

UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

+ + + + +

MEETING

+ + + + +

WEDNESDAY
OCTOBER 19, 2016

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The Advisory Board met in the Comfort Inn Oak Ridge-Knoxville, 433 S. Rutgers Avenue, Oak Ridge, Tennessee, at 8:30 a.m., Steven Markowitz, Chair, presiding.

MEMBERSSCIENTIFIC COMMUNITY:

JOHN M. DEMENT
MARK GRIFFON*
KENNETH Z. SILVER
GEORGE FRIEDMAN-JIMENEZ
LESLIE I. BODEN

MEDICAL COMMUNITY:

STEVEN MARKOWITZ, Chair
LAURA S. WELCH
ROSEMARY K SOKAS
CARRIE A. REDLICH
VICTORIA A. CASSANO

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KIRK D. DOMINA
GARRY M. WHITLEY
JAMES H. TURNER
FAYE VLIIEGER

DESIGNATED FEDERAL OFFICIAL:

ANTONIO RIOS

ALSO PRESENT:

RACHEL LEITON, Director, DEEOIC*
JOHN VANCE, Branch Chief, DEEOIC Policy,
Regulations and Procedures

*Participating by phone

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1 P-R-O-C-E-E-D-I-N-G-S

2 (8:40 a.m.)

3 DEFINING EEOICPA'S STANDARD FOR
4 WORK-RELATEDNESS

5 CHAIR MARKOWITZ: Thank you. We
6 will begin this meeting this morning.

7 I'd just like to start off by
8 thanking those members of the public who are
9 participating today, by phone or in person, and
10 also those of you who are here today and also,
11 participated yesterday. Many of the Board
12 members were very interested in discussing some
13 of the comments from the public comment period,
14 and we look forward to additional public
15 comments today.

16 I would say that later in the
17 morning, we're going to -- one of the Advisory
18 Board process issues that we'll discuss is the
19 timing of the public comment period, whether
20 it's to come at the end of the day or during
21 the day, and also the length of the public
22 comment period because it would -- because it

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1 was a little rushed yesterday, and the question
2 is whether we should leave some additional time
3 for public comments.

4 So, I have reconfigured the agenda
5 for today, and I just want to walk through it
6 and see if it's okay, and see if people have
7 any suggested changes.

8 To the extent that there is still
9 issues involving causation, aggravation and
10 contribution, we could resume that discussion
11 this morning. I think actually Ms. Pope had a
12 comment, she may have wanted -- but hold off.

13 We'll resume that discussion, for a
14 limited time period, and then I think we should
15 talk about some recommendations that some of
16 the subcommittees may want to be propose,
17 whether we want to vote on them or not, and
18 then we will talk about the two letters that
19 the Board received from ANWAG in the last
20 several months, talk about the content of those
21 letters.

22 We can then discuss the status, if

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1 members -- if Board members want to, we can
2 discuss the status of the -- our Advisory Board
3 requests from the past. We received a 24 page
4 description of those requests and the status.

5 We will take a break at some time,
6 although I would say having had coffee over the
7 last hour or so, you're welcome to take a
8 break, whenever you want to.

9 But we will then discuss more about
10 presumptions, the use of presumptions --
11 current use of presumptions, how our thinking
12 is about presumptions. It's really a beginning
13 of that kind of discussion, and we will then
14 talk about administrative matters of the Board,
15 next meeting, our process, whether our process
16 needs could be improved in some respect and the
17 like.

18 So, are there any -- anything that I
19 forgot to add or any suggestions? Dr. Redlich?

20 MEMBER REDLICH: Just in terms of
21 public comments, I think some of us, because of
22 flight availability -- sorry, just as far as

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1 public comments, some of us, I think because of
2 flight availability, have flights. Mine is at
3 three. So, I would prefer the public comments
4 --

5 CHAIR MARKOWITZ: Yes, well, we
6 can't --

7 MEMBER REDLICH: -- sooner.

8 CHAIR MARKOWITZ: We can't change it
9 for today.

10 MEMBER REDLICH: Okay.

11 CHAIR MARKOWITZ: Because it was --

12 MEMBER REDLICH: I understand.

13 CHAIR MARKOWITZ: -- set in stone in
14 the Federal Register.

15 MEMBER REDLICH: Okay.

16 CHAIR MARKOWITZ: Two months ago.
17 But I'm talking about in the future.

18 MEMBER REDLICH: Okay, sorry.

19 CHAIR MARKOWITZ: And that's why I
20 believe --

21 MEMBER REDLICH: Yes, I thought we
22 couldn't change it. I misunderstood.

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1 CHAIR MARKOWITZ: The public
2 comments are transcribed, right?

3 PARTICIPANT: Yes.

4 CHAIR MARKOWITZ: Okay, so, they are
5 available. I mean, it's better hearing them in
6 person, obviously. But they are -- they are
7 available after the fact. Any other comments?

8 Okay, so, let's resume our
9 discussion about the causal standard in
10 EEOICPA, and I think, Ms. Vlieger, you were the
11 one that mentioned that actually -- this is a
12 question, that DOL actually has developed their
13 own definition, and there was a second instance
14 you mentioned in which there's been an occasion
15 to define how it's used.

16 So, we need to obtain those details.
17 I don't think we're going to get them right now
18 for today, but this is a very important
19 fundamental topic that we're going to continue
20 to discuss.

21 MS. VLIEGER: When we left off
22 yesterday, we had been discussing the

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1 statistical definition for significant, and how
2 it's applied against as likely as not.

3 So, we run into this definition
4 being misconstrued by a number of different
5 professionals from their perspective, and so,
6 in my experience, when they say as likely as
7 not, they really expect it to be 50 percent
8 standard. They like that thought pattern, and
9 then when they say significant, they add that
10 on top. So, as likely as not, a significant.

11 So, I do believe we need to at least
12 have some sort of training document that
13 discusses the -- where this actually comes from
14 in statistical language, so that it's not --
15 it's not a common definition which is additive
16 to the as likely as not.

17 CHAIR MARKOWITZ: Yes, Dr. Redlich?

18 MEMBER REDLICH: No.

19 CHAIR MARKOWITZ: Okay, yes, I don't
20 really think it's primarily a statistical
21 question, actually, but I would like to comment
22 actually, on an example that Dr. Welch gave

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1 yesterday, of would we -- how would we think
2 about the second -- someone who is exposed to
3 secondhand smoke, who is also -- was an active
4 smoker, if they developed lung cancer, and she
5 mentioned actually that if the secondhand smoke
6 gives you 20 percent increase in risk and the
7 active smoking gives you a 2,000 percent
8 increase in risk, how would we look at that
9 added contribution from the secondhand smoke?

10 My reaction to that is, I would
11 regard the added contribution from secondhand
12 smoke, at least in my opinion, would be not a
13 significant factor. It's dwarfed really by the
14 act of smoking, and I think that probably
15 reflects common sense.

16 But I would point out that there are
17 very few risk factors that give you a 20-fold
18 increase risk of disease, and you're hard-
19 pressed to really think of any, maybe outside
20 of infectious diseases, in which there is such
21 an over -- that some non-occupational factor is
22 so overwhelmingly important in the causation,

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1 that it would so clearly dwarf an occupational
2 factor.

3 So, I think that's an interesting
4 example, but usually the amount of risk
5 attached to a toxin would be much closer to the
6 amount of risk -- increase in risk to other
7 risk factors besides toxins.

8 Dr. Boden? I'm sorry, Ms. Leiton
9 wants to make a comment, so let me just call on
10 her.

11 MS. LEITON: Okay, I'm trying to get
12 this away from as many speakers as possible.
13 Can you hear me?

14 CHAIR MARKOWITZ: Yes.

15 MS. LEITON: Okay. So, when you
16 talked about the at least as likely as not,
17 somebody yesterday mentioned that 50 percent
18 are -- the lawyers, our lawyers do look at 50
19 percent are not, as at least as likely as not,
20 but we do have that aggravation and
21 contribution, and I thought that Dr. Markowitz
22 gave a really good explanation of how that

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1 could be used, and that could really help us.
2 I just believe that he described it.

3 So, I just want to put that out
4 there. They do say, because they're seeing in
5 radiation, being 50 percent are not, when we
6 say at least as likely as not, but for most of
7 it, that's where it gets under this. I just
8 wanted to put that out there.

9 CHAIR MARKOWITZ: Okay, thank you.
10 Dr. Boden?

11 MEMBER BODEN: Yes, so before I go
12 to where I was originally going to go, I want
13 to make a comment about what we just heard,
14 that is, it seems to me that there is a
15 potential ambiguity in the language that we're
16 clearly on one side of, and on the side that
17 Dr. Markowitz described yesterday, but that the
18 lawyers who are used to thinking about things
19 like negligence suits, where more likely --
20 where more likely than not refers to the
21 likelihood that this, as opposed to something
22 else, was more than 50 percent likely or 50

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1 percent or more likely to have caused the
2 injury.

3 So, it's perhaps, something that we
4 need to also convey to the DOL lawyers, and may
5 require us to sort of think a little more about
6 how we might present that.

7 I do think that from our
8 perspective, that if the more likely than not
9 refers to the word 'substantial', and if that's
10 -- that we should at some point, recommend that
11 instructions, for example, to the CMCs make it
12 clear, what more likely than not means, because
13 they, in their own lives, will have their own
14 idea about that, and it ought to be consistent
15 across everybody.

16 CHAIR MARKOWITZ: Dr. Sokas?

17 MEMBER SOKAS: This is in response
18 to the comment that, you know, the -- the --
19 there are not very many examples of a smoker,
20 you know, has secondhand smoke.

21 But I think that may not be so true.
22 We may encounter that quite a bit when we come

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1 with the very common diseases.

2 So, diabetes has all these other
3 factors that contribute, and so, it would be --
4 you know, that makes it challenging. Prostate
5 cancer, you know, things like that, that can be
6 -- that occur quite a bit can be challenging.

7 CHAIR MARKOWITZ: Right, let me just
8 respond to --

9 MS. LEITON: This is Rachel. We
10 actually instruct our CEs to not place any
11 emphasis on smoking. So, I just -- I heard
12 this again yesterday, so, I just want to make
13 it clear that smoking is not to be a factor in
14 most cases, when we're talking about asbestos.

15 CHAIR MARKOWITZ: All right, okay.
16 That's very interesting. Dr. Friedman-Jimenez?

17 MEMBER FRIEDMAN-JIMENEZ: Yes, the
18 smoking example is very interesting, and I
19 think it's something that we should think about
20 and help us understand.

21 Smoking, all right, if it raises the
22 risk of lung cancer by 10-fold, let's say, or

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1 20-fold, it -- what's important is not that
2 it's a very strong and common risk factor.
3 What's important is the mathematical form of
4 the interaction of the smoking with the other
5 risk factor.

6 So, if you're considering say,
7 asbestos and smoking, smoking is irrelevant
8 because there is what we call a multiplicative
9 interaction between asbestos and smoking.

10 So, the asbestos raises your risk of
11 lung cancer five-fold. Smoking raises it 10-
12 fold. The combination raises it 50-fold and
13 whether you're a smoker or not, asbestos still
14 raises the relative risk five-fold.

15 So, the smoking is no longer
16 relevant to the issue. It's just asbestos
17 exposure or not. But the example of
18 environmental tobacco smoke and cigarette
19 smoking is fundamentally different, because
20 it's not a multiplicative interaction. It's an
21 additive interaction.

22 So, if you have 10-fold or 10.2-

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1 fold, that's the increase in risk, and as
2 you're saying it's dwarfed and among smokers,
3 the relative risk of environmental tobacco
4 smoke is much lower than it is among non-
5 smokers.

6 So, you can't -- so, smoking does
7 enter into the question and it becomes a big
8 factor, and I think we have to think about
9 this. The problem is that these, what we call
10 interactions, are not commonly studied in
11 epidemiology because they require huge data
12 sets and really, really complete data sets, and
13 it's not very common that you have a population
14 you can study then.

15 So, I think we're at somewhat of a
16 loss to actually work this out in a rigorous
17 way, and I don't think we're ever going to be
18 able to have a calculable probability of
19 causation.

20 When you say 50 percent more likely
21 than not that something was caused by some
22 factor, you're talking about a probability of

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1 causation, and the mathematics have been worked
2 out to some degree.

3 But when you say more likely than
4 not that it was caused or contributed to or
5 aggravated significantly, no one has worked out
6 the math for that, and we're really -- we're in
7 a new realm now, and we don't really understand
8 how that works.

9 So, it makes it more of a
10 qualitative judgment, but the bottom line is,
11 it comes down to who are the doctors that are
12 making these determinations and how were they
13 trained?

14 So, what I think would be useful is
15 for some of us to maybe put together a package
16 explaining to all the doctors, so they have a
17 standardized reference, of how to think about
18 this question of more likely than not, that
19 something was significantly contributed to or
20 aggravated or caused by the factor, and so,
21 that we'll have -- all the doctors will have to
22 read this and try and figure it out and work

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1 with it, and we can be helpful to them and
2 explain it to them, but I think there needs to
3 be some standardization here because the
4 interpretation of this is going to be all over
5 the map, because nobody understands it, because
6 it's not well understood.

7 CHAIR MARKOWITZ: Dr. Cassano?

8 MEMBER CASSANO: Hi. Good morning,
9 everybody. You know, we can go down a rabbit
10 hole on this forever and ever and ever.

11 But I think we -- we do not want to
12 do a statistical evaluation of this, because
13 that's not -- we're looking for a legal
14 standard, and when I do this, and I do this all
15 the time, when I see what -- what saves us here
16 is the word contributory and/or aggravated.

17 If you were just looking at, at
18 least as likely as not causes, then you're
19 stuck with the 50 -- with the -- with the 50
20 percent.

21 But because it says causes,
22 contributed or aggravated, even with the word

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1 substantial there, that drops the contribution
2 of the occupational exposure below the 50
3 percent threshold of causation.

4 So, therefore, you have a lot more
5 wiggle room, and how I parse these a lot of
6 times is, I think I said this yesterday, and
7 I'm going to add to it. The fact of the matter
8 is the exposure you're talking about, while it
9 needs to be -- it needs neither to be necessary
10 or sufficient in and of itself, to cause the
11 disease.

12 What we're really saying is that,
13 let's take smoking and diesel exhaust, both of
14 which cause lung cancer. You cannot say that
15 the person would not get lung cancer if he
16 hadn't smoked nor that he would definitely get
17 lung cancer if he had smoked.

18 Therefore, the diesel exhaust
19 obviously played a role in the development of
20 this cancer, and that's how I parse it for the
21 lawyers and for all the people that are going
22 to sit there and say, you know, the guy smoked,

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1 and therefore, nothing else counts.

2 CHAIR MARKOWITZ: Ms. Vlieger?

3 MS. VLIEGER: Rachel, if you're able
4 to hear me, I just wanted to bring up that even
5 though the CEs are told that it's not a factor,
6 since it does appear, smoking as a question
7 does appear on the Occupational History
8 Questionnaire, the referrals to the CMCs often
9 cite that history when it goes to the CMCs, and
10 I don't think they're actually ever told to
11 disregard it. So, that's just what I've seen.

12 So, when we're looking at
13 redesigning that Occupational History
14 Questionnaire or how we refer things to the
15 CMCs, I think we need to be mindful that that's
16 a portion of the training that I think has not
17 be explained to everyone.

18 MS. LEITON: Okay, thanks. I
19 understand that. I also know that we have said
20 it a lot, but we do a questionnaire for NIOSH,
21 that sometimes gets confused with the
22 occupational history questionnaire.

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1 Since we're talking -- since I have
2 the mic for the minute, we are very close to
3 sharing a new version of the OHQ with the
4 Board.

5 So, I know that came up yesterday,
6 and I just wanted to let you know that.

7 CHAIR MARKOWITZ: Dr. Boden?

8 MEMBER BODEN: Could you clarify,
9 when you say sharing a new version, does this
10 mean a new draft version or a new final
11 version?

12 MS. LEITON: This actually means a
13 new draft.

14 MEMBER BODEN: Good.

15 MS. LEITON: We sent it to our CEs,
16 and we're not going to finalize it until we
17 hear back from the Board.

18 MEMBER BODEN: Okay, good.

19 CHAIR MARKOWITZ: Thank you. So, I
20 would like to raise, for a few minutes, a
21 different question as part of this, which has
22 to do with possible versus probable.

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1 I showed a slide yesterday where I
2 used the International Agency for Research on
3 Cancer's ratings for what causes cancer, and
4 the level of certainty that the expert
5 committees come to about particular agents, and
6 there's some agents in which the committees
7 decide that there is definite evidence in favor
8 of human carcinogenicity, and there is some
9 agents in which the decision that they're
10 probably -- after looking at all the animal,
11 human evidence, mechanistic evidence, they're
12 probably human carcinogens.

13 But there's a third category 2B, in
14 which after a thorough review of all the
15 scientific knowledge available, the committee
16 decides that it's possible that this agent is a
17 carcinogen, but we can't say beyond that.

18 My view is that if the decision
19 about causation is that it's possible that
20 that, to me, doesn't meet the standard under
21 the Act of that it would represent a toxin that
22 you could relate to the disease that a claimant

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1 might have, that if there is enough scientific
2 knowledge and if the decision is no higher than
3 it's possible that it caused that disease, that
4 I don't see the basis whereby that would fit
5 under the causal standard of the Act, and I
6 just wanted -- that's my own personal opinion,
7 but I wanted to know other people's reactions
8 to that. Dr. Friedman-Jimenez?

9 MEMBER FRIEDMAN-JIMENEZ: One
10 difficulty is that neither IARC nor NTP usually
11 rate carcinogens for a specific cancer. For
12 example, lung cancer or thyroid cancer or colon
13 cancer. It's -- whether it's a carcinogen or
14 not is where they have the -- the known human
15 carcinogen or reasonably anticipated human
16 carcinogen for NTP or the Category 1 human
17 carcinogen versus 2A probable, 2B possible for
18 IARC.

19 So, we're frequently left in the
20 situation where we know it's a carcinogen, but
21 it's been shown -- the studies have shown it
22 for a different organ, and so, we don't have

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1 enough information. We don't have a
2 determination from IARC for that particular,
3 say prostate cancer. I ran into it yesterday
4 and explained it.

5 So, that situation I think really
6 requires some level of expert review of the
7 case and the literature, in order to make a
8 determination, since we don't have a clear
9 guidance from IARC and NTP.

10 CHAIR MARKOWITZ: But I would say,
11 and there are many agents for which IARC has
12 concluded that they may be related to cancer,
13 it's possible. That applies to all the organ
14 sites that they looked at, all the organ sites
15 that have been studied.

16 So, if they -- their final
17 determination is that it's a possible
18 carcinogen then there is no specific cancer for
19 which they believe that it probably causes
20 cancer.

21 Whereas, your point is that when
22 they decide something is a definite human

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1 carcinogen, that doesn't apply to all cancers.
2 That applies to this or that particular cancer
3 that's been studied, that the studies show
4 that.

5 But if their determination is that
6 it's possible, that is -- globally applies to
7 all cancer sites and there is no cancer site
8 for which they decided probably or definite, it
9 is related to cancer. Dr. Cassano?

10 MEMBER CASSANO: I agree with you in
11 part, because I think as far as determining a
12 presumption, obviously anything below -- some
13 things in 2A may not fit, and anything below 2A
14 definitely doesn't.

15 However, some IARC monographs are
16 pretty old, and the fact of that matter is that
17 I think within the realm of possible, it might
18 be listed in some training document as really,
19 the CMC has to do some additional research to
20 make sure that there's no new research, since
21 the IARC monograph, that actually brings it to
22 the level of probable. That's the only reason

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1 I think they may be considered at some point.

2 But other -- you know, and the other
3 thing is, we're also talking -- IARC is just
4 talking about cancer. There is no real
5 equivalent levels for stratification, I should
6 say, for those things that are not
7 carcinogenic, and we have to find out where
8 that bar is for those types of outcomes.

9 That's the only reason I -- when I
10 wrote my little recommendation, I said 2B in
11 there as an example of those things which,
12 somebody should do research before they deny a
13 claim, to make sure there is no new -- new
14 evidence to support it.

15 CHAIR MARKOWITZ: Let me just
16 respond. That review of the knowledge and
17 decision about whether a particular toxin is --
18 probably causes state-of-the-art knowledge,
19 that should be program-wide. That shouldn't be
20 something that the CE is going to look at, or
21 in my view, even that the CMC should usually
22 look at.

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1 If you want consistent decisions,
2 then you need information that's used
3 consistently throughout the program, and so,
4 that would be -- that would fall into what Dr.
5 Friedman-Jimenez was recommending, which is
6 some consistent materials that could be used by
7 -- Dr. Redlich?

8 MEMBER REDLICH: I think Leslie was
9 first.

10 CHAIR MARKOWITZ: Dr. Boden?

11 MEMBER BODEN: Just a brief comment
12 about that. So, we're going to be talking
13 about presumptions in a little while, and this
14 relates to the question of presumptions.

15 We need to be clear, using the 2B
16 carcinogens -- 2A carcinogens rather, as an
17 example, that a presumption is a floor and not
18 a ceiling.

19 There is often the risk of a
20 presumption being interpreted as a ceiling,
21 when it shouldn't be.

22 CHAIR MARKOWITZ: And for people who

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1 haven't quite memorized this 2B, 2A business,
2 2B ---

3 (Laughter.)

4 CHAIR MARKOWITZ: -- 2B is the
5 designation of a probable carcinogen and 2A is
6 a possible carcinogen, or the other way around.
7 Dr. Redlich?

8 MEMBER REDLICH: Yes, I was just
9 going to follow up on what Steve has said.

10 I think part of the confusion -- I
11 mean, for the B condition, we know what
12 diseases beryllium causes. We know what
13 diseases silica causes. So, that's clear, and
14 even with that, as we've seen, there still can
15 be a huge amount of trouble in deciding what
16 the individual has, given that no one is
17 questioning causation for the substance.

18 Now, it seems to me on the E side,
19 it's gotten so complicated because we're asking
20 a contract medical physician to both decide,
21 you know, can x cause y in general, and then
22 what about this individual, and I completely

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1 agree with what Steve says.

2 I don't think -- there is no way to
3 have consistency, or that is not what -- if all
4 of us were asked to come up with a conclusion
5 of if A caused B, we'd probably have multiple
6 different answers to that, and so, to me, that
7 shouldn't be in the hands of the -- that should
8 be organization-wide and then there should be
9 guidance in how you would interpret that,
10 because it other just -- it's just --

11 CHAIR MARKOWITZ: Okay, few more --
12 time for a few more comments and then we -- I'm
13 not sure who is next. So, Dr. Friedman-
14 Jimenez.

15 MEMBER FRIEDMAN-JIMENEZ: Yes, we've
16 focused this discussion mainly on cancer,
17 because that's where most of the epidemiology
18 has been done, but I'm looking at this EEOICPA
19 bulletin 1601 on asthma, and criteria for
20 establishing causation for asthma.

21 I think asthma would be a good
22 example for us to think about, not necessarily

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1 discuss at this meeting, but this is an ongoing
2 discussion into the future, because asthma,
3 contrary to the way it's defined here,
4 typically is divided into -- work-related
5 asthma is divided into occupational asthma that
6 was caused in someone who never had asthma
7 before, and work exacerbated or work aggravated
8 asthma in someone that had asthma and then the
9 occupational exposure made it worse.

10 So, there is a more clear
11 distinction between aggravation and causation
12 and I think this might be a good model for us
13 to think about this expanded definition of
14 causation, contributed to and aggravation.

15 So, in the future, I think maybe we
16 can talk about asthma in that way, but we have
17 to all think about it and I don't know that we
18 can do this discussion today.

19 CHAIR MARKOWITZ: Okay, okay, great.
20 Final comments? Ms. Vlieger?

21 MS. VLIEGER: I just want to second
22 the thought that this is a floor, not a ceiling

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1 and many times in processing claims, the
2 claimants, you know, have a certain mind set.

3 But going back to the way diseases
4 are categorize and looked at by claims
5 examiners, I would rather paint with a broad
6 brush then drill down to minuscule little
7 diseases that have a particular causation, and
8 the reason being is that if we do that, we have
9 a lot of -- I see a number of claims where the
10 difference between a disease is the last three
11 letters and claims have been denied because the
12 claims examiner mistook one disease that wasn't
13 covered, for a disease that is covered.

14 So, when we do this, those are the
15 type of things we're dealing with, and it's
16 just because of the volume of claims that
17 claims examiners deal with. So, a broad brush
18 rather than detailed, if it's going to be in
19 the claims examiner's hands initially.

