Statement of the AFL-CIO
Before the Department of Labor Forum on Ergonomics
George Mason University, Arlington, Virginia

July 16, 2001

This statement is submitted on behalf of the AFL-CIO, a federation of 65 national and international unions representing 13 million working men and women and their families. It outlines the position of the AFL-CIO on why an OSHA ergonomics standard is urgently needed to protect workers in this country. It will be presented at the Department of Labor's ergonomic forum at George Mason University by AFL-CIO Secretary-Treasurer Richard L. Trumka and AFL-CIO Safety and Health Director Peg Seminario.

The AFL-CIO has a long and deep interest and involvement in the ergonomics issue. Musculoskeletal disorders (MSDs) caused by exposure to ergonomic hazards are the nation's biggest safety and health problem, affecting millions of workers each year. In all economic sectors and in most industries, ergonomic hazards are the major source of workplace injury and illness. Workers in meatpacking, poultry, auto assembly, nursing homes, transportation, warehousing, construction, agriculture and data entry are among those at risk.

For more than two decades, unions have been working hard to prevent these injuries through research, joint efforts with employers, union training programs, and by requesting OSHA enforcement actions under the general duty clause.

Since the late 1980's, we have been seeking an OSHA standard to prevent unnecessary musculoskeletal disorders and to control ergonomic hazards. It has been eleven years since former Secretary of Labor Elizabeth Dole committed the Department of Labor to "taking the most effective steps necessary to address the problem of ergonomic hazards on an industry-wide basis" and to develop an ergonomics standard.

After years of struggle against fierce industry and right wing political opposition, workers finally won protections against ergonomic hazards when OSHA issued its Ergonomic Program management standard in November, 2000. This standard, while not fully protective, was a major step forward in efforts to protect workers from work-related MSDs. It was based on sound and extensive science and patterned after the successful ergonomics programs in place in many workplaces. It would have prevented hundreds of thousands of unnecessary painful injuries each year.

But, with President Bush in the White House and Republicans in control of the Congress, the Chamber of Commerce, National Association of Manufacturers, UPS and other business opponents of ergonomic protections wasted no time in seeking to overturn this rule. At the beginning of March at the urging of business groups, in a blitzkrieg like move, Congressional opponents brought a resolution of disapproval to overturn the ergonomics rule to the floor of the

Senate and then the House. In less than 48 hours, with no hearings and little debate, the standard which was more than 10 years in the making, was overturned. On March 21, 2001, President Bush, in his first significant legislative act, signed the legislation repealing this important standard, leaving workers with no legal protection against the nation's biggest job safety problem.

Since this cruel act, more than 500,000 workers have suffered unnecessary injuries and illnesses, many serious and disabling, as a result of exposure to ergonomic hazards.

When the OSHA ergonomics standard was overturned, Secretary of Labor Elaine Chao promised that the Administration would pursue a comprehensive approach to ergonomics to protect workers from injuries. President Bush reaffirmed that commitment, stating that the "safety and health of our Nation's workforce is a priority for my Administration." But over the past four months, the administration has done no such thing. Instead, the administration has refused to commit to or take any action to protect workers and has continued to cow tow to business interests.

Testifying in late April before the Senate Appropriations Subcommittee for Labor, Health and Human Services and Education, Secretary Chao set forth no plans for addressing ergonmic hazards and refused to commit to any timetable for a standard or any actions to protect workers, instead stating that no action could be taken until a consensus was reached.

Several days later, the President nominated one of the lead industry opponents of ergonomic protections, Eugene Scalia, to be the Solicitor of Labor, a position with significant regulatory and enforcement responsibilities. Mr. Scalia, is not just an opponent of regulation, but is an anti-ergonomics zealot, calling ergonomics "junk science," stating that unions' only interest in an ergonomics standard is to increase the number of jobs and dues paying members and opposing efforts of the Labor Department to take enforcement actions on ergonomic hazards under the OSHAct's general duty clause even in industries where injuries are at epidemic proportions.

Appearing again before the Senate Appropriations Subcommittee for Labor, Health and Human Services and Education on May 2, 2001 and before the House Appropriations Subcommittee on May 22, 2001, Secretary Chao still refused to provide any plans for action on ergonomics.

And then at the end of June, bowing again to industry pressure, Secretary Chao announced that the Department of Labor was postponing the provisions of OSHA's regulation on Recording and Reporting Occupational Injuries and Illnesses that define and classify musculoskeletal disorders. The NAM and other industry opponents have made clear that they want to change the definition and recording of musculoskeletal disorders so that fewer injuries are identified and recorded. With its action to postpone the recordkeeping provisions for MSDs, it looks like the Department of Labor is following the industry's script and hopes it can simply define the problem of MSDs away.

And now the Department of Labor is conducting 3 public forums on ergonomics that are a one-sided exercise examining only questions raised by industry opponents in a continued effort to sow confusion and obfuscate the issue. The most important question - how can we protect workers from these crippling injuries - has not even been asked.

The questions that have been posed - what is an ergonomics injury, how can OSHA, employers, and workers determine whether an ergonomics injury is was caused by work, and what are the most useful and cost-effective types of government involvement to address ergonomic injuries - have already been asked and answered many times. They were asked and answered in 1992, when the Department of Labor issued an advanced notice of proposed rulemaking on ergonomics. They were asked and answered again in 1995 when the Department held stakeholder meetings and circulated a draft ergonomics standard, and again in 1999 when the ergonomics standard was formally proposed. These questions were also posed by the Congress to the National Academy of Sciences - twice. And in two reports, one in 1998, the other in 2001, the National Academy of Sciences answered these questions.

