LABOR OCCUPATIONAL HEALTH PROJECT

• MONITOR •

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OCCUPATIONAL/ENVIRONMENTAL CANCER

Phillip L. Polakoff, M.D.

Since the beginning of 1974, increasing numbers of news headlines have suggested that industrially-used chemicals are carcinogenic (cancer-causing). Examples are: "Goodrich Firm Probes Three Cancer Deaths" (Louisville Courier Journal, 1-24-74); "Now It's Vinyl-idine Chloride Which May Be Carcinogenic" (Occupational Health and Safety Letter, 10-8-74); "Arsenic Linked to Cancer Rate" (San Francisco Chronicle, 8-30-74); and "Worries Over Drinking Water — Cancer Causing Agents May Be Present" (San Francisco Chronicle, 11-2-74).

Unfortunately, the end of this growing list is not in sight to this day—men, women, and children continue to serve as experimental guinea pigs.

The magnitude of our nation's cancer problem is staggering. As early as 1964, the World Health Organization (WHO) officially stated that environmental agents (such as cigarette smoke) are a major causative factor in 75-85 percent of all cancers. The American Cancer Society estimates that 700,000 new cancer cases and approximately 380,000 cancer-caused deaths occur each year. More specifically, over 1000 substances ordinarily found in American work environments have been proven to be cancer-causing (see Table 1 for most commonly used agents), or are suspect of being carcinogenic (see Table 2). Presently, there exists no data which would indicate the total number of persons exposed to all these numerous cancer-causing agents. However, the National Institute of Occupational Safety and Health estimates: 1.5 million persons risk exposure to arsenic; 200,000 currently, but 3.5 million at one time or another, risk exposure to asbestos; and 100,000 risk exposure to cadmium.

In addition, occupational/environmental related cancer is not solely a 20th century phenomenon. In 1775, the English surgeon Sir Percival Pott described and recorded his observations that a rare form of scrotal cancer occurred only among young boys employed as chimney sweeps. Approximately 100 years later, scrotal cancer was also attributed to exposure to paraffin and shale oils. Within the same time period, skin cancer was attributed to exposure to tar. In the late 1890's, lung cancer was also diagnosed as an occupational disease among miners in Austria. There seems to be no end to continuing disclosures of additional carcinogenic substances in the work environment. More recently, bladder tumors have been attributed to exposure to aromatic dyes — beta and alpha napthalamine, and benzidine.

TABLE I

Agents proved or suspected of being cancer causing for workers on an epidemiological (people) basis:

Agent	Cancer Site
Ultraviolet radiation	Skin cancer
X-rays	Skin cancer Leukemia
Uranium ore	Pulmonary cancer
Arsenic	Skin and (lung cancer)
Asbestos	Lung cancer Pleural mesotheliomas (Abdominal cancer)
Chromium	Lung cancer
Nickel	Lung cancer Nasal and paranasal cancer
Iron ore	Lung cancer
Bis-chloromethyl ether	Lung cancer
Benzene	Leukemia
Isopropylic oil	Paranasal cancer
Soot, tars, mineral oils and cutting oils	Skin cancer
Carbon black	Lung cancer
Mustard gas	Laryngeal cancer
Aromatic amines	Bladder and upper urinary tract cancer
Vinyl chloride	Liver—angiosarcoma

Characteristics of Work-Related Cancers

Occupational/environmental induced cancers share characteristics which are not common to other cancers:

(1) Such cancers usually appear after a lengthy exposure in the related occupation;

(2) There exists a substantial latent period between initiation of cancer (first exposure to toxic agent) and the time the cancerous lesion appears averages between 11 and 20 years. Although the exposure period has been as short as 2 years, the potential range is as long as 40 years.

(3) These cancers generally develop at an earlier

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HAZARDS OF EXPOSURE TO CARBON MONOXIDE

Leo Seidlitz, Ph.D.

It is well known that connecting a hose from the tailpipe of a car to its interior is a relatively painless and simple way to end it all. In fact, the Greeks and Romans used carbon monoxide (CO) both to commit suicide and to execute criminals. What is not as well known are the effects of a less-than-fatal dose of CO or the effects of chronic (continuous) exposure to lower levels of CO.