20 CHAIR MARKOWITZ: Thank you. Let's
21 move on to recommendations, and let me just see
22 which subcommittees have some recommendations

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1 they want to discuss, and then how many. Two?
2 Okay, three? Okay, fine.

3 So, on the Part B lung disease,
4 Carrie, I don't think -- were there any
5 recommendations? There was, I think, something
6 about sarcoidosis, right?

7 Okay, so, I don't know if you want
8 to -- there is time now, but if you want to
9 consider proposing recommendations.

10 Let me -- let me -- and then there
11 is -- I promised to come up with something
12 around the post '95 exposure circular that we
13 looked at. So, that's another piece.

14 Let me just say though about these
15 recommendations. We can vote on them today or
16 not. Some may not be quite ripe enough to vote
17 on. We may not have enough knowledge or there
18 may not have been enough opportunity for
19 discussion. They may be one -- there may be
20 interest in further discussion at the
21 subcommittee level.

22 We don't have to wait six months to

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1 vote on them as a Board. We can meet by
2 telephone, with six weeks' notice, with public
3 access. We can't vote electronically, because
4 there has to be an opportunity for discussion
5 and for the public to access that deliberation.

6 But we could, six weeks from now or
7 10 weeks from now, or three months from now
8 have a meeting by telephone, in which we
9 discuss recommendations and then vote on them
10 at that point.

11 So, we don't -- if we -- we don't
12 have to feel compelled at all to come to a
13 decision today, nor worry that we're going to
14 lose half a year, because we're not going to
15 meet again probably for six more months.

16 Okay, so, I just wanted to start
17 that off. Dr. Sokas, do you want to start?

18 MEMBER SOKAS: Well, no, I just have
19 a comment on that, which is, I think we should
20 go -- whatever we do get to vote on today,
21 commit to having a letter go to the Secretary
22 with that information, within a defined period

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1 of time, so we're not waiting six weeks and
2 then six weeks and then six weeks.

3 CHAIR MARKOWITZ: Okay, and thank
4 you, and I would remind you that that
5 recommendation has to be accompanied by a
6 rationale, and the hope today was in proposing
7 some recommendations, that we also either have
8 or will formulate just the bullet points that
9 would go into that rationale.

10 So, do you want to start, Dr. Sokas
11 or --

12 MEMBER SOKAS: There was a question,
13 I think, about who should start in terms of --
14 I mean, the ones I presented yesterday, I've
15 tweaked a little bit, you know --

16 CHAIR MARKOWITZ: Okay.

17 MEMBER SOKAS: -- with feedback, but
18 I thought that there was some question about --

19 CHAIR MARKOWITZ: Dr. Cassano, you
20 want to go first?

21 MEMBER CASSANO: I can go through
22 recommendation one.

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1 CHAIR MARKOWITZ: All right, okay.

2 MEMBER CASSANO: The entire case
3 file should be made available to both -- sorry,
4 I don't boom that loudly.

5 The entire case file should be made
6 available to both the industrial hygienist and
7 the contracted medical consultant, while can't
8 -- I don't type very well, when a referral is
9 made to either, and not just that information
10 that the claims examiner believes to be
11 relevant.

12 The CE should map the file to
13 indicate where relevant information is believed
14 to be and that way, that helps get it -- if
15 you've got a 3,000 page file, at least you sort
16 of know where to look first, and then the
17 industrial hygienist has all -- and the CMC has
18 all of the other information available, if they
19 want to look at it.

20 The rationale is that by limiting
21 the information, either the IH or CMC have
22 access to, based on the determination of

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1 someone with no expertise in either field, and
2 I have to wordsmith this. Sorry. Denies the
3 claim in a truly comprehensive evaluation of
4 their claim.

5 The professional is asked to opine
6 on these cases, may therefore be drawn into a
7 faulty conclusion because pertinent information
8 was not made available to them.

9 Well, to provide -- she doesn't like
10 opine. Okay, so, provide and -- I will change
11 that and I will wordsmith that.

12 Kevin, could you sort of -- I have
13 some typos. It's consistent when and then at
14 the map, I have denied or -- I have -- yes,
15 please, because I can't type at six o'clock in
16 the morning.

17 Now, there was a question about
18 whether the IH and the CMC have access to the
19 file anyway, and that they could be looking at
20 this. But from what we learned from the
21 department, it didn't sound like it, and maybe
22 the department could answer that. Rachel?

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1 John?

2 MR. RIOS: Can you repeat that?
3 What is your specific question to the
4 department?

5 MEMBER CASSANO: The specific
6 question is, does the IH and the CMC actually
7 already have access to the entire file, through
8 a portal or whatever, or do they -- because we
9 were told no, they only get what the CE sends
10 them.

11 So, I wanted to clarify that, before
12 this went forward.

13 MS. LEITON: This is Rachel, and the
14 government IHs right now have access, but the
15 rest don't, and we can look at whether we can
16 give them access to the portal at some point.

17 MEMBER CASSANO: So, the answer is
18 no. The answer is no, right now. So, I think
19 this then becomes germane.

20 MR. RIOS: Rachel, Dr. Markowitz
21 indicated that he did not fully understand your
22 response. So, we can do one of two things.

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1 Either you can repeat your response
2 or we can have John come up here and provide
3 the response. Which is your preference?

4 MS. LEITON: John.

5 MR. RIOS: Okay, he's coming up to
6 the room now -- to the podium.

7 MR. VANCE: Good morning, everybody.
8 So, in responding to that question, what Rachel
9 was saying is that our internal federal
10 industrial hygienists have access to the full
11 case file that's imaged in OIS. They would not
12 have access unless the case file, the paper
13 case file had been referred to them.

14 Most of the referrals that we get in
15 DC now for IH examination are for imaged files,
16 but they also can be for hybrid files. So,
17 they don't have access to the paper component,
18 unless it's sent to us.

19 Our contract industrial hygienists
20 do not have access to the full file. What they
21 would be having access to would be the
22 industrial hygiene data, the referral

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1 information that the CE extracts out of the
2 case file. So, they're not given a copy of the
3 entire case file. Does that answer your
4 question?

5 MEMBER BODEN: One clarification.
6 Does the CE have access to this non-electronic
7 part of the file?

8 MR. VANCE: Yes.

9 MEMBER BODEN: Yes?

10 MR. VANCE: They would have access
11 to the full complement of the paper file,
12 anything that's maintained in the permanent
13 record, along with any records that are in the
14 imaging system.

15 MEMBER BODEN: So, then it might be
16 possible, even under this scenario, for those
17 limited number of files that go to the
18 evaluating physicians, that the paper part of
19 those files could be elect -- could be scanned.
20 Is that a feasible thing?

21 MR. VANCE: I would say anything is
22 feasible. The question is logistics.

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1 MEMBER CASSANO: John?

2 MEMBER BODEN: Right.

3 MEMBER CASSANO: John, we went -- we
4 answered the question for IH. What about the
5 CMCs?

6 MR. VANCE: No, the CMC, so the CEs,
7 what they're trained to do is basically extract
8 out the medical documentation from the case
9 file, and that material goes to the CMC.

10 MEMBER CASSANO: Okay.

11 MR. VANCE: Along with the -- if
12 there is an industrial hygiene referral, they
13 would include the IH assessment referral
14 response.

15 MEMBER CASSANO: So.

16 CHAIR MARKOWITZ: The CMC gets the -
17 OHQ, gets the EE3 or whatever work history form
18 there is. The doctor doesn't get --

19 MR. VANCE: No, usually the doctor
20 is going to get the medical documentation, and
21 if there has been an industrial hygiene
22 analysis by one of the IH's, they would get

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1 that.

2 CHAIR MARKOWITZ: But if there isn't
3 an industrial hygiene analysis and the
4 physician is asked to give an opinion about
5 causation, where is their exposure information
6 coming from besides whatever --

7 MR. VANCE: That would be contained
8 -- there is a going to be a statement of
9 accepted facts that outlines the CEs finding
10 with regard to whatever the job information is
11 that's available, and any kind of factual
12 findings that the CE can extract out of the
13 case file.

14 But in most instances, where you're
15 talking about the extent or issue or nature of
16 exposure, you're going to be getting an IH
17 referral.

18 So, for example, in ones that we
19 don't, the asthma cases are an example of ones
20 where they're going to get just about
21 everything because the issue there is just we -
22 - there are so many things that can cause

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1 occupational asthma or aggravate or contribute
2 to it.

3 So, they would just basically ask
4 the question, is there any indication from
5 their understanding of the case evidence, that
6 asthma has a connection to something that the
7 employee could have been exposed to. So, it's
8 a very broad -- that -- they are going to get
9 more information in those cases.

10 CHAIR MARKOWITZ: Okay, thank you.
11 Dr. Dement?

12 MEMBER DEMENT: Well, actually some
13 of the cases that we've started to review,
14 we've observed some habits that probably would
15 be addressed by this recommendation.

16 For example, a uranium miner being
17 considered for -- I think it was silicosis or
18 pneumoconiosis, at least, where the CMC was
19 told that the exposure of interest was actually
20 aluminum. The CMC opined about Shaver's
21 disease, and never really -- you know, the
22 known risk of silicosis in uranium miners was

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1 never really addressed. Yes, there were
2 multiple ones like that.

3 MEMBER CASSANO: I mean, I saw
4 several too, where you know, a truck driver at
5 a uranium mine was considered not exposed
6 because he was a truck driver, not a uranium
7 miner.

8 CHAIR MARKOWITZ: Dr. Friedman-
9 Jimenez?

10 MEMBER FRIEDMAN-JIMENEZ: My
11 question is, how do the doctors find out what
12 the workers were exposed to?

13 I tried last night to look at the
14 SEM, and it seems -- maybe I did it wrong, but
15 it seems that job title is not in the SEM.

16 So, how do you map from what the
17 patient tells you that they worked as a laundry
18 worker, which is not in the SEM, what that
19 laundry worker job is exposed to, because
20 doctors need that exposure information to make
21 a determination of causality.

22 MR. VANCE: Actually, that

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1 information is in the site exposure matrices.
2 The site exposure matrices has multi-filtering
3 capabilities and one of the categories you
4 could filter is on labor category. It would
5 not be job title, but that's essentially what
6 it means.

7 So, you can go in and look for labor
8 categories and you can filter by other
9 components of data that's maintained in the
10 database.

11 So, if you're looking for a laundry
12 worker, you would look for that labor category.
13 If you're looking for, you know, clothing
14 cleaner or something like that, you can also
15 look under a work process search filter that is
16 in the site exposure matrices.

17 So, you have the big search
18 filtering functionality in the site exposure
19 matrices is labor category, work process,
20 building or site location. That information,
21 once you start filtering that data, is going to
22 pull out and extract those toxins that are

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1 known to be associated with that type of work
2 or that type of labor category.

3 CHAIR MARKOWITZ: Dr. Welch?

4 MEMBER WELCH: I think it's -- I'm
5 making an assumption here, but it's unlikely
6 that the CMC is going to the site exposure
7 matrix to look at it, and the job of the CE is
8 to collect all that exposure information, and
9 currently now, to summarize it, in the
10 statement of accepted facts.

11 So, if the silicosis for a miner is
12 not in the SEM, which it's possible, it seems
13 unlikely, but it's possible, then it's very
14 possible you could have this -- a case where it
15 follows the whole procedure, but something that
16 seems so obvious to us is missed, and I'm not
17 so sure in that particular case you're talking
18 about, that anyone would even raise a hand and
19 say, this should go to an industrial hygiene
20 referral.

21 So, it's hard to know where -- you
22 know, but it's a good example, but I'm not

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1 quite sure how we know how to fix that problem,
2 because I think Carrie, you also mentioned
3 cases of silicosis where silica wasn't
4 identified as one of the exposures, although
5 that's something, you know, we could make it a
6 specific recommendation to fix in the SEM, to
7 add silica exposure to all the tasks -- well,
8 not -- there aren't that many tasks. There are
9 93 processes. So, there's a lot more tasks,
10 but I know John wants to comment on that.

11 MR. VANCE: Well, let me just say,
12 you know, keep in mind that the site exposure
13 matrices and I -- I agree with Dr. Welch, quite
14 adamantly that, you know, the site exposure
15 matrices is not complete, and the data that
16 predicates how the information is reported when
17 you do your searches is based on specific data
18 that Paragon, the SEM contractor is able to
19 obtain and tie to a particular job or work
20 process.

21 So, going back to the example that
22 someone mentioned about a truck driver.

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1 If you are working at a uranium
2 mine, but the only information that we have on
3 truck drivers is that that's the role that they
4 played. They played the role of a truck
5 driver, does that mean that the Paragon team
6 was able to identify any epidemiological or
7 workplace data that says, a truck driver
8 working at this mine was exposed to silica.

9 So, your point about the Board
10 looking at that and saying that's not a
11 realistic finding, that anybody who was working
12 at that mine, you know, whether they are a
13 truck driver, a laborer, or what have you,
14 would have been exposed to a significant -- you
15 know, level of silica, that would be something
16 that would be very helpful, because what we --
17 we utilize in developing the material for the
18 site exposure matrices is tied to data that we
19 obtain from DOE or from workers. You know,
20 that kind of specific documentation that
21 supports what they were actually doing or
22 exposed to.

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1 CHAIR MARKOWITZ: Dr. Sokas?

2 MEMBER SOKAS: So, I have a question
3 about the order in which we're doing this.

4 I thought that at some point, there
5 was going to be a recommendation that the IH or
6 the CMC would also have the ability to actually
7 call, and that's your recommendation.

8 Okay, so, maybe we should have
9 started with the other recommendation first,
10 but they are kind of connected.

11 I did also want to ask Kevin to
12 change opine to provide an opinion on, but that
13 -- that could -- the -- so -- so, in a way, I
14 think we do have pretty substantial discussion
15 already that the hope here, or the expectation
16 is that the changes or the recommendations that
17 we're making would allow for a competent CMC
18 and IH to be able to look at the record.
19 Maybe the SEM should clearly be updated and
20 improved, you know, in any way possible.

21 But that doesn't change this
22 recommendation. I mean, basically this

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1 recommendation is made in the expectation that
2 it would allow, with additional information,
3 allow someone to take a look and say oh, wait a
4 minute, you know, they claimed or they were
5 concerned about a uranium mine, and therefore,
6 I can pull in my knowledge that silica might
7 have been present, right?

8 So, I would like to suggest that
9 maybe we can proceed with seconding the
10 recommendation.

11 CHAIR MARKOWITZ: Okay, still open
12 for comments. Dr. Silver?

13 MEMBER SILVER: I want to underline
14 the importance of the claims examiner mapping
15 the file to indicate where relevant information
16 is. Creating a table of contents is probably
17 well within the skill set of all of the claims
18 examiners.

19 We reviewed a case of sarcoidosis
20 and the obvious questions are, what was the
21 timing of the diagnosis of sarcoidosis relative
22 to working in legacy DOE site, where she may

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1 have been exposed to beryllium, and the only
2 way I could confidently answer those questions
3 in a 250 page claim file was to create my own
4 bloody table of contents, and I can only
5 imagine how much money would be wasted if the
6 CMC's received an un-accessioned, un-mapped
7 claims file.

8 CHAIR MARKOWITZ: Dr. Friedman-
9 Jimenez?

10 MEMBER FRIEDMAN-JIMENEZ: I
11 understand your response to my question.
12 However, it seems that most doctors aren't
13 really going to be able to navigate the SEM in
14 a way, as you suggest.

15 My question is, is there a manual, a
16 user manual or some training that will allow
17 them to do that, and it seems to me that this
18 needs to be built into the process and probably
19 should be built into the recommendation that
20 the SEM needs to be made user-friendly and
21 accessible to the physicians, as an additional
22 source of information on exposure, so that they

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1 have as much exposure information as can be
2 gotten, at the time when they're supposed to be
3 developing a -- a diagnosis, an etiologic
4 diagnosis of whether it's work-related or not.

5 CHAIR MARKOWITZ: Dr. Welch?

6 MEMBER WELCH: The one thing I
7 wanted to say my impression, and John will
8 correct me.

9 Currently, the current system now is
10 that the CE does that, which is -- I think
11 that's reasonable, that the CE can go through
12 the SEM and look for exposure information, and
13 I disagree with you, that the doctors should be
14 doing it, for a bunch of reasons.

15 But the -- I think one of the
16 problems is that then what happens is the CE
17 makes a statement of accepted facts, okay.

18 If something in that statement of
19 accepted facts is wrong, there is no way to
20 correct it, as it goes down the system, and so,
21 the audit that looked at the reports, which as
22 Dr. Sokas mentioned, was somewhat of a process

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1 report, you know, the -- we'd like to know that
2 the CMCs and the industrial hygienists, they
3 really roll out this new process.

4 We'll answer the questions the CE
5 wants answered. That's a problem in its own
6 right, that -- but we'd also -- and I don't
7 know how to build it in, but if -- but some --
8 there is a problem with limiting those experts
9 to a narrow set of facts, that may be
10 incomplete, and the experts should be
11 encouraged to go back and say, well, this
12 doesn't -- this case may not make sense, given
13 what I know about the case or -- but I'm not
14 sure how we fix that.

15 I just think we need to think about
16 it as we go through our recommendations because
17 just giving the entire file and having the
18 consultants expected to go through the -- to
19 the SEM is not going to solve the problem, if
20 the files are really big.

21 So, it's a good idea, but it's not -
22 - there still needs to be some, you know,

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1 mapping or -- but once you're doing that, you
2 are narrowing what people -- you're necessarily
3 narrowing what people will look at.

4 CHAIR MARKOWITZ: You know, but
5 actually, let me just say that George's idea of
6 the physician accessing the SEM is related, but
7 somewhat different from this recommendation.

8 So, instead of continuing that
9 discussion, which can be lengthy, maybe we
10 should just stick to this recommendation and
11 make a decision about it or not, and then
12 consider that issue separately.

13 So, on this -- just to follow on
14 this specific recommendation are there -- I
15 have a comment, but are there other additional
16 comments?

17 MEMBER CASSANO: Just a response to
18 Laura. It's not a perfect solution because
19 it's going to depend on how curious the CMC is,
20 obviously. They may just look at the statement
21 of facts and not bother.

22 But I think the majority of CMCs

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1 would, you know -- you know, the red flag would
2 go up at some point, at least if they look at
3 the EE1 and see what the guy actually claimed,
4 rather than just looking at a statement of
5 fact, or looking at the EE3, because what's
6 happening now is, the CE is putting blinders on
7 both the IH and the CMC, and allowing them only
8 to look at what somebody with no expertise
9 deems relevant, and that's sort of crazy, I
10 think.

11 CHAIR MARKOWITZ: By the way, why
12 does the industrial hygiene need the medical
13 records? MEMBER CASSANO: I don't

14 know if the industrial hygienist needs the
15 medical records per se, but maybe there is
16 something in the medical records that clues an
17 industrial hygienist to, oh, this guy actually
18 has this particular disease, and gee, maybe I
19 need to look for this exposure, to see if this
20 disease was actually caused by an exposure
21 that's possible in this environment.

22 CHAIR MARKOWITZ: Ms. Vlieger?

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1 MS. VLIEGER: What we all observed,
2 I'm going to speak for everybody -- I'm sorry,
3 but what we all observed in the case files that
4 we reviewed is that this lack of continuity of
5 information was detrimental in making any
6 determination of what was there.

7 So, I'm not sure how to eat this
8 elephant. However, we have to make some
9 progress in improving the communication through
10 this whole process, and I think it starts with
11 making more of that claim file available to the
12 people who are making the important decisions.

13 CHAIR MARKOWITZ: So, okay. So,
14 final comments? Mr. Domina? Yes.

15 MEMBER DOMINA: I guess, you know,
16 from my job experience, and you know, I'm still
17 a current worker, I'd -- they've got to learn
18 look wider and not smaller, because if you look
19 at the type of work that we have done and
20 continue to do, just because -- like the
21 example that was used earlier, as a truck
22 driver.

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1 Well, there are several sub-sets of
2 stuff that truck drivers do under that, and
3 several other jurisdictions of workers that
4 work with -- because like my job in -- as an
5 operator, you take operations and you take
6 health physics technicians. They work with
7 every craft, every day, and there could be
8 multiple crafts doing -- working on a process
9 or a job at the same time.

10 So, by -- and I don't know how to
11 properly frame this or -- you just got to look
12 wide, really wide and by the statement of
13 accepted facts and stuff, you just can't put
14 that this guy was a truck driver, because
15 sometimes in my opinion, it could put
16 somebody's mindset that this is what this guy
17 did, this narrow scope, or the scope is a whole
18 bunch wider, just because of the type of work
19 that we do, because -- and you know, there are
20 several different jurisdictions that go under
21 those and -- or depending on an upset condition
22 or whatever, it's everybody is doing something

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1 to get you back to where it's supposed to be,
2 and that crap goes out the window.

3 So, I'm just trying to figure out a
4 way that you know, you don't go in with, this
5 is what it is. You go in with, this is what it
6 is. I mean, I don't know how else to try and
7 say it.

8 CHAIR MARKOWITZ: No, no, you've
9 said it well, actually. Dr. Sokas?

10 MEMBER SOKAS: So, again, I'm
11 perfectly willing to, you know, act on this
12 one, but it might be helpful to go through all
13 of the recommendations because at least three
14 of them have inter-relationships to address
15 some of the aspects of what we've been talking
16 about, just to sort of say, okay, maybe we
17 don't need to talk about this piece if, in
18 fact, we're going to then propose that the IH
19 be able to, you know, kind of talk to the
20 individual, et cetera.

21 CHAIR MARKOWITZ: Yes. We could do
22 that. I mean, people think we could -- we

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1 should hold off on voting until we see the
2 spectrum, and then if we need to fiddle with
3 this one or that one, we can do that.

4 I would say though that before we
5 move onto the next recommendation, whereas the
6 language of the recommendation is what we would
7 be voting on, the rationale, we want to see the
8 elements of the rationale, but the rationale
9 that's provided by the recommender isn't the
10 final word. That could be wordsmithed.

11 There are some recommendations about
12 this rationale, for instance, but we don't have
13 the time to do that.

14 But I want to just make it clear,
15 that rationale is subject to change, at least
16 in the way it's described, even though we
17 should identify the important elements.

18 Okay, so, if there are no other
19 comments, let's move onto the next, which is --
20 no, let's handle the ones that sort of flow
21 from this. Dr. Sokas?

22 MEMBER SOKAS: Yes, I really don't

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1 see the need -- you know, I think it would take
2 a lot of time to kind of craft and do them, you
3 know, separately.

4 I also think that the one on having
5 the claimant have access to the record is
6 relevant here, because then it gives people the
7 chance to, you know, correct errors, etcetera.

8 So, I would really think it's useful
9 to go through at least -- you know.

10 CHAIR MARKOWITZ: Okay, so -- no,
11 no, no, we're going to go to the ones that are
12 directly relevant to the first.

13 MEMBER WELCH: I didn't actually add
14 a rationale. I just did the kind of -- I worked
15 on the language that we would put in the
16 recommendation, but I do think we definitely
17 discuss the rationale in detail yesterday.

18 So, I had three recommendations. If
19 you want, we can -- we could skip over the
20 first one, come back to it. The first one was
21 that DEEOIC incorporate the sources that were
22 on Table 3.1 in the IOM report, as a start, and

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1 we're not necessarily limiting all our
2 recommendations to that, and that they
3 accomplish that by using a contractor to
4 identify new causal agents and the contractor's
5 work would then be reviewed by an external
6 committee.

7 I'm not sure we need that specific
8 recommendation. But since the OWCP felt like
9 the recommendations in the IOM report were
10 broad and not specific enough to really let
11 them get to work, I really -- we could consider
12 adding -- that's really a process.

13 We can definitely vote -- we could
14 definitely deal with the top paragraph and
15 decide whether to include the second, or let
16 them develop their own process.

17 MEMBER FRIEDMAN-JIMENEZ: Could you
18 remind us what Table 3.1 is?

19 MEMBER WELCH: It's a -- it's a
20 table that's got all the sources that one could
21 go to for other information, IARC, NTP, NIOSH
22 criteria documents. It includes the California

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1 Prop 51? Sixty-five list of substances. So,
2 it's a pretty comprehensive source, I think,
3 and I'd originally thought somebody -- that
4 we'd have to have a contractor develop the
5 source list, but I think we can just go with
6 what IOM identified. It's sources. It's not -
7 - it's not --

8 CHAIR MARKOWITZ: Let me just list
9 them for you, just to make it easier.

10 It's IARC, NTP, Health Assessment
11 and Translation Evaluations, which are called
12 OHAT by NTP. IRIS evaluations, EPA, tox
13 profiles by ATSDR. California EPA on their
14 technical support documents on cancer. NIOSH's
15 pocket guide, if you're familiar with that.