We know what these injuries are - they are injuries to the muscles, tendons nerves and other soft tissues like carpal tunnel syndrome, tendinitis and back injuries. They are painful, disabling and crippling injuries that devastate workers lives.

We know what hazards at work cause these injuries - it's forceful and repetitive jobs, like those in poultry processing where workers process thousands of chickens a day; it's the heavy lifting done by nursing home workers, warehouse workers and delivery workers and it's the vibration from tools and machinery that destroy workers' nerves.

And we know what the government should do to address the problem. It must issue a strong ergonomics standard to protect all workers that requires employers to take action to reduce and if possible eliminate these hazardous exposures, before workers are hurt or injured.

The American people did not vote last year to take away protections for working families. They didn't vote to let hundreds of thousands of workers every year to continue to suffer disabling injuries that we know how to prevent. After more than a decade of effort to address the biggest job safety hazard facing workers, the American people did not vote to go back to the starting line again.

What American workers need is what they were promised when the OSHAct was passed 30 years ago: the right to a safe and healthful workplace, the right to be able to come home in the same condition they go to work in every day, the right to do their jobs without being crippled or injured. We have come today to demand that the promise be kept. We will accept nothing less.

DETAILED POSITION OF THE AFL-CIO ON THE NEED FOR AN OSHA ERGONOMICS STANDARD

Work-Related Musculoskeletal Disorders are the Nation's Leading Job Safety Problem

Work-related musculoskeletal disorders are the leading type of occupational injury and illness in America today. These disorders include upper extremity disorders such as carpal tunnel syndrome, tendinitis, tenosynovitis, and rotator cuff injuries, and disorders of the low back. The Bureau of Labor Statistics (BLS) reports that over 582,000 musculoskeletal disorders involving days away from work were reported by private sector employers in1999, accounting for more than one in three of all injuries and illnesses involving recuperation away from work. The National Academy of Sciences, in its January 2001 report, found that approximately one million people lose time from work each year due to musculoskeletal disorders.

While the total number of lost-time MSDs reported by the Bureau of Labor Statistics has declined since 1992, the problem of workplace MSDs is still great. Despite the downward trend in total numbers of reported cases, MSDs have consistently accounted for more than one-third of total lost worktime cases since 1992. More disturbing, the downward trend in the numbers and rates of reported MSDs is by no means universal. Indeed for some types of MSDs the rates are increasing; in many industries the overall rates of MSDs are on the rise.

According to the most recent BLS survey, the rate of lost workday injuries associated with repetitive motion rose from 1998 to 1999 in every industrial sector except finance, and increased over 9 percent nationally. The rate of lost workday injuries caused by overexertion increased in construction and mining in 1999.

A detailed analysis conducted by the AFL-CIO of BLS data shows that from 1998 to 1999 the rate of lost workday injuries and illnesses involving musculoskeletal disorders (as defined by the BLS)[1] increased in about half of the industry sectors. Industries where increases in lost workday MSD rates were reported include meatpacking (SIC 2011), poultry processing (2015) bakery products (SIC 205), numerous textile and garment industries (SIC 221, 224, 226, 228, 223, 238,

[1]BLS definition of injuries and illnesses with days away from work involving musculoskeletal disorders: Includes cases where the nature of injury is: sprains, strains, tears; back pain, hurt back; soreness, pain, hurt except back; carpal tunnel syndrome; hernia; or musculoskeletal system and connective tissue diseases and disorders and when the event or exposure leading to the injury or illness is: bodily reaction/bending, climbing, crawling, reaching, twisting; overexertion; or repetition. Cases of Raynaud's phenomenon, tarsal tunnel syndrome, and herniated spinal discs are not included. Although these cases may be considered MSDs, the survey classifies these cases in categories that also include non-MSD cases. (Lost Worktime Injuries and Illnesses: Characteristics and Resulting Time Away From Work, 1999, Bureau of Labor Statistics, U.S. Department of Labor, March 2001.

and 239), grocery stores (SIC 541), building services (SIC 734), computer and data processing services (SIC 737) and hospitals (SIC 806). (See Appendix A).

In many of these sectors, these increases follow years of declining MSD rates that occurred after OSHA general duty enforcement actions in these industries in the late 1980's and early 1990's. These 5(a)(1) enforcement actions resulted in corporate wide settlements, the establishment of ergonomic programs and the reduction in injuries. However, these agreements have long since lapsed and there has been no follow-up government action to ensure that ergonomic programs are maintained or hazards abated.

It is important to recognize that the large numbers of injuries reported by the BLS and NAS, however, do not represent the total scope of the problem of musculoskeletal disorders. These cases represent only those injuries and illnesses which result in more than one day of lost time from work. Based upon the ratio of non-lost work-time injuries to lost work-time injuries which occur in the workplace, (2 to 1), the Department of Labor has estimated that a total of 1.8 million MSDs are reported by employers to the Bureau of Labor Statistics each year.

But even this number understates the magnitude of the problem. The BLS survey only reports injury and illness data for the private sector. The injury experience of the more than 16 million state, county and local public sector workers, and 2.8 million federal sector workers, including postal workers, is not reflected in the survey (Employment and Wage Annual Averages, 1997, BLS, 1998). While comprehensive and detailed injury data for these groups of workers is not collected, the data that is available shows that MSDs are a major problem for these workers as well. For the 28 states and territories where injury and illness data is collected for state and local public employees, in 1998, the BLS reported 63,374 musculoskeletal disorders that resulted in lost work days.