The potential for occupational exposure of workers to CO is greater than that for **any** other chemical or physical agent. More people succumb to acute CO poisoning than to any other single toxic agent, except for alcohol. If you work in a kraft pulp mill, petroleum refinery, iron foundry, sintering mill, auto repair shop or a warehouse you may be exposed to carbon monoxide. Other exposed occupations include arc welders (particularly when working with a carbon dioxide-shielded arc), traffic controllers, toll collectors, truck and bus drivers, tunnel workers, fork-lift operators, printers, construction equipment operators, cooks, bakers and fire fighters. Salamander heaters at indoor construction sites, furnaces, ovens, stoves, forges, kilns or any equipment or process where incomplete combusion occurs can be a significant source of CO.

Hazards of Carbon Monoxide

Carbon monoxide is a tasteless, odorless, colorless gas. Since you can't detect it by the senses, serious damage can take place without warning. CO has about the same weight as air, so it will not accumulate in high or low spaces. Instead, it tends to spread uniformly through the air.

The only significant way the gas can enter the body is by inhalation but it will not directly harm any cell of the human body. It does its dirty work after passing from the lung's air sacs into the blood stream by attaching itself to the hemoglobin found in the red cells of the blood.

Hemoglobin normally performs the task of distributing oxygen from the air sacs to the tissues of the body. When CO is present in the blood, it displaces the oxygen from the hemoglobin so that the red blood cells are not able to carry as much oxygen to the various parts of the body. In fact, CO is bound 200-300 times more tightly to hemoglobin than is oxygen. In addition, the oxygen that does get distributed by the red blood cells is taken up less efficiently by the tissues when CO is present. The harmfulness of these effects is increased by high heat or humidity or by physical exertion because of increased breathing rates. Fortunately, CO does not accumulate indefinitely in the blood, but rather reaches a final amount which depends on the concentration of CO in the air being breathed.

The initial symptoms of acute CO poisoning include headache and a feeling of oppression in the chest, followed by dizziness, nausea, weakness of leg muscles, mental confusion or perhaps drowsiness and finally, loss of consciousness. The victim at first becomes pale and then cherry red. This effect in non-whites can be checked by seeing if their mucous membranes become darker pink. The entire process is accelerated by physical exertion which, of course, requires more oxygen.

First aid consists of immediate removal to fresh air, including the administration of oxygen which should be available where CO exposure can be significant. Mouth-to-mouth resuscitation and external cardiac massage must be administered if breathing has stopped. Rescuers must be supplied with self-contained breathing apparatus.

Recovery may be complete if the exposure was short enough to prevent damage to vital organs, particularly the brain and heart. On the other hand, recovery may be apparent but pneumonia or damage to the brain, central nervous system, heart, blood vessels, or the kidney may show up days or even many weeks later. The damage to the brain and the central nervous system may be subtle and apparent only upon psychomotor testing or there may be permanent phychosis or paralysis resulting from the exposure.

The chronic, long-term effects of exposure to lower levels of CO are not as well established, but there is an increasing conviction that harmful effects do occur. Symptoms of this kind of exposure can include a sense of pressure in the head or other forms of headache, dizziness, weakness in the legs, fatigue and lack of energy. There may be deterioration of mental sharpness, visual sensitivity, reaction time, hand-eye coordination and other behavioral characteristics. Workers are less able to respond quickly and accurately to the demands of their job and, therefore, accident rates increase. CO accelerates the formation of cholesterol deposits in arteries (arteriosclerosis). By reducing the circulation of oxygen to the brain, heart, blood vessels and kidneys, CO may produce long-term damage to these organs. As stated earlier, CO itself does not accumulate in the body, but it is believed that the damage is due to the slow accumulation of many small effects produced by the lower concentrations of CO.

Methods of Protection

In workplaces where considerable amounts of CO are produced, continuous monitoring instruments should be set up. These instruments can be adjusted to give an alarm at a pre-set value. It is advisable that workers periodically check the alarm settings them-

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selves because cases are known in which the settings were maintained at a dangerously high level. Total enclosure of some CO-producing processes might be possible, but if not, then local exhaust and adequate general ventilation must be provided. Workers exposed to CO who complain of fatigue and lack of energy often achieve a sense of well-being and increased energy if adequate ventilation is installed.

