

chairman for the Phoenix Boys and Girls Clubs and remains active on their Board of Directors. Robson also is or has been involved with a number of civic boards including Bank One, St. Luke's Foundation, United for Arizona and American Heart Association.

Robson's extraordinary achievements have not gone unnoticed. Arizona State University named him "Entrepreneur of the Year" in 1994 and Ernst & Young named him the same in 1996. In 1998, Northwood University named Robson one of the "Outstanding Business Leaders" in the United States. He was also the recipient of the 1998 Ellis Island Medal of Honor whose past honorees have included Presidents Bill Clinton, Ronald Reagan, and George Bush. Also included in this list of honorees is Frank Sinatra, Bob Hope, Mickey Mantle and Barbara Walters. Robson's personal favorite achievement was his induction into his High School Hall of Fame in Arlington, Massachusetts.

As you can see, Ed leads by example. He is truly an outstanding individual who deserves to be recognized. Therefore I ask you to please join me in wishing my friend Ed Robson a Happy 70th Birthday and continued success.

Mr. Speaker, I rise before you today to pay tribute to the man behind one of the largest home building operations in America, Mr. Ed Robson. As he prepares to mark his 70th birthday on September 21, I'd like to share the history of this outstanding American and Arizonan with my colleagues.

Known as the man behind Robson Communities, Ed grew up in a middle class home environment in Boston, Mass. Although he knew the value of a good education, his love for sports and adventure was even greater. After graduating in 1954 with a degree in business and banking from Colorado College in Colorado Springs, Ed played hockey for Team U.S.A. and was an alternate member of the U.S. Olympic Hockey Team. After leaving the hockey team, Robson joined the U.S. Marine Corps and was assigned as a naval aviator at Pensacola. He served for five years as a helicopter pilot and attained the rank of Captain before leaving the Marines.

Ed began his impressive career as a home builder in 1960, when he decided to pursue real estate and joined Coldwell Banker in Arizona as a real estate agent. He quickly became a broker for one of their offices. He left Coldwell Banker in 1962 and joined the Del Webb Corporation, which is his chief competitor today. As Director of Corporate Sales for the Del Webb Corporation, Robson gained immeasurable experience in all areas of the construction business.

In 1965, Robson decided to leave Webb to test his expertise and budding entrepreneurial spirit with his own real estate projects. With two other Webb employees, Robson marketed resort homesites in Bullhead City, Ariz., and then developed the Pinewood Golf Community in Flagstaff, Ariz. The success of these projects enabled Robson to acquire farmland in 1972, which became Sun Lakes. Robson's competitive drive and business acumen carried him through some tough periods including the energy crisis and recession.

Today, Sun Lakes is a 3,500-acre community with more than 14,000 residents. Robson also markets and develops three other active adult communities in Arizona and recently announced expansion plans in Texas. Robson

Communities and its affiliated companies employ more than 1,170 employees and have closed more than 12,500 homes.

Father of five children and grandfather of 13, Robson still finds time to participate in community affairs. He was the 1993 Heart Ball Honoree Chairman and was instrumental in netting approximately \$1 million for the American Heart Association. In 1994, he was the chairman for the Phoenix Boys and Girls Clubs and remains active on their Board of Directors. Robson also is or has been involved with a number of civic boards including Bank One, St. Luke's Foundation, United for Arizona and American Heart Association.

Robson's extraordinary achievements have not gone unnoticed. Arizona State University named him "Entrepreneur of the Year" in 1994 and Ernst & Young named him the same in 1996. In 1998, Northwood University named Robson one of the "Outstanding Business Leaders" in the United States. He was also the recipient of the 1998 Ellis Island Medal of Honor whose past honorees have included Presidents Bill Clinton, Ronald Reagan and George Bush. Also included in this list of honorees is Frank Sinatra, Bob Hope, Mickey Mantle and Barbara Walters. Robson's personal favorite achievement was his induction into his High School Hall of Fame in Arlington, Mass.

