

TESTIMONY OF

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**BEFORE THE
FEDERAL MOTOR CARRIER SAFETY
ADMINISTRATION**

**AND
FEDERAL RAILROAD ADMINISTRATION**

**Public Listening Sessions on Obstructive Sleep Apnea
Among Commercial Motor Vehicle Drivers and Rail
Workers**

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My name is John Risch and I am the National Legislative Director for the Transportation Division of the International Association of Sheet Metal, Air, Rail and Transportation Workers (SMART TD). SMART TD – formerly the United Transportation Union – is an organization representing approximately 125,000 transportation workers most of whom are employed in freight and passenger rail operating crafts. Our membership also includes transit and airline workers

I want to start off by saying that any rulemakings regarding obstructive sleep apnea (OSA) should be handled separately by the FRA and the FMCSA.

FRA:

On the rail side of things we believe the top 3 safety issues in the freight rail industry are Fatigue, Fatigue and Fatigue and sleep apnea is a very small part of the solution to that problem.

The biggest contributing factor to fatigue in the freight industry is unpredictable work schedules. Our members are forced to be on call 24 hours a day, 7 days a week for their entire careers. They are forced to show up for work with as little as 90 minutes notice to work 12-hour shifts, often at night, in terribly demanding conditions.

Fatigue in the freight rail industry desperately needs to be addressed in a comprehensive way, either by the railroads and their employees working together (and there's not much hope here) or by government fiat.

Singling out sleep apnea as a fix to fatigue in our industry, and ignoring the most significant contributing issue of unscheduled work, is like fighting world hunger with a pick-up truck load of watermelons. Until the real problem of unscheduled work is addressed, piecemeal efforts, like focusing on sleep apnea, will do little to reduce fatigue-related rail accidents.

Besides, we have been addressing sleep apnea on the rail side. The discussions in the RSAC working group considering medical standards agreed that regulation was not the answer to addressing sleep apnea. Rather, a railroads' medical department could adequately deal with the issue by evaluating for sleep apnea during our members regular required physicals.

Instead of proposing a separate rule on sleep apnea we recommend that FRA work with our nation's railroads and rail labor on implementing the Fatigue Management plans required by the Rail Safety Improvement Act of 2008 (RSIA). That current law states that in their fatigue management plans, railroads shall consider the need to include elements addressing: *"opportunities for identification, diagnosis, and treatment of any medical condition that may affect alertness or fatigue, including sleep disorders."* Several major railroads have already made significant progress in this regard.

In addition to sleep disorders, the RSIA states that fatigue management plans shall consider the need to address *"Scheduling practices for employees, including innovative scheduling practices, on-duty call practices, work and rest cycles, increased consecutive days off for employees, changes in shift patterns, appropriate scheduling practices for varying types of work, and other aspects of employee scheduling that would reduce employee fatigue and cumulative sleep loss."*

It is clear that the RSIA encourages a much more comprehensive approach to combatting fatigue and sleep disorders in the rail industry than simply focusing on sleep apnea.

FMCSA:

On the motor carrier side: In 2012 the Motor Carrier Safety Advisory Committee (MCSAC) and the Medical Review Board (MRB) issued recommendations for FMCSA to consider when developing regulations on sleep apnea.

We believe that current company practices for diagnosis of sleep apnea are, in many cases, discriminatory and unfairly deprive our members of pursuing their livelihood. That is why we would welcome a rulemaking that incorporates many of the recommendations in the 2012 report that would establish stricter criteria for company medical examiners in diagnosing sleep apnea and make drivers eligible for conditional certification.

Current FMCSA guidance encourages MEs to consider whether the driver has a respiratory condition, such as OSA, that could impact their ability to drive safely. Unfortunately, these practices have resulted in some of our members being removed from service solely based on their physical characteristics, such as weight and neck size, rather than a viable physical exam. We have had cases in which 40-year bus drivers with no accident history and 2 million safe miles driven were removed from service, despite showing no symptoms of sleep apnea, simply because they are a bit overweight and/or have a large neck.