Whereas diesel engines do not emit CO, if properly adjusted, gasoline-powered engines of course, can emit abundant amounts of CO, particularly when run at slow speed. It is imperative that the exhaust pipe be directly connected to an exhaust manifold.

If it is necessary to enter a confined space where CO is present or suspected to be present, breathing apparatus with compressed air supply must be worn. Canister masks, even with activated charcoal filters, are generally not adequate. No one should work alone in such spaces.

Workers having difficulty with their heart, blood vessels, or kidneys should not further strain these organs by exposure to significant amounts of CO. Likewsie those suffering from anemia or respiratory diseases should avoid such exposure. Pregnant women are also at greater risk from exposure to CO.

Rotation of duties is a method of control of exposure to CO where the level is inherently high. For example, in New York City's Holland Tunnel, a vehicular tunnel, police are assigned to two hours duty in the Tunnel alternated with two hours of non-exposed duty. Intensive medical examinations of these people, even after eleven years of tunnel duty, have shown no effects due to CO.

OSHA requires that exposure to CO be no more than 50 parts per million (ppm) averaged over an eight-hour day. In 1972 the National Institute of Occupational Safety and Health (NIOSH) recommended that this level be lowered to 35 ppm with a ceiling of 200 ppm at any one time period. NIOSH states that the present limit of 50 ppm does not adequately protect workers having the conditions referred to above nor does it prevent the undersirable behavioral effects of CO. Even NIOSH admits that its reduced standard may not provide a margin of safety for workers with symptoms of heart or blood vessel disease. As a matter of fact, healthy workers engaged in heavy labor are not adequately protected by the new proposed standard. It is believed that the limit for such workers should be ⅓ to ½ of that for workers doing light activity.

As of yet, OSHA has not acted upon this or other NIOSH recommendations, even though it is obligated to do so by law. A single copy of the NIOSH recommendation, "Occupational Exposure to Carbon Monoxide" can be obtained free of charge by writing to: Office of Technical Publications, NIOSH, Post Office Building, Cincinnati, Ohio 45202.

It would be a serious omission to end this article without commenting on the relation of cigarette smoking and CO exposure. The serious effects of cigarette smoking are sometimes used as a cover-up or a convenient scapegoat in order to minimize the importance of occupationally related diseases. In the case of CO, there is no question that the harm done by industrial exposure can be made even more serious for smokers. Just one fact can substantiate this conclusion — the "air" inhaled while smoking contains about 700-800 ppm of CO, more than ten times the OSHA standard!

Occupational Alcoholism: A New Approach

The following article is taken from the December 16, 1974 special edition of the SAN MATEO COUNTY LABOR newspaper. The edition contains an excellent assortment of articles dealing with the emerging concept of Occupational Alcoholism. The MONITOR highly recommends that this special edition be read by all persons interested in obtaining background information on this most critical issue. To obtain copies, please contact: Harold Rossman, Managing Editor, 300 Eighth Avenue, San Mateo, CA 94401, or phone (415) 343-1412.

Why is a joint labor-management approach to the treatment of occupational alcoholism the best way to go?

For an answer from the labor side of that combination, we quote the following remarks to a Chamber of Commerce group by Frank Winn, special assistant to the president of the United Automobile Workers:

"I am convinced that the growing interest in a cooperative labor-management approach is the most significant development in the treatment of alcoholics since the establishment of Alcoholics Anonymous some 30 years ago and the subsequent pronouncement by the American Medical Association that alcoholism is, rather than a weakness of character, an illness and a treatable illness.

"I think the labor-management approach is important for a number of reasons. Obviously, the first reason is that it offers an opportunity for the recovery and rehabilitation of alcoholics in far greater numbers than any of the heretofore rather piecemeal and haphazard approaches, and at an earlier stage in the progress of the disease than might otherwise be the case.

"A second reason is that I believe the successful and widespread operation of such a labor-management program will create enough demand and pressure on the medical profession, hospital administrations, public health departments and other appropriate government agencies that we can begin to overcome the existing deficits in treatment facilities, in the employment of professional personnel trained in alcoholic treatment and rehabilitation and what I and many others have reluctantly had to conclude is, at best, an indifference and, at worst, outright resistance on the part of most of the medical profession and hospital administrations to dealing with and treating alcoholism as an illness.

". . . Now when we talk about a cooperative labor-management approach, the question naturally arises: Why a joint labor-management approach?

