industry facilities from any significant risk of COVID-19 transmission in these settings.

***IV. It Would be Technologically and/or Economically Infeasible to Apply the Permanent COVID-19 Requirements to Embedded Medical Clinics***

Coalition members express concern that it would be technologically and/or economically infeasible and certainly unnecessarily time-consuming and operationally challenging to apply certain requirements of the Healthcare ETS, which acts as the proposed permanent standard, to their clinics. For example, one employer reported that it is extremely time consuming to put together policies and procedures in accordance with applicable law. This employer has a very comprehensive, robust set of COVID-19 policies and procedures for its entire workplace, but they are not organized in the way that the proposed permanent standard contemplates. It would take significant time, energy, and resources – which could be better kept towards advancing safety in a real way – to collect and condense and revise these separate policies and procedures to come into compliance with the proposed permanent standard, all with minimal to no safety benefit. Additionally, the employer reported that, after quickly and constantly adapting to keep up with the science, the company has learned how to manage COVID-19; it would be unwise at this point to unnecessarily “shake things up” for employees when there is no scientific reason for doing so, and when doing so could arguably result in further confusion, tension, and lack of confidence among employees.

Additionally, another employer reported concerns about complying with the proposed permanent standard’s physical distancing requirements. The Healthcare ETS states, “The employer must ensure that each employee is separated from all other people by at least 6 feet when indoors unless the employer can demonstrate that such physical distancing is not feasible for a specific activity (e.g., hands-on medical care).” See 29 C.F.R. Section 1910.502(h)(1). The employer described that, where the medical staff work, it is impossible to maintain physical distances. Although the physical distancing provision expressly incorporates an element of feasibility into the requirement, OSHA provided guidance that “[t]he burden is on the employer to demonstrate that it is infeasible to comply with the required physical distancing for a specific activity or workspace. If the employer can demonstrate that the space cannot be expanded, and that multiple employees must be in that space at the same time (i.e., that there are no other feasible alternatives that would permit 6 feet of physical distancing), the employer satisfies its burden under the physical distancing requirements. However, in such cases, employers must ensure that employees maintain as much physical distance as possible.” See OSHA [Healthcare ETS FAQs](#) #28. Employers are concerned about having to demonstrate infeasibility, particularly because compliance officers might issue citations without a thorough

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the Benzene decision, there is likely good question as to whether OSHA would be able to meet the legal threshold of “significant risk” with respect to these embedded medical clinics.

review of infeasibility, leading employers to then have to expend, if they can, significant resources towards defending (meritless) citations.

Employers also express concern about the proposed standard's masking requirements. Per the Healthcare ETS, "[e]mployers must provide, and ensure that employees wear, facemasks that meet the definition in paragraph (b) of [the ETS]; and [t]he employer must ensure a facemask is worn by each employee over the nose and mouth when indoors and when occupying a vehicle with other people for work purposes. The employer must provide a sufficient number of facemasks to each employee to comply with this paragraph and must ensure that each employee changes them at least once per day, whenever they are soiled or damaged, and more frequently as necessary (*e.g.*, patient care reasons)." See 29 C.F.R. Section 1910.502(f)(1)(i)-(ii). Although many employers' medical clinic staff and emergency medical personnel wear facemasks and/or respirators in their clinical setting, unfortunately, masking has become a political issue, and requiring employees to wear masks is difficult. In this increasingly tight labor market, the Coalition expresses concern over this requirement if the permanent standard were to apply to its embedded medical clinics.

Furthermore, coalition members expressed concerns about the ventilation and physical barrier requirements of the proposed permanent standard for similar reasons as those set forth above for physical distancing. For example, although coalition members recognize that there is an element of feasibility built into the ventilation provisions, they are concerned that this might not be so obvious to compliance officers, even if explained. See 29 C.F.R. 1910.502(k). Additionally, similar to the physical distancing requirement, while coalition members recognize that the physical barrier requirements of the ETS incorporate an element of feasibility – the provisions states that "[a]t each fixed work location outside of direct patient care areas (*e.g.*, entryway/lobby, check-in desks, triage, hospital pharmacy windows, bill payment) where each employee is not separated from all other people by at least 6 feet of distance, the employer must install cleanable or disposable solid barriers, ***except where the employer can demonstrate it is not feasible***" – members again express concern about the potential for misguided citations. See 29 C.F.R. Section 1910.502(i) (emphasis added).

Accordingly, it would be technologically and/or economically infeasible for embedded medical clinics to adhere to the proposed permanent standards requirements, and the screening exemption should be preserved.

Our comments to this point address the preservation of the screening exemption for general industry embedded clinics and emergency medical services. However, because coalition members are particularly troubled by the standard's potential existence in perpetuity, we provide a specific comment on that topic below.

#### ***V. To the Extent the Permanent Standard Applies, it Should Include a Sunset Provision***

To the extent that the permanent standard applies to embedded medical clinics and onsite emergency medical personnel – again, which it should not – it should include an express sunset provision. The Coalition understands that OSHA is seeking comment on whether the

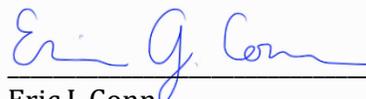
permanent standard should apply “not only to COVID-19, but also to subsequent related strains of the virus that are transmitted through aerosols and pose similar risks and health effects.” See 87 FR 16428. The Coalition urges OSHA to not take such an approach. This is in part because the ETS was designed to address the unique characteristics of transmission of the SARS-CoV-2 virus and required mitigation strategies and prevention techniques tailored to prevent transmission of this particular coronavirus. Accordingly, the permanent standard should include a sunset provision triggering automatic expiration based on some designated official status, such as issuance of OSHA’s infectious diseases standard, the President declaring an end to the National Emergency Status, the Department of Health and Human Services Secretary decision to not renew the Public Health Emergency, or the World Health Organization removing the global pandemic designation from the public health crisis description, whichever comes first. The standard should serve its purpose, and then expire.

Indeed, OSHA commenced a rulemaking to develop a more generic infectious disease standard applicable to the healthcare industry over a decade ago, but never completed that rulemaking. It would be inappropriate to short-circuit further rulemaking efforts on an infectious disease standard by keeping the permanent standard based on a COVID-19 Healthcare ETS “on the books” in its place. If OSHA wishes to promulgate a broader infectious disease standard to address a broad range of infectious diseases, it should pick up the rulemaking process set aside in 2017, and actively continue that process, rather than converting the ETS and this permanent rule into such a standard. Public participation in the emergency rulemaking process was by definition virtually non-existent, and also is severely limited in this abbreviated permanent standard rulemaking. A Section 6(b) rulemaking for infectious diseases will provide stakeholders a much better opportunity for input into the development of the standard and likely would result in a better standard than simply expanding the COVID-19 standard to cover all next versions of the coronavirus. This is not to say that the lessons learned from the mitigation strategies employed during this pandemic should not inform the agency in another, broader rulemaking to develop an infectious disease standard. However, the ETS should not automatically transform into that. It should expire upon the end of the SARS-CoV-2 pandemic.

### **CONCLUSION**

On behalf of our coalition members, we respectfully request that OSHA give meaningful consideration to these comments and recommendations in considering the development of any permanent COVID-19 healthcare standard.

Sincerely,



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