16 The NIOSH criteria documents, NIOSH
17 current intelligence bulletins. OSHA, the
18 preambles to their final rules. The ACGIH's
19 TLV documentation and then two source --
20 additional sources in California, the
21 proposition -- Proposition 65 hazard
22 identification documents and technical supports

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1 relating to support on exposure level. So,
2 that is the universe in that table.

3 MEMBER WELCH: So, rather -- I'd
4 suggest let's -- let's see if people agree with
5 the first sentence that -- that DEEOIC begin by
6 reviewing the sources listed in Table 3.1 as
7 the basis for adding new disease exposure links
8 to SEM.

9 MEMBER REDLICH: Can I --

10 CHAIR MARKOWITZ: Yes, I'm sorry.

11 MEMBER REDLICH: Can I just ask one
12 question? Do any of those sources include, not
13 specific agents, but job categories?

14 Let's say the -- a summary of
15 machinists.

16 MEMBER WELCH: NIOSH has that.

17 MEMBER REDLICH: Okay, so the --

18 MEMBER WELCH: The NIOSH pocket
19 guide. IARC does for some mixtures and some
20 occupations for cancer.

21 MEMBER REDLICH: Okay.

22 MEMBER WELCH: I mean, they list

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1 occupations for which the source isn't known,
2 but they say there's a -- and then --

3 MEMBER REDLICH: Because there are
4 some job categories such as machinist, which
5 there are clearly a lot of machinists who
6 worked at these sites where there is -- you
7 know, like a -- a strong literature for lung
8 disease, but those -- I mean, job categories in
9 general, are some of them addressed?

10 MEMBER WELCH: Somewhat, and that's
11 why --

12 MEMBER REDLICH: But that could be
13 added to, right?

14 MEMBER WELCH: Right. That's why we
15 were saying --

16 MEMBER REDLICH: Okay.

17 MEMBER WELCH: -- this wouldn't be
18 the only source --

19 MEMBER REDLICH: Sure, okay.

20 MEMBER WELCH: -- but this is a --
21 this is a -- it's not exactly low-hanging
22 fruit, because it's a big task, but it is --

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1 these are ones --

2 MEMBER REDLICH: Sure.

3 MEMBER WELCH: -- where there have
4 been expert committees that already reviewed
5 the literature and came up with these
6 conclusions.

7 So, it's the -- what needs to be
8 done is figuring out how to make them fit into
9 this particular system because as George
10 pointed out, the IARC doesn't tell us which
11 cancer. We know that is a carcinogen, but you
12 can use the IARC report to decide which cancer
13 the report is based on.

14 For example, so, it's going to be --
15 and as we know, many of the ones, particularly
16 things that are in the NIOSH pocket guide
17 should have found their way into Haz-Map,
18 because I don't know when the last edition of
19 pocket guide was.

20 So, some if it is just -- it's
21 cross-checking. You know, there might be one
22 thing in the NIOSH pocket guide that wasn't in

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1 Haz-Map for some reason. So, I don't have --

2 MEMBER REDLICH: Okay, thank you.

3 CHAIR MARKOWITZ: No, no. So, I
4 don't know the order here. But let's just go
5 right down. Dr. Friedman-Jimenez.

6 MEMBER FRIEDMAN-JIMENEZ: When we
7 get patients in our clinic, we frequently use
8 many of these sources. But often, we find that
9 we have to go beyond them and do individual
10 MEDLINE searches or TOXLINE, or some other
11 search, and it's labor-intensive, but we
12 frequently find lots of associations that are
13 not in the reviews.

14 IARC has only limited number of
15 chemicals they've reviewed. NTP, likewise, and
16 they are limited to cancer, and for non-cancer
17 outcomes in particular, there aren't these kind
18 of compendium sources.

19 So, I think that there needs to be
20 some provision made and recognized in this
21 recommendation of the need for intelligent
22 MEDLINE and TOXLINE searches.

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1 CHAIR MARKOWITZ: Dr. Cassano?

2 MEMBER CASSANO: Actually, this is
3 more wordsmithing than anything else.

4 I'm not sure what begin by reviewing
5 means. I think it might be better said, we
6 recommend that in addition to Haz-Map, DEEOIC
7 review the sources listed in Table 3.1 as the
8 basis for adding. I'm not sure why -- what
9 we're beginning, that's all.

10 MEMBER WELCH: I think you're right.
11 What we were trying to say was that this would
12 not be the only source of additions to the SEM
13 for disease exposures links, but that this --
14 the initial effort should focus on this finite
15 list of sources.

16 MEMBER CASSANO: Right, so, I think
17 we should take 'begin by reviewing' and just
18 say 'review', and say that this is not -- you
19 know, again, you might want to add this is not
20 an exclusive list at the end. Other sources
21 should also be looked at.

22 MEMBER WELCH: But I think part of

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1 it is, we're -- I was -- in crafting it, I was
2 responding to the OWCP response of the IOM
3 report, which is, it's so broad, we have no way
4 to tackle it.

5 MEMBER CASSANO: Okay.

6 MEMBER WELCH: So, in the rationale,
7 maybe I think would be the place to discuss
8 that there are other sources that can be used
9 for adding disease exposure links. That
10 doesn't address George's question, but I sort
11 of feel like we want to get off the ground.

12 MEMBER CASSANO: Right.

13 MEMBER WELCH: I mean, the IOM
14 report was published -- well, I don't have it
15 anymore. Twenty-ten?

16 MEMBER CASSANO: Twenty-zero-eight?

17 MEMBER WELCH: Twenty-thirteen. So,
18 and because of the -- the way I understand it,
19 because of including these broad
20 recommendations, we really should be including
21 everything that's -- could have a causal
22 relationship and have a process for doing it,

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1 so that it's delayed getting going.

2 MEMBER CASSANO: So, just take the
3 'by' out and just say that we recommend that
4 DEEOIC begin reviewing the sources.

5 MEMBER WELCH: Okay.

6 MEMBER CASSANO: Rather than --

7 CHAIR MARKOWITZ: Well, I'm not --
8 I'm sorry, let me just respond to that.

9 It's not a question of reviewing.
10 We want them to do more than that. We want to
11 ensure that the exposure -- disease exposure
12 links that are identified in those sources are
13 included in the SEM. I mean, that's -- it's not
14 just reviewing. It's actually endorsing them,
15 right, and including them internal --
16 internalizing them into the SEM.

17 So, it's a -- we recommend, if it's
18 all right, that the DEEOIC ensure that the
19 disease exposure links identified in those
20 sources, are included in the SEM. I think many
21 of them are, by the way, already, probably the
22 vast majority. But this is just ensuring

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1 completion.

2 MEMBER WELCH: Identified by the
3 sources? You can take out begin by reviewing.
4 Now, you can take out begin by reviewing the
5 sources.

6 CHAIR MARKOWITZ: This was so much
7 fun in April, we decided to redo it now.

8 MEMBER WELCH: Yes, I think that's
9 it. CHAIR MARKOWITZ: No, are included,

10 or I'm sorry. After the IOM report, are
11 included in the SEM.

12 MEMBER WELCH: Are included in the
13 SEM.

14 CHAIR MARKOWITZ: Dr. Sokas?

15 MEMBER SOKAS: I don't know if we
16 can get at Dr. Friedman-Jimenez's question in
17 that second paragraph, but the -- kind of --
18 about whether the contractor could also do a
19 PubMed search for updating, you know? No?
20 Okay.

21 MEMBER WELCH: We'd have to spend
22 much more time to talk about it. I wouldn't do

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1 that.

2 CHAIR MARKOWITZ: Dr. Boden?

3 MEMBER BODEN: I agree in principle
4 with Dr. Friedman-Jimenez's suggestion. But it
5 seems to me that keeping this simple and well-
6 defined is a worthy goal and that if this is
7 done some time in the near future, then it
8 would be an appropriate time to revisit
9 broadening the scope of sources.

10 I would be very happy to see this
11 done over the next year or two.

12 CHAIR MARKOWITZ: Dr. Redlich? Oh,
13 I'm sorry. So, not to be repetitive, but I
14 completely agree with Dr. Friedman-Jimenez,
15 that we need to move beyond this, and that this
16 subcommittee should, in its next meeting,
17 discuss some specifics around how to describe
18 what it is that we think the program should do
19 to move beyond this because this -- we're now
20 into a more difficult literature, and I think
21 we need to provide some specific or guidance
22 around that literature.

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1 Okay, so --

2 MEMBER REDLICH: Do we have an
3 agreement, whether we think a more extensive
4 look at the literature should be happening at
5 the level of a contract medical physician or at
6 the level of, you know, centrally deciding, you
7 know, with either a group of workers or an
8 exposure is causally linked to 'x' disease?
9 I'm just asking that.

10 CHAIR MARKOWITZ: Right, right.
11 Well, Dr. Welch?

12 MEMBER WELCH: Can I just clarify?
13 You're saying beyond building in these new
14 links, if there were -- if a case came in that
15 wasn't addressed by the updated SEM, whether
16 that should be bounced back to the Policy
17 Branch to develop a policy wide or have it done
18 in individual case review? Is that what you're
19 saying?

20 MEMBER REDLICH: Well, what I'm
21 hearing is I think two different things.

22 One is that the individual contract

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1 physician might say, "Oh, let me look at
2 whether, you know, this type of worker," you
3 know, is at increased risk of 'x' disease, or
4 this exposure is, what -- you know, really, if
5 you get that -- that link has not -- doesn't
6 already exist in the SEM, or whether, you know,
7 there is an understanding of what exposure
8 disease associations we think exist, and then
9 we're applying it to that worker.

10 CHAIR MARKOWITZ: I'm sorry, is that
11 a -- is that recommendation directly related to
12 what we're discussing or is it really a
13 separate recommendation?

14 MEMBER REDLICH: Well, I guess --

15 CHAIR MARKOWITZ: Because if it is -
16 - if it is, I just want to stay on topic --

17 MEMBER REDLICH: I guess --

18 CHAIR MARKOWITZ: -- and then we can
19 --

20 MEMBER REDLICH: Sure. No, maybe
21 clarification for me, because and I'm not on
22 the SEM committee, is -- is the SEM identifying

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1 the relevant exposures or is it identifying the
2 exposure disease associations?

3 MEMBER WELCH: It does both. It
4 does both.

5 MEMBER REDLICH: Okay.

6 MEMBER WELCH: So, it -- and that's
7 what Haz-Map was designed to do, was designed
8 to give primary care physicians a list of
9 exposure disease relationships. So, that's
10 built into SEM.

11 So, both -- it's a compendium of all
12 the exposure information that the DOE complex
13 has been able to find on these sites, by
14 building, operation, location, which has its
15 limitations because not everything was
16 assessed.

17 But it also allows the -- the claims
18 examiner, in some ways, to know that this
19 disease is linked -- this exposure is linked to
20 that disease, and the workers themselves use it
21 that way.

22 They go into it and say, well, I

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1 worked at this plant and I worked in this
2 building, and what diseases could have arisen
3 from that?

4 MEMBER REDLICH: Okay, because I
5 trust you, Laura, to fix this, because the four
6 or five that I looked at, just basic common
7 sense would say that they made no sense, like a
8 miner in aluminum or you know, one single
9 exposure for COPD.

10 So, I assume that the
11 recommendations hopefully will end up in fixing
12 what has seen like some of the glaring
13 problems.

14 MEMBER WELCH: In my humble opinion,
15 no. We'll fix a lot of things. But you know,
16 if somebody sent you a case that was a miner
17 with rounded upper lung opacities, and the
18 exposure was aluminum, you'd say uranium mines
19 don't have aluminum. Okay?

20 MEMBER REDLICH: Yes, so, how do we
21 fix that problem?

22 MEMBER WELCH: Not my committee.

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1 MEMBER REDLICH: No, but I thought
2 that was. So, this is --

3 CHAIR MARKOWITZ: Okay.

4 MEMBER REDLICH: Is someone going to
5 fix it?

6 MEMBER WELCH: Well, I mean, it's
7 sort of like who is reviewing the file?

8 If something starts down a process,
9 and there is never a way in which an individual
10 along the way says, "Wait, this doesn't make
11 sense."

12 So, that could be the industrial
13 hygienist, could be the CMC. It could be a
14 senior case examiner, if they're reviewing the
15 files. Just the idea that there is some
16 feedback in there that says this does not make
17 sense.

18 So, currently, now, I don't think
19 the CMC -- you know, I'm a -- you know, I'm
20 looking at the toe of the elephant. I see
21 denials from our members, and I look at it and
22 say, he said what? You know? So.

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1 So, you know, but I -- but there is
2 lots of cases that -- that get accepted and
3 they pay billions of dollars in claims, and I
4 don't see those claims.

5 CHAIR MARKOWITZ: So, everything is
6 --

7 MEMBER REDLICH: John and --

8 CHAIR MARKOWITZ: Everything of
9 course, is connected to everything else, but
10 let's focus on this particular recommendation,
11 and then we can move on.

12 So, I see people who want to
13 comment, but I ask you as opposed to having
14 further discussion about other aspects of the
15 SEM, whether this actually is two
16 recommendations, whether there are any
17 particular comments on what we're looking at on
18 this screen? Okay, Dr. Dement?

19 MEMBER DEMENT: No.

20 CHAIR MARKOWITZ: Okay, Dr.
21 Friedman-Jimenez?

22 MEMBER FRIEDMAN-JIMENEZ: Well,

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1 respecting what you said, but I wanted to
2 respond to what Carrie brought up.

3 I think it's important that the SEM
4 have a learning function built into it, and in
5 other words, as Laura was saying, as a CMC or
6 an industrial hygienist realizes that there's
7 something missing from the SEM, to address
8 Carrie's concern that it's greatly incomplete
9 for many of these associations, that there be a
10 process that -- by -- by which someone can
11 easily nominate new information to be included
12 in the SEM, and then a process by which that is
13 -- is evaluated by some sort of an expert
14 committee, and then gets added, so that the SEM
15 will be hopefully, continually improved over
16 time, as we realize that things are left out
17 and missing, because the way you're going to
18 realize that is when you're doing it, and you
19 say, my God, this isn't included in it. It
20 needs to be, and you add it on, but you can't
21 just add it on without anyone overseeing it.

22 So, there needs to be a process.

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1 CHAIR MARKOWITZ: Okay, so, that is
2 Dr. Welch's committee --

3 PARTICIPANT: Yes.

4 CHAIR MARKOWITZ: -- and -- and it
5 will be added. But we're going to restrict our
6 comments to what we're looking at on the screen
7 now, with all due respect, just because we need
8 to get through some of this, or we won't get
9 through these things, right?

10 So, other -- further comments on
11 what we're looking at?

12 Now, Dr. Welch, the second
13 recommendation that you have, so, you're saying
14 that we want to -- this is about telling DEEOIC
15 how to do this, hire a contractor and make sure
16 it's reviewed by an external expert committee?
17 Is that it?

18 MEMBER WELCH: Yes, and I think it's
19 -- that is not a really big recommendation.
20 It's more of a process.

21 So, potentially, we could -- I'd
22 suggest a friendly amendment on my own slide,

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1 that we leave that off for now, and it become
2 part of the discussion of the first
3 recommendation. Is that okay with everybody
4 else?

5 CHAIR MARKOWITZ: Dr. Sokas, yes.

6 MEMBER SOKAS: So, I think that is
7 probably not ready for this voting cycle, but
8 that it probably should be expanded to include
9 the 14 areas where, you know, the DOL has asked
10 us for guidance and whether or not this
11 committee is -- and so, I think that there is a
12 lot that could be in that, that will require
13 some more discussion.

14 So, it's not just a rationale for
15 the -- of the one above. It's how the SEM or
16 the other committees and how this Advisory
17 Board interacts with making, you know, kind of
18 those recommendations and reviewing those
19 recommendations.

20 So, I would just recommend taking
21 that off for now, and maybe in the next six
22 weeks, coming up with an actual recommendation

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1 that we'd be able to discuss and vote on.

2 CHAIR MARKOWITZ: Okay, so, if you
3 could take that off, Kevin. Yes, she proposed
4 -- she is -- she proposed it, actually.

5 Okay, so, any further comments on
6 this?

7 So, are we -- should we vote on it
8 or do we want -- need -- okay, fine.

9 Okay, so, we recommend that DEEOIC
10 ensure that the disease exposure links
11 identified by the sources listed in Table 3.1
12 of the IOM report are included in the SEM.

13 All those in favor, raise your hand.
14 All those opposed, raise your hand.

15 Okay, so, the vote by all Board
16 members present, which I think are 14, is in
17 favor.

18 Okay, next recommendation. Time
19 check, I just need to know how many we have.
20 Laura, you have?

21 MEMBER WELCH: I have two more.

22 CHAIR MARKOWITZ: Yes, and you have

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1 --

2 MEMBER SOKAS: Three.

3 CHAIR MARKOWITZ: Okay.

4 MEMBER WELCH: I think the other
5 two, I do think we -- I really do think we
6 already definitely all agree on the other two
7 recommendations. So, we could hold back our
8 comments that may be, "Wow. Great idea. I like
9 it. Can we extend it this way," blah, blah,
10 blah.

CHAIR MARKOWITZ: So, let's
11 do those two, actually.

12 MEMBER WELCH: So, the next one is,
13 we recommend that DEEOIC establish a process
14 whereby, the industrial hygienist may interview
15 the claimant directly.

16 MEMBER SOKAS: Yes. Second the
17 motion.

18 CHAIR MARKOWITZ: Okay, discussion?
19 No, no, we're not -- no, no, we're not -- no
20 compound recommendations. Can't deal with it.
21 Can't deal with it. Discussion?

22 PARTICIPANT: No.

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1 CHAIR MARKOWITZ: Okay, so, all
2 those in favor of this recommendation, raise
3 your hand. All those opposed?

4 So, the vote is unanimously in favor
5 of this recommendation. Next recommendation?

6 MEMBER WELCH: So, the third one is
7 that we recommend that former workers from DOE
8 facilities be hired to administer the
9 occupational history questionnaire.

10 I guess the amendment I might make
11 is that -- because I realize it's not just for
12 any facility, it's for the specific facility. I
13 don't know how to express that. But it's like,
14 you know, if people are coming into the
15 resource center here --

16 PARTICIPANT: To this facility.

17 MEMBER WELCH: Right.

18 PARTICIPANT: Or that DOE facility.

19 CHAIR MARKOWITZ: Well, there is a
20 practical problem, which is, I don't think
21 their resource centers which administer the
22 occupational questionnaire, are located in

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1 every DOE community.

2 So, then you necessarily would have
3 some resource centers in places where there are
4 not DOE communities. So, it would be a little
5 hard to get that specific.

6 MEMBER WELCH: So, one of -- one
7 option is to add another sentence, where
8 feasible, the former worker should be from the
9 same facility as the claimant. Does that make
10 sense, or should we run -- not even bother?
11 Just have it sort of straight forward.

12 MS. VLIEGER: Just a point, so you
13 understand, many of the facilities are razed.
14 They don't exist anymore.

15 So, where you're going to find
16 workers from in the area are going to be from
17 the major facilities, which all are close to
18 resource centers.

19 So, when you say this, the resource
20 centers cannot have a cadre of 300 people that
21 they'll tap on one person, two or three times a
22 year for an obscure facility. So, you need

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1 someone that's got background in it, and I
2 think Kirk can talk to this more effectively
3 than I can, but you need someone that's --
4 wasn't a secretary in the head-shed in town,
5 type of thing.

6 So, how we qualify that, how we
7 write a job qualification or a job standard
8 right now, I think is going to be outside our
9 reach. But it does need to be someone familiar
10 with the majority of the facilities, I would
11 say.

12 CHAIR MARKOWITZ: Dr. Boden?

13 MEMBER BODEN: A suggestion, which
14 is perhaps -- a suggestion, which is that the
15 things that we've been talking about now, which
16 I think are important, could be included in the
17 rationale, so that we wouldn't have to
18 wordsmith so much on the recommendation.

19 MR .VANCE: Can I ask a question? I
20 just -- and I'm not trying to make any
21 suggestions, other than just a comment.

22 So, your prior recommendation was

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1 with regard to the industrial hygienist
2 interacting with the claimant, and then you
3 have this recommendation.

4 So, are you talking about, just for
5 clarity sake, are you talking about having the
6 industrial hygienist do something different
7 than what you would be having the former
8 workers do, as far as the -- the process of
9 conducting the occupational history
10 questionnaire?

11 Then that distinction should
12 probably be very clear because I was just
13 wondering whether you were talking about having
14 the industrial hygienist commit to doing the
15 occupational history questionnaire, and then
16 what the role of -- okay. Okay.

17 CHAIR MARKOWITZ: So, you know, one
18 thing we're not doing actually is identifying
19 the elements of the rationale, for each of
20 these recommendations. We've discussed them,
21 but we're not agreeing on them, and that
22 rationale is important when we transmit the

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1 recommendation.

2 So, I'm thinking there's a way of --
3 the method is that if that rationale could be
4 finalized by the subcommittee, which would have
5 to be with six weeks' notice, with a public
6 access -- through a public access mechanism,
7 and endorsed by the subcommittee, that could
8 support the recommendation that's endorsed by
9 the entire committee, Board, and then
10 transmitted to the Department of Labor. Dr.
11 Sokas?

12 MEMBER SOKAS: I still think that
13 there should be what -- what we can come out of
14 here today with that's ready should be
15 forwarded.

16 So, if before the end of today,
17 those points on the rationale can be provided
18 to the group and are acceptable, then the goal
19 is to come out of today with something that
20 could be just edited lightly for the Secretary,
21 and if we can't do it on a particular
22 recommendation, then that recommendation is

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1 held for six weeks. But I don't think all of
2 them need to wait for six weeks, for rationales
3 to be developed.

4 CHAIR MARKOWITZ: But that's fine,
5 but then the recommender has to just give us
6 the bolded items that are -- it's not that
7 complicated, but we need to see them and agree
8 on them. That's all.

9 MEMBER SOKAS: So, that will be
10 before the end of today.

11 CHAIR MARKOWITZ: Okay, well, the
12 end of today is in a few hours, just to remind
13 you. So.

14 Okay, so, are there further --
15 further discussion on this recommendation?

16 Okay, so, we will vote on this
17 committee recommends that former DOE workers, I
18 guess, or workers from DOE facilities be hired
19 to administer the occupational health
20 questionnaire. All those in favor? All those
21 opposed?

22 So, every -- it's unanimously --

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1 unanimous vote in favor of this recommendation.
2 We need to move onto additional
3 recommendations.

4 MEMBER CASSANO: Yes, we had
5 originally decided that we were going to go
6 through all of the recommendations and then
7 vote on them.

8 CHAIR MARKOWITZ: Right, right.

9 MEMBER CASSANO: So, could we just,
10 since we're not doing that, could we go back to
11 mine now, since it becomes very obvious why the
12 industrial hygienist needs the entire record
13 before he talks to the former employee? Can we
14 go back and look at that one?

15 CHAIR MARKOWITZ: Yes, I apologize
16 actually for --

17 MEMBER CASSANO: Thank you.

18 CHAIR MARKOWITZ: -- for violating
19 what I said a half-hour ago. It's not
20 personal.

21 But just to keep track though, are
22 these -- do you have additional

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1 recommendations?

2 PARTICIPANT: No.

3 CHAIR MARKOWITZ: Okay, you have
4 three?

5 MEMBER SOKAS: I have -- I have
6 three, but again, I agree with Dr. Cassano, I
7 think we can vote on her first one.

8 CHAIR MARKOWITZ: All right. So,
9 let's bring that one up.

10 MEMBER SOKAS: Move to approve.

11 MEMBER BODEN: Second.

12 CHAIR MARKOWITZ: Okay, so, there is
13 a motion to approve with a second. Any further
14 discussion on this or are we -- we've done
15 that.

16 Okay, so, the recommendation is that
17 the entire case file should be made available
18 to both the industrial hygienist and the
19 contracted medical consultant, when a referral
20 is made to either, and not just that
21 information that the claims examiner believes
22 is relevant.

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1 The CE should map the file to
2 indicate where relevant information is believed
3 to be.