"I think a very general, and yet simple, answer to this question is that if management in an organized plant or office unilaterally established an alcoholism rehabilitation program, its implementation would be subject to the regular grievance procedure provided for in the collective bargaining agreement. And the usual grievance procedure which is, like our government courts, an adversary procedure, does not in my opinion lend itself adequately and appropriately to determining whether a person is suffering from the disease of alcoholism and, if he is, what can be done to help him recover from this illness.

"Under the kind of plan I believe would work, if there is a deterioration in the quality of an employee's work, in the quantity of his output, in his attendance and concentration on his job, and there is reason to

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PROJECT ACTIVITIES

COMMITTEE AND STAFF: Huddling during the recent seminar on occupational health and safety at the Villa Hotel in San Mateo are seen (from the left) Bruce Poyer, staff member of the Center for Labor Research & Education; Bob Aaron, Fire Fighters 2349; Dr. Leo Seidlitz; Ed Basye, Steelworkers 1069; Jackie Darracott, Office & Professional 3; Bob Fowler and Morris E. Davis. Dr. Seidlitz is coordinator of research for the Occupational Health Program; and Fowler and Davis are coordinators. The others are members of the Labor Council committee.

• On December 5, 1974, the Labor Occupational Health Project co-sponsored a workshop and seminar with the San Mateo County Central Labor Council. The day long session was held at the Villa Hotel and 45 registrants were in attendance.

The workshop and seminar covered a variety of topics ranging from an overview of health and safety legislation to organizing local health and safety committees. One main result of the meeting was that arrangements are now being discussed for a follow-up program aimed specifically at rank and file unionists interested in health and safety. Although no date has been set, the meeting will be held in the auditorium of Steelworkers Local 1069 in South San Francisco.

Ed Basye of the Steelworkers Local 1069 and Chairman of the Council's Occupational Health and Safety Committee, opened the sessions and welcomed the participants. Program participants included LOHP staff associates Bob Fowler, Bruce Poyer, Phillip L. Polakoff, M.D., Morris Davis, and Leo Seidlitz, Ph.D.

The program proved to be quite successful and future meetings hold the promise of establishing a fruitful relationship between the LOHP and unionists associated with the San Mateo Central Labor Council.

• The Labor Studies Program of the City College of San Francisco will offer a course entitled Health and Safety in the Workplace. The course will begin on February 11, 1975 and meets weekly on Tuesday nights from 7-9 p.m. Leo Seidlitz, PhD., Science and Research Coordinator of the LOHP, will conduct the course.

Description: Designed to provide the tools for recognizing, understanding and controlling the hazards of work. Discussion topics include principles of industrial hygiene and safety; utilization of union and collective bargaining activity; and medical testing or screening approaches that are feasible at the workplace level. The course will also cover the analysis of the background, content and practical impact of both federal and state OSHA legislation and a survey of resources and agencies available for assistance in the recognition and control of workplace hazards. For further information, contact: Labor Studies Program, San Francisco Community College, 33 Gough St., San Francisco, CA 94103; or call (415) 864-3200.

OCCUPATIONAL CANCER CONTINUED FROM PAGE 1

age than non-occupational related cancers. The cancer's development is largely dependent upon both the age at which exposure occurs and the latent period necessary for tumors to develop.

(4) Pre-cancerous abnormalities, i.e. growths, enzyme disturbances, etc. almost invariably precedes the cancer. These abnormalities are often characteristic of particular occupations.

(5) Localization of the tumor is remarkably constant in any one occupation. For instance, farmers, foresters, and fishermen have higher rates of lip and skin cancer. Woodworkers and painters exhibit higher incidences of nose and nasal cavity cancers. Likewise, white-collar workers and professionals have higher rates of cancer in the large intestine.

(6) Occupational tumors, unlike other forms of cancer, are frequently multiple.

Construction workers—extremely hazardous type of work.

Skin cancer—in part caused by overexposure to sunlight which is common amongst construction and agricultural workers.

Methods of Prevention

Having discussed the magnitude and seriousness of the problem, the question remains as to the adequate means of resolving this crisis. Dr. Cesare Maltoni, a noted cancer researcher from Italy, has suggested an essential and realistic preventative approach:

(1) Correct the presently inadequate methods used for experimental testing of substances. To this end, Congress must pass the Toxic Substance Control Act of 1972, which would require the testing of all new agents **before** they are marketed.