There is also extensive evidence that the BLS survey understates the extent of the MSD problem for private sector workers. More than 16 studies submitted to the record of OSHA's rulemaking on ergonomics demonstrated significant under recording and under reporting of workplace injuries. Based on this evidence OSHA found that "for every reported MSD, another MSD goes unreported. Thus, the total number of work-related MSDs estimated by OSHA to occur in the United States annually is 3.6 million." (OSHA, 2000) This estimate does not include MSDs suffered by state, local or federal employees.

A comparison of data from the BLS survey, workers' compensation data and surveillance data for several states confirms that the BLS data under-represents the extent of work-related MSDs. A review by the AFL-CIO of available BLS data and state workers' compensation data on musculoskeletal disorders for three states ─ Massachusetts, Oregon and Washington ─ for a several year period in the 1990's found that the numbers of cases of MSDs reported to BLS were significantly less than the number of MSD cases accepted for workers' compensation - in many instances 50 percent less. These differences are even more significant since the criteria for compensation are much more restrictive than the recording and reporting criteria under the BLS

survey (i.e. compensation for MSDs required 4 or 5 days off the job, compared to one day of lost time for reporting to BLS). See Appendix B.

Recent studies have demonstrated that only a small percentage of workers suffering from work-related back injuries, carpal tunnel syndrome and other musculoskeletal disorders are filing workers' compensation claims for these injuries. A study published in the January 2000 Journal of Occupational and Environmental Medicine found that only 25 percent of the group of Michigan auto workers studied with diagnosed work-related musculoskeletal disorders filed for workers' compensation (Rosenman et al, 2000). A similar study of Connecticut workers found that only 10 percent of workers with musculoskeletal disorders filed workers' compensation claims (Morse et al, 1999).

Based upon these studies, it appears that the under reporting of MSDs may be far greater than found by OSHA in its ergonomics rulemaking and the true magnitude of work related MSDs far greater than 3.6 million cases a year.

Work-related MSDs are among the most severe injuries facing American workers. The BLS reports that among major disabling injuries and illnesses, median days away from work are highest for carpal tunnel syndrome (27 days). This is significantly higher than the median days away from work for fractures or amputations.

While MSDs occur in every sector and industry across the economy, some sectors have been hit harder than others. Over one quarter of all MSDs involving time away from work occur in the service sector and over one quarter in manufacturing. Nursing aides, orderlies, and attendants, along with registered nurses, accounted for almost 10 percent of all lost time work-related MSDs in the U.S. in 1999. Air transportation, nursing and personal care facilities, beer, wine and distilled beverages, and grocery stores are among the industries with the highest rates of MSDs.

BLS data show that for many types of MSDs involving the upper extremities, including carpal tunnel syndrome, women workers suffer a disproportionate number of injuries. In 1999, women suffered 67 percent of reported carpal tunnel syndrome cases (18,651) and 61 percent of reported tendinitis cases (10,127) even though women comprise about 46 percent of the workforce and accounted for 33 percent of total workplace injuries (BLS, 1999). As with other musculoskeletal disorders, the number of cases of carpal tunnel syndrome, tendinitis and other repetitive motion injuries reported by BLS understates the extent of the problem found among these workers.

Ergonomic hazards are also a significant problem for workers in construction, maritime and agriculture. These sectors should be covered by an OSHA ergonomics standard just as they are currently covered by standards in the states of California and Washington. According to the BLS survey, in 1999 there were 59,092 reported cases of lost-time injuries involving MSDs in these sectors. These types of injuries accounted for 25 percent of all reported lost work-time injuries in construction, 24 percent of reported lost time injuries in maritime (SIC Codes 44 and 373), and 20 percent of reported lost work-time injuries in agriculture. A large percentage of construction

workers suffer from back injuries, shoulder injuries and other musculoskeletal disorders.

Defining Musculoskeletal Disorders

The Department of Labor has requested comments on the following question: "What is an ergonomics injury? The Department of Labor is interested in establishing an accepted definition that the Occupational Safety and Health Administration, employers and their employees can understand and apply."

Contrary to the claims of industry opponents, the AFL-CIO believes that establishing a definition of an "ergonomics injury" is a straight forward matter. While there are many different types of injuries associated with ergonomic hazards, for the immediate task, we believe that DOL should develop and issue a new standard that is focused on reducing exposure to the physical workplace factors that cause musculoskeletal disorders (force, repetition, awkward postures, heavy lifting and vibration). While ergonomic injuries and illnesses such as vision problems associated with computer use, and job stress from poor work organization are a real concern, we believe that a standard that is directed at reducing or eliminating exposures to the physical workplace hazards that cause MSDs is the most effective action that the agency can take. This has been the approach that the agency has taken in its enforcement actions, the meatpacking guidelines, and November 2000 ergonomics standard. Reducing exposure to physical workplace ergonomic risk factors and preventing MSDs are also the focus of most employer and union ergonomic programs.

While the popular terminology for these injuries has varied (e.g. CTDs, RSIs, MSIs, MSDs) the operational definitions utilized by OSHA for more than a decade in guidelines, enforcement and standards have been quite similar, as have the definitions utilized by employers.[2] For example, in 1990 OSHA defined the term CTD in its meatpacking guidelines as:

> "CTDs is the term used in these guidelines for health disorders arising from repeated biomechanical stress due to ergonomic hazards. Other terms that have been used for such disorders include "repetitive motion injury," "occupational overuse syndrome," and "repetitive strain injury."
> "CTDs are a class of musculoskeletal disorders involving damage to the tendons, tendon sheaths, synovial lubrication of the tendon sheaths, and related bones, muscles, and nerves of the hands, wrists, elbows, shoulders, neck and back. The more frequently occurring occupationally induced disorders in this class include carpal tunnel syndrome, epicondylitis (tennis elbow), tendonitis, tensynovitis, synovitis, stenosing tenosynovitis of the finger, DeQuervain's Disease, and low

[2] See Appendix C for a comprehensive listing of definitions for MSDs utilized by OSHA and the National Academy of Sciences.

back pain." (Ergonomics Program Management Guidelines for Meatpacking Plants, 1990, (1993 reprinted) p. 20) .

