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ASBESTOS INFORMATION ASSOCIATION/NORTH AMERICA

in regard to the

DEPARTMENT OF LABOR

IONAL SAFETY AND HEALTH ADMINISTRATION

PROPOSED RULEMAKING

)ENTIFICATION, CLASSIFICATION AND
.GULATION OF TOXIC SUBSTANCES
)SING A POTENTIAL OCCUPATIONAL
ARCINOGENIC RISK"

29 CFR Part 1990

42, No. 192 - Tuesday, October 4, 1977

Presented at the public hearing in
Washington, DC on July 19, 1978 by
Dr. H. B. Rhodes, Chairman, AIA/NA
Standards Advisory Committee

PLAINTIFF'S EXHIBIT

UC-4333

X401943

D R A F T June 20, 1978

My name is Harrison B. Rhodes and I am employed as a Technology Manager in the "Calidria" Asbestos Department of the Union Carbide Corporation. My educational background is in chemical engineering where I hold a degree of Dr. Eng. Sci. from Columbia University in New York City.

This brief talk today is presented on behalf of the Asbestos Information Association/North America. AIA/NA is an incorporated, nonprofit organization of 53 firms in the United States and Canada engaged in the manufacture or processing of asbestos-containing products and in the mining and milling of asbestos fiber. I serve the AIA/NA as Chairman of the Standards Advisory Committee, Chairman of the Committee on Air Monitoring, and as a member of the Executive Committee.

INTRODUCTION AND SCOPE OF COMMENTS

The present rulemaking on a "generic" approach to the regulation of occupational exposure to carcinogens places the asbestos industry in a unique and somewhat ambiguous position. As you are well aware, asbestos was the subject of OSHA's first health standard promulgated in June 1972. Extensive revisions to this standard were proposed on October 9, 1975. These revisions were to be applied to the manufacturing segment of the industry only. The construction industry, which is extremely important to us because it uses about 70% of all of the asbestos-containing products manufactured, was excluded from the proposed revisions. It is to be the subject of a separate rulemaking.

The wisdom of separate treatment for the construction industry was borne out by a series of OSHA Construction Industry Advisory Committee hearings on asbestos held during 1976. The Committee found numerous serious problems in the application of the requirements of the proposed asbestos manufacturing standard to the construction setting.

At this time, therefore, the asbestos industry is approaching a combined rulemaking on asbestos exposure in both manufacturing and construction. The position that OSHA takes in these upcoming asbestos hearings will undoubtedly be influenced by this generic rulemaking. We feel, however, that there is little that our industry as a group can add to what is already being said on the broad general issues of reasonable and realistic allocation of resources for the protection of the worker from the hazards of exposure to carcinogens. Our remarks will, therefore, be confined to a brief discussion of two specific issues which impact us directly and which are receiving very limited coverage by others. They are:

1. The relationship of existing standards to those that will be promulgated under a generic approach.
2. The development of appropriate standards for the construction industry and other industries characterized by non-fixed places of employment.

THE RELATIONSHIP OF THE PROPOSED GENERIC STANDARD TO EXISTING STANDARDS

OSHA today has health standards in effect which cover asbestos, 14 specific carcinogens, vinyl chloride, and coke-oven emissions. Standards for benzene and acrylonitrile have been promulgated but are under court review. All of these standards were developed during appropriate administrative hearings where the various parties involved could present their special problems and the consequences of various alternatives were examined. The final regulations were, in effect, tailored in the arena of adversity for the particular conditions in the industries involved.

The generic approach proposed in this hearing is expressly intended to speed the promulgation of standards for substances for which standards do not exist. Of necessity, its model standards are broadly drawn and do not reflect specific adaptations for given industries or for segments of industry.

For substances now covered by OSHA standards, the workers are already

highly protected. Any further changes relate to incremental additional protection at the very low end of the risk extrapolation; i.e. a reduction in risk that is already low to an even lower level. In view of the extensive records that have been developed in the promulgation of the existing standards, we believe it is inappropriate for OSHA to override the record with a broadly drawn formula standard. Any changes in existing standards which OSHA believes to be appropriate should be made selectively under the current administrative procedures with no issues excluded from consideration by OSHA policy. It should also be made explicitly clear that OSHA intends to consider the standards for the construction industry separately. It is therefore requested that the following words be added to Subpart A, Paragraph 1990.1 Scope:

> "Substances for which health standards have been promulgated and are in effect shall not be subject to the provisions of Part 1990. This section does not apply to construction work within the scope of paragraph 1910.12 of this part or to other non-fixed places of employment."

CONSIDERATIONS FOR OSHA HEALTH STANDARDS - INDUSTRIES WITH NON-FIXED PLACES OF EMPLOYMENT

Over the past six years OSHA has evolved a basic format for health standards which relies heavily upon widespread, repeated monitoring to determine compliance. Universal medical surveillance is also required with both medical and moitoring records stored by the employer for forty years or more. These principles are well exemplified by the present "generic" proposal

The Asbestos Information Association/North America has contracted with Equitable Environmental Health, Inc. to conduct a detailed study of the use of asbestos-containing products in the construction industry. We have also been working closely with various trade and contractors associations. As this work progresses it has become increasingly evident that there are two fundamental

difficulties in applying the repeated monitoring and universal medical surveillance principles of OSHA standards to the construction industry:

1. There are hundreds of thousands of "transient" work places, i.e, work places that generally exist for only a few months or less and are replaced by others. A standard where each work place must be monitored is completely impractical.
2. A work force of several million persons is involved. A majority of this force works for a number of different employers over the course of a year. Contractors also enter and leave the market with great regularity. Any sort of all-inclusive medical surveillance and record-keeping by individual employers is clearly unworkable. Such a program would also be too fragmented to contribute to the protection of the worker or to research.