TABLE II

Agents suspected of being cancer causing for workers on an experimental basis:

Beryllium	Pesticides (DDT, aldrin, dieldrin, haptachlor, chlordane)
Cadmium	Thiourea and related compounds
Cobalt	Tannins
Lead	Detergents
Selenium	Alkylating agents
Zinc	Nitrosamines
Carbon tetrachloride	Azo-dyes
Chloroform	
Estrogens	

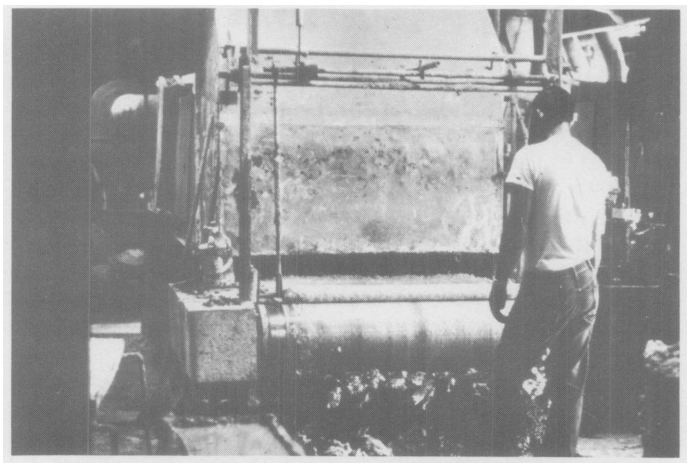
(2) Compile up-to-date epidemiological data from various categories of workers exposed to risk.

(3) Enactment of legislation which would prohibit the production and use of agents shown (experimentally or epidemiologically) to be strongly cancer-causing.

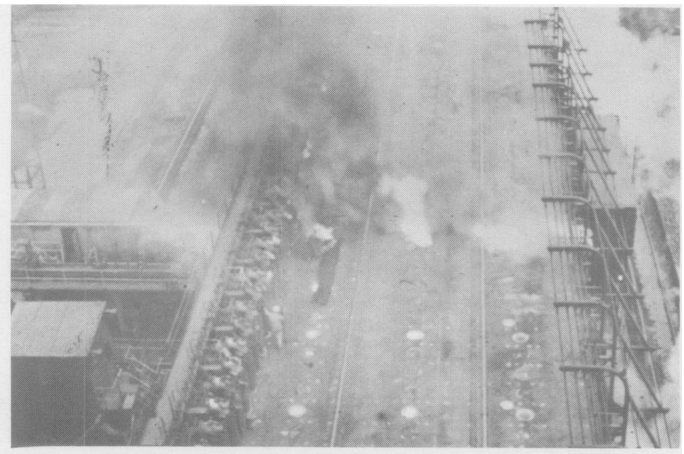
(4) Provide technical protection measures where weak or doubtful carcinogens continue in use of production.

(5) Perform specific medical checks for the early detection of precancerous growths, as well as to determine occupational risk potential.

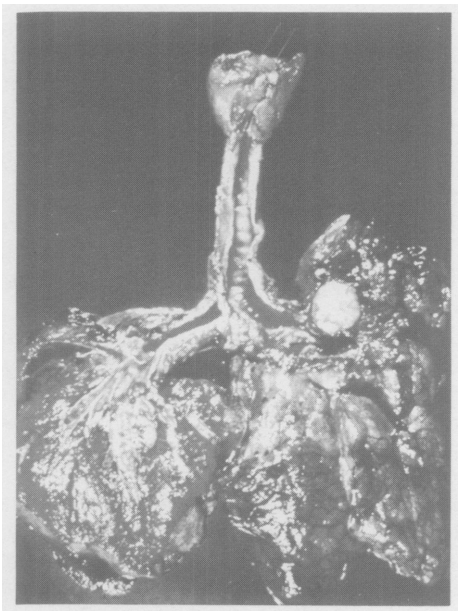
If the above preventative measures are to become a reality, our nation must drastically alter its priorities. A substantial percentage of new cancers can be prevented. Currently the so-called War on Cancer has an annual budget of $663 million with only $1.2 million budgeted for occupational/environmental cancer research. This type of neglect can no longer be tolerated.