A similar definition of CTD was utilized in most of the corporate wide settlement agreements on ergonomics in the late 1980's and early 1990's.

> "The term CTD shall include but is not limited to the following conditions: CTDs are chronic soft tissue problems of the musculoskeletal and peripheral nerve system. Examples of specific diagnoses within this class of disorders includes tendonitis, tenosynovitis, synovitis, carpal tunnel syndrome, stenosing tenosynovitis of the fingers (trigger finger), epicondylitis (tennis elbow or golfer's elbow), and low back strain." (Corporate Wide Settlement Agreement, General Motors Corporation, 02/05/1991).

The November 2000 Ergonomics Program Final Standard utilized the term "musculoskeletal disorder " (MSD), but the definition was similar encompassing disorders to the body's soft tissues that occur as a result of chronic, repeated exposures:

"Musculoskeletal disorder (MSD) is a disorder of the muscles, nerves, tendons, ligaments, joints, cartilage, blood vessels, or spinal discs. For purposes of this standard, this definition only includes MSDs in the following areas of the body that have been associated with exposure to risk factors: neck, shoulder, elbow, forearm, wrist, hand, abdomen (hernia only), back, knee, ankle, and foot. MSDs may include muscle strains and tears, ligament sprains, joint and tendon inflammation, pinched nerves, and spinal disc degeneration. MSDs include such medical conditions as: low back pain, tension neck syndrome, carpal tunnel syndrome, rotator cuff syndrome, DeQuervain's syndrome, trigger finger, tarsal tunnel syndrome, sciatica, epicondylitis, tendinitis, Raynaud's phenomenon, hand-arm vibration syndrome (HAVS), carpet layer's knee, and herniated spinal disc. Injuries arising from slips, trips, falls, motor vehicle accidents, or similar accidents are not considered MSDs for the purposes of this standard." (November 14, 2000 Ergonomics Program Final Rule, 1910.900(z), 65FR68853)

The definition of MSD utilized by OSHA in its November 2000 final ergonomics standard is totally consistent with the definition of musculoskeletal disorder set forth by the National Academy of Sciences in its January 2001 report *Musculoskeletal Disorders and the Workplace:*

"1. What are the conditions affecting humans that are considered to be work-related musculoskeletal disorders?

"The disorders of particular interest to the panel, in light of its charge, focus on the low back and upper extremities. With regard to the upper extremities, these include rotator cuff injuries (lateral and medial), epicondylitis, carpal tunnel syndrome, tendinitis, tenosynovitis of the hand

and wrist (including DeQuervains' stenosing tenosynovitis, trigger finger, and others) and a variety of nonspecific wrist complaints, syndromes, and regional discomforts lacking clinical specificity. With regard to the low back, there are many disabling syndromes that occur in the absence of defined radiographic abnormalities or commonly occur in the presence of unrelated radiographic abnormalities. Thus, the most common syndrome is nonspecific backache. Other disorders of interest include back pain and sciatica due to displacement and degeneration of lumbar intervertebral discs with radiculopathy, spondylolysis, and spondylolisthesis, and spinal stenosis (ICD 9 categories 353-357, 722-724, and 726-729)." *Musculoskeletal Disorders and the Workplace: Low Back and Upper Extremities*, National Research Council and Institute of Medicine (2001).

The definition of MSD that was utilized by OSHA in the November 2000 final standard and incorporated into the January 2001 Part 1904 Regulation - *Recording and Reporting Occupational Injuries and Illnesses* (1904.12(b)) is a sound definition that has a scientific basis, is easy to understand and can be practically applied by employers, unions, workers, the government and safety and health professionals. It should be maintained and utilized in future government initiatives on ergonomics and OSHA's recordkeeping regulation.

Determining Whether MSDs are Work-Related

The Department of Labor has also requested comments on: " How can the Occupational Safety and Health Administration, employers and employees determine whether an ergonomics injury was caused by work-related activities or non-work-related activities; and, if the ergonomics injury was caused by a combination of the two, what is the appropriate response?"

The AFL-CIO believes that the answer to this question is also a straight forward matter that has already been answered by the Department of Labor in its new regulations on recording occupational injuries and illnesses that Secretary Chao has announced will be implemented in January. The work-relatedness of MSDs should be determined using the same criteria as determining the work-relatedness for all injuries and illnesses, approaches that have been utilized by OSHA and employers successfully for years.
Under the Department of Labor's 1986 Recordkeeping Guidelines for Occupational Injuries and Illnesses, an injury or illness is work-related when it results from an event or exposure in the work environment. An occupational injury is defined as an injury that results from a work accident or from an exposure involving a single incident in the work environment. The term occupational illness applies to those conditions or disorders that are caused by repeated exposure to environmental factors associated with employment. An illness is considered work-related if exposure to a workplace agent causes, contributes to or aggravates the disorder or condition.