As an alternative to this approach three basically new concepts are suggested:

1. The regulation would only apply to those work places where there is a reasonable possibility for significant release of asbestos fiber. Situations where exposure would be very low, occasional, and fleeting would not be covered.
2. Monitoring would be replaced by a series of Certified Fabrication, Installation or Removal Methods. Such a method is a specification or description of the way an asbestos-containing material is to be handled on the job-site. It would include the work practices used to control asbestos exposure and any engineering or administrative controls that were feasible.

3. The medical examination and attendant recordkeeping burden would be brought under control by reducing the frequency of examinations for the first 10-15 years after exposure, defining "exposure" to include both requirements of working a certain minimum days per year with the hazardous material as in the present coke-oven standard and a lower limit of concentration below which examinations are not required.

If a regulation of this type were to be promulgated it would be necessary to study the various construction operations in sufficient detail to obtain a realiable picture of the range of exposures that could normally occur. Where exposures were found to be above either of the allowable limits, work practices would be modified and engineering controls, and/or administrative controls, to the extent feasible, would be required to be incorporated to reduce exposure to below the allowable limits. Where feasible procedures would not reduce levels below the limits they would be required, but respirators would be permitted.

Once an overall "Method" is developed and reduced to writing, the contractor would be responsible for the training of his workers in the correct procedures and supervision to require conformance to the procedures. Compliance would be determined by an OSHA inspector in terms of proper use of the proper method. If the inspector elected to monitor and found levels above those certified and the procedure was being followed correctly, the contractor would be given an opportunity to make corrections before being subject to citation.

It is noteworthy that the asbestos-cement pipe industry is in the process of extensive testing of a "work procedures" method to control asbestos exposure. Installation methods have been developed and the corresponding exposure levels documented. Field use of the methods appear to be very successful. The Resilient

Flooring Industry is also moving to follow the same approach. We expect to have some solid documentation on its practicality and problems by the time of the OSHA asbestos hearings.

Turing now to the question of medical surveillance, we believe that the very substantial reduction in the number and frequency of medical examinations proposed herein takes a long step towards feasibility but it still leaves very serious problems in the construction industry if any significant percentage of eligible employees should elect to accept the examinations as offered. In seeking a solution to this problem it is important to note that OSHA has adopted the medical surveillance concept in all of the health regulations so far promulgated and appears to fully intend to continue to do so in future regulations. We believe that in the next several years a substantial fraction of the workers in the construction industry (as well as in other industries) will be eligible to be offered an OSHA mandated medical examination as a consequence of exposure to some regulated substance. It makes sense to look now for a basic, workable plan by which compliance could be achieved rather than treat the problem piecemeal for each substance as it comes up.

There are three aspects of the broad medical examination problem that need to be considered:

1. The quality of examinations.
2. The "permanent" storage of records.
3. The content of the examinations.

It is suggested that the quality of the examinations and the record storage aspects could be handled satisfactorily if the Federal Government, possibly acting through NIOSH, would set up a certification program for medical facilities similar to that now used by the American Industrial Hygiene Association for industrial hygiene laboratories. The skills, professional staff, equipment, and operating procedures need by local medical facilities to conduct the medical examinations mandated by OSHA would be specified. Record storage capability would be required. Medical facilities that met the qualifications would be certified.

When an employee becomes eligible for a medical examination due to exposure to any regulated health hazard, he would be offered the opportunity to receive it, and if accepted, would report to the designated local health facility. The facility would provide the examination and send the results as required by the OSHA regulations to the employer and employee. The employee would be provided a card certifying that he had received a medical examination and the date. The employer would only be required to keep the records for the employee's term of employment. Permanent and complete records would be stored by the examining facility.

As noted previously, the direction in OSHA medical examination is moving towards a situation where a worker can become eligible for a multiplicity of examinations each year. These examinations have some parts in common but each has additional special requirements. We do not believe it is feasible, either technically or economically, to impose this sort of multiple medical examination burden on any industry but more particularly on an industry with a transient workforce. OSHA must develop a single, comprehensive, but reasonable

and realistic examination for general use with exposure to toxic substances.

SUMMARY AND CONCLUSIONS

We have today touched on two spei-fic difficulties that the proposed generic standard presents to the asbestos industry and have requested that wording be introduced into Section 1990 to alleviate these problems. Such wording would specifically exclude substances wherein health standards are already in force and industries characterized by non-fixed places of employment from the present rulemaking. We believe that this is a reasonable request and is in keeping with both the intent of the gneric proposal and with the past record of the other standards.

Some important regulatory concepts that have come from our studies of the construction industry were described briefly and offered for consideration by OSHA when standards are developed for this industry. These include the use of certified Fabrication, Installation and Removal Methods as an alternative to extensive compliance monitoring and the following points relating to medical surveillance:

1. A reduction in the frequency of examinations during the first 15 years after exposure when recognizable symptoms of the hazard monitored are not expected to appear.
2. A clear specification of "exposure" to include both a lower concentration limit and a specified number of days per year above this limit. Both of the criteria would have to be met before a medical examination would be required.
3. A qualification program for medical facilities including record storage capabilities.
4. A basic genral physical examination for exposure to toxic substances.