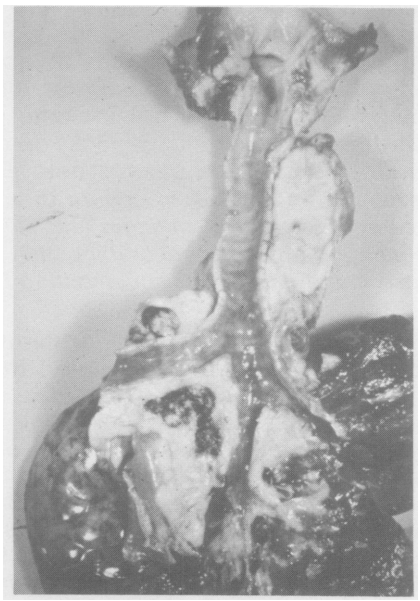
Asbestos worker — 50% chance of getting lung disease after 20 years.



Coke ovens — much higher rates of lung and skin cancer associated with this type of work.



Mesothelioma—very rare form of lung cancer but is quite common amongst asbestos workers.



Bronchogenic carcinoma—asbestos, chemical and mining workers all have higher risk of getting it.

CAL/OSHA DEVELOPMENTS

Feds Criticize Cal/OSHA

Federal officials have recently completed a review of the Cal/OSHA program and have made several findings relative to the effectiveness of the State Division of Industrial Safety's implementation of the Cal/OSHA program.

The California Occupational Safety and Health Plan was submitted to the U.S. Department of Labor on September 25, 1972 and was approved by the DOL on April 24, 1973. The federal review of Cal/OSHA covers the first six months of operations — from January through June of 1974.

The federal report generally acknowledged that certain developmental steps had been accomplished since the Plan had been approved. It also recognized the fact that there was a significant number of qualified personnel to assure proper enforcement of standards. In addition, the report commended the State for the amount of time it had devoted to initial in-service training of Safety Engineers and clerical support staff.

The more critical aspects of the report seems to further amplify many of the complaints which employees have been voicing since the inception of the California Plan. The following is a partial summary of the findings:

— Of the 716 case files reviewed, 155 (22%) do not indicate whether employees or employee representatives participated in the walkaround and/or were interviewed. Of the 208 complaint files reviewed by one of the OSHA Area Offices (31 of which were anonymous), 28% had no evidence that the complainant had been informed of action or non-action taken. **Recommendation:** *Have field personnel reminded of obligations under AB150 (California Occupational Safety and Health Act of 1973), regarding employee participation in inspections, and of the need for documentation of this participation in the case files. The complainant should receive an original copy of the reply since he instigated the inspection.*

— Uniform instructions for Safety Engineers and Industrial Hygienists regarding contents and conduct of opening and closing conferences do not appear to exist in a written, statewide basis. Of the 716 case files reviewed, 71 (10%) do not indicate whether an opening conference was held; 32 (5%) do not indicate whether a closing conference was held. **Recommendation:** *Develop a Policy and Procedure Directive regarding contents and conduct of opening and closing conferences, including references concerning the necessity of holding these conferences and documenting them in case files.*

— With regard to the State Department of Health, the administrative personnel estimated that referrals for assistance from DIS make up over 90% of the workload of the currently staffed Industrial Hygienists (IH). However, the evaluation revealed that only 205 inspections, which represented 3% of total inspections during the 3rd and 4th quarters of fiscal year 1974, had been conducted in health. An inconsistency appeared between workload estimates and the number of health assisted inspections. **Recommendations:** *Assign at least two industrial hygienists to each DIS regional office; and preferably, locate an industrial hygienist at each DIS district office. Also, examine current industrial hygiene manpower utilization and productivity.*

— Review of case files with IH participation indicates that the Health Department does not receive copies of the citations issued by DIS as a result of IH surveys. The Occupational Health Section is therefore unaware of whether a citation is issued, the violation is accurately cited, or whether abatement of the violation occurs. Employers' plans for interim and final corrective measures are not received by the IH to determine effectiveness. **Recommendation:** *Carry out a joint investigation by the safety engineer and the industrial hygienist in cases where the complaint involves a health matter. When the results of the industrial hygiene survey are completed, have the industrial hygienist present a closing conference with the employer to explain fully the violation (if any), interim control measures, and to determine if the abatement period is reasonable. Send copies of citations and correspondence involving health of Occupational Health Section.*