OSHA's new recordkeeping regulation includes similar provisions for determining work-relatedness of injuries and illnesses. Under the new revised regulation an injury or illness must be considered to be work-related "if an event or exposure in the work environment either caused or

contributed to the resulting condition or significantly aggravated a pre-existing injury or illness. Work-relatedness is presumed for injuries and illnesses resulting from events or exposures occurring in the work environment, unless an exception in Section 1904.5(b)(2) specifically applies" (Recording and Reporting Occupational Injuries and Illnesses Section 1910.5).

These definitions and criteria for work-relatedness have applied to musculoskeletal disorders just as they have to determining the work-relatedness for all workplace injuries and illnesses. Under the new recordkeeping regulations the criteria for determining work-relatedness also apply to musculoskeletal disorders. On June 29, 2001 Secretary Chao announced that the Department would put this provision of the regulation into effect as scheduled January 1, 2002. That decision was correct. There is no reason that different criteria for determining work-relatedness should apply to MSDs than apply to all other occupational injuries and illnesses. The criteria for determining work-relatedness endorsed by the Secretary less than two weeks ago should be maintained and utilized in any standard or initiative on ergonomics.

For years OSHA and employers have been utilizing the definition of an OSHA recordable CTD or MSD (including the criteria for work-relatedness) in ergonomic guidelines and programs. The ergonomic program guidelines for meatpacking incorporate the criteria for work-relatedness from the recordkeeping requirements, as do all of the corporate wide settlements agreements on ergonomics. Employer ergonomic programs, including programs at GM, Ford, Chrysler, Dow, Boeing, and IBP all utilize the OSHA recordable injury/illness definition in their ergonomics programs. The log of injuries and illnesses is routinely assessed to identify potential problem jobs. Individual reports of a recordable case result in job evaluations and medical assessment.

While the AFL-CIO believes that an exposure based ergonomics standard and exposure based ergonomics programs are more preventive and protective than, and are preferable to, an injury based standard, we do believe that experience demonstrates that employers are quite capable of making determinations of work-relatedness of MSDs as part of their efforts to address ergonomic hazards in the workplace.

In determining work-relatedness, the crucial determination relates to identifying worker exposure to hazards occurring in the workplace. For MSDs, the worker's job should be evaluated to determine if there is exposure to the risk factors that increase the risk of developing an MSD (e.g. force; vibration; awkward postures; repetition; contact stress; manual material handling; and heavy physical work). Determination of work-relatedness can also include an assessment of other reported injuries or illnesses in similar jobs and a medical evaluation which includes a work history, medical history and exposure assessment.

With respect to MSDs that are caused by a combination of work-related and non-work-related factors, the operative issue should be whether or not the worker is exposed to workplace ergonomic hazards. Most occupational illnesses, including lung cancer, hearing loss, dermatitis, and asthma can be caused by both workplace and non-workplace factors. This hasn't stopped

OSHA from regulating the workplace exposures that cause these diseases, nor does it stop employers from controlling these exposures.

In our view, where workers are exposed to workplace physical ergonomic risk factors at levels or for durations that increase risk the risk of injury, the employer should be required to take action and to reduce exposures whether or not an injury has occurred. This is the case for all other safety and health hazards regulated by OSHA. For example, even though lung cancer is caused both by exposure to asbestos and smoking, OSHA requires that workplace exposure be controlled to less than .1 fiber/cc. This requirement applies to all workplaces where asbestos is present whether or not a lung cancer case occurs.

If the Department of Labor truly wants to be preventive in its approach to ergonomics, as the Secretary has stated, it should issued a protective exposure based standard on ergonomics just as have been issued to protect workers from other major safety and health hazards.

An OSHA Standard is Needed to Protect Workers from Ergonomic Hazards and Musculoskeletal Disorders

In the announcement for these public forums the Department of Labor has asked “what are the most useful and cost-effective types of government involvement to address workplace ergonomics injuries (e.g., rulemaking, guidelines, "best practices," publications/conferences, technical assistance, consultations, partnerships or combinations of such approaches)?"

The AFL-CIO believes that the foundation and center of government action on ergonomics must be the promulgation of a strong protective ergonomic standard that will prevent injuries and illnesses.

The key finding motivating Congress to enact the Occupational Safety and Health Act in 1970 was the fact that "personal injuries and illnesses arising out of work situations impose a substantial burden upon, and are a hindrance to, interstate commerce in terms of lost production, wage loss, medical expenses, and disability compensation payments," 29 U.S.C. §651(a). The purpose of the Act was to assure so far as possible every working man and woman in the nation safe and healthful working conditions and to preserve the country's human resources.

Without question, work-related musculoskeletal disorders are painful, disabling and costly injuries. As the major source of job injury and illness in the nation today, work-related musculoskeletal disorders are precisely the type of problem that the Act was intended to address. Just as the Congress acted in 1970 and passed the Occupational Safety and Health Act to address the high toll and cost of workplace injuries and illnesses, it is imperative that OSHA promulgate an ergonomics standard to address the toll and cost of musculoskeletal disorders.

According to the National Academy of Sciences, a conservative estimate of the costs imposed by

MSDs on the American economy is between $45 and $54 billion every year (NRC/IOM, 2001). These figures only include the actual monetary losses that result from MSDs, but do not account for the enormous pain, suffering and disability that these preventable disorders cause.

The pain and toll of these injuries was described by dozens of injured workers who testified at OSHA's ergonomic hearings on why a standard was so important - workers like Ron Kline, an auto worker from Maryland, Carol Py, a clerk typist from Pennsylvania and Nancy Foley a newspaper reporter from Massachusetts, all who developed serious work-related MSDs.