4 So, all those in favor of this
5 recommendation? Anyone opposed?

6 Okay, so, the vote is unanimously in
7 favor of this recommendation. Next?

8 MEMBER SOKAS: And I just would
9 suggest that the rationale, we agree on enough,
10 so that anything else is just word-tweaking at
11 this point, so we don't have to re-vote on it.

12 CHAIR MARKOWITZ: Well, I have a
13 comment. I would -- I would take out some -- a
14 little bit of the opinion in this rationale.

15 For instance, truly, I don't think
16 we need the word truly, and I wouldn't say that
17 the claims examiners have no expertise. I would
18 just tone some of that down.

19 But other than that -- sure. So,
20 the rationales will be written by -- not by a
21 subcommittee, but by a sub-set of the
22 subcommittee, and which will accompany the

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1 recommendation. Okay.

2 MEMBER SOKAS: And take out quotes.

3 PARTICIPANT: Could you take out the
4 quotes from relevant? It seems to me --

5 CHAIR MARKOWITZ: Okay, but that's
6 fine.

7 PARTICIPANT: Then we have to re-
8 vote. Right?

9 CHAIR MARKOWITZ: No, that's fine.
10 But do make your suggestions before we vote.

11 PARTICIPANT: I tried to, but you
12 were so fast.

13 CHAIR MARKOWITZ: Okay, so, the --
14 Doctor -- should we do one more before --
15 let's do one more before we take a break, if
16 that's all right.

17 Okay, Dr. Sokas, we'll do one more
18 before we take a break. Yes.

19 MEMBER SOKAS: And again, we
20 discussed these yesterday. I modified the
21 wording a little bit to tone it down.

22 So, we recommend DOL consider

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1 reviewing the policy teleconference notes,
2 redacting confidential information and putting
3 the information into a database searchable by
4 topic area. I think I forgot publicly
5 available, actually.

6 Posting the information, I guess
7 implies publicly available. I don't know if I
8 need to say it.

9 Okay, in a publicly available
10 database. So, if you could just put publicly
11 available before database, and that way if
12 there are concerns that they have about, you
13 know, this is not ready for prime time, they
14 wouldn't have to do it.

15 CHAIR MARKOWITZ: Discussion?
16 Garry?

17 MEMBER WHITLEY: I'd take out the
18 word 'consider' and just say we recommend that
19 they review it.

20 MEMBER SOKAS: Okay. Okay, so
21 delete 'consider' and put 'review'.

22 CHAIR MARKOWITZ: Other discussion?

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1 Can we then just -- I'm sorry, did you review
2 the rationale yet? No?

3 MEMBER SOKAS: So, I can -- the
4 rationale is also sort of tweaked, but it's
5 extremely useful information about case
6 determination and guidance is available and
7 would be of use to claimants broadly, while it
8 is important to maintain the free exchange of
9 information for internal -- this internal
10 mechanism allows for a thoughtful redaction to
11 exclude -- I can't read -- okay.

12 Claimant personally identifiable
13 information, as well as material not broadly
14 applicable, will allow the program to post
15 useful guidance and improve transparency.

16 CHAIR MARKOWITZ: Well, I would say
17 though that the rationale describes redaction
18 of not just confidential information, but also
19 material that's not broadly applicable.

20 MEMBER SOKAS: Well, so, it's in
21 there.

22 CHAIR MARKOWITZ: Which is not in

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1 the recommendation. The recommendation is
2 redacting confidential information.

3 MEMBER SOKAS: Well, no,
4 confidential information is not the same as
5 personally identifiable information.

6 Confidential is anything they don't
7 really want to have, you know, kind of out
8 there.

9 CHAIR MARKOWITZ: Okay, so, that
10 would include then what you describe in the
11 rationale --

12 MEMBER SOKAS: That's right.

13 CHAIR MARKOWITZ: -- not broadly
14 applicable.

15 MEMBER SOKAS: That's right.

16 CHAIR MARKOWITZ: Okay, thank you.
17 Okay, any further discussion?

18 MEMBER SOKAS: I'm sorry? Thank
19 you.

20 CHAIR MARKOWITZ: I think -- you
21 know, you could add to the -- I'm sorry, you
22 have transparency as the last word. Yes.

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1 Any other discussion? So, all those
2 in favor of this recommendation, raise your
3 hand. All those opposed?

4 So, I'm sorry, Dr. Redlich, I don't
5 mean to interrupt you, but are you in favor?

6 MEMBER REDLICH: Yes.

7 CHAIR MARKOWITZ: Okay, so, the vote
8 is unanimously in favor, and we will now take a
9 15 minute break until 10:30 and continue.
10 Thank you.

11 (Whereupon, the above-entitled
12 matter went off the record at 10:12 a.m. and
13 resumed at 10:33 a.m.)

14 CHAIR MARKOWITZ: Okay. So, just to
15 -- we have an -- remind the group here, we have
16 an hour and a half. We have, I think four
17 recommendations to get through, and then we
18 have -- we want to discuss the ANWAG letters
19 that were sent to us. We can just briefly go
20 over, if there any particular issues around the
21 Board requests to the DOL and the information
22 that we've received from them.

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1 But we want to -- we do want to save
2 some time for discussion of presumption. So, I
3 just want to remind the group of that. Thank
4 you.

5 MEMBER SOKAS: Okay, thank you. So,
6 I'd like to kind of plow through the second --
7 another recommendation which is, we recommend
8 that DOL explore the feasibility of having new
9 case files made accessible to the claimant
10 through a password-protected electronic portal.

11 The rationale for that is that
12 claimants already have the right to access
13 their records, although the current system only
14 allows this after the fact. Access in real-
15 time would promote transparency and may offer
16 the opportunity to decrease misunderstandings
17 and allow claimants to offer additional
18 information at an earlier stage, where needed.

19 So, this is the whole idea where if
20 somebody is labeled a laundry worker when
21 they're a laborer, they would have the chance
22 to say, "Wait a minute. That's not the case."

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1 CHAIR MARKOWITZ: Open for
2 discussion. Dr. Boden?

3 MEMBER BODEN: I think this is a
4 great idea. I would only make one suggestion
5 again, to the end of not being as polite as Dr.
6 Sokas.

7 Just say, we recommend that DOL make
8 accessible, new case files to the claimant
9 through password-protected electronic portal.
10 That is rather than just exploring feasibility.

11 MEMBER SOKAS: Okay, thank you.

12 CHAIR MARKOWITZ: You know, my
13 concern about not -- is moving to that language
14 is that I don't really know what's involved
15 with making these case files electronic.

16 I mean, having lived through the
17 conversion to electronic medical records over
18 the last few years, and just knowing on all
19 ends, the certainly financially, it's been very
20 costly. But also, it's been painful from the
21 users point of view, and I just don't know how
22 much is involved.

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1 So, I do think it's in part, a
2 feasibility issue. So, I'm not sure we should
3 entirely take that out of this recommendation.

4 MS. LEITON: This is Rachel. Can I
5 make just one comment?

6 CHAIR MARKOWITZ: Sure.

7 MS. LEITON: So, we have a lot of
8 records electronic, since a couple of years
9 ago, we went electronic. Before that, we had
10 hybrid cases. So, some are paper and some are
11 electronic.

12 The possibility of making things
13 proper like we are already considering, in
14 terms of the portal, making the claimants be
15 able to access their own case files
16 electronically, so that it will be the entire
17 case file, is going to be available in some
18 cases right now, because we only have -- some
19 cases -- like all the new cases, since the last
20 two years are electronic. But before that,
21 they're paper.

22 So, that might be the difficulty,

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1 just for your information.

2 MEMBER BODEN: Right. So, I would
3 still suggest that keep the wording the way it
4 is, but in the rationale, that we note that
5 some case files will be difficult to do
6 electronically, because they haven't been
7 scanned or something to that effect, and I do
8 think this is a different order of magnitude
9 then the electronic medical record, because
10 this is simply a matter of taking things that
11 are already electronic and available to, for
12 example, the CE's, and making them available to
13 the claimant. So, it's much less complicated.

14 CHAIR MARKOWITZ: Dr. Cassano?

15 MEMBER CASSANO: Two things. It
16 already says in the case file, so I don't -- it
17 already says new case files, so I don't think
18 there is any -- the way you wrote it, Rosie, we
19 -- they -- you don't -- you don't expect them
20 to go back to the old.

21 So, as a new case file comes on.
22 The other thing I would say, just to make it a

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1 little bit less onerous, I would say in read-
2 only format, so that they can't edit --

3 MEMBER SOKAS: Yes.

4 MEMBER CASSANO: -- through the
5 portal. If they see something that's wrong --

6 MEMBER SOKAS: Right.

7 MEMBER CASSANO: -- they need to
8 call up.

9 MEMBER SOKAS: They need to call up,
10 right.

11 MEMBER CASSANO: And talk to
12 somebody.

13 MEMBER SOKAS: So, I agree with
14 that. I think that available to the claimant in
15 read-only format is fine.

16 MEMBER CASSANO: Or read-only
17 access, I think is the proper word.

18 MEMBER SOKAS: Well, I think -- yes,
19 I think that's good enough.

20 MR. RIOS: Adding to Rachel's
21 statement, I'm going to take my DFO hat off,
22 and I'm going to put on my co-chair for the

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1 OWCP Steering Committee hat on.

2 I can tell you that I think
3 originally when we saw this recommendation, you
4 likened it to accessibility that's provided
5 through other medical facilities.

6 The government is bound by different
7 requirements that are imposed upon us by OMB,
8 identity, credential and access management
9 requirements or FICAM requirements.

10 I can tell you that the committee
11 that I co-chair looks at accessibility to case
12 files, to claimants for, like I said, all four
13 programs.

14 Recently, the security requirements
15 have been increased on us, and that has made it
16 very difficult to provide this type of access.
17 It has proved very difficult to provide this
18 type of access to claimants.

19 So, I only note that because you're
20 changing the language from 'look into' to 'make
21 available' and I would just caution you that
22 this might be more difficult than just being

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1 able to access electronic records to do private
2 industry or private sector businesses.

3 MEMBER SOKAS: So, if we leave it,
4 explore the feasibility, that's okay then.

5 CHAIR MARKOWITZ: Okay, further
6 discussion? I should say that on the previous
7 recommendations we voted on, Mark Griffon was
8 on the phone and communicated to Tony that he
9 votes in favor of all those.

10 So, on the record it should be clear
11 that Mr. Griffon also voted in favor, and I
12 guess, I don't know if Mark can actually speak
13 on the phone, at this point, on the next
14 recommendations, but if you can, please do
15 weight in, otherwise we'll get it through -- he
16 can't? Okay, fine, we'll get it and add it to
17 the record.

18 So, this recommendation, all those
19 in favor of this recommendation we're looking
20 at on the screen, raise your hand.

21 Okay, there is no one opposed,
22 because everybody is in favor. I would say Dr.

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1 Welch is not present at the moment, but
2 everyone else present has voted in favor of
3 this recommendation. Next recommendation.

4 MEMBER SOKAS: So, this is longer
5 than it needs to be, but we recommend DOL
6 reorganize the occupational physician in-time
7 office -- I'm sorry.

8 We recommend DOL reorganize its
9 occupational physicians into an office
10 comparable to the organizational structure to
11 the Office of the Solicitor of Labor with
12 physicians, organized in groups to support
13 OSHA, MSHA, OWCP and other units, as well as to
14 provide overarching support to DOL.

15 The rationale is the gap between the
16 current program and the medical community
17 reflects serious communication issues that
18 require in-house expertise.

19 However, physicians and other
20 healthcare professionals like attorneys, face
21 challenges when working in isolation. The
22 Office of Occupational Medicine in OSHA is an

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1 example of how professionalism and quality can
2 be maintained. But it would be more efficient
3 for DOL to develop an office directly reporting
4 to the Secretary that can offer the same
5 quality service across the department,
6 including for the smaller units.

7 Such an arrangement would allow
8 cross-coverage and avoid that gaps that have
9 been problematic with this program.

10 CHAIR MARKOWITZ: I would add to the
11 rationale. I would try to tie it more
12 specifically to our mission -- our assigned
13 tasks, which is, this comes in part from the
14 fact that in review of how the claims process
15 works and the SEM and the circulars, bulletins
16 and other policies, that there need -- would
17 appear to be a more -- need for a more
18 substantive and consistent input on
19 occupational medicine into the operation and
20 policies of the program, and that that --
21 that's part of the rationale, why we are taking
22 on this suggestion of reorganizing it, in

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1 order to facilitate that occurring. Ms.
2 Vlieger?

3 MS. VLIEGER: During this
4 discussion, I have a question that needs to be
5 answered by the department. I'm not sure if
6 Rachel would be the correct one to answer it,
7 or whether John Vance would be.

8 But currently, there was a job
9 position posted for nurses in the District
10 offices and there was an opening for the
11 national medical director for this program,
12 that had been unfilled for some time.

13 So, I would like the questions
14 answered of whether the national medical
15 director for this program has been filled, and
16 what is the purposes of the nurses in the
17 District offices?

18 MS. LEITON: This is Rachel. Can
19 you hear me?

20 CHAIR MARKOWITZ: Yes.

21 MS. LEITON: Okay, so, we have
22 filled the medical director position. That

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1 person is working on our program and doing a
2 little work, I believe for some of the other
3 divisions in OWCP.

4 The nurses are -- we are -- we have
5 nurses in the District offices already, but we
6 are centralizing some of those services, in
7 terms of home healthcare.

8 So, the nurse divisions are mostly
9 already existing, but they're going to report
10 centralized, so that we have a consistent way
11 of dealing with our medical bills, our home
12 healthcare services.

13 MS. VLIEGER: So, it's my
14 understanding from your answer, Rachel, is that
15 the nurses are not dealing with claims
16 management, as far as it goes for deciding a
17 case for its acceptance?

18 MS. LEITON: That's correct.

19 CHAIR MARKOWITZ: Additional
20 discussion? Dr. Welch?

21 MEMBER WELCH: I think for the
22 reasons we discussed yesterday, I think this is

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1 a really good idea, because having one
2 physician in isolation, we see what happened
3 with -- that happens to people who are in
4 private practice. They -- the -- the synergy
5 of discussing complicated questions with other
6 experts in the same area, or having fellows and
7 students ask questions that the -- this
8 responsible physician would have to answer, is
9 a way -- that keeps people really on their
10 toes, in a way that doesn't happen when you're
11 the only expert all by yourself, and it's the
12 same building and the Office of Occupational
13 Medicine has spent -- has had -- you know, a
14 number of really excellent leaders who have
15 spent time developing and understanding how to
16 make it a place where people really want to
17 work, so that the quality is better, if you're
18 attracting people to a group.

19 So, I think it's a -- as I said
20 yesterday, it's brilliant.

21 CHAIR MARKOWITZ: Dr. Silver?

22 MEMBER SILVER: Maybe one of the

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1 physicians who has worked on the inside of the
2 Department of Labor, would have an answer to
3 this.

4 We've frequently heard the
5 leadership of this program say, when we go to
6 our lawyers or we're taking it to our lawyers,
7 would this new structure ensure that the medico
8 part of medico legal questions gets an
9 amplifier?

10 MEMBER SOKAS: It should. I mean, it
11 takes the -- typically, the physicians right
12 now are three layers down in the organizational
13 structure, and the solicitors aren't. They're
14 -- I mean, you could have -- you know, people
15 with a law degree who are working as claims
16 examiners, but if you're a solicitor or an
17 attorney in the Department of Labor, you
18 clearly have the support of the other attorneys
19 there. You clearly have someone who is sitting
20 at the table, and this would allow occupational
21 health to -- it clearly would not ever be as
22 large.

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1 I mean, I think probably half the
2 people working in that building are in the
3 Solicitor's Office. I'm exaggerating, but not
4 by much.

5 But it would -- it -- it would be a
6 step in that direction.

7 MEMBER SILVER: Harder to ignore the
8 medical voice. Okay.

9 CHAIR MARKOWITZ: Actually, I would
10 add Dr. Welch's point to the rationale, which
11 is that it would make the department a more
12 attractive place to work, which is no small
13 thing, actually. There are very few
14 occupational medicine -- not that it's an
15 unattractive place to work, but for a
16 physician, there are very few occupational
17 medicine physicians around, and it's hard to
18 attract any, much less a good one.

19 So, I think that's part -- this
20 would make it more attractive.

21 So, I think that's all for your
22 recommendations, right? Okay, so, let's go to

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1 Dr. Cassano.

2 MEMBER BODEN: Are we voting?

3 CHAIR MARKOWITZ: I'm sorry, we're
4 voting, yes. Of course.

5 So, all those in favor of this
6 recommendation, raise your hand, and so, Mark
7 Griffon will weigh in, indirectly by phone, but
8 the vote is unanimously in favor of this, and
9 so, let's continue with the next
10 recommendation, which I think is Dr. Cassano.
11 You have one more? Okay, Dr. Redlich, let's do
12 that one.

13 MEMBER REDLICH: We may want to
14 tweak the wording, but this recommendation was
15 for the presumption, as far as sarcoidosis.

16 So, the current wording, we
17 recommend a presumption of chronic beryllium
18 disease in situations with a diagnosis of
19 sarcoidosis and an individual who meets the
20 definition of a covered beryllium employee
21 under Part E or Part B.

22 A positive BeLPT is not required to

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1 make a diagnosis of CBD in this situation,
2 where pre or post CBD criteria are used, and I
3 think that the rationale would -- needs
4 tweaking, but I put down some of the key
5 points.

6 CHAIR MARKOWITZ: And I'm very
7 sorry, could you just review the rationale?

8 MEMBER REDLICH: Okay, the first --
9 the blood BeLPT can be falsely negative,
10 especially in a patient with chronic beryllium
11 disease on immuno-suppressive treatment, a
12 bronchoscopy with lavage in order to obtain --
13 a lung lavage lymphocyte proliferation test, is
14 an invasive procedure that can be too risky to
15 perform in a patient with chronic lung disease.

16 The blood BeLPT test is not now and
17 will never be a routine blood test. It is
18 difficult to obtain on a patient who is not
19 currently in a beryllium surveillance program,
20 and then the prevalence in CBD in beryllium
21 exposed workers is higher than the prevalence
22 of sarcoidosis in the general population.

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1 CHAIR MARKOWITZ: Discussion? Dr.
2 Welch?

3 MEMBER WELCH: Just a friendly
4 amendment. Up on the top, the pre and post
5 should say pre and post 1993.

6 MEMBER REDLICH: I'm sorry, yes.
7 Thank you. Could you add that in, Kevin? In
8 the second paragraph.

9 MEMBER WELCH: Yes.

10 MEMBER REDLICH: I would ask someone
11 more familiar, does that wording of a covered
12 beryllium employee, is that the way one should
13 describe --

14 MS. LEITON: Yes, that should work.

15 MEMBER REDLICH: Thank you.

16 CHAIR MARKOWITZ: So, I have a
17 question. The diagnosis -- I don't know how
18 frequently people are given the diagnosis of
19 sarcoidosis mistakenly, and the question that
20 is, whether this language needs to be specified
21 at all.

22 For instance, biopsy-proven

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1 sarcoidosis or some qualification.

2 MEMBER REDLICH: So, it is usually
3 diagnosed on the basis of a biopsy.

4 CHAIR MARKOWITZ: Meaning that since
5 that's the usual, it's unlikely to be diagnosed
6 otherwise and we need not worry about it, yes.

7 MEMBER REDLICH: Yes.

8 CHAIR MARKOWITZ: Okay.

9 MEMBER REDLICH: But I -- I think
10 with any of these, when you start getting into
11 this specific cases, there might need to be
12 some additional guidelines for implementation.

13 CHAIR MARKOWITZ: Okay, Dr. Welch?

14 MEMBER WELCH: I think that if
15 Carrie were the doctor, she would use a biopsy,
16 but I think that -- I think people can make --
17 people do make a diagnosis of sarcoidosis with
18 very characteristic findings on the CT scan.

19 MEMBER REDLICH: Yes.

20 MEMBER WELCH: But that might be
21 sufficient. The other thing is, but with a
22 presumption you can't -- if you have a

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1 presumption, that's it. If you wanted to, you
2 can't sort of review the case and undo the
3 presumption. You know what I mean?

4 So, if there is something you want
5 to exclude from the presumption, it has to be
6 here.

7 This would allow Department of Labor
8 to develop a definition of the diagnosis of
9 sarcoidosis without specifying it, which could
10 be good, could be not what you wanted.

11 So, I'm not completely sure what the
12 -- what the rationale is.

13 MEMBER REDLICH: I'd propose -- I'd
14 actually probably just do a little more
15 homework on what the -- what existing criteria
16 exists, sort of in the medical literature for
17 the sarcoidosis diagnosis, just to better
18 answer that question.

19 CHAIR MARKOWITZ: Meaning that --
20 meaning before we vote on the recommendation
21 you're saying?

22 MEMBER REDLICH: No, I think that

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1 would just have to do more with potentially
2 instructions on what -- let's say you might get
3 to -- the contract medical, or whoever just to
4 -- what is a diagnosis of sarcoidosis.

5 CHAIR MARKOWITZ: Right, okay.

6 MEMBER REDLICH: Something like
7 that.

8 CHAIR MARKOWITZ: Okay, right. So,
9 we can, yes, leave this as-is, discuss and vote
10 and then later, consider weighing in on --

11 MEMBER REDLICH: That's right.

12 CHAIR MARKOWITZ: -- what are --

13 MEMBER REDLICH: For how you
14 actually just implemented it.

15 CHAIR MARKOWITZ: Right. Okay.
16 Other discussion? Okay, so, let's vote on
17 this. All those -- realize, actually, Mr.
18 Griffon probably is -- is he -- he may or may
19 not be looking at this screen, right?

20 Okay, so, let me read the
21 recommendation.

22 We recommend a presumption of

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1 chronic beryllium disease in situations with a
2 diagnosis of sarcoidosis in an individual who
3 meets the definition of a "covered beryllium
4 employee" under Part E or Part B.

5 A positive beryllium lymphocyte
6 proliferation test is not required to make a
7 diagnosis of chronic beryllium disease in this
8 situation, whether pre 1993 or post 1993
9 chronic beryllium disease criteria are used.

10 So, all those in favor, raise your
11 hand. Okay, everyone is in favor. So, it's
12 unanimous and we'll get Mr. Griffon's vote by
13 phone and add it.

14 Okay, next recommendation, I think
15 that's all for you, right? Okay, back to Dr.
16 Cassano.

17 MEMBER CASSANO: Remember that whole
18 thing about the 1995, the 1506 memo about 1995.

19 CHAIR MARKOWITZ: That's going to be
20 done after your --

21 MEMBER CASSANO: Okay.

22 CHAIR MARKOWITZ: I'll introduce

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1 that one after you.

2 MEMBER CASSANO: So, can you put
3 recommendation two up? My recommendation two
4 up, and this may need some tweaking based on
5 Steve's discussion before, but I did a little
6 bit.

7 So, for exposures which have a high
8 volume of claims, so not for everything, where
9 presumptives are not yet considered
10 appropriate. So, things that sort of fall in
11 between the 2A and the 2B on the IARC and stuff
12 like that, DOL should develop in-depth training
13 circulars, which discuss the nature of the
14 habit, the potential sources of exposure, a
15 non-exclusive list of the job classifications
16 and tests that are typically associated with
17 exposure and the possible medical outcomes of
18 exposure, and those can be stratified as to
19 probable, possible, et cetera.

20 This information should be available
21 to CEs, IHs and CMCs. It should also include
22 information on how to interpret -- that's -- we

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1 need to wordsmith that, on how to interpret the
2 information presented in the training
3 documents, when providing an opinion -- a
4 causation opinion, rather than opining on it,
5 and the rationale, as well.

6 The SEM provides the links between
7 exposure disease and so, John, it is
8 incomplete. Additionally, it requires some
9 understanding of exposures disease processes to
10 utilize effectively. Providing some background
11 information on the more common exposures allows
12 CEs to make better decisions regarding how to
13 use SEM and when to refer to IH or CMC.

14 CHAIR MARKOWITZ: So, discussion?
15 Dr. Welch?

16 MEMBER WELCH: So, you know, the
17 claims come in as a disease, with maybe --
18 maybe with or without an exposure being
19 identified for that disease, and it's the
20 claims examiner's responsibility to use the SEM
21 or the occupational history questionnaire to
22 identify possible links.

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1 I do not think -- I mean, you could
2 ask senior people in Department of Labor, what
3 they think are exposures which have a high
4 volume of claims, but there is no way to
5 identify that from the database the DOL
6 currently has, because it's based on disease,
7 not exposures.