— In the Industrial Hygiene Report, when a standard is violated, it is the responsibility of the industrial hygienist to determine the seriousness of the violation. It appears that this judgment is very arbitrary and without uniformity between field industrial hygienists. The safety engineer may or may not concur with the industrial hygienist recommendation of severity of the hazard. In some of the citations the violation was reworded by the safety engineer and lost some of the meaning that the industrial hygiene report attempted to convey. **Recommendation:** *Develop a standardized method for rating the severity of a health violation.*

— Thirty-six Safety Engineers attended 24 hours of NIOSH training on the recognition of environmental hazards. According to interviews with DIS officials, only about 3% of the field investigations result in a referral to the State Department of Health for Industrial Hygiene services. This indicates a need for the training of the field engineers in the recognition of health problems during their routine inspections. **Recommendations:** *Establish liaison between DIS and the Occupational Health Section to determine specific needs and programs for cross-training of industrial hygiene and safety personnel.*

— In the first six months of operation, there had been virtually no evidence of involvement from the Office of the State Fire Marshall in providing technical assistance to DIS. Although $300,000 was allotted in fiscal year 1974, only $4,000 had been spent through March, 1974. **Recommendation:** *DIS should develop communications and utilize the Office of the State Fire Marshall as described in the State plan, agreement and grant. Explicit procedures should also be developed so that DIS district managers can utilize the State Fire Marshall in identification of fire hazards.*

ALCOHOLISM CONTINUED FROM PAGE 3

believe that the cause is alcoholism, then the question of whether he is suffering from alcoholism should be decided by an examination and diagnosis of a doctor whose professional competence and the acceptance of whose judgment has been agreed upon by labor and management in advance.

If the diagnosis is alcoholism, then union and management would work together for the primary and over-riding purpose of restoring a distressed human being to a useful and productive life. In this manner, union and management become cooperating partners in an endeavor that is of great credit to them both.

Operating Room Personnel Face Health Dangers

Anesthetic gases found in hospital operating rooms are strongly suspected of causing a variety of health risks in men and women who work in surgery regularly, a study released here shows.

The study, sponsored by the National Institute of Occupational Safety and Health (NIOSH), surveyed nearly 50,000 men and women who work as anesthesiologists, nurse anesthetists, operating room nurses and operating room technicians.

Among the results were found:

— Cancer rates among women that are far higher than normal.

— More liver and kidney disease among both men and women.

— More spontaneous abortions and birth defects among children of women who work in operating rooms.

— A 25 percent increase in birth defects among babies fathered by anesthetists, apparently indicating sperm or gene damage.

The increased health hazards were found by comparing health data from these employees with those who work in other areas of the hospital.

Dr. Ellis N. Cohen, who reported on the survey to the meeting of the American Society of Anesthesiologists, said it was not proven that anesthetic gases were the cause of these health hazards. But he cited the fact that operating room personnel run a higher risk in contacting these diseases than other hospital personnel, and also that animal experiments showed the gases have ill effects on health and pregnancy.

Dr. Cohen, of Stanford University School of Medicine, said 20 percent of the 25,000 operating rooms in U.S. hospitals already have equipment to capture and remove waste anesthetic gases. For many hospitals it would cost only about $100 per operating room to install the equipment, he added.

Under arrangement with NIOSH, Stanford University is now studying control procedures to prevent overexposure to the gases, and they are expected to be ready by Jan. 1, 1975. But hospitals, with assistance from NIOSH, can immediately take steps of their own.

NIOSH is now preparing recommendations on exposure levels (parts per million) of the gases, and will present them to the U.S. Labor Department for promulgation and enforcement through its Occupational Safety and Health Administration (OSHA). This will take some time, and NIOSH emphasized that hospitals can initiate action with the advice and assistance of NIOSH.—Service Employee, Nov./1974

HEALTH AND SAFETY SHOPTALK

The Dangers of Clerical Work

Janet Ross, Clerical Worker

For many years, office work was considered an easy, privileged, safe type of work — no dangerous chemicals (supposedly), or machines, relatively low noise level, "desk jobs." However, office work is neither safe nor healthy for the thousands, primarily women, who work in them.