> Starting with my right elbow, the illness became so severe, I could not lift the air gun. As this was occurring, my reaction was to start using my left hand to complete my assignment.
>
> As the pain worsened, even with local treatment from the dispensary, it required surgery.
>
> The time away from work for my right arm required 13 weeks away from work with less than complete recovery, leaving me with 15 percent permanent loss of full use of my right arm.
>
> I also endured one year of physical therapy for my right arm.
>
> Subsequently, I required surgery on my left arm with seven weeks away from work. (Oral testimony of Ron Kline at OSHA Ergonomics Hearings, Tr. 7950)
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> *******
>
> I developed cumulative trauma disorder which is like multiple muscular injuries due to repetitive motion, DeQuervains disease in my thumb here, cubital tunnel syndrome which is the ulnar nerve, compression of the ulnar nerve the elbow and trigger finger.
>
> During the next 12 months, the pain in my hand was so unbearable that I had to have repeat surgery on my right hand. I have trouble turning the pages. I never returned to work as my medical restrictions were so limited that my company could not find me a job.
>
> Last year, I had surgery on my other hand because my thumb would not move.
>
> Today, I have difficulty driving, cleaning, cooking, and food shopping. And my husband, he mostly does all my shopping for me. And my grandchildren do a lot of the cleaning for me, too. The yard work is out of the question since I cannot rake or mow the lawn. I had to give up the things that I used to love like sewing and gardening. Before I was injured, I even had a green belt in karate. My arms are so weak now that I can barely take care of my three grandchildren. (Oral testimony of Carol Py at OSHA Ergonomics Hearings, Tr. 6321-6322).

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> By the time I left the newspaper I was so severely injured that my recovery has been very slow. I may never fully recover. I live with chronic pain every day. Sitting still triggers pain. I have trouble carrying groceries into my house and doing simple housekeeping tasks. I am trying to retrain to be a school teacher, but my injuries make the retraining difficult. I do my school work by lying in bed and talking into a voice-activated computer.
>
> I loved my job. I remember thinking how lucky I was to have a job that was so much fun. It was a great disappointment to me to have to give it up...I have suffered from severe depression as a result of losing my career and living with chronic pain. I have lost thousands of dollars in income. I had hoped to have children some day, but I cannot pick up and carry my eight-month old niece. (Oral testimony of Nancy Foley at OSHA Ergonomics Hearings, Tr. 7321-22).

The pain and disability caused by musculoskeletal disorders is widespread. Dr. Robin Herbert of the Mt. Sinai Medical Center, an occupational physician who testified at the OSHA's ergonomics hearings reported that 25 percent of her patients with musculoskeletal disorders have permanent disabilities, and of those 25 percent, ten percent are never able to return to work (Oral testimony at OSHA Ergonomics Hearings, Tr. 1736-37). Preliminary results of one study showed that 15 percent of all patients with MSDs of the upper extremities are characterized as disabled (Oral testimony at OSHA Ergonomics Hearings, Tr. 1738). In New York State, between 1993-1995, 86 percent of workers with carpal tunnel syndrome were deemed to be permanently disabled by workers' compensation judges (Herbert, 1999). A study of workers' compensation claims for ergonomic injuries in North Carolina found that 19.4 percent of the injuries resulted in permanent partial disability; 22 percent of the claimants were unable to return to work (Waldorf and Snow, 1996).

The financial and social consequences of these injuries on workers are significant. Many injured workers receive no workers' compensation. Their injuries and disabilities destroy or severely limit their ability to make a living. Financial burdens created by these injuries result in workers losing their homes, cars and health insurance. Injured workers are often unable to lead a normal life experiencing great difficulty performing routine activities such as writing, cleaning, caring for children, bathing and driving a car. The effects of these injuries on injured workers' well-being is also significant. Workers suffering MSDs report higher levels of depression, anxiety and stress at home.

The severity of the problem of MSDs and the need for government action was recognized more than 10 years ago by Secretary of Labor Elizabeth Dole when she committed to initiate rulemaking and to take the most effective steps necessary to address the problem of ergonomic hazards. The need for such action was reaffirmed in 1992 by Secretary of Labor Lynn Martin when she started the standard setting process on ergonomics and issued an advance notice of

proposed in response to a petition from the United Food and Commercial Workers, AFL-CIO and many unions.

Unfortunately ideological opposition to government action by industry groups and some in Congress has delayed and blocked these needed protections. More than 10 years after government action was promised, workers still lack legal protection against ergonomic hazards.

In the aftermath of the recent action by Congress and the Bush Administration to repeal OSHA's November 2000 ergonomics standard, Secretary Chao committed the Department of Labor to developing a comprehensive approach to address musculoskeletal disorders. The AFL-CIO supports and has long advocated a comprehensive approach to addressing MSDs. But any approach to addressing MSDs must have as its core and foundation a mandatory protective OSHA standard. Voluntary compliance assistance, outreach, education and further research can and should complement and supplement regulatory action. But voluntary approaches alone have proven to be insufficient to provide workers the protection they need and deserve.

For more than a decade the government has engaged in a series of voluntary initiatives on ergonomics, including the development of the ergonomic program guidelines for meatpacking, convening national and regional best practice conferences, funding ergonomic training programs for workers and employers, conducting research, publishing manuals and guides and developing extensive web-based and electronic information and assistance tools. With all of these initiatives, there still are more than 1.8 million MSDs reported every year, ergonomic hazards remain the biggest workplace safety and health problem.