8 So, I'm not -- I mean, it's not a
9 bad idea, that if there are exposures that are
10 difficult to deal with, that have been
11 problematic in some way, that DOL develop
12 training circulars that talk about how to
13 assess the hazard from that exposure.

14 But on the other hand, it may be
15 unnecessary if we have the industrial hygienist
16 interviewing the workers and this -- so, I'm
17 not sure. I just -- I'm just saying that
18 because I think it might be hard for -- to --
19 that first clause, exposures which have a high
20 volume of claims, to actually identify what
21 exposures are important, for which this would
22 be implemented.

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1 MEMBER CASSANO: What I was trying
2 to --

3 MS. LEITON: I agree.

4 MEMBER CASSANO: Rachel?

5 MS. LEITON: I was just saying, yes,
6 it is just as -- it's difficult, as Dr. Welch
7 just said, to know what those exposures are.

8 So, putting a generalized statement
9 like that, it's going to be difficult for us to
10 implement.

11 MEMBER CASSANO: What I was -- I
12 mean, one of the requests that you had was to -
13 - for us -- for our subcommittee develop the
14 training document, you know, to help with the
15 training documents.

16 Right now, the CEs are sort of
17 working blind. So, that's why I presented
18 that -- that VA training thing on asbestos and
19 environmental exposures.

20 Maybe it needs a little bit more
21 tweaking, before we bring it prime time, but
22 they need something, other than just the SEM,

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1 to be able to rationalize -- to rationally go
2 through a claim, because it -- it doesn't --
3 it's not working very well.

4 CHAIR MARKOWITZ: So --

5 MS. LEITON: Yes, so, we could
6 incorporate into training, some materials that
7 are provided to us.

8 CHAIR MARKOWITZ: So, let me -- yes,
9 let me just -- I'm for -- all for additional
10 training, but I think this is very problematic.

11 The way in which new written
12 circulars are likely to be used, if you look at
13 what recommended, which is the potential
14 sources of exposure, so, some things will be on
15 that list and some things won't be, because
16 it's very hard to make things comprehensive in
17 the DOE complex.

18 If you think about a non-exclusive
19 list of job classifications such as -- this is
20 -- this will create -- has the potential to
21 recreate some of the problems with the SEM,
22 which is that some job tasks or titles will

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1 make it and other won't, and if this material
2 takes on a life of its own, then it will be
3 used in decision making, and will replicate
4 some of the current problems that we've seen.

5 Similarly, the issue of the possible
6 medical outcomes, in my view, for the purpose
7 of consistency and fairness depends in part on
8 consistency that -- the idea that there are
9 possible medical outcomes related to specific
10 exposures would give a broad range of latitude
11 for a different -- different kinds of
12 decisions.

13 So, I appreciate the intent here, to
14 increase the level of knowledge and training,
15 but I am -- I am concerned that these materials
16 will be used in the process, in a way that
17 would be problematic and would not overcome
18 some of the problems we've seen so far. Dr.
19 Friedman-Jimenez?

20 MEMBER FRIEDMAN-JIMENEZ: Just a
21 point of clarification. By non-exclusive you
22 mean -- by non-exclusive, do you mean complete?

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1 MEMBER CASSANO: No, what I mean is
2 that, that list should not be used to exclude
3 another exposure.

4 What I'm afraid of and maybe we're
5 not -- this is not ready yet to -- and I'm
6 perfectly happy to withdraw it.

7 What I'm afraid of is that once we
8 do establish presumptions, if there is -- if
9 it's not a presumption, they're going to deny
10 it, and so, this would be the second tier of
11 okay, it's not a presumption, but here is some
12 possible -- here is a list of -- and we can
13 tweak it to make it disease-oriented rather
14 than -- than exposure-oriented.

15 But what I'm afraid of if it's not a
16 presumption, there is no second step to say
17 okay, this is -- these are all the other things
18 that could be considered and therefore, I need
19 to send this to the IH and the CMC.

20 That's my -- that's what this was
21 trying to fix, but I'm perfectly willing to
22 withdraw it, until we have some other things

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1 set first.

2 CHAIR MARKOWITZ: Dr. Sokas?

3 MEMBER SOKAS: So, one way to
4 potentially adapt it would be to have these
5 educational materials created around the 14
6 problem areas that were suggested, and some of
7 those are exposures and some of those are
8 outcomes, and all of them are kind of
9 challenging. So, that might be --

10 MEMBER CASSANO: Yes, I think that
11 was where I was headed, but I wasn't thinking
12 all the way through it. So, I will tweak this,
13 and then in six weeks or whatever it is, I'll
14 re-present it in something that actually may be
15 feasible.

16 CHAIR MARKOWITZ: Dr. Friedman-
17 Jimenez?

18 MEMBER FRIEDMAN-JIMENEZ: Another
19 way to -- to state this might be to develop
20 training in the approach to making these kinds
21 of determinations, where you're not going to
22 prescribe what -- what diseases are caused by

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1 what exposures directly, but how to approach
2 this, you know, how do you approach a chemical
3 and a cancer, in determining causality? How do
4 you approach a non-cancer outcome and a
5 chemical cause, and it would be a more general
6 training program.

7 I'm not sure a written circular
8 would be adequate. It might have to be an
9 actual training program. But I think focusing
10 on the approach, rather than the, you know,
11 possible outcomes and possible associations
12 might be better.

13 CHAIR MARKOWITZ: Mr. Turner?

14 MEMBER TURNER: Talking about all of
15 these diseases. I wonder what could be changed
16 to like disorder. A CBD chronic beryllium
17 disorder, instead of disease? Is there any way
18 possible?

19 People hear the word disease and
20 think of something being contagious.

21 CHAIR MARKOWITZ: Other --
22 condition? Right, disorder.

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1 MEMBER CASSANO: We'll withdraw it
2 at this time.

3 CHAIR MARKOWITZ: Okay, so, we'll --
4 then you're going to table this recommendation
5 --

6 MEMBER CASSANO: Yes.

7 CHAIR MARKOWITZ: -- and put it back
8 into the subcommittee --

9 MEMBER CASSANO: Yes.

10 CHAIR MARKOWITZ: -- for
11 reconsideration?

12 MEMBER CASSANO: For tweaking.

13 CHAIR MARKOWITZ: Okay, Dr. Boden?

14 MEMBER BODEN: Very briefly, and
15 something that I really don't want to discuss
16 now, but I just want to plant a seed, and that
17 is thinking about what it is that is reasonable
18 to ask CEs to do, and what is kind of going to
19 be outside their range and should be referred
20 on.

21 So, I'm a little hesitant about
22 putting too much on the CEs, so, just to think

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1 about it for further discussion.

2 CHAIR MARKOWITZ: Okay, and so, that
3 -- okay, go ahead, I'm sorry. Dr. Redlich.

4 MEMBER REDLICH: I was just going to
5 raise the same point. I run a training program
6 for occupational medicine physicians, who have
7 already all completed and are board certified
8 in internal medicine, and we have two years to
9 teach them how to do what we want various
10 people in this system to do, and our success
11 rate -- I mean, they pass their boards, but
12 many of our graduates -- and we have, I think
13 fortunately, some of the best trainees, are
14 really incapable of what we're asking people to
15 do.

16 So, I think as much -- and I don't
17 mean for any, but in general for the whole
18 system, as much as we can put in place that
19 happens more automatically and with less
20 individual decision making, might create a more
21 fair and sort of systematic process. So, just
22 as a general statement.

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1 CHAIR MARKOWITZ: Okay, yes, final
2 comment on this. We need to move on.

3 MEMBER CASSANO: Final comment on
4 that. I think what I am sort of envisioning is
5 that a CE based on the information that they
6 have available, can accept a claim, and under
7 very strict situations, let's say it's not a
8 covered employee or it's definitely not a
9 covered disease or whatever, they would be able
10 to reject a claim.

11 But when you're talking about either
12 industrial hygiene exposure information or
13 medical information, that it has to go down the
14 process, in order to be denied.

15 So, if the CE can't approve it
16 because of questions about exposure or
17 questions about disease, then it needs to go to
18 the IH, if the IH -- if they still can't
19 approve it after the -- unless it's something
20 very definitive from the IH, saying no way, not
21 only no, but you know, definitely no, it still
22 can't be disapproved until it goes to the CMC.

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1 I mean, now, there are obviously
2 going to be exceptions to that, but that's the
3 concept that I'm -- that I think we're all
4 trying to get to, is that you don't deny
5 somebody until they've had the full benefit of
6 the evaluation process.

7 CHAIR MARKOWITZ: Thank you. We're
8 going to move on. Kevin, could you bring up
9 the Circular 1506, the post 1995?

10 So, yesterday I -- we discussed this
11 and I said that I would come up with a
12 recommendation that reflected the sense of the
13 group, and write up the rationale.

14 I wrote up the rationale, which I
15 can show you next, but looking through the text
16 of this circular, actually the only
17 recommendation that I could figure out that met
18 the -- kind of the sense of the group was to
19 recommend that the circular be withdrawn,
20 entirely withdrawn, because I couldn't really
21 see any language that could fix it.

22 But that's kind of important

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1 recommendation. So, I'd like to just re-look
2 at the language of the circular. It's not all
3 that extensive, and there is a memo that
4 followed it, that we discussed yesterday with
5 the rationale, and then a note that followed
6 that.

7 But so, in this circular it says at
8 the end of the first paragraph, "Therefore, in
9 the absence of compelling data to the contrary,
10 it's unlikely that covered party employees
11 working after 1995 would have been
12 significantly exposed to any toxic agents at a
13 covered DOE facility," and then if you scroll
14 down, after 1995, it is accepted that any
15 potential exposures that they might have
16 received would have been maintained within the
17 existing regulatory standards and/or
18 guidelines.

19 Continuing, "If there is compelling
20 evidence," excuse me, "compelling probative
21 evidence," I forgot that word, "that documents
22 exposures at any level above this threshold or

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1 measurable exposures in an unprotected
2 environment, the CE is to contact the national
3 industrial hygienist to discuss referral," and
4 then language any -- finally, "Any findings of
5 exposure, including infrequent, incidental
6 exposure require review of physician to opine
7 on the possibility of causation."

8 So, if you then could go to the
9 rationale. It's the file that starts with
10 'rec'.

11 So to summarize, kind of the
12 discussion yesterday about our view of this,
13 which I've fortunately, committed to memory.
14 It's not in the briefing book manual. It was
15 in -- it was outside of that. It's called 'rec
16 re: post 1995 exposure', and if you don't have
17 it, Kevin, I have it.

18 So, the -- the first was that -- we
19 had it for a moment there.

20 Okay, so, that issuance of plans and
21 guidelines does not constitute evidence that
22 exposures were kept below those guidelines.

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1 Secondly, that exposures below
2 standards may still lead to health effects, and
3 third, since exposures after the early 1990s
4 may have been lower on average than previously,
5 claims based on exposures post 1990s require IH
6 review into the extent, duration and intensity
7 of exposure, to permit decision on exposure
8 disease link.

9 That post 1900s, you should add post
10 early 1990s. So, discussion? Ms. Vlieger?

11 MS. VLIEGER: I provided evidence to
12 the Board of a response from the U.S.
13 Department of Energy, that they do not have IH
14 information on duration, quality and kind of
15 exposures.

16 So, we're going to go down the same
17 rabbit hole, when there's no evidence they're
18 going to say no, and so, I'm concerned about
19 this language, because there is no evidence.
20 The IH is running blind on this, and because
21 there's no evidence, they end up saying no.

22 CHAIR MARKOWITZ: But then -- so,

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1 let me just understand.

2 Then if the work history is
3 provided, there is an occupational health
4 questionnaire. The CE is looking at that.
5 This is a post -- this is exposure that began
6 after 1995, or whenever.

7 Sending that -- there is no -- if
8 they do away with the circular, there's no
9 presumption either way, that if there was or
10 wasn't significant exposure, the industrial
11 hygiene, you're saying, probably won't have
12 much to weigh in on.

13 Then it goes from the CE to the
14 physician, either the treating physician is
15 weighed on, that's accepted, or it goes to the
16 CMC without the IH input. That's what you're
17 saying?

18 MS. VLIEGER: No, the IH says there
19 is no evidence of exposure, because there's no
20 evidence of exposure, and then Mr. Domina has
21 talked about this before, is that the labor
22 categories are not linked to the processes and

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1 site exposure matrix, to show all the chemicals
2 that they were probably exposed to.

3 But when we get down to this, you
4 know, where they want kind, quality and
5 duration of exposure, there is no evidence to
6 provide in very, very tiny instances, where
7 they actually took air quality measurements
8 after an accident.

9 There may be delayed type of
10 monitoring, but for IH monitoring for toxic
11 materials, this could be expanded, although I
12 don't know how the Department of Labor is going
13 to get these records easily, if they would
14 actually use area monitoring and job monitoring
15 that was done. But they're not in the
16 individual employee records.

17 CHAIR MARKOWITZ: Okay. So, then it
18 claims if we change this to say, "Didn't
19 require IH review, but required individual
20 assessment of exposure," that would leave it
21 open, as to whether it's the CMC that does that
22 or someone else.

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1 MEMBER CASSANO: I'm sorry. I'm a
2 little bit confused. I don't know -- true, and
3 unrelated, I don't know how removing this memo
4 fixes or keeping this memo fixes that problem.

5 Maybe we should say something about,
6 you know, just because there are regulations in
7 place, we should see fewer cases, but that it
8 doesn't change the exposure disease -- exposure
9 condition link.

10 But I don't see how totally just
11 withdrawing this affects that at all, what Faye
12 is concerned about. I think that's a different
13 issue, unless I'm not following this properly.

14 CHAIR MARKOWITZ: Dr. Boden?

15 MEMBER BODEN: It is a different
16 issue, and it just seems to me that that
17 doesn't negate proposed recommendation.

18 It sounds, however, like we
19 shouldn't really -- that number three doesn't
20 quite work in the rationale, and that we should
21 just eliminate number three. That's a matter -
22 - it's a matter of -- in a way, of speculation

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1 on our part, and we don't have any evidence for
2 it.

3 CHAIR MARKOWITZ: Yes, that would be
4 fine. Dr. Dement, did you want to --

5 MEMBER DEMENT: I think your point
6 one, probably covers it. My concern is that
7 most of exposure measurements, that are
8 actually done, are not done under sort of
9 abnormal situations.

10 The situation has already occurred.
11 The exposure is gone, and we measure exposures
12 during relatively quiescent periods, and so, we
13 never capture that.

14 The other thing that concerns me a
15 bit is that some of the assumptions again, on
16 lower exposures are based on use of PPE, and as
17 we discussed yesterday and the day before, PPE
18 sometimes doesn't work, many times doesn't
19 work.

20 CHAIR MARKOWITZ: So, fine. So, we
21 can -- Kevin, you can just eliminate number
22 three.

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1 Are there other elements though,
2 that need to be added to the rationale?

3 MEMBER CASSANO: Yes. I have a
4 recommendation, which is actually Carrie's
5 original recommendation, but I wanted to add
6 another recommendation to this, that says that
7 the process by which this memo was developed
8 should be explained to the Board, so we can
9 improve it and -- and this does not occur
10 again.

11 MEMBER WELCH: We did get that.

12 MEMBER CASSANO: We did?

13 MEMBER WELCH: We did get it.

14 CHAIR MARKOWITZ: Sure. There is --
15 there is a note that followed the memo --
16 recently, a note actually, it was provided to
17 the Board, because we asked for that, and we
18 received that note, and it's -- it's in your
19 packet actually or -- Dr. Boden?

20 MEMBER BODEN: Yes. So, in order to
21 have time to discuss the presumptions, I would
22 move that this recommendation be approved.

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1 CHAIR MARKOWITZ: Okay. So, if you
2 could write up the recommendation, Kevin, since
3 it's not written, about the rationale, and I
4 guess the recommendation is that the Circular
5 1506 be rescinded. Okay. Okay, yes, be.

6 Okay, so, if there's no further
7 discussion, is there a second for this -- for
8 no further discussion? Let me just read it,
9 for people on the phone.

10 "Recommend that Circular 1506 post
11 exposure 1995 -- exposure," let's see, "Post
12 1995 exposures be rescinded."

13 So, all those in favor, if you'd
14 raise your hand. It's unanimous. All those --
15 no one is opposed. We'll get Mr. Griffon's
16 vote by phone.

17 Okay, so, I think that's -- we're
18 finished with the recommendations, and we can
19 move on.

20 We have 40 minutes until our break
21 for lunch, and there are several things we need
22 to get to. The first is hopefully, a brief

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1 review of the letter sent by ANWAG to us.

2 Secondly, some discussion of
3 presumptions, and then I want to spend just a
4 few minutes on advisory -- on administrative
5 issues, next meeting, how we can improve the
6 Advisory Board process and the like.

7 So, let's start with the ANWAG
8 letters, which you all have received, and so,
9 let me just summarize and get to the point.

10 The June 3rd letter to -- addressed
11 to me, from ANWAG addresses one particular
12 issue, and that is that there -- apparently,
13 there are certain Department of Energy
14 facilities that are not considered Department
15 of -- or number of facilities that are not
16 considered Department of Energy facilities, and
17 that's because the Department of Energy, or
18 Department of Labor has designated -- has
19 decided they don't meet a certain standard in
20 the statute.

21 The key phrasing in the statute is
22 that Department of Energy has not had -- needs

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1 to have a proprietary interest in that
2 facility, and ANWAG is -- has requested from
3 the Department of Labor, a definition for what
4 proprietary interest is, because it's not
5 really very clear, why those facilities don't
6 make that standard.

7 Now, the question is, is this an
8 Advisory Board issue? Is this relevant to the
9 tasks provided to us at all, and if so, what
10 would we say about it?

11 I think just to -- while you're
12 thinking about that, ANWAG's argument is that
13 since we are tasked with looking into the SEM
14 and its improvement, that if there are --
15 certain facilities that aren't considered DOE
16 facilities, then exposure can't be considered
17 if they're not actually within the realm of the
18 program, as defined by DOL. Yes, Dr. Dement?

19 MEMBER DEMENT: Just a point of
20 clarification. To what extent are these
21 actually written into the enabling statutes
22 versus administrative decisions that DOL has

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1 actually made? It's not clear to me in this at
2 all.

3 I mean where -- if it's in the -- in
4 the statute, then we have no control. We can't
5 do anything with it.

6 CHAIR MARKOWITZ: Right. Well, the
7 statute gives a definition of what's considered
8 a Department of Energy facility, and it's that
9 -- that there is a proprietary interest of the
10 Department of Energy in that facility.

11 The question is, how is that defined
12 and does it meet that standard? Ms. Vlieger?

13 MS. VLIEGER: We're struggling,
14 because none of us have the letter in front of
15 us.

16 CHAIR MARKOWITZ: Right. I don't
17 know whether -- yes.

18 MEMBER CASSANO: It was sent in an
19 email. Let me go back.

20 CHAIR MARKOWITZ: Friday. Last
21 Friday.

22 MEMBER WELCH: From the Board, and

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1 the title is 'correspondence', of the email.
2 So, there's an email from the Board. Sure, do
3 you have it?

4 MEMBER BODEN: Let me just take a --
5 there's a question -- is this a question of
6 law, of legal interpretation, in which case, it
7 seems to me to be outside the bounds of our
8 charge.

9 CHAIR MARKOWITZ: Dr. Welch?

10 MEMBER WELCH: Yes, I would agree
11 with that, because the statute uses the term
12 'proprietary' and the letter says it's unclear
13 how proprietary is interpreted.

14 So, that additional -- if it was
15 interpreted in a more open -- more liberal
16 fashion, additional facilities could be added.
17 But I think that's something that we have, as
18 you just said, I would agree with what you
19 said, I don't -- I don't feel like that's part
20 of our charge or you know, it's an issue for
21 the labor solicitors, correct?

22 I mean, we could, in theory, weigh

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1 in, but it's not -- certainly not in my -- in
2 my area of expertise, to have anything to say
3 about what proprietary means. Department of
4 Labor had a proprietary interest in a facility.
5 I feel like that's out of the scope of our
6 expertise.

7 CHAIR MARKOWITZ: Yes, Mr. Domina?

8 MEMBER DOMINA: Well, I think one of
9 the issues that we have right now, and I'll
10 just speak for Hanford, is they put our
11 workers, who are covered by all these other
12 statutes, in leased facilities and DOE doesn't
13 want to take responsibility for them, because
14 they're managed by some other entity.

15 However, with that being said, they
16 still have to protect us from the hazards
17 because of where we work, and we've run into
18 this, especially with our beryllium affected
19 workers, because of finding beryllium on
20 contactors and elevators and so -- you know,
21 and so, we need to be careful that -- and then
22 we have people at the Richland Airport and

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1 other places, where they've just -- all the
2 sudden, they need space, so they throw people
3 in there.

4 But our people need to be protected
5 and they have to do that, but then DOE doesn't
6 want to take responsibility, that's a DOE
7 facility.

8 CHAIR MARKOWITZ: Ms. Vlieger, your
9 card is up. I don't know if you want to speak
10 or not.

11 MS. VLIEGER: Yes. Well, we have
12 the person who authored the letter here. So, I
13 don't know if we're allowed to ask these
14 questions of the direction of this.

15 I understand the question of whether
16 we consider it's germane to our charter. But
17 if the issue is the same issue we have with the
18 SEM, like labor categories that should be
19 there, that aren't there, with exposures that
20 should be there, that aren't there, and that is
21 part of our charter, I think this is one of
22 those deficiency areas.

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1 CHAIR MARKOWITZ: Dr. Sokas?

2 MEMBER SOKAS: So, I guess I'm even
3 a little more confused. I mean, I do have the
4 letter in front, but if it's -- if it's
5 something that DOE needs to do, rather than DOL
6 needs to do, I guess I'm feeling a little
7 overwhelmed as a Board, and I think there were
8 a number of issues that, for example, were
9 raised yesterday, about changes in procedure
10 that we had no idea about, that seemed to be
11 much more directly related to what we might be
12 able to offer. This just seems to be a step
13 removed.

14 CHAIR MARKOWITZ: Other comments?
15 Yes, Dr. Silver?

16 MEMBER SILVER: A few years ago, I
17 was denied a Freedom of Information Act request
18 because the material was sensitive. So, I
19 asked the Department of Energy for a definition
20 of the word 'sensitive', and they replied in
21 writing, "We don't have a definition."

22 I see this as kind of another

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1 example of the Department of Labor maybe
2 catching that old Atomic Energy Commission
3 disease. They have a memo that defines their
4 interpretation of proprietary interest. They
5 really ought to release it, so that the
6 advocates can, you know, figure out why certain
7 facilities have been excluded.

8 CHAIR MARKOWITZ: Dr. Cassano?

9 MEMBER CASSANO: I do think it's
10 probably outside our purview, but we might want
11 to officially/unofficially say something in
12 writing to DOL that says, "This was forwarded
13 to us. It is of concern, though outside of our
14 purview, we believe. We would like this to be
15 addressed by the appropriate organization,"
16 people, whatever.

17 That way, at least -- we can -- we
18 can track it and see what's happening with it,
19 but I don't think we can make this decision.

20 CHAIR MARKOWITZ: Okay, so, the --
21 I'm not entirely sure whether we should take a
22 vote on this, but I think actually, that's the

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1 easiest way to reflect our thinking, and I
2 think the vote then would be whether this issue
3 is an issue that the Board feels is within its
4 domain, and should offer an opinion or support
5 the request, and the question is, is there
6 further discussion on that? Okay, so,
7 then all those in -- I guess, to make it clear,
8 then -- go ahead, Dr. Boden.

9 MEMBER BODEN: I'm not sure that I'm
10 prepared to say yes or no at this point,
11 because I don't think I understand everything.
12 I would propose that we table this.

13 CHAIR MARKOWITZ: Okay, we could.
14 Does anybody second that?

15 MEMBER WHITLEY: Second.

16 CHAIR MARKOWITZ: Okay, we could get
17 some more background on this issue, and then if
18 -- I mean, I was just concerned about the six
19 month time frame before the next meeting, but
20 if we have another meeting by telephone, then
21 we can address this.

22 So, the recommendation is that we

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1 table this issue, and reconsider it when we get
2 additional information.

3 All those in favor of this? If you
4 could raise your hand. It's unanimous. So,
5 that's what we'll do.

6 The second letter is ANWAG is dated
7 September 9th, 2016, and raises a few issues, I
8 think issues actually a little bit more
9 familiar to us, I'm happy to say, and that's
10 not to discourage people from raising issues
11 that are unfamiliar to us.