The office where I work is a prime example. Conditions are terrible. It is located in the basement of a small hospital, well isolated from the main building. Eight billers, seven women and one man, and a woman supervisor sit crammed in a space so small that we must walk sideways to fit between the desks. Even then, it is hard to avoid bumping into typewriter trays. All of us have black and blue marks on our legs.

Headaches

By midday, so much oxygen has been used up that people lose concentration and become tired and irritable. On several occasions, women have felt nauseous and faint. Cords from typewriters and adding machines lie all over the floor; at least one person trips over them each day. With the machines going, phones ringing, people talking and the boss yelling, the noise is unbearable. By noon one day, four out of 8 billers had headaches. We are always popping aspirins. Many of us suffer from nervous tension.

Another problem is the heat. The room is so poorly constructed that the women sitting by the window freeze, while those sitting at desks less than two feet away are too warm. On cold days, the office is really damp. The heater is a blower suspended from the ceiling which blows hot, dry air on everyone in its path. We are all very afraid of fire, too, since hundreds of files are not in metal cabinets but on open bookshelves along the front of the room. With only one door, people say that we will have to jump out the window in case of fire!

Employees Complain

All this may be hard to visualize, but it is a terrible place to be stuck for 40 hours a week. Because of the crowding, a woman gashed her leg on her desk drawer last week. She didn't have enough room to move away from the desk to open the drawer!

Everyone who works there has complained for months; we have repeatedly asked for a bigger, safer workplace. Management has never listened. People become so tired of pointing out the problems, suffer-

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Labor Dept. Issues New Rules For Federal Employee Safety and Health

New regulations for federal employee job safety and health became effective Nov. 1, 1974. Secretary of Labor Peter J. Brennan announced that the new rules will implement Executive Order 11807, signed September 28, 1974, by President Ford. The new rules appeared in the Federal Register on October 9, 1974.

The rules apply only to federal workers, including the military. They do not cover employees of private contractors working under federal contract regardless of whether the work is performed on government-owned property. Brennan said the rules require that all federal departments and agencies maintain logs of occupational injuries, illnesses and deaths. Serious accidents resulting in fatalities, hospitalization of five or more workers, or property damage of $100,000 or more must be reported to OSHA within two working days.

Other requirements of the new rules include the following:

— Each agency head must appoint an official of the rank of assistant secretary or equivalent to head the agency job safety and health program.

— Workplace inspections should be conducted by "personnel with sufficient technical competence to recognize unsafe or unhealthful working conditions."

— Employees may report unsafe or unhealthful conditions or may request an inspection of the workplace.

— Imminent danger provisions in the rules call for immediate abatement of the danger or withdrawal of affected workers from exposure to the hazard.

— To assure unsafe conditions are corrected, re-inspections, where practicable, will be conducted.

— Job safety and health standards for federal agencies must provide protection for federal employees "at least as effective as" that offered by OSHA standards for the private sector.

— Field federal safety and health councils will be continued to facilitate the exchange of ideas and information throughout the government on matters of job safety and health.

HEALTH & SAFETY CONTINUED FROM PAGE 7

ing under the conditions, and getting nowhere that someone filed a formal complaint with the California Occupational Safety and Health Administration.

OSHA Inspection

The OSHA man came and inspected the office. The Director of Personnel introduced him by saying "Now girls, this man wants to look over your office, so smile and look pretty!"

He found nothing wrong with the crowding, noise, heating or ventilation. Our boss told us that since the office met OSHA standards we must stop complaining. We told her that the inspector should work in that dungeon for a week and **then** make a decision. One worker remarked, "If this place doesn't violate OSHA standards, I'd like to see an office that does! Cal/OSHA standards must be really low."

Even though the supervisor works in the same room under the same bad conditions, she has no sympathy for the workers' feelings. Management refuses to listen and the hospital "Safety and Health Committee" ignores us. No one from our department is on that committee. In many hospitals, including ours, the clericals are not in the union, so we can't complain to the union and get it to put some pressure on management.

Talking Union

With office conditions as only one of many problems, we have started to talk about unionizing. It is in the discussion stages, but there is a very strong feeling that organizing into a union will help. We know that the one way we are going to improve things and save our health and sanity is by uniting with each other as workers.—Union WAGE, Nov.-Dec./1974

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