As you can see, Ed leads by example. He is truly an outstanding individual who deserves to be recognized. Therefore I ask you to please join me in wishing my friend Ed Robson a Happy 70th Birthday and continued success.

INTRODUCTION OF THE
"NEEDLESTICK SAFETY AND
PREVENTION ACT"

HON. MAJOR R. OWENS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Monday, September 18, 2000

Mr. OWENS. Mr. Speaker, I am proud to join with my colleague, the Chairman of the Subcommittee on Workforce Protections of the Committee on Education and the Workforce, the Honorable CASS BALLENGER, to introduce the Needlestick Safety and Prevention Act. This legislation modifies the Bloodborne Pathogens Standard (29 C.F.R. 1910.1030) issued in 1991 by the Occupational Safety and Health Administration of the U.S. Department of Labor to improve the protection afforded to health care workers from the spread of bloodborne pathogens such as the HIV virus, hepatitis B, and hepatitis C, as a result of accidental needlesticks and other percutaneous injuries.

Though controversial at the time it was issued, today all agree that the Bloodborne Pathogen Standard has helped to significantly reduce the spread of bloodborne pathogens among health care workers. There is, however, more that can be done.

In March, the Center for Disease Control and Prevention estimated that more than 380,000 needlestick injuries occur in hospitals every year. At an average hospital, there will be an estimated 30 reported needlestick injuries for every 100 beds. It is estimated that there are between 600,000 and 800,000 needlestick injuries every year in all health

care settings. Nurses, doctors, laboratory staff, emergency medical technicians, and housekeepers have all been victimized by needlesticks. Needlestick injuries may account for as much as 80% of occupational exposures to blood.

Needlestick injuries, unfortunately, are not uncommon among health care workers. However, they are by no means trivial. Needlestick injuries impose unnecessary and unacceptable costs on our health care system. Costs to employers associated with followup medical examinations to determine whether needlestick victims have been infected by a bloodborne pathogen are by no means insignificant and can run into the thousands of dollars. Where workers are found to have been infected as a result of a needlestick injury, costs of treatment and compensation can easily run into the hundreds of thousands of dollars. For those who are infected as a result of a needlestick injury, the costs cannot be measured in dollars, they are life-threatening.

At a hearing held on this subject in June, the Subcommittee on Workforce Protections heard from Karen Daley who testified on behalf of the American Nurses Association. In July 1998, Ms. Daley reached into a needle box with a gloved hand to dispose of a needle with which she had drawn blood and was stuck by a needle. Five months later, she was diagnosed with both HIV and hepatitis C. Ms. Daley has had to give up direct nursing care, work that she loves and had performed for twenty years. Ms. Daley has suffered weight loss, nausea, loss of appetite, hair loss, headaches, skin rashes, severe fatigue, and bone marrow depression as a consequence of treatments for her injury. Her life now revolves around treatment for her diseases. Even more seriously, current research indicates that co-infection of HIV and hepatitis C can accelerate progression to liver failure and may lead to cirrhosis, cancer, or failure in five to ten years.

What is most tragic about Ms. Daley's story and that of many like her is that her injury was not simply accidental, it was unnecessary and therefore inexcusable. In Ms. Daley's own words:

[T]his injury did not occur because I wasn't observing universal precautions. I did everything within my power—taking all the necessary precautions including wearing gloves and following proper procedures—to reduce my own risk of exposure to bloodborne pathogens. This injury did not occur because I was careless or distracted or not paying attention to what I was doing. This injury and the life-altering consequences I am now suffering should not have happened. And, worst of all, this injury did not have to happen and would not have happened if a safer needle and disposal system had been in place in my own work setting.