The advances that have been made in protecting workers from MSDs and the implementation of many workplace ergonomic programs have come in large measure as a result of mandatory action required by OSHA enforcement under the general duty clause. Ergonomic programs in auto manufacturing, meatpacking, poultry, and garment industries all have their roots in the settlement agreements that stemmed from OSHA enforcement actions. Indeed, the meatpacking guidelines, while technically voluntary were accompanied by strong enforcement under the general duty clause. The ergonomic programs implemented in the meatpacking industry were a direct result of mandatory settlement agreements that stemmed from these enforcement actions.

It is important to point out that in 1990 when OSHA circulated draft ergonomic program management guidelines for the rest of general industry, industry groups objected. They took the position that if OSHA intended to enforce against ergonomic hazards, it should issue a standard and not utilize guidelines and the general duty clause. As a result of their intervention, the 1990 general industry ergonomics guidelines were never issued. But as the past decade has shown the bottom line is that the Chamber of Commerce, the NAM and recalcitrant employer groups want no mandatory or even voluntary ergonomic requirements at all.

Experience and evidence shows that the ergonomic programs implemented under OSHA's

corporate wide settlement agreements resulted in significant declines in musculoskeletal disorders in the covered workplaces and sectors. But, as noted earlier, these settlement agreements are no longer in effect and in some industries and workplaces that were covered by these agreements the rates and numbers of MSDs have increased as efforts have lapsed. However, in industries such as auto manufacturing and workplaces where efforts have continued as a result of collective bargaining and employer and union efforts, injury rates have continued to fall.

Because of increased employer opposition, the use the general duty clause to enforce against ergonomic hazards has become much more difficult. Review Commission rulings have affirmed that indeed ergonomic hazards are a recognized hazard that should be controlled, but have required that OSHA prove on a case by case basis that there are feasible controls to reduce exposure to these hazards. Since these decisions were issued, the agency has undertaken few ergonomic enforcement cases under the general duty clause, and no significant cases of the kind that resulted in the establishment of corporate wide ergonomic programs and initiatives.

It is clear that the only way preventive ergonomic programs and practices will be instituted on a wide scale in sectors and workplaces where workers face a significant risk of injuries is through the promulgation and enforcement of a mandatory protective standard.

The AFL-CIO has long advocated that an OSHA ergonomics standard be based on the good employer practices that have been demonstrated to be effective at reducing the incidence and severity of work-related MSDs. As the National Academy of Sciences (NRC/IOM, 2001) and General Accounting Office (GAO, 1997) have both reported, these effective practices implement ergonomic principles and follow a programmatic approach which includes employer commitment and employee participation, job analyses and control, training and medical management.

These basic elements form the foundation of OSHA's 1990 Meatpacking Guidelines and settlement agreements that have been implemented successfully in key industries. These basic elements also form the basis of many employer ergonomic programs that have been effective at reducing MSDs. They also form the basis of the voluntary standard on MSDs, which is being developed by the Z 365 ANSI standard setting committee. These basic elements were also the backbone of the November 2000 ergonomics standard issued by OSHA.

We believe that the application of these practices and principles can vary depending upon the severity and extent of the problems in a particular workplace or industry. For example, a workplace with a small number of hazardous jobs may not need a full blown or extensive program. Identifying and fixing the hazardous jobs and providing workers with training and access to medical management may be sufficient. However, in workplaces with large numbers of hazardous jobs and widespread problems, a full ergonomics program, which includes a systematic ongoing approach to hazardous identification and control, training, worker participation, medical management, and evaluation is appropriate and necessary.

To be effective at preventing injuries and consistent with the OSHAct, the AFL-CIO believes that an OSHA ergonomics standard should also do the following:

- Cover all sectors and all workers at significant risk of injury. OSHA's November 2000 ergonomic standard was limited to general industry and excluded construction, maritime, agriculture and railroads. MSDs are a major source of injury and illness for workers in all sectors. State ergonomic standards in California and Washington apply to all employers and workers. Any federal OSHA ergonomics standard should cover workers in all sectors as well.

- Be pro-active and preventive. OSHA's November 2000 standard was triggered only in response to worker reports of MSD injuries or persistent symptoms, when workers also had significant exposure to identified ergonomic risk factors. In the absence of any injury, no action was required, even if the employer had knowledge that serious hazards were present. All other OSHA standards are triggered by worker exposure to hazards, not reports of injuries. To be preventive an ergonomics standard should respond to hazardous exposure, whether or not an injury has occurred. We recommend that the Department of Labor adopt an exposure based ergonomics standard such as that adopted by the State of Washington. Under an exposure based standard, action would not be dependent on the identification of a work-related MSD. Those determinations would be relevant to the medical management program, but would not be the primary basis for hazard identification and control measures, as is the case with all other OSHA standards.

- Provide for early detection of MSDs and early intervention. MSDs are cumulative progressive injuries that become more serious, disabling and costly with continued exposure. One of the keys to a successful ergonomics program is the early detection of these injuries, so interventions can be made before damage is serious and permanent. Early detection and intervention is also key to reducing the cost of these injuries.

- Encourage reporting of MSDs and hazards and participation by workers and their representatives. The early detection of MSDs is only possible if workers feel free to report MSDs and MSD hazards. Any standard must prohibit discrimination and retaliation against workers who make such reports and prohibit practices or policies that discourage worker reports. Such provisions were appropriately included in OSHA's ergonomics standard. To encourage early reporting and participation in any medical management program, employees should not have to face loss of wages for making these reports. This was the purpose of the work restriction protection provision of OSHA's ergonomics rule. The standard mandated that an employer follow a health care provider's medical

determination for job restriction of injured workers. It also provided that on a temporary basis when such restrictions were required, workers should not have to lose wages or benefits.