12 But the first issue on this is
13 really about inaccuracy within the SEM, which
14 is that there -- and they gave an example of
15 radiation monitor, which was a job that was
16 labeled differently at various sites and had
17 different toxic agents associated within the
18 SEM, at different sites.

19 We've heard of this problem before.
20 It occurs. It needs to be corrected when it
21 arises. Ideally, it would be corrected before
22 it arises, but we recognize this problem and

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1 we're trying to figure out ways to improve the
2 SEM.

3 So, I just want to acknowledge that
4 issue, that it's on our radar and we are
5 working to move on that.

6 On page two, so page two actually
7 addresses the same issue.

8 So, on page three, the first full
9 paragraph, the letter raises the important
10 issue of recognizing that people who have not
11 had traditionally recognized hazardous
12 occupations also have had the opportunity for
13 toxic exposures within the complex, and the
14 examples given are administrative workers who
15 are -- have worked in buildings where toxic
16 agents are used, and therefore, have exposures,
17 and the importance of recognizing that those --
18 making sure that the system recognizes that
19 those workers have potential exposure,
20 important exposure to toxic agents, even though
21 they don't have the job that necessarily is
22 associated with recognized hazards.

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1 This is an issue I think that --
2 actually, we -- I think the SEM subcommittee
3 should explicitly discuss, which is how does
4 the SEM address this issue, because I -- we
5 haven't really -- we've heard about this, we
6 recognize it, but we haven't really looked into
7 it at all.

8 So, I think if Dr. Welch could take
9 this into her committee and try to help figure
10 out an appropriate approach to this.

11 Then the final issue in this letter
12 is -- relates to the proprietary interest, a
13 gentle reminder that I hadn't responded to the
14 previous letter, and I thank you for being
15 gentle in that aspect.

16 So, that's it, really. I don't
17 really think there are further issues to
18 discuss from the ANWAG letters.

19 CURRENT AND FUTURE USE OF PRESUMPTIONS
20 IN THE EEOICP

21 We need to move ahead now, and we're
22 going to have a discussion on presumptions and

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1 then leave a few minutes for administrative
2 issues, and I think that we have looked at now
3 and discussed, a couple of presumptions.

4 We certainly looked at the post 1995
5 presumption, and we looked at the CBD or -- the
6 hearing loss presumption, and found there is in
7 both of those policies, where we've suggested
8 improvements or alterations.

9 So, I have prepared -- I don't -- we
10 don't have time to do this, but I have prepared
11 a number of additional circulars with -- that
12 use presumptions on asbestos, on asthma, on TCE
13 and kidney cancer, and then there are a couple
14 of others.

15 But we really don't have time to go
16 through that now, and what I suspect is that in
17 all those circulars, we would find areas in
18 which we agree and areas in which we would
19 recommend some improvements.

20 So, but what we really need to do is
21 identify a process going forward, where we can
22 do that, and so, I'm open to suggestions about

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1 how we might approach this. Dr. Sokas?

2 MEMBER SOKAS: Okay, this is not in
3 direct response to your request. Just to
4 clarify.

5 So, I think we did have the
6 presumption discussion about the solvents and
7 hearing loss. We did not come to any
8 recommendations or conclusions about it, and I
9 would like to acknowledge that there were
10 specific questions raised by the public about
11 assembly machinists at the Y-12 plant, about
12 instrument technicians at X-10, and that we
13 forward both a request for -- a response to the
14 -- so, this could be framed as a request to the
15 Department of Labor, and we don't really have
16 time on the agenda for this, but I want to
17 raise it, that we list our requests going
18 forward to the Department of Labor in writing,
19 as you've suggested we need to do.

20 But that we could ask the Department
21 of Labor for a response to the presentation
22 about the hearing loss presumptions, and

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1 specifically whether the -- the question about
2 the nine years continuously and the individuals
3 who raised those issues last night, if there
4 could be, you know, kind of a -- including
5 their concerns in that request.

6 MEMBER WELCH: Maybe I was trying to
7 multi-task, and so, I didn't completely
8 understand what you were -- do you want to -- a
9 rationale from Department of Labor for that
10 presumption?

11 MEMBER SOKAS: I think we raised
12 some questions about the presumption.

13 MEMBER WELCH: Yes.

14 MEMBER SOKAS: So, we would like the
15 Department of Labor to respond to the questions
16 that we've raised, about whether they might
17 reconsider the presumptions the way that
18 they're currently written. I think the next
19 conversation on generally speaking going
20 forward, how should presumptions be handled is
21 -- I don't want to interfere with that
22 conversation because I think that's critically

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1 important.

2 But this might be the first test
3 case, along with asbestos, to see -- you know,
4 we're giving some information. Is it useful?
5 Can you tell us if it's affected your plans for
6 revising this and oh, by the way, in these two
7 instances, how would that change?

8 CHAIR MARKOWITZ: Dr. Dement?

9 MEMBER DEMENT: I sort of disagree.
10 I think we need to have a process that we sort
11 of go through these things, having had that
12 valuable input from our people that have
13 experienced these situations as background and
14 input as we go forward, and we consider these
15 presumptions, either the ones that are there,
16 and how we might make them better, or ones that
17 we might come up with ourselves, as a Board.

18 I'd rather not start with that, and
19 then we'll probably change it later anyway.

20 CHAIR MARKOWITZ: I agree with Dr.
21 Dement, because that discussion was extremely
22 useful, but didn't actually end at any

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1 particular observations or any particular, even
2 soft recommendations.

3 So, I'm not sure exactly what they'd
4 be responding to. But if we could move ahead
5 with that, as part of the larger presumption,
6 then it might be -- it might just lead to a
7 more fruitful interchange. Dr. Cassano?

8 MEMBER CASSANO: My experience,
9 there's two parts to every presumption. There
10 is one presumption that says that if you did
11 this or if you worked here or if you were
12 involved in this process, it is presumed you
13 were exposed to.

14 The second part of a presumption is,
15 if you were exposed to, it is presumed that
16 your known -- that the disease that we know
17 there is a link between was due to that
18 exposure.

19 It is, in some ways, basically an
20 unqualified link from job to exposure to
21 disease outcome, and there is not of ands, ifs
22 or buts about it, and so, presumptions don't

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1 need to be qualified to the end degree, such as
2 the auto-toxicity one was.

3 So, I think the simpler we keep
4 them, the less confusing they are to people.
5 But remember, you're looking at two different
6 presumptions in the process.

7 CHAIR MARKOWITZ: Ms. Vlieger?

8 MS. VLIEGER: I just have a point
9 that we can belabor later on. But Dr.
10 Redlich's concern about the process of how we
11 got to some of these issues already in the
12 program, with the pre and post '93 and the 10
13 years before 1990, the memo that we were
14 provided is not a current response to how did
15 we get here. It's from 2015.

16 So, the response we were given is
17 not a current answer for the question. This
18 was an old answer that was inadequate at the
19 time. So, the DOL response.

20 CHAIR MARKOWITZ: Right, but just a
21 point of correction. There is a third
22 communication. There is what's called a note,

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1 and it's short, but that was a recent comment
2 on the previous --both the circular and the
3 memo.

4 It won't overwhelm you but it -- I
5 don't mean that critically, I'm just saying --

6 MS. VLIEGER: No, no.

7 CHAIR MARKOWITZ: -- there is a
8 recent response.

9 MS. VLIEGER: My point is, if you
10 review the information that's been provided to
11 the Board, from the different groups, for our
12 meetings, these are not new answers. These are
13 answers from 2015.

14 So, the answer of how we got here
15 and how to prevent this in the future, I think
16 is still viable. That's all I wanted to say.

17 CHAIR MARKOWITZ: Okay, Dr. Boden?

18 MEMBER BODEN: So, I think given the
19 time, that question that we have to answer
20 perhaps now, is how do we proceed? How do we
21 organize ourselves to examine both existing
22 presumptions and presumptions that this group

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1 might want to recommend to the Department of
2 Labor, and since in a way, the issue of
3 presumptions overlaps the different current
4 subcommittees, we might think about setting up
5 a working group that would consist possibly of
6 people from the different subcommittees, to
7 meet in the interim and to bring to the Board,
8 suggestions about how to proceed.

9 CHAIR MARKOWITZ: So, for Mark
10 Griffon, who is on the phone, people are
11 nodding their heads in agreement with this
12 idea, forming a working group that's going to
13 cut across the subcommittees, to address
14 presumptions.

15 To review current presumptions and
16 sort of tease out the DOL's reasoning, also
17 look for issues within those presumptions, and
18 then both develop -- develop some advice on
19 future presumptions, as well as a broader
20 discussion of the use and limitations of
21 presumptions.

22 So, who would like to serve on that

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1 working group, to cut to the chase here?

2 Okay, for the record, Dr. Cassano,
3 Ms. Vlieger, Dr. Boden, Dr. Silver, Gary
4 Whitley, and I will, as well, and Dr. Welch and
5 Dr. Dement, okay, and I think -- and I'm
6 imagining Mark Griffon raising his hand, but
7 we'll see about that. Okay.

8 MEMBER REDLICH: If specific issues
9 come up related to pulmonary diseases, I am
10 happy to chime in, but I --

11 CHAIR MARKOWITZ: Okay.

12 MEMBER REDLICH: -- would rather
13 not. Just because of time constraints.

14 CHAIR MARKOWITZ: Okay.

15 MEMBER SILVER: You've earned your
16 presumption pay this meeting.

17 CHAIR MARKOWITZ: Okay. Okay, so,
18 let's move on, and discuss administrative
19 issues.

20 ADVISORY BOARD PROCESS: DISCUSSION

21 CHAIR MARKOWITZ: We need to decide
22 actually, or think about where we want to meet

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1 next. I'm assuming we're going to meet in six
2 months. Roughly April, and just to kick off
3 this discussion.

4 It's been extremely useful to meet
5 here in the field in Oak Ridge, to hear
6 directly from people, to have a tour of the
7 facilities, and I could see replicating that at
8 other locations for the same reasons,
9 basically.

10 As to the next meeting, I do have
11 some concern that there will be a new
12 Administration and I don't know how much
13 turnover there is in the Secretary -- in the
14 Department of Labor, but there is some
15 advantage to having some face time in
16 Washington, with whoever will be there.

17 So, as for the next meeting, I'm
18 sort of on the fence about those things, but I
19 open it up for discussion. Mr. Domina?

20 MEMBER DOMINA: I think we need to
21 go west. I mean, we've been east of the
22 Mississippi twice, and I understand what your

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1 point is with the new Administration. But I
2 think we need -- there is a need, you know.
3 Nevada test site, Denver area, the uranium
4 miners or Hanford, with everything that's going
5 on with the tank farms.

6 We need to go. We've been east
7 twice, the first two times. We got to go west.
8 I mean, because other -- I'm afraid on how it
9 may look, and I know it's bad for some of you
10 folks that live east, but you know, we don't --
11 you know, yes, like John said, suck it up. We
12 did it twice already. So, come on.

13 CHAIR MARKOWITZ: Okay.

14 MEMBER WELCH: I'm glad you consider
15 Denver west. So, that's good, although I'd
16 love to go to Hanford.

17 CHAIR MARKOWITZ: Dr. Sokas?

18 MEMBER SOKAS: I mean, I do think
19 that I'm a little concerned at the number of
20 DOL people who are here and participating. I
21 appreciate the fact that Rachel is on the
22 phone.

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1 I had actually earlier, requested
2 that if there was a new occupational physician
3 working in this program, that that person might
4 be actually be able to be at this meeting. I'm
5 not sure how that request was forwarded.

6 But again, I think there is lots of
7 limitations, in terms of that. So, maybe an
8 alternative would be to plan out the next two
9 meetings, one that could be with a little bit -
10 - because frankly, I would like to be in the
11 position where the recommendations that go
12 forward have a chance to be responded to in a
13 kind of more immediate way.

14 So, if we have two meetings
15 scheduled, one, you know, far, and one, you
16 know, in DOL itself, I think that might be
17 helpful.

18 CHAIR MARKOWITZ: Dr. Boden?

19 MEMBER BODEN: I would just suggest
20 that if we have our next meeting west, that
21 wouldn't preclude one or more people from this
22 committee meeting with the -- any new people

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1 who came in through the leadership in the
2 program.

3 CHAIR MARKOWITZ: Dr. Cassano?

4 MEMBER CASSANO: Somebody needs to
5 turn on -- oh, there we go.

6 Just a note that if we do go west,
7 the ACOEM meeting is in Denver, the third week
8 of August -- of April, and so, sometime around
9 -- it would be very convenient for the
10 physicians that attend that meeting, to
11 actually be out there at the same time and all
12 that.

13 CHAIR MARKOWITZ: Other comments?
14 Mr. Turner?

15 MEMBER TURNER: Maybe you can visit
16 the National Jewish, that have that sarcoidosis
17 facility there.

18 CHAIR MARKOWITZ: I think there's a
19 vote for Denver. I hear a vote. I hear an
20 indirect vote for Denver.

21 MEMBER REDLICH: I actually think
22 that the needs are greater in the issues, in

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1 terms of uranium miners. So, I would propose
2 heading further west.

3 MEMBER DOMINA: Vegas, baby.

4 MEMBER REDLICH: I mean the site --
5 my understanding is the physical site -- not
6 that there still aren't a lot of workers in the
7 Denver area, and this may be that I am in
8 regular communication with the group, the
9 National Jewish.

10 But I feel that the -- you know,
11 Kirk's point.

12 CHAIR MARKOWITZ: Okay, so, yes, go
13 ahead, Mr. Domina.

14 MEMBER DOMINA: Well, I -- you know,
15 in -- and I understand the logistic stuff, but
16 you know, I'm here representing the workers,
17 and it's about the workers, and I know it
18 inconveniences people or whatever, but you
19 know, a lot of us have done a lot of shift
20 work. We've done a lot of inconveniences over
21 the -- and we need to go where the people need
22 stuff, and I agree with Dr. Redlich, yes, the

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1 uranium miners, the Navajo Nation, a lot of
2 these people have been under-served, and I
3 think it would mean a great deal to them, to
4 come out there and show that we really care,
5 because -- and I understand about the new
6 Administration and stuff, but you know what?
7 They come and go, just like all the contractors
8 I've worked for. But guess who is still here
9 almost 34 years later? That would be me, and
10 it's those people sitting out in the audience
11 today.

12 CHAIR MARKOWITZ: Okay, so, my sense
13 is that so far, most of the speaking has been
14 in favor of meeting at or near a site in the
15 west, and that provisionally, we could consider
16 next fall meeting at Department of Labor in
17 Washington, but that would be a provisional
18 kind of thing, to be re-discussed at the April
19 meeting.

20 Does anybody have anything to add to
21 that?

22 MS. VLIEGER: Before we get too far

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1 afield, Dr. Redlich, do you have a particular
2 place in mind that you're thinking of, a
3 central place, since you work with a lot of
4 that community?

5 MEMBER REDLICH: Well, I mean, a
6 colleague of mine is -- you know, sees a lot of
7 the miners, you know, and he's at University of
8 New Mexico. But I think Kirk could probably
9 recommend, you know, what would be the optimal
10 location, or not optimal but --

11 MEMBER DOMINA: Well --

12 MEMBER REDLICH: -- reasonable.

13 MEMBER DOMINA: -- I said what it
14 was earlier, but anyway.

15 CHAIR MARKOWITZ: Right, right.

16 MEMBER DOMINA: Yes, but I guess the
17 other thing, just to throw out there, and maybe
18 we could have with the new Administration,
19 because I hate to cut the workers short, about
20 a possibility of a third meeting, to have maybe
21 a day or day and a half in D.C., because that's
22 not conducive for the workers to get there, and

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1 it's very expensive to be inside the Beltway,
2 and that's a big concern of mine, because it
3 does not look like it's worker-friendly.

4 CHAIR MARKOWITZ: Okay, well, okay,
5 so, we've had different votes on where west,
6 but at least we've agreed on meeting out west.
7 So, I think we can turn onto other -- turn it
8 over to other topics.

9 I want to just -- we only have a
10 couple of minutes. Ms. Leiton wants to take
11 five minutes and speak to us before lunch.

12 But I want to -- are there
13 particular issues in the process over the past
14 six months, in the Advisory Board process, that
15 we should pay attention to, that we could
16 improve? I'm not sure we can finish that
17 discussion, but I do think we should at least
18 start it. Dr. Sokas?

19 MEMBER SOKAS: So, this is a request
20 that we've discusses and apparently, there --
21 but one of the requests that we, as a Board,
22 need to have out there is that changed in

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1 circulars and bulletins and policy manual, I
2 don't have the wording, but I would like to
3 have our list of requests going forward made
4 very clear and that when one of those happens
5 after -- you know, it doesn't have to be that
6 we have a decisional role in it, but that at
7 least we're informed, because again, of the
8 questions that were raised yesterday, I think
9 were a surprise to most of us.

10 CHAIR MARKOWITZ: Right, yes, we
11 agree on that. Sure. Yes, Ms. Vlieger?

12 MS. VLIEGER: Just an administrative
13 point. Since it takes so long for us to
14 publish our meetings and have our meetings, if
15 we could set a regular schedule for the
16 subcommittee meetings, and even if we don't
17 have a lot to say at that time, if we can
18 schedule it and get it in the Register, and
19 have the agenda be open enough that, you know,
20 we can fit in what we need, because right now,
21 we're constantly falling behind that publish
22 meeting, meeting type of situation.

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1 So, if we could set up an every six
2 week or eight week schedule going forward, so
3 that they're there if we need them, and if we
4 don't need them, we convene shortly, and you
5 know, adjourn. But that other issue where we
6 want to make everything available to the public
7 is kind of hamstringing us in our ability to
8 publish the meetings and then hold the
9 meetings.

10 CHAIR MARKOWITZ: I think it's a
11 good idea. I mean, I think we've done very
12 well actually in schedule the meetings --
13 scheduling the meetings.

14 Most committees had two subcommittee
15 meetings since April, so, we have done well.
16 But I agree with you to a regular schedule, and
17 then have a short meeting, if necessary. Dr.
18 Cassano?

19 MEMBER CASSANO: Yes, well, a
20 comment on that. I think we have to be very
21 careful to de-conflict, you know, other
22 responsibilities for all the people involved.

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1 If we just set them at every six weeks, we're
2 going to run into other meetings and other
3 conferences and stuff like that. So, it's
4 going to have -- if we're going to do that, we
5 need to be very careful about it. The
6 other point that I actually, originally wanted
7 to make was, I think it would be very helpful
8 if, in addition to subcommittee meetings, you
9 had some kind of phone conference with the
10 subcommittee chairs, so that we knew what each
11 of us was doing, and coordinating our efforts,
12 because I came here not knowing that there were
13 issues about industrial hygienists and the SEM,
14 and I was working on some of the same things,
15 and the training and all of that. So, I think
16 it would be very helpful.

17 CHAIR MARKOWITZ: Yes, good idea,
18 adopted. Yes. Dr. Redlich, do you have --

19 MEMBER REDLICH: This is somewhat
20 following up on Rosemary's point.

21 To understand the process of these
22 bulletins that come out, like there are -- in

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1 the past year, there are two that are topics
2 near to my heart. One on COPD and asthma, and
3 they have an effective date and an expiration
4 date, and I see substantial issues with both of
5 them, that are beyond discussing today, but
6 moving forward, it's almost like could we
7 prevent damage before it happens?

8 So, this process, I'm a little
9 unclear on, how these are developed and then,
10 implemented and why there's an expiration date.
11 That may just be a technicality of the
12 bulletin.

13 CHAIR MARKOWITZ: Right, right.

14 MEMBER REDLICH: But --

15 CHAIR MARKOWITZ: I think we
16 probably --

17 MEMBER REDLICH: And I think for the
18 topic for the future, I do think -- I am
19 curious what the status of these two are, the
20 asthma and the COPD, because you know?

21 CHAIR MARKOWITZ: Yes.

22 MEMBER REDLICH: They could use a

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1 halt before, if they haven't gotten to them,
2 but I don't know.

3 CHAIR MARKOWITZ: Right, right. So,
4 we can --

5 MEMBER REDLICH: And that's beyond
6 today.

7 CHAIR MARKOWITZ: Right. Beyond
8 today, but the question just of -- just a
9 specific question for Mr. Vance.

10 When a circular expires, is it
11 routinely re-adopted and given a new active
12 period and I'm --

13 MR. VANCE: Yes. No, the circulars
14 and the bulletins have an expiration date, but
15 they will remain in effect until incorporated
16 into the federal Procedure Manual.

17 So, generally, what you will see is
18 eventually that will be, when we go and do our
19 editing process for transmittals to the
20 procedure manual, we will go back and look at
21 information that should be incorporated into
22 the procedure manual, unless it is something

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1 that is a temporary procedural issue that
2 resolves with the -- the expiration date.

3 So, most of the bulletins will
4 eventually be incorporated into the procedure
5 manual and some mechanism or some way, as long
6 as it's applicable to the chapter that's under
7 revision.

8 CHAIR MARKOWITZ: Okay, thank you.
9 Last item I'd like to raise and then we're
10 going to hear from Ms. Leiton, is so, all of
11 our subcommittees are chaired by physicians,
12 and much of the conversation last three days
13 has been by physicians, and we want to
14 encourage full participation by all Board
15 members, and I'm throwing out an idea that we
16 don't really need to discuss, but just to think
17 about, that some of the subcommittees perhaps,
18 could have a co-chair that would not be a --
19 probably not be a physician, that might help
20 increase the input by the non-physicians into
21 the Board discussions. Just an idea to
22 consider.

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1 So, we're now going to move on.
2 Rachel wants to take five minutes and give us
3 some remarks.

4 MS. LEITON: Thank you for letting
5 me --

6 CHAIR MARKOWITZ: I'm sorry, just
7 ask --

8 MS. LEITON: Thank you.

9 CHAIR MARKOWITZ: -- speak slowly.

10 MS. LEITON: First of all, I wanted
11 to say I'm sorry I'm not there. I came down
12 with an illness, then I couldn't travel, and
13 so, I want to thank John for being there, John
14 Vance.

15 I also want to thank the Board and
16 everyone who is there, putting in the work for
17 this because I do actually take this very
18 seriously, and I think that you guys can help
19 us with some of the most difficult problems
20 that we have in the program.

21 So, I heard some people have some
22 concern that the Department is not going to

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1 take your recommendations, we'll just throw
2 them under the table. That's far from the
3 truth.

4 We really are happy that you're
5 there. We're happy we have, you know, doctors,
6 scientists, advocates helping us with this
7 program, because it's just challenging, and so,
8 you know, we will, and have tried our best to
9 give you everything you've asked for.

10 If there are problems with anything
11 that we've asked you -- that you've asked us
12 for, please let us know what those are. We are
13 happy to supplement.

14 We do not have dedicated resources
15 to this, but we are trying to do our best to
16 provide it as quickly as we can, with what we
17 have.

18 I did also want to address quickly,
19 Dr. Armstrong, who is our new medical director.
20 There reason that he is not there is, he just
21 came onboard after we got the request for him
22 to be there, and he needs to -- he wanted to

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1 have a better understanding of the program,
2 before he attended one of these meetings. But
3 he is willing to do that, you know, if he can,
4 next time.

5 With regard to travel, you guys
6 mentioned changed administrations. We --
7 budget allowing, we do travel. As Mr. Lewis
8 mentioned, we travel for the JOTG often, and
9 that can be on the west coast, it can be
10 anywhere in the country, and so, we'll make
11 ourselves available to you, wherever you are,
12 regardless of a change in administration,
13 because I'm still here. Our attendance will be
14 here. Our major shift is still going to be
15 here. So, we will make ourselves available,
16 wherever you decide to go next time.

17 So, I just wanted to say those
18 things, and again, we really do value your
19 input and appreciate the fact that you guys put
20 in hours and hours and hours of time into
21 providing us with the recommendations.

22 So, thank you all for that very

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1 much. Thank you to Tony Rios and Carrie
2 Rhoads, for making all this happen, and that's
3 all I have to say. Thank you.

4 CHAIR MARKOWITZ: Thank you. We're
5 going to take an hour for lunch. We'll come
6 back promptly, promptly at 1:00. We have, I
7 think 12 speakers identified so far, and we
8 don't want to, in any way, we're not going to
9 cramp that time.

10 So, we will start at 1:00, and
11 appreciate your timeliness.

12 (Whereupon, the above-entitled
13 matter went off the record at 12:00 p.m. and
14 resumed at 1:00 p.m.)

15 PUBLIC COMMENT SESSION

16 CHAIR MARKOWITZ: Okay, we're going
17 to begin the public comment period. I'd like
18 to welcome people. We look forward to the
19 comments that you're going to make.

