Doctors’ offices should be exempt from one-size-fits-all OSHA rule

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A one-size-fits-all interim federal rule for health care workplace protections against COVID-19 may be appropriate for hospitals and long-term care facilities but creates burdensome and duplicative requirements for physicians’ offices and ambulatory clinics.

The AMA is urging the Occupational Safety and Health Administration (OSHA) to exempt 161,977 physician offices and 10,568 mental health physician-specialty offices from its emergency temporary standard (ETS) interim final rule (IFR) on exposure to COVID-19.

“Given all the experience and the steps physician practices have already undertaken to address infection control issues with COVID-19, the AMA urges OSHA to immediately exempt physician practices from the ETS and not move forward with making the ETS interim final rule permanent,” AMA Executive Vice President and CEO James L. Madara, MD, wrote in a letter to Labor Secretary Marty Walsh.

A possible exemption for physician practices is included in the ETS, but it would require screening all nonemployees and banning them from entry to the office if they have or are suspected of having COVID-19. The broad definition of COVID-19 symptoms would prevent the entry of many patients with general symptoms, including: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting and diarrhea.

“In reality, physician practices are placed in an untenable position by having to choose between seeing patients who may have those common symptoms—but not actually have COVID-19—or refusing to provide services in order to be able to take advantage of the exemption,” Dr. Madara’s letter says. “The exemption, while well-intended, is unworkable and could result in less access to care for patients and disrupt continuity in care.”
Been there, done that

Dr. Madara also noted that physician offices took numerous steps to stem the transmission of COVID-19, including investing in technology, rapidly adopting telehealth, revamping scheduling practices, and purchasing significant amounts of personal protective equipment and disinfectants—often at inflated prices.

His letter notes that many of the IFR’s provisions appear duplicative of existing infection-control standards that practices have already implemented—making them unnecessary. Other provisions impose new requirements and costs that constitute unfunded mandates on practices struggling to stay open and financially viable during the year and a half of the COVID-19 pandemic.

These unfunded mandates include new requirements regarding heating, ventilation, and air conditioning systems, as well as paid leave for employees who develop general COVID-19 symptoms or have had contact with a co-worker who has COVID-19.

Little notice was given

OSHA, an agency within the U.S. Department of Labor, published the COVID-19 health care ETS—with little to no advance notice—in the Federal Register June 21. The ETS took effect that day.

Comments on the interim final rule were due July 21, and the AMA said that fast timeline didn’t give physicians or other health care stakeholders enough time to review the IFR and provide meaningful input to OSHA. Due to the advocacy of AMA and other stakeholders, OSHA extended the comment deadline to Aug. 20.

Dr. Madara called for OSHA to provide a real opportunity to engage in a meaningful dialogue with physicians and the health care community about the scope—and the need—for the ETS for physician practices.

The AMA COVID-19 resource center offers clinical information, guides and resources, and updates on advocacy and medical ethics.