It is estimated that 80% of all needlestick injuries could be prevented if greater use is made of available sharps with engineered sharps injury protections, such as retractable needles, and needleless systems. Since the publication of the bloodborne pathogen standard, there has been a substantial increase in the number and assortment of effective engineering controls that are commercially available. There is a large body of research concerning the effectiveness of engineering controls, including safer medical devices. Further, there is general consensus among health care employers as well as health care workers that

the overall cost of using sharps with engineered sharps injury protections and needleless systems is substantially cheaper than the costs of contending with unnecessary needlestick injuries associated with the use of less safe devices.

The under-utilization of safer medical devices is a national issue. As of August 31st, sixteen States had already enacted legislation requiring the use of safer medical devices and a seventeenth was in the process of doing so. The State laws, however, only partially address the concern. They may not be applicable to private health care sector workers and impose differing requirements that may create burdens for both employers and medical equipment manufacturers. Legislation introduced earlier in this Congress by the Hon. FORTNEY PETE STARK and the Hon. MARGE ROUKEMA to address this same issue, the Health Care Worker Needlestick Prevention Act, H.R. 1899, currently has 187 cosponsors.

To its credit, the Occupational Safety and Health Administration (OSHA) has already acted to ensure that there is greater use of sharps with engineered safety protections and needleless systems. In November 1999, OSHA issued a revised Compliance Directive on Enforcement Procedures for Occupational Exposure to Bloodborne Pathogens and has sought to highly publicize the new compliance directive. One of the principal purposes for issuing the new directive was to emphasize the requirement that employers identify, evaluate, and make use of effective safer medical devices in order to minimize the risk of occupational exposure to bloodborne pathogens.

The legislation that Mr. BALLENGER and I are introducing today builds on OSHA's efforts. By making modest changes in the bloodborne pathogen standard, this legislation, if adopted, will help to achieve substantial improvement in the safety and health of American health care workers. This legislation will help to ensure that health care workers use the safest available medical devices, that they are trained to ensure proper usage, and that employers and workers review and learn from experience to ensure continued improvement.

Specifically, the legislation amends the standard to provide for definitions of "engineering controls," "sharps with engineered sharps injury protections," and "needleless systems" in order to provide greater clarity of the requirements of the standard. The legislation ensures that employers regularly monitor and assess the development of "appropriate commercially available and effective safer medical devices" and implement use of the such devices appropriately. It further ensures that those who must use the equipment will have a voice in its selection and will be properly trained in its use. Finally, the legislation promotes greater awareness and more active vigilance by ensuring that needlestick injuries are monitored and tracked.

In developing this legislation, Mr. BALLENGER and I have sought the greatest possible consensus. For example, I have reluctantly agreed to leave aside for now the issue of extending the protections of the bloodborne pathogen standard to health care workers employed by state and local governments. We have sought to address the concerns of both health care employers and health care workers. While reinforcing the requirement that safer medical devices be used where they are commercially available, this legislation does

not mandate the use of engineered controls where such controls are not commercially available. Neither this legislation, nor the underlying standard it amends, requires anyone to use any engineering control, including a safer medical device, where such use may jeopardize a patient's safety, an employee's safety, or where it may be medically contraindicated. This legislation leaves intact all of the affirmative defenses available to employers related to the use of engineered controls under the Bloodborne Pathogens Standard. Finally, we have worked closely with OSHA to ensure that this legislation appropriately builds upon and complements the existing standard.

In conclusion, I want to thank the many people who have worked with Mr. BALLENGER and I to develop this legislation. For my part, I want to especially thank Madeleine Golde and Lorraine Theibaud of the Service Employees International Union; Barbara Coufel of the American Federation of State, County, and Municipal Employees; Bill Cunningham of the American Federation of Teachers; and Stephanie Reed and Karen Daley of the American Nurses Association. Finally, I would like to pay special tribute to Peggy Ferro. At a 1992 hearing by another committee entitled "Healthcare Worker Safety and Needlestick Injuries," Ms. Ferro testified about how she contracted HIV from a conventional needle. Ms. Ferro died in 1998. I sincerely commend Chairman BALLENGER for his efforts to ensure that we are more responsive to Ms. Daley than we were to Ms. Ferro.