This work restriction protection was not a workers' compensation system. It's purpose was to encourage early reporting, not after the fact compensation. It in no way changed or altered workers' compensation laws or benefits. Similar provisions have been included in OSHA standards since 1978 when medical removal protection was included in OSHA's lead standard. Such provisions have been upheld by reviewing courts as permissible and appropriate protective measures under the OSHAct. Such a provision should be included in an OSHA's ergonomics standard.

- Provide for the reduction of exposure to ergonomic hazards to the extent feasible. The reduction of exposure to ergonomic risk factors – force, repetition, awkward posture, and vibration – must be the heart of any ergonomics standard, just as it is the heart of all OSHA standards. An ergonomics standard must require employers to reduce exposures to ergonomic risk factors so they no longer pose a hazard, or if that is not possible, reduce them to the extent feasible.

As stated earlier, some employers have already taken action and implemented measures similar to those outlined above to protect workers. Many countries around the globe have implemented ergonomic standards or manual handling standards. These include British Columbia, Canada, Australia, Sweden and the member states of the European Community which have adopted regulations to implement the European Community directive on manual handling (Council Directive 90/269/EEC, May 29, 1990) and directive on video display terminal use (Council Directive 90/270/EEC, May 29, 1990).

The only reason why a mandatory ergonomics standard is not in place in the United States today is because of the fierce ideological opposition by some business groups, including the U.S. Chamber of Commerce and the National Association of Manufacturers, and others to any government intervention on this issue.

For 10 years these business groups have opposed any and every attempt to regulate ergonomics at the state and federal level. They opposed state standards in California, North Carolina and Washington. They opposed efforts by states and federal OSHA to enforce against ergonomic hazards under the general duty clause. They are now challenging longstanding OSHA regulations that require musculoskeletal disorders to be recorded on the OSHA log. **They are even trying to block a voluntary ANSI standard on MSDs that is now close to being finalized.**

The misrepresentation by these groups of the facts and the science and their fierce opposition to any ergonomic protections is directly responsible for the serious and preventable injury to millions of workers in this country. Unfortunately this past March, a majority in the Congress

and President Bush decided to side with these opponents of protections and acted to repeal OSHA's ergonomics standard.

We believe that it is time that the Bush Administration stopped doing the bidding of corporate special interests and started acting on behalf of the working people of this country. The Department of Labor should move immediately to develop and issue a new ergonomics standard to protect American working men and women.

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APPENDIX A

Comparison of Total Injury and Illness Cases Involving Days Away from Work to MSD Cases Involving Days Away from Work, 1992 - 1999

Chart included in hard copy, not available in electronic format.

APPENDIX B - MSD Data Comparison from Three States

Work-related Carpal Tunnel Syndrome in Massachusetts
Massachusetts SENSOR Program vs. Massachusetts BLS, 1993 - 1996

Year	Massachusetts SENSOR			CTS Cases Reported by Massachusetts BLS
	All Workers Compensation Cases	Additional Physician Reported only Cases	Total Unique SENSOR Cases	
1993	1076	281	1,357	379
1994	1156	185	1,341	627
1995	885	86	971	321
1996	915	104	1,019	431

Source: The Commonwealth of Massachusetts, Executive Office of Health and Human Services, Department of Public Health, January 20, 1999.

Musculoskeletal Disorders in Oregon
Number of Injuries by Event that Caused the Injury, 1992 - 1994

	1992		1993		1994	
	W C[3]	B LS[4]	W C	B LS	W C	B LS
Repetitive Motion	5,450	950	1,038	857	1,521	1,156
Overexertion	12,325	7,966	11,786	7,752	11,697	7,315
TOTAL	12,870	8,916	12,824	8,609	13,218	8,471

Source: BLS State data for 1992, 1993, 1994 and *Oregon Workers' Compensation Characteristics Calendar Year 1995*, Research & Analysis Section, Oregon Department of Consumer & Business Services, June 1997.

Musculoskeletal Disorders Resulting from Overexertion in Washington State
Industrial Insurance Claims vs. BLS Data, 1992 - 1994

Year	BLS Data[5]	Industrial Insurance Claims[6]

[3] These are time-loss claims with 4 or more days away from work. Private insurers accounted for 49% of the claims, the SAIF Corporation for 31%, and self-insured companies for 20 percent.

[4] Number of private industry nonfatal occupational injuries and illnesses involving three or more days away from work. Days-away-from-work cases include those which result in days away from work with or without restricted work activity.

[5] Reflects both State fund and Self Insured employers.

[6] The term claims refers to accepted claims only. Data reflects both State fund and Self Insured employers.

	1 or More Days Away - Overexertion	3 or More Days Away - Overexertion	Total # MSD[7] Claims - Overexertion	Total # Time-loss MSD Claims[8] - Overexertion
1992	17,107	13,258	48,019	21,575
1993	16,488	12,514	46,970	20,578
1994	14,345	11,046	45,747	19,768

Source: ***Work-Related Musculoskeletal Disorders: Washington State Summary 1992-1994*****, State of Washington Dept. of Labor and Industries, Oct 1996 and data from the State of Washington Dept. of Labor and Industries, Jan/Feb 1999.**

[7] MSDs can include strains/sprains, joint inflammation, lower back pain and nerve compression syndromes. **93%** of all MSD claims were coded overexertion.

[8] Washington state defines time-loss claims as those claims with 4 or more days away from work and includes claims where the employee is kept on salary, has loss of earning power or provisional time loss.