20 There have been five people who
21 requested time in advance, and they're
22 scheduled for seven minutes, but we also have

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1 an additional nine speaker who would like to
2 present.

3 So, to accommodate everybody, we
4 would ask that the scheduled speakers try to
5 restrict their comments to closer to five
6 minutes. If I interrupt you, I apologize in
7 advance, but it's merely for the purpose of
8 trying to make sure we have enough time for
9 everybody.

10 So, we will start with Paige Gibson.

11 MS. CISCO: Hello. Thank you,
12 Board. This is actually -- I'm Jeannie Cisco,
13 right now. She's from Portsmouth and she is
14 also with and she worked at Portsmouth for 30
15 years. She was unable to be here, due to some
16 family illness.

17 She wanted to make sure that you
18 knew that she and a group of her work turned in
19 over 200 chemicals with MSDS sheets, and
20 letters from the -- the company, explaining
21 what buildings those chemicals were in. They
22 were added to the SEM and then mysteriously,

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1 they were taken out with no explanation.

2 So, she wanted you all to know that,
3 and would really like to know why, especially
4 with all the background information they had.

5 She also heard DOL make the
6 statement that people diagnosed with beryllium
7 sensitivity are flying all over the country to
8 receive medical treatment. I caution the
9 subcommittee to evaluate that statement.

10 An individual diagnosed with
11 beryllium sensitivity has to travel to receive
12 treating -- treatment or testing for chronic
13 beryllium disease. DOL wants a medical
14 protocol from the subcommittee. Form EE7 is
15 explicit. The choice of doctors, very
16 important to the DOE workers, most do not trust
17 Oak Ridge, due to the conflict of interest.

18 The treatment and testing should be
19 determined by the treating physician, not DOL,
20 and this has to do with flying out west, and
21 most of their sensitivities, once they fly out
22 west, their blood sensitivities turn into the

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1 flow blow disease, when the further testing is
2 done.

3 Two points that came up today. On
4 the hearing and in general in the SEM, I can't
5 stress enough, the job classifications and the
6 tasks for each site is different.

7 The SEM doesn't address this. Out
8 of the 22 job categories that are listed for
9 the hearing, for example, the letter I gave you
10 of that gentleman, his basic job was a
11 radiation control technician, a surveyor. He
12 worked with 19 of those 22 jobs, in a hot area,
13 with the chemicals and the noise, dressed
14 exactly the same way they were, and because DOL
15 does not know what we do for our jobs, they
16 don't list it.

17 The same is true -- a custodian,
18 they are on the list. However, a
19 decontamination worker who not only does
20 custodial work, but also radiation work and
21 chemical work is not on that list.

22 So, the list just really needs

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1 looked at. You can't narrow it to 19. At
2 Portsmouth, their RCTs, HPs don't go in on
3 jobs, but at Hanford, they do.

4 So, you know, you have to look at
5 these jobs independently and you have to have
6 someone with knowledge in order to get this
7 classifications right.

8 Just to let you know, the
9 occupational worker -- or health questionnaire,
10 they're already being done on the phones. So,
11 it doesn't matter where the former worker
12 lives. They can still do it on the phone.
13 Okay, thank you.

14 CHAIR MARKOWITZ: Thank you very
15 much. Next is Terrie Barrie.

16 MS. BARRIE: Hello, again, and this
17 is Terrie Barrie with the Alliance of Nuclear
18 Worker Advocacy Groups, and I thank you all
19 again for all the hard work. You've been
20 working very hard to get those recommendations
21 out in such a short amount of time.

22 There is discussion about -- oh, and

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1 I also want to thank you for discussing the
2 ANWAG letters, and considering them. We do
3 really appreciate that.

4 There is a lot of discussion about,
5 you know, reviewing certain diseases that could
6 be presumed from being exposed at the
7 workplace, and I would like to offer a
8 suggestion to look at the Radiation Exposure
9 Compensation Act.

10 This is for -- strictly for uranium
11 workers, and some down-winders, and under that
12 legislation and program, lung cancer, certain
13 non-malignant lung diseases, renal cancer,
14 chronic renal disease and the 22 specified
15 cancers are presumed to be the result of
16 working or being -- or working with uranium or
17 being exposed to atomic testing, and it would
18 seem since this is similar, a lot more similar
19 than the VA benefits and the -- that we could -
20 - or you could probably take a look at this and
21 see if it can be brought over to EEOICPA.

22 The last thing I'd like to just to

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1 remind everybody of is, when I hear the
2 discussion of this chemical or this exposure, I
3 want everybody to remember that the workers
4 worked daily in a toxic soup. It was not just
5 working with TCE or with radiation. They
6 worked -- you know, they would take the part
7 and then dip it in carbon tetrachloride, and
8 then move on.

9 So, it's multiple exposures that
10 they were -- they experienced every day, and I
11 thank you again.

12 CHAIR MARKOWITZ: Okay, thank you.
13 So, I just want to point out to people here
14 that we're not -- the Board isn't responding to
15 any of the commenters. There is no normal,
16 kind of discussion back and forth, because that
17 is not the format that we use. It would also
18 cut into time for the public to make their
19 comments.

20 So, don't be put off by that lack of
21 interaction. We do want to hear what you have
22 to say and we value your remarks.

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1 Next is Vina Colley on the phone,
2 and while she is getting set up, if Tim Lerew
3 and step forward and sit down and be prepared
4 to be next, just in case there is a delay on
5 the telephone.

6 MR. LEREW: Thank you, Dr. Markowitz
7 and Board.

8 CHAIR MARKOWITZ: But Mr. Lerew,
9 hold on a second, because if we can get Ms.
10 Colley on the phone, we'll go with her. I just
11 don't want to --

12 PARTICIPANT: And let her know to
13 take it off mute. Sometimes she leaves it on
14 mute.

15 CHAIR MARKOWITZ: Ms. Colley, are
16 you --

17 MS. COLLEY: My name is Ms. Colley
18 and I'm a worker in Piketown, Ohio, and I co-
19 chair the National Nuclear Workers for Justice.
20 Thank you for allowing me to speak.

21 We are inviting you again, and
22 encouraging you to have a meeting in

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1 Portsmouth, Ohio, where breaking the story
2 about plutonium at the plant on the same day as
3 the Bazooka workers in 1999, that made the news
4 spread fast and everyone scramble to help these
5 workers.

6 DOE failed to protect workers with
7 adequate monitoring, protection from radiation,
8 UF6, heavy metal, toxic chemicals, beryllium,
9 strontium, cesium, a whole list of chemicals
10 that Jeannie Cisco says that she -- the union
11 put together, and they're paying no attention
12 to that list.

13 Workers were never told until we
14 released the records in 1999, that we were
15 working with plutonium. The story was
16 downplayed. We've had plutonium here since
17 1953, and I have the documents to back it up,
18 those are company documents.

19 The plutonium started fading out on
20 the equipment in 1962. You have failed to
21 recognize the relevant causation which are
22 affirmed by the claims experts and the treating

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1 physicians. Withholding of the sick workers
2 entitlement and medical benefits under the
3 stipulation of the Act, can not be viewed in
4 any other manner than death of entitlement and
5 medical benefits. It's a crime, and it has been
6 well documented by the U.S. Department of
7 Labor, and the U.S. Human Health and Services
8 secretary.

9 If we are focused -- if we are
10 focused as a force to file a federal lawsuit,
11 we will request compensation and punitive
12 damages that shall be worth millions of
13 dollars.

14 There is so many conflicts of
15 interests in these cases and this program
16 regarding the energy employees compensation
17 act. We object to the demands that the sick
18 workers have to go through.

19 An example, NIOSH is a conflict of
20 interest because they have been used in court
21 cases against the sick workers, for the DOE and
22 the corporations, in demonstrating that they

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1 are not acting in the best interest of the
2 workers.

3 There is so many contractors
4 involved that the left hand doesn't know what
5 the right hand is doing, which prevents money
6 from going out to get the claims paid. It is
7 time to cut out the studies and take care of
8 the sick workers, who are listening to the
9 doctors that treat us and are experts.

10 On Monday, I heard you talk about
11 workers wearing protective clothing. You
12 cannot protect these workers in these plants.
13 Many jobs should have called for a robot. The
14 best, at least you can do is start fighting the
15 illnesses.

16 If we are forced to -- okay, I
17 listened to the Oak Ridge workers testify
18 yesterday, and it took me back to the 80s, when
19 we started this process, and when the
20 government was letting workers give testimony
21 by 1992, in D.C., we were called whistle
22 blowers then.

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1 We seem not to be going forward, but
2 backwards. In 1999, Congressional hearings
3 were held and workers told all they knew. We
4 recommend that the workers be compensated and
5 stop the studies and get the workers medical
6 cards that is owed to them. We are being
7 studied to death.

8 I am going to try to explain to you
9 why workers can't be evaluated by -- we are
10 talking about multiple chemical exposures
11 daily. At a meeting yesterday, I heard that
12 these workers found out a worksheet that is
13 used as part of the way they look at our case.
14 Many workers never knew what they were exposed
15 to.

16 Currently, workers are at a high
17 risk of exposure also, and they are not
18 protected under this bill. As electrician, I
19 clean down uranium contaminated electrical
20 equipment in confined spaces for six months at
21 a time, with no respiratory protection, until I
22 got so sick, they finally come and took a test

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1 and I exceeded a 15 minute test in seven
2 minutes, the first time that I ever had wore a
3 respirator and they done away with that job and
4 no one was allowed to do it.

5 Actually, I cleaned this radiation
6 from the piping -- the piping system in these
7 process buildings, they had oil leaking out of
8 them. I found out that the oil had radioactive
9 material.

10 The workers who went into these
11 process buildings where the oil was were being
12 exposed to radiation on a daily basis. Workers
13 would take air hoses and they would blow
14 uranium contaminated dust into -- without us
15 having protection on. We would walk into the
16 area, when a worker was taking an air hose to
17 blow off the dust, that they thought was dust,
18 that was uranium contaminated dust.

19 Workers at the nickel plant in 1979,
20 one of my friends who helped bury that plant,
21 at age 42, died of a brain tumor.

22 You have a cylinder that drops 1978,

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1 that lost over 21,000 pounds of uranium tetra
2 chloride to the air and the water. We are not
3 checked for these exposures.

4 According to a Congressional
5 hearing, from 1953 to 1992, you have six
6 releases every day, exposures on a daily basis
7 and the piping plant. The 720 building was a
8 machine shop. We worked with welders,
9 machinists, lab people, varnishing paint,
10 electrical shop, all these shops was in this
11 one building, and it was open to the atmosphere
12 and no one, not even supervisors, wore
13 protective equipment.

14 Just walking into the plant, we was
15 getting contaminated. Not to mention, taking
16 it home to our families.

17 Since the position has elapsed, I
18 have not been able to get any of my conditions
19 compensated or they've all been denied from the
20 Cleveland office.

21 My claims for pulmonary neuropathy,
22 multiple myeloma, hypothyroidism, lung nodules,

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1 pulmonary edema, toxic pneumonia, immune system
2 disorder, was sent to the Cleveland office and
3 remanded for further investigation.

4 Amanda Bauer, who works for the
5 Trial Board in Washington, D.C., in my records,
6 that says that medical records of -- the
7 medical evidence of record is significant
8 enough to establish the diagnosis of
9 neuropathy, multiple myeloma, hypothyroidism,
10 arthritis, and lung nodules and pulmonary edema
11 and immune disorder.

12 All of these went to the Cleveland
13 office. When they got to the Cleveland office,
14 they were turned down, and I want to mention
15 that you just awarded these women for their
16 follicle tubes and their uterine cancer. So, I
17 have three tumors. I went to my gynecologist
18 and he called me, it was two months later, that
19 he did another test on me, and within two
20 months, I had three large tumors.

21 He called me at home at 7:30 at
22 night and said, "We need to do emergency

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1 surgery on you because of the chemicals that
2 you worked in and your job classification and
3 the enlargement of your stomach."

4 So, he did a total hysterectomy at
5 age 35, and I have all these consequential
6 illnesses from these exposures that I can't get
7 taken care of, because insurance will not pay
8 for job-related illness, and then I wanted to
9 touch a little bit on the --

10 CHAIR MARKOWITZ: Ms. Colley? Ms.
11 Colley? If you could wrap it up. You've got
12 about a minute. That would be great.

13 MS. COLLEY: Okay, and the prostate
14 cancer is being turned down.

15 So, I found in February 10th of
16 2004, that skin cancer and prostate cancer was
17 granted to a person, the docket number is
18 118302004.

19 So, they had skin cancer and was
20 granted their prostate cancer.

21 Again, I want to stress, this is
22 where the story broke about the contamination

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1 in the plant, and we have been looked over.
2 I'm asking you guys to have a meeting here, and
3 give our workers the chance to come out and
4 explain to you and show you what they have been
5 working in and how they've been exposed to it,
6 and until they look at us and -- on a one to
7 one basis, to see what we've been exposed to,
8 they're never going to be able to document
9 this.

10 So, we're asking you to come here
11 and let us tell our story again. I mean, you
12 know, this is pathetic that we have to keep
13 doing this, but there is so many conflicts of
14 interest and I'm asking you to stop the study,
15 and that we know that from John Hoffman, Dr.
16 Alan Stewart, and my friend Dr. Rosa Patella.
17 We know all these studies that have gone way,
18 way back to the radiation that harmed the fetus
19 of a baby when they took an X-ray.

20 We have the highest rate of cancer
21 in this area. We're asking you to hold a
22 meeting here.

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1 CHAIR MARKOWITZ: Okay, so, thank
2 you, and if you have --

3 MS. COLLEY: And if you need any more
4 --

5 CHAIR MARKOWITZ: Ms. Colley, we
6 need to close now, but if you have additional
7 comments, please submit them in the record --
8 DOL through their email, so that they can be
9 part of the written record. That would be very
10 useful. But thank you very much. Next will be
11 Tim Lerew.

12 MR. LEREW: Thank you, Dr. Markowitz
13 and Board.

14 This morning I spoke with Richard
15 Anderson, a retired Y-12 engineer, who is
16 married Janine Anderson. Some of you know
17 Janine from her work with getting the original
18 energy employees compensation act passed. She
19 was present at the White House on October 30th,
20 back in 2000, when that was signed into law.

21 Eight years ago, we had our first
22 National Day of Remembrance, and we can thank

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1 Janine and many others, but especially Janine
2 for her work with that. I had sent earlier in
3 the day, an email to Carrie, that might be
4 forwardable to the Board members if that's
5 possible, Carrie, with a short one and a half
6 minute video of a news piece on that first
7 National Day of Remembrance and how it came to
8 be.

9 This year, starting at the end of
10 this week and into next, we'll have our eighth
11 National Day of Remembrance around the complex,
12 10 different sites, including the Doubletree
13 Hotel here in Oak Ridge, on Monday at 10:00
14 a.m., and anyone in the audience of course, is
15 welcome to participate in that.

16 But one of our missions at Cold War
17 Patriots is to keep the memory of the 700,000
18 men and women who have worked in the nuclear
19 weapons complex alive. You know, the complex is
20 a shadow of its former self. We're going to be
21 down to 1550 operational warheads next couple
22 of years, from the peak of 70,000 that many of

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1 the men and women here and around the country
2 helped create.

3 But the human legacy is going to go
4 on for decades yet. The work of this Board is
5 going to be instrumental in meeting the ongoing
6 health needs of that human legacy, and we're
7 just very, very appreciative for the hard work
8 you've done and will continue to do on behalf
9 of the worker community. Thank you.

10 CHAIR MARKOWITZ: Thank you. Next
11 is Tee Lea Ong.

12 MR. ONG: Hi. This is Tee Lea Ong,
13 Professional Case Management.

14 First of all, thanks to the Board,
15 as well as Dr. Markowitz, for allowing me to
16 speak, as well as the incredible amount of work
17 that you put into this.

18 I sat through the April event and
19 yesterday and today. So, I really appreciate
20 the in depth discussion and analysis you've
21 done on the topic.

22 Please continue on. This is going

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1 to be very important for a lot of former
2 workers out there.

3 The topic I'd like to comment on, it
4 will be brief, is that it -- the headline is
5 still medical second opinion, but it is timely
6 that Rachel Leiton this morning brought up, the
7 role of the nurse consultants.

8 I would urge the Board, especially
9 the two subcommittees, primarily the medical
10 evidence subcommittee, secondarily, the one on
11 CMC, to take a look and perhaps help the sick
12 former workers and other stakeholders
13 understand the scope and medical practices of
14 these nurse consultants, because as --
15 especially as it relates to the MSO. What is
16 in scope, what is out of scope, perhaps the
17 experience and expertise within the certain
18 illness categories of these people, the
19 training that they brought with them to the
20 job, the job description, as well as perhaps
21 initial onboarding training, when they joined
22 the Department of Labor, as well as ongoing

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1 training.

2 It's a very similar topic, I know
3 the Board spent a lot of time on, in terms of
4 claims examiners, what is the background, what
5 is the training, what's ongoing training?

6 I think similar attention --
7 guidance from these two subcommittees,
8 especially by the Board, would be very
9 important, because we want to make sure that
10 there's ongoing attention paid to make sure
11 that what's in scope and out of scope is
12 clearly specified for everybody.

13 There are two topics related to
14 that, and it's related to what was brought up
15 on day one by Dr. Markowitz.

16 One is that if there are changes
17 proposed to the roles, the scope of these
18 positions, nurse consultant positions, then it
19 ought to be communicated in a timely fashion to
20 this Board, as well as to all stakeholders.

21 As I understand from day one's
22 communication, there are oftentimes bulletins

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1 and transmittal sheets and so on, that does not
2 make it in time to people, for them to comment
3 on ahead of time, before the changes are made,
4 especially for this Board, which is well
5 positioned to advise people on that.

6 Secondly, there has been a history
7 of topics that were not spelled out, but -- or
8 rather it was spelled out in one way, in
9 procedural manuals, and current practices, but
10 it slipped over time, due to scope changes or
11 scope creep and so on, and over time, it became
12 -- while we're not changing any rules, we're
13 just codifying what's current practice anyway.

14 So, that will be a very important
15 topic for the Board to take on. So, I just
16 urge the Board and the Department of Labor to
17 pay special attention to the role of nurse
18 consultants, their background and expectations
19 and scope, especially as it relates to medical
20 second opinion. Thank you for your time again.
21 Safe travels.

22 CHAIR MARKOWITZ: Okay, thank you.

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1 Next is Janet Michel, and then as she's coming
2 -- I just want to, for the next people who are
3 going to speak, I just want to reassure you,
4 sometimes people get a little nervous speaking
5 in public or whatever. Don't worry about that.
6 We just want to hear stories, we want to hear
7 about issues. We are on your side on this --
8 on the issue of improving the compensation
9 program. So, we're all kind of in the same
10 place.

11 MS. MICHEL: Hi, and good afternoon,
12 and thank you for the opportunity to speak. I
13 am Janet Michel. I'm a first-generation Oak
14 Ridger, and born to parents who both worked at
15 K-25, and I worked at K-25, and I apologize for
16 being late, not being here on Monday, but I've
17 been very sick with bronchitis, probably hear
18 me coughing in the back, and I've been working
19 on these issues since late 1995, as my health
20 has allowed me.

21 I started with the group called The
22 Exposed and then Coalition for a Healthy

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1 Environment. As president, it was a non-
2 profit. We incorporated, and it was a support
3 group, and then with ANWAG.

4 With a Coalition, we held many
5 public meetings in East Tennessee. We made
6 many trips to D.C., to educate both the
7 Executive and Legislative Branches of
8 government, and we wrote hundreds, if not
9 thousands of letters to newspapers, agencies
10 and elected officials.

11 In my professional capacity, I
12 worked as a pollution prevention project
13 manager, and I spent two years at DOE
14 headquarters. I visited many of the DOE sites,
15 and I organized and ran DOE-wide technical
16 conferences, put on training programs and ran
17 many projects.

18 So, with all that said, just to kind
19 of tell you who I am, I waited -- I became
20 disabled in 1996. So, just to let you know,
21 things were not perfect in 1995, as I think you
22 understand.

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1 In 1996, I worked in the barrier
2 plant at K-25, which is where they processed
3 the nickel. So, in that letter that you
4 received, Dr. Markowitz, I am the person that
5 was the Development Associate 3, which tells
6 you nothing about what my job was, and I was
7 exposed to nickel in the barrier plant.

8 So, because of the way the law was
9 structured, it didn't make sense for me to file
10 a claim until about -- until 2006, and during
11 all this time, I had researched nickel.
12 Incredibly, I submitted 3,000 pages of medical
13 records and medical journal articles, some of
14 which Dr. Silver helped me find. It was --
15 since I don't have access to the libraries at
16 universities, and all of this was cross-
17 referenced in three-ring binders. I basically
18 did the job for my claims examiner, with maps
19 of the site, and all the things that I had been
20 exposed to.

21 But I was denied twice, and I
22 requested my complete file and I saw the SEM

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1 that was used to look at my claim, and it was
2 pathetic.

3 So, it -- part of it, I think was
4 probably my job title that threw them off, and
5 then maybe part if it was a nickel study that
6 was done in the early 80s, where DOE had
7 contracted with Oak Ridge Associated
8 Universities. I don't know if you are aware of
9 that study. It's a pretty pathetic scientific
10 study, where the conclusion is stated in the
11 hypothesis, and if you haven't seen that study,
12 you might want to take a look at it.

13 So, anyway, I finally was approved
14 for nickel, but not any of the other
15 contaminants that I had asked for, and I was
16 also approved for 14 consequential conditions,
17 but the diagnosis codes that I was given, about
18 half of them made absolutely no sense.

19 So, before I even received my money,
20 I wrote a letter. I got no response. For six
21 years, I have written letters. I have called.
22 I have faxed and no one had ever responded

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1 about these crazy diagnosis codes.

2 So, finally I went to the resource
3 center and I was told, you have to re-file your
4 claim. So, anyway, I'm not going to go into
5 all that.

6 I wanted to say that in addition to
7 what Terrie was saying about the toxic soup,
8 some of the things that have happened at K-25,
9 that you may or may not have heard about, are
10 the cross-connection of pipes that took place
11 out there.

12 This was another thing that we
13 uncovered as our -- with our sick worker group,
14 where potable water and process water got
15 cross-connected in the pipes at the site, and
16 Richard Anderson, who Mr. Lerew talked about,
17 Janine is one of the people that I worked with
18 a lot on this issue, and Richard still has the
19 draft report, that has all the engineering
20 drawings that shows all these cross-connected
21 pipes.

22 This was all turned in to DOE and it

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1 came back 25 pages that basically said, if
2 there is a problem, we'll fix it.

3 So, this is the kind of thing that
4 comes out of DOE.

5 Another thing that happened during
6 this time was the cyanide problem, where they
7 did relining of the old sewer pipes and super-
8 heated this epoxy resin, which gave off cyanide
9 compound. So, every person on the site was
10 exposed to that. So, those are just a couple
11 of things. I will try to hurry, okay.

12 CHAIR MARKOWITZ: Yes, because we
13 have a lot of people, so I need to ask you to
14 wrap up.

15 MS. MICHELLE: Okay, that's what I'm
16 doing.

17 Okay, so, I just want to say that I
18 see sort of two choke points in the work that
19 you all are doing, and one of them is the
20 claims examiners, and of course, I'm seeing
21 this from my viewpoint.

22 I've had many claims examiners over

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1 these years, only one of them has been helpful,
2 and most of them act like they have a chip on
3 their shoulder. Most of them seem like they
4 don't care.

5 So, I know you guys are working on
6 that. I don't know if more training is needed
7 or whether different ones need to be hired, but
8 that seems to be a choke point in the whole
9 process.

10 The other choke point is, no matter
11 how many issues you all are dealing with and
12 the in-depth that you are going through and
13 looking at all these issues, the choke point is
14 whether DOL will accept them and implement
15 them, and I just am hoping and praying, because
16 we have wanted so long for this Board to come
17 into being, and I just hope that it will
18 happen. So, thank you for your time.

19 CHAIR MARKOWITZ: Thank you, and
20 just to remind you, for those of you who don't
21 get to say everything that you want to say, we
22 welcome written comments.

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1 Donna Hand is next, and I forgot to
2 say that people need to really take just three
3 or four minutes for their remarks.

4 MS. HAND: I'll be very quick and
5 try to get this done and taken care of.

6 OWCP was committed to helping
7 claimants. It says so in the statute, and it
8 is mandated by 42 USC 7384(b) that they shall,
9 the CE shall develop pertinent facts relevant
10 to the claim. That's binding, weight of law,
11 force.