Under current practices, a significant burden is placed on drivers who are simply suspected of having sleep apnea. After a driver is removed from service, they must make an appointment with their general practitioner to get a referral to see a sleep specialist and go through expensive testing to prove their innocence or get treatment. This is a very costly process that can force a driver to go 2-3 months without pay. This process could be shortened if company medical examiners would simply make the initial referral to a sleep specialist, but unfortunately most refuse to do it.

When a bus driver is referred to a specialist for possible sleep apnea based on observed risk factors, like their weight and neck size, the driver should be given the opportunity to obtain a conditional certification pending a sleep study, as recommended in the 2012 report. And if a driver is ultimately diagnosed with sleep apnea and complies with his doctors recommended treatment they should be eligible for conditional certification – something that was also recommended in the 2012 report.

Simply put, motor carrier operators, who may, or do have sleep apnea should be granted the same conditional certification as drivers who have high blood pressure or diabetes and are being effectively treated for those conditions.

The Federal Aviation Administration (FAA) currently employs a policy similar to what we would like to see from the FMCSA. Under the FAA's sleep apnea policy, pilots identified as being at risk are provided with a medical certificate that allows them to continue working for 90

days pending further evaluation. If a pilot is diagnosed with sleep apnea, and provides documentation of effective treatment, they are considered for a special medical certification that allows them to resume flying.

Costs for Testing for Sleep Apnea:

The cost of determining sleep apnea vary widely and are costly. Treatment is also very expensive. The costs vary, depending upon the lab and type of study performed. Normally, there will be charges for the doctor's consultation and for the equipment. If a sleep apnea diagnostic test is confirmed with one particular test, then another night in the lab may be necessary, all of which can cost many thousands of dollars.

Thank you for the opportunity to appear here today and for your willingness to consider our views. We are committed to working with the agencies of the DOT and our nation's railroads and bus companies to comprehensively address all the issues in the workplace that contribute to fatigue.

I've attached a list of costs associated with diagnosing and treating OSA to this testimony.

Research on Costs

For example, a Home Sleep Test (the least expensive and not as effective) costs approximately \$250 to \$800, and there may be an additional physician fee. This is a cheaper test because less data is collected and the overhead costs of the sleep center and technician do not exist.

The Polysomnogram (PSG) In –Lab Sleep Test technical fee varies from about \$900 to \$5,000 and the added physician fee is \$1,100. At the Sleep Center at Greenwich Hospital in Greenwich, CT, the cost was \$6,177 plus interpretation and doctor's fees separate. The Trinitas Regional Medical Center in New Jersey charges \$5,070, and the Chilton Hospital's Health Institute charges \$4,200. Stanford University in Palo Alto, CA is the highest at \$8,500. The CPAP Titration Study technical fee can be up to \$4,000 and the physician fee \$1,200. (That test usually follows the PSG test). With both tests combined, the Summit Medical Group in New Jersey charges approximately \$2,700 for a PSG and \$3,100 for a PSG with a CPAP. Hackensack University's Institute for Sleep/Wake Disorders charges \$1,900 for each procedure. The fees at the Greenwich Hospital are \$7,801.

The Multiple Sleep Latency Test technical fee can be up to \$2,500 and the physician fee \$1200. This test is not used regularly to test for sleep apnea, but it has been used. To demonstrate how varied the costs are, at the New Jersey Sleep Center for Sleep Medicine at St. Claire's Hospital is \$850, while at Trinitis the bill is \$4,158. Lastly, the Maintenance of Wakefulness Test technical fee can be up to \$2,500 and the physician fee \$1,200.

Treatment:

Assuming one tests positive for sleep apnea, a CPAP machine and mask will rent for approximately \$75-100 per month. The retail cost of a CPAP machine is up to \$3,000, depending on the make and model, and the average cost of supplies (mask, tubes and filters) is up to \$800/yr.

Using dental devices, instead of the CPAP, the costs range from \$1,800 to \$2,000.

There exist other treatments, such as surgery, but the CPAP or use of dental devices are the normal types of treatment.