INTRODUCTION OF THE NEEDLESTICK SAFETY AND PRE- VENTION ACT

HON. CASS BALLENGER

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Monday, September 18, 2000

Mr. BALLENGER. Mr. Speaker, I am joined by my colleague and ranking member of the Subcommittee on Workforce Protections, the Honorable MAJOR R. OWENS, in the introduction of the Needlestick Safety and Prevention Act. This bipartisan legislation will address an important public health issue confronting our nation's health care workers.

The Needlestick Safety and Prevention Act derives from the convergence of two critical circumstances that have a profound effect on the safety of health care workers. The first circumstance is the increased concern over accidental needlestick injuries suffered by health care workers each year in health care settings. "Needlesticks" is a term used broadly, as health care workers can suffer injuries from a broad array of "sharps" used in health care settings, from needles to IV catheters to lancets. The second circumstance is the technological advancements made over the past decade in the many types of "safer medical devices" that can be used in health care settings to help protect health care workers against sharps injuries.

The Needlestick Safety and Prevention Act would modify the Bloodborne Pathogens Standard (29 CFR 1910.1030), one of the leading health and safety standards promulgated by the Department of Labor's Occupational Safety and Health Administration (OSHA). The legislation builds on the most re-

cent action taken by OSHA related to the Bloodborne Pathogens Standard—the November 1999 revision of OSHA's Compliance Directive on Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens.

The concern about accidental injuries to health care workers from contaminated sharps first entered the public consciousness in the mid-1980's as concern over the AIDS epidemic grew, along with concern about the spread of hepatitis B. By the end of the decade, there were a number of documented cases of health care workers contracting the HIV virus by accidentally getting stuck with a needle when treating a patient. In 1991, responding to many of those concerns, OSHA issued the Bloodborne Pathogens Standard, which specified workplace safety requirements to protect against occupational exposure to bloodborne pathogens.

Since that time, numerous studies have demonstrated the continuing serious risk to health care workers of percutaneous injuries from contaminated sharps. In March of this year, the Centers for Disease Control and Prevention estimated that more than 380,000 percutaneous injuries from contaminated sharps occur annually among health care workers in United States hospital settings. Estimates for all health care settings are that 600,000 to 800,000 needlestick and other percutaneous injuries occur among health care workers annually. At an average hospital, workers incur approximately 30 reported needlestick injuries per 100 beds per year. While most reported needlestick injuries involve nursing staff—laboratory staff, physicians, housekeepers, and other health care workers are also injured.

At a Subcommittee on Workforce Protections hearing in June, Mr. Charles Jeffress, the Assistant Secretary of OSHA, testified about the most recent federal action to address this issue—OSHA's revised Compliance Directive on Enforcement Procedures for Occupational Exposure to Bloodborne Pathogens. While the goals of the Bloodborne Pathogens Standard are clearly stated, many aspects of the standard give employers considerable flexibility in choosing the methods most feasible for accomplishing those goals. Thus, the standard directs employers to use engineering controls and work practices to eliminate or minimize employee exposure to bloodborne pathogens, but it does not list or specify particular engineering controls (such as which medical devices) that employers must use. This approach allows the rule to take into account the continual progress of medical research and technology and the diversity of workplaces and workplace operations and processes, and allows the employer to determine what engineering controls will provide the best protection.

A highlight of the revised Compliance Directive, and indeed one of the main reasons for its revision, is the emphasis on the need for employers to identify, evaluate, and make use of effective commercially available engineering controls, including "safer medical devices" to reduce or minimize the risks of occupational exposure to bloodborne pathogens. These devices are also referred to as "safety devices" or "safe-needle devices," but their common element is that they have a built-in safety mechanism that reduces or eliminates exposure to the needle or sharp. Neither the Compliance Directive, nor the current bloodborne