

April 21, 2022

Douglas L. Parker  
Assistant Secretary of Labor for Occupational Safety and Health  
Occupational Safety and Health Administration  
Department of Labor  
200 Constitution Avenue, NW  
Washington, D.C. 20210

OSHA-2020-0004

**Re: Reopening of Comment Period for Interim Final Rule Establishing an  
Emergency Temporary Standard (ETS), “Occupational Exposure to COVID-  
19”**

Dear Assistant Secretary Parker:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the Occupational Safety and Health Administration’s (OSHA’s) Emergency Temporary Standard (ETS), “Occupational Exposure to COVID-19.” We understand that OSHA is developing a final standard and thus seeks comment on specific topics and questions related to the ETS to help inform that process. Emergency physicians have been and continue to serve on the front lines combating the COVID-19 pandemic since it first arrived in the United States two years ago. We therefore are the most likely to be exposed to the disease and are well suited to help inform the COVID-19 safety standards that should be in place going forward.

In general, ACEP believes that the OSHA final standard should be *solely focused on protecting the health care workforce*. At times during the pandemic, the safety and wellbeing of health care workers were jeopardized because a priority was placed on ensuring an adequate supply of workers to staff health care facilities. For example, frontline workers infected with COVID-19 were often asked to return to work even when they were still positive and showing symptoms. ***Such policies that put health care workers and their patients at risk should be explicitly forbidden in the final standard.***

To make sure that health care workers are sufficiently protected, OSHA should use guidance released by the Centers for Disease Control and Prevention (CDC) as the basis for which to establish the *minimum safety standards* in its final standard. While hospitals and other facilities could establish protocols that are more stringent than the CDC guidance, the CDC guidance should serve as the minimum threshold for safety-related requirements. OSHA should also allow for flexibility as the CDC continues to revise its guidance. At the time that OSHA finalizes the standard, the agency should ensure that its safety requirements align with the latest CDC guidance. However, OSHA should also provide a safe harbor that allows hospitals to refine their protocols over time as CDC guidance evolves. Hospitals should not be penalized for following the latest CDC guidance.

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Another significant issue that has impacted emergency physicians and other practitioners working in the emergency department (ED) has been the lack of personal protective equipment (PPE). Insufficient PPE and other ancillary medical supplies resulted in a notable amount of contention and animosity between different hospital services (e.g., emergency department vs. inpatient ward vs. critical care units), health care staff, and hospital administrators, as well as health care personnel and the CDC during the initial phases of the COVID-19 pandemic. Multiple incidents occurred in which hospital administrators did not allow health care staff to utilize personally acquired PPE to supplant that which the hospital was conserving or could not supply. Furthermore, across the country, various levels of "airborne" vs. "droplet" precautions, protective measures, and cleaning protocols were utilized, sometimes because of the lack of sufficient PPE to conform to contemporary guidelines.

As OSHA considers a long-term standard around PPE and other “controls” against the spread of COVID-19, it should take into account this variability in the supply of PPE as well as each individual health care worker’s overall comfort level given the ongoing risk of contracting the virus. While we agree with OSHA’s idea to link its regulatory requirements for controls to measures of local risk in the community, OSHA should also allow physicians and other health care workers to protect themselves further and wear their own PPE if they feel unsafe with the level of protection their hospital/employer provides. **Physicians and other health care workers should also be protected from punishment and/or retaliation for taking additional safety precautions beyond those prescribed in the final OSHA standard.**

Current [OSHA standards around PPE](#) require employers to implement “PPE programs.” These programs should “address the hazards present; the selection, maintenance, and use of PPE; the training of employees; and monitoring of the program to ensure its ongoing effectiveness.” Unfortunately, some emergency physicians have found that the PPE programs instituted by hospitals during the pandemic have failed to protect them from the virus. First, many hospitals did not supply their employees with a sufficient level of PPE, requiring health care workers to reuse PPE beyond their intended use. While supply chain issues contributed to this practice initially, the reuse of PPE continued even after these supply issues were resolved. Second, as alluded to above, many of these PPE programs made it extremely difficult for health care workers to use their own PPE. Although it was technically allowed, hospitals would create numerous steps and hurdles before officially approving a health care worker’s own PPE for use. Lastly, there were concerns over the PPE properly fitting health care workers. Hospitals often changed the brands of PPE that were used, and there has not been sufficient fit testing supplies to ensure that the PPE have been properly worn. **Given these issues with PPE programs, ACEP requests that OSHA refine their requirements around PPE to ensure that health care workers have the flexibility they need to feel properly protected.**

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP’s Director of Regulatory and External Affairs, at [jdavis@acep.org](mailto:jdavis@acep.org).

Sincerely,



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ACEP President