12 It also in the rules and
13 regulations, which is binding, the OWCP
14 exposure matrices are site profiles of toxic
15 substances. Toxic substances is defined as any
16 material, because of its radiological nature,
17 chemical nature and/or biological nature.

18 As we spoke to DOE, when they were
19 talking about the proposed beryllium rules,
20 beryllium compounds is soluble and insoluble.
21 So, there is a different biokinetic. So, there
22 is a different health effect.

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1 You know, you inhale, you ingest,
2 you absorb, and it comes through the wounds, as
3 well. So, you've got external, internal
4 exposure. So, it's -- and this is what a case
5 examiner normally wouldn't even address.

6 But this is what the IHs should be
7 addressing. Was it inhaled? Was it soluble?
8 Was it insoluble? You know, does it have a
9 possibility? Is it plausible, a potential?

10 From the very beginning in 2005,
11 when Part E was implemented, into October of
12 2004, the policy procedure manual kept on
13 insisting for the CEs -- it doesn't have to be
14 100 percent. It doesn't have to be definitive.
15 All it has to be is plausible, potential
16 exposure. That's it.

17 Does that toxic substance have the
18 plausible or potential to do that? In fact, the
19 OWCP in the regulations, interpreted
20 significant factor to mean any factor.

21 Also, when they did the DMC
22 handbook, which is now the current CMC

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1 handbook, the medical director and the
2 solicitor got together and said OWCP will use
3 the Federal Rules of Evidence and make it
4 reasonable suspicion. So, it's got to be more
5 than a reasonable suspicion, but less than the
6 preponderance of evidence.

7 So, you've got less than 50 percent,
8 but you have more than a reasonable suspicion.
9 The EconoMatrix was the one that said, well, if
10 we're going to do a site exposure matrix, let's
11 make it a two to one. If the risk is more than
12 a two to one statistical, then we're going to
13 say that that actually causes it. That's a
14 known established causal link.

15 When the SEM finally became public,
16 that's exactly what it says, these are known
17 toxic substances with a known causal link. We
18 do not address aggravating or contributing to.

19 They will list, and in fact, even
20 now, you can go to and you do pulmonary
21 disease, without a site, just go to pulmonary
22 disease, and it will list 25 agents and 19

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1 processes.

2 You go to X-10, it lists a lot less.
3 In fact, and so, in fact, it lists 19 agents
4 and only nine work processes. So, those other
5 25 agents, are they there or not there?

6 Also, in the site exposure matrix,
7 in the very front page that they have, quote,
8 when a labor category is displayed with no
9 buildings identified, it does not mean that the
10 worker was not on the site. Instead, it can
11 mean that the labor categories work location on
12 the site is unknown, or in the case of labor
13 categories, such as janitors, guards and
14 groundskeeper, they worked in many locations
15 all over a site.

16 So, if you cannot find that labor
17 category, then you have to presume again, that
18 they were everywhere. So, the whole site
19 exposure, they have potential to.

20 The regulation says proof of
21 exposure is did that employee come in contact
22 with? Was it in that building? So, we don't

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1 need a high standard. We don't need medical
2 certainty. We don't need statistics. That was
3 the whole thing when doctor -- when they first
4 implemented this, with DOE, everything, is that
5 it is all plausible presumptions. That's all
6 that's required.

7 CHAIR MARKOWITZ: If you could wrap
8 it up.

9 MS. HAND: Programmatic evidence was
10 always accepted, and in the DMC handbook, OWCP
11 gave the references. The references then were
12 to be ATSDR, hazard substance database and some
13 other internet, the NIOSH, OSHA and they could
14 be all used as references.

15 But when we turn those references
16 in, especially you know, coming from the
17 internet part of the NIOSH or OSHA, they will
18 not accept the programmatic evidence, but
19 regulations and rules says you can.

20 We even used the same reference
21 sources that the CMCs use to confirm our claim
22 on toxic substance. They refused to accept

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1 them.

2 So, basically, I will be turning in
3 other things to address other issues, but we
4 need also for the Committee on the Chronic
5 Beryllium Disease, to define chronic
6 respiratory disorder, because that's one of the
7 issues and also, the characteristics of the X-
8 ray abnormalities, they list in a procedure
9 manual, but that should not be limited to,
10 because in the reference sources that I have
11 found, you can have a normal chest X-ray and
12 still have chronic beryllium disease.

13 So, these are a couple of issues
14 that needs to be addressed and I will follow
15 up.

16 CHAIR MARKOWITZ: Thank you very
17 much. Etter Pegues.

18 MS. PEGUES: Good afternoon. I
19 thank you all for listening to me today. My
20 name is Etter Pegues and I am the widow of
21 Eldred Pegues. He worked at Y-12 for 32 years.
22 Sadly, he passed away on January of 2015, with

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1 lympho-myeloma, bone cancer.

2 While he was there working, Eldred
3 came down with -- he had a problem with a tumor
4 in his head, and it was protruding out his eye,
5 and we had to go to -- go to Vanderbilt,
6 because there was no one here in Knoxville that
7 -- Knoxville or Oak Ridge that could help him.

8 So, we had to go down there, and
9 they was able to shrink that tumor, but a few
10 months later, the cancer came back in his
11 shoulder. He had to have rotator cuff surgery.
12 The tumor -- I mean, the cancer ate up two of
13 his ribs.

14 Few months later, then he had to
15 have a partial hip replacement and a few
16 months later, he end up having to have -- he
17 broke his femur bone, just crossing his leg,
18 and the doctor told him, he said that -- his
19 bone was so fragile, just brittle, that it's
20 just like a Mack truck had came in and hit him
21 and just broke every bone in his body, and in
22 2014, he was just sitting, and he just broke

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1 his bone here.

2 But some of the things that, you
3 know, he went through -- he went through a lot
4 with that, and some of the areas that Eldred
5 worked in, he was a machinist, but he was there
6 for 32 years. He was a machinist. He worked
7 in the landfill. He worked in laborer. He was
8 a chemical operator. Some of the areas he
9 worked in, he worked in Alpha-5, 9201, 9212,
10 Beta 4, Beta 3, 9201, 9204, and he was exposed
11 to benzene, beryllium, plutonium, which he was
12 grinding tubes that was contaminated with -- in
13 the hot area there, and ferrum and uranium, in
14 the depleted area there and they also had some
15 type of little chemical fire or something
16 during the time he was there.

17 So, he was exposed to a lot of
18 things. So, he wasn't just confined to just one
19 area there, at all. So, I just wanted -- I'm
20 just glad, you know, to talk to you all about
21 him. I'm glad you all are not just focusing
22 just on the diseases and things that going on,

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1 because there -- I'm glad you all are looking
2 at some of the exposure that these workers, you
3 know, affected by there in the plant. So, I
4 thank you for listening.

5 CHAIR MARKOWITZ: Thank you very
6 much. Dorothy Colquitt.

7 You know, I'm wondering, can we move
8 the microphone to her, to make it a little
9 easier? Up to you.

10 MS. COLQUITT: Good afternoon. My
11 name is Dorothy Colquitt. I worked at Y-12
12 since 1980 to 1999.

13 I am a victim, I guess you would
14 call -- say, of nine borderline and abnormal
15 results from beryllium. I worked there in
16 packing. That's where I came into contact with
17 the beryllium parts.

18 I was working one day and I found
19 out that my arm done got as white as a piece of
20 cotton. I'm sorry, and I asked my supervisor,
21 I said, what is this stuff on me? Oh, it's
22 nothing. Don't worry about it. I said, yes,

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1 it's something.

2 So, he said, well, I'm going to call
3 Health Physics and let them come and do air
4 testing, and I said, I think you need to do
5 that.

6 So, he did, and he said he got back
7 a negative result. But my hand -- arm, from my
8 finger tip to my shoulder, I had rolled up my
9 sleeve and pinned it, was white as this paper,
10 and I started wearing the face mask, little
11 paper thing you cut grass in, and I believe
12 that's why I'm still alive, because we did a
13 lot of those parts, shipping them out. When
14 the bags come in, you had to take the bag out
15 of a locked container that -- you had to pull
16 this bag and then pull the part out.

17 But I'm just wondering what's going
18 to happen to this. Dr. Ficker talked to case
19 workers, downtown Oak Ridge, and this guy was
20 very rude to him. I hate to say this. I hope
21 nobody is here, that work. But he was rude to
22 him.

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1 So, in the meantime, Dr. Ficker
2 called me that afternoon. He said, Ms.
3 Colquitt, this guy in Oak Ridge has got the
4 wrong information on you. I said, well, how
5 did he get that? I don't have any idea how he
6 got information on me, he said, but he did, and
7 Department of Labor is trying to -- you know,
8 deny this, and they did deny it.

9 Every time that these -- well, I get
10 -- I don't know who send forms in now, to them,
11 but it's been denied two or three times, and
12 I'm just wondering why, you know, they are
13 denying me, because I've had nine studies done,
14 and five of them was borderline abnormal. The
15 other four was borderline normal. So, I don't
16 know what's going on with my body. I don't
17 have no idea.

18 If you all would, if you get a
19 chance, kind of check it before I leave here,
20 if you would, and another thing, I like to
21 thank Mr. Whitley. He's been very nice. Very
22 nice. Call him anytime. He's same thing, but I

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1 thank you, and you all have a blessed day.

2 CHAIR MARKOWITZ: Thank you. Thank
3 you very much, and yes, we'll be in touch.
4 We'll be in touch. Susan Adkisson.

5 MS. ADKISSON: My name is Susan
6 Adkisson. I just wanted to discuss a case that
7 I worked on.

8 This gentleman was a fireman for a
9 short time at K-25, not long enough to be
10 special exposure cohort.

11 He then transferred to Y-12. He
12 came down with B-cell mantle cell lymphoma,
13 non-Hodgkin's lymphoma. At the time his claim
14 was in process, we searched the SEM database
15 and there was a link to diesel and gasoline
16 exhaust.

17 The SEM sheets were printed. He
18 took his exposure history and the SEM printouts
19 to his physician at Vanderbilt. Discussed what
20 he had done in his work with the physician, who
21 wrote a well-rationalized letter with regards
22 to benzene which is a component of the exhaust

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1 fumes.

2 The fire engines were started daily
3 in the fire hall with no ventilation. Some of
4 the firefighters did request that ventilation
5 be put into the fire hall. To my knowledge,
6 that has not been done yet.

7 During the claim process, there was
8 an update to the site exposure matrix. The
9 gasoline and diesel exhaust fumes were removed
10 because they were mixtures of compounds.

11 So, at the time, a few months later,
12 his claim was denied for that reason. He
13 passed away. The family had an oral hearing
14 with the final adjudication branch, discussed
15 the site exposure matrix issues with them, and
16 they were told well, it could have been in
17 reverse.

18 The exhaust fumes from gasoline and
19 diesel could have not been in the SEM, and it
20 could have been added, and then your claim
21 would have been approved.

22 They also objected to the fact that

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1 no IH or CMC review was done on this case. It
2 never was done. So, to date, the claim is
3 still denied.

4 There was another fireman who worked
5 in the same area at Y-12. He had been a
6 fireman at X-10 prior to going to Y-12. He has
7 the same type of cancer and is fighting a
8 denial on his claim at this time. Thank you.

9 CHAIR MARKOWITZ: Thank you. Sherry
10 Oran.

11 MS. ORAN: Thank you for hearing me
12 today. I hope you'll bear with me, because I
13 really wasn't prepared to speak today. I have
14 a few papers with me, though, and I would like
15 the opportunity, if you'll bear with me.

16 I worked at K-25 and ORNL for 10
17 years. I had several job classifications, but
18 I believe that my problems occurred when my
19 office was located at K-1200 near the TSCA
20 incinerator, and at that time, I was in
21 telecommunications, and I went throughout the
22 plant, all over the place, being in

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1 telecommunications, as well as some of the
2 other plant sites.

3 I'm glad to hear the discussion of
4 the respiratory illnesses today because COPD, I
5 do believe my problem was caused by inhalation
6 from TSCA.

7 COPD and the whole umbrella of COPD,
8 including asthma and bronchitis is sometimes
9 hard to tear apart, even in a hospital stay or
10 with your physician, sometimes the terminology
11 is quite interchangeable, and so, I appreciate
12 you addressing this today.

13 I was a young mother of two
14 children. I was a single mom. My career had
15 just started. I was finally an exempt employee
16 at K-25, and I suddenly started having COPD-
17 type symptoms that were just unreal.

18 I would wind up in the hospital for
19 up to 30 days. People think asthma is just
20 little squirt of an inhaler and go your way and
21 breathe better. We're talking about lying in
22 the hospital for up to 30 days at a time, with

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1 IVs, with Solu-Medrol, Decadron, PICC lines
2 because your veins are going, and ultimately,
3 ports implanted.

4 I would get out of the hospital, I
5 would try to go back to work, and Medical would
6 send me home, or I would wind back up in the
7 hospital through the ER. Approximately nine or
8 10 hospital visits in three years during that
9 time. So, it was very severe.

10 In fact, I got on Social Security
11 much quicker than even some people I know who
12 developed cancer, and I would like to say that
13 I went to my closest coworker's funeral, with
14 brain cancer.

15 Like I said, I wasn't prepared here.
16 I do have some paperwork though. I'd like to
17 just cite one or two things for you.

18 I was denied and then my request for
19 reconsideration to reopen the case was denied,
20 and there were two words used earlier today,
21 that I made note of, commonsense and rationale.
22 Okay, and I want to cite two of the -- two of

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1 the statements, when I was denied for
2 reconsideration, and this is actually the first
3 one.

4 You state that the final decision
5 and recommended decision were in error in
6 finding that you were diagnosed with bronchitis
7 in 1965. Yes, I had some childhood asthma. At
8 the same time, I had gone to UT. It had been
9 12 years since I had any problem at all, and
10 I'll address that here in just a second too.

11 That diagnosis of bronchitis -- and
12 the diagnosis of bronchitis was made in 1989,
13 one year after you started your employment.

14 A review of the record shows that
15 you were first diagnosed with acute bronchitis
16 on November 17th, 1965. Three years old, I had
17 bronchitis.

18 You have not submitted any new
19 argument or evidence to dispute the diagnosis
20 of acute bronchitis. I wasn't trying to
21 dispute it.

22 There is no new argument or evidence

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1 to warrant reconsideration.

2 My FAB hearing officer found the
3 fact in my records. It was in my medical at K-
4 25, that says that, you know, the patient has
5 come in with bronchitis now, bronchitis-type
6 symptoms and has not had any problems for 12
7 years.

8 Number four, you state that the
9 recommended denial was in error in finding that
10 you did not submit sufficient medical evidence
11 for a pre-1993 diagnosis of CBD. You state that
12 facts were ignored that show asthma had been
13 resolved for 12 years, that work records
14 diagnosed a respiratory illness before 1993,
15 and the decision ignored the physician's letter
16 stating you had abnormalities characteristic of
17 CBD.

18 The diagnosis of asthma was made in
19 childhood in 1965. Work records show ongoing
20 treatment for your asthma and bronchitis, but
21 do not show that exposure to a toxic substance
22 used in the production of atomic weapons was a

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1 significant factor in aggravating, contributing
2 to or causing your bronchitis.

3 The medical record from Dr. Keith
4 Kelly dated August 16th, 2012 indicates that he
5 reviewed chest X-rays from November 24th, 1999
6 and April 4th, 2000, and a pulmonary function
7 test.

8 Dr. Kelly indicated that these
9 findings could be characteristics of
10 abnormalities of CBD. He did not make a
11 definite diagnosis of CBD or bronchitis.

12 I do show a trace amount from Dr.
13 Markowitz's study of CBD in my blood. But it's
14 not up to the limits.

15 I did have a hearing, and the
16 hearing was actually stopped and muted. I
17 don't understand why, but there was
18 conversation going on, on the other side, and I
19 said, okay, all you need is a letter from Dr.
20 Kelly, stating this fact. I said, so, that's
21 all that I need to prove -- prove my illness,
22 and they said yes. That's in the transcript.

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1 So, I feel like I was lied to, even
2 in the hearing, and it has been an -- you know,
3 I have not even looked at my case, you know,
4 for two years. I just now wrote to
5 Jacksonville and requested the paperwork be
6 sent back to me, because I felt like it was
7 time to review it again, and so, I am very
8 happy to hear you talking about the --

9 CHAIR MARKOWITZ: Ms. Oran, I need
10 to ask you to wrap it up.

11 MS. ORAN: Certainly. Certainly.
12 But to wrap it up, I submitted all factual
13 evidence, affidavits from coworkers, letters
14 from the doctors. I did meet all criteria that
15 I was asked to meet, that occurred at the
16 hearing.

17 I would just like to say briefly,
18 that when the EEOICPA was signed into law, it
19 was signed into law to help people like myself
20 and all the other workers, but we've seen the
21 administrative cost increase. We've seen the
22 number of approvals decrease and we're seeing

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1 people in our community die before they get
2 approved. Thank you for the opportunity to
3 speak.

4 CHAIR MARKOWITZ: Thank you. Next is
5 Shirley Watkins.

6 MS. WATKINS: Good afternoon. I
7 appreciate the opportunity to speak this
8 afternoon. I am Shirley Watkins, and I worked
9 at the Y-12 plant in 1969 to 1973.

10 I worked at the Y-12 plant from 1969
11 to 1973 and I was diagnosed with Parkinson's
12 disease in 2012.

13 When I was working at Y-12, my
14 office was off of -- in the area where
15 machinists and welders worked. It was about
16 150 feet from where they worked.

17 The toxin that I have in my body was
18 mercury, and the Beta building, one of the Beta
19 buildings that I worked in was known to have a
20 lot of mercury in there, in that building.

21 When I was here, it came to my
22 memory yesterday, that I was -- I had tremors,

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1 internal tremors. I thought it was dizzy
2 spells, that I was going to treat -- was
3 treated for, and that's the thing that was
4 really prevalent.

5 The thing that got me, they
6 disproved this 40 years later. You know, I
7 claimed injury compensation, but this is --
8 this disease is really crazy. It -- no two
9 people are affected the same way. It's just
10 affecting me differently. I just thank God that
11 I was able to work as long as I did to be able
12 to get retirement, because you know, I couldn't
13 make it otherwise.

14 But anyway, I'd like to see my -- I
15 was a secretary, stenographer, and I'd like to
16 see it be part of the SEM, because it's not the
17 disease or my position was not a part of the
18 SEM. So, that's all.

19 CHAIR MARKOWITZ: Thank you. Thank
20 you very much. Next is J.B. Hill.

21 MR: HILL: Good evening. My name is
22 J.B. Hill. I am a sick worker and identified as

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1 a beryllium worker.

2 Now, not necessarily sure, and was
3 still classified as that. There's some, what
4 we call, information that's not been passed on
5 on a regular basis. But I do want to say that
6 I'm glad to be here this evening, to see each
7 and every one of you. Hope that you have a
8 pleasant stay in our atomic city of Oak Ridge.

9 I started to work at the Y-12
10 working plant in 1970, April of 1970. I came
11 here from the military to work in the T&T,
12 that's training and technology facility, at the
13 Y-12 working plant. There, I taught non-
14 destructive testing. It has to do with X-ray,
15 has to do with ultrasonics, eddy current,
16 liquid penetrant examination. I am an
17 inspector, a third level degree inspector. That
18 means I went through the training of level one
19 and level two, and got certified as a
20 professional, as a level three.

21 So, when you talk to me about non-
22 destructive testing, that's my bailiwick. But

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1 nevertheless, I'm glad to see each and every
2 one of you, like I said before, and I wanted to
3 say, put a little plug in, and say something
4 about the doctors on the panel. I don't know
5 how many are here on panel.

6 But it's good that you're here,
7 because in Oak Ridge, the doctors, for some
8 reason, are not in our favor. The doctors are
9 not in our favor in Oak Ridge.

10 Give you one -- one example. I
11 didn't want to get into this, but let me say
12 this. We had a doctor who would diagnose his
13 patients with illnesses that was related to
14 exposure at the plants. Well, that doctor is
15 no longer here. They ran him off because of
16 his opinion.

17 But nevertheless, there are doctors
18 here, and when you say get a doctor's opinion,
19 I kind of smile, you know, get a doctor's
20 opinion. Yes. Okay, but nevertheless, in my
21 case, as I said, I'm a beryllium worker. I'm
22 hoping that being a beryllium worker will keep

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1 me in line with the -- what we call the health
2 effect program that they got going on, where
3 you actually go every so often, to get
4 examinations, and I was talking to the doctor
5 here, about that.

6 I was last diagnosed as being
7 borderline. What does that mean? Borderline?
8 Either I got it or I don't have it. That's
9 what we're here for. Do you have it or do you
10 not have it, and if you've got it, what can we
11 be doing -- done about it?

12 I'm sitting here, been here all day,
13 yesterday and the day before, just sitting in
14 the back, looking and observing. But I do
15 applaud your efforts for coming here to Oak
16 Ridge and seeing what Oak Ridge is about,
17 because Oak Ridge is a secret city, so to
18 speak. There's a lot of secrets still kept.

19 There is a sign that I do -- posted
20 for the visitors. I didn't bring it with me,
21 but it's one that says, what you see here, you
22 leave it here. You don't take it with you.

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1 You leave it here. As a cautionary measure.

2 But nevertheless, after spending 33
3 years at the plant, I retired in 2003. I
4 applied for compensation and been denied, and
5 I'm going to apply again, but I was hoping that
6 it was some direction that would -- hopefully,
7 before I leave here, there will be some
8 direction, which way I should go with my next
9 steps, because there is a lot of people who
10 applied for the sickness for the compensation,
11 and not been given the opportunity to apply
12 again, or they -- like the lady said, there was
13 some individuals and I had some conflict with
14 Jackson Square also. There's an individual up
15 there, he really doesn't need to be there
16 because he's not in our favor. He's really not
17 in our favor. I don't know what's wrong with
18 him, but the fact is, something needs to be
19 done about that.

20 But nevertheless, let me get off
21 that. This Advisory Board, hope you can do
22 something positive, and as an action item, I

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1 know you had some recommendations, but as an
2 action item, I would ask that you would
3 actually make sure that the individuals, the
4 workers, the -- whether they're sick workers or
5 beryllium workers, let them be aware that
6 they're being followed, and what I mean
7 followed, that means that we haven't forgot
8 about you.

9 I'm a sick worker. I'm a beryllium
10 worker. But right now, I'm not sure what I
11 have -- what I am. I don't know how they got
12 me classified now. All right?

13 CHAIR MARKOWITZ: Okay.

14 MR. HILL: Thank you so much.

15 CHAIR MARKOWITZ: Thank you. We're
16 going to just a little bit beyond 2:00 p.m.
17 Next is Carl -- we have two more speakers, Carl
18 Richardson.

19 MR. RICHARDSON: Good afternoon.
20 I'm Carl Richardson. I've worked at X-10, Y-
21 12, K-25, all these plants. I just received my
22 50-year reward this week, belonging to

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1 International Brotherhood of Electrical Workers
2 here in Oak Ridge, and I filed a claim and it's
3 been four or five years ago, and what happened,
4 I had a melanoma in my right eye, and very
5 thankful that, going to Memphis, that they got
6 -- I go every six months, that they got that
7 cleared up.

8 But anyway, I'll be fast. I know
9 you in a hurry. You want to get out of here.

10 But anyway, I was denied, like I
11 believe 2/13, right at early 2/14. But anyway,
12 they agreed with -- that I did receive a
13 certain dose of radiation in my right eye, from
14 places of work, back in 1969 at Y-12, and no
15 monitoring very hazard conditions, then in the
16 70s, then you come back and see them dressing
17 you out, later years, shoes and all and it
18 scares you.

19 But anyway, the reason I'm wanting
20 to say this, maybe it will help people that's
21 going to file a claim. You know, one of the
22 questions they put to you first thing is, what

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1 chemicals were you exposed to, hazardous
2 chemicals?

3 Well, back late 60s and 70s, they
4 didn't tell me what chemicals I was exposed to,
5 you know, and then after -- I got denied here,
6 I get on the computer and do research, there's
7 a lot of them, you know.

8 Now, what I'm saying, that ought to
9 be brought out to new clients, if you say, I
10 worked in Y-12 in Building 5 in 1968, they know
11 exactly what chemicals was in there. It's on
12 the computer, you know.

13 But now, anyway, there was -- we all
14 know, very little monitoring. All I had was a
15 film badge, and but anyway, they made me feel
16 good. They said they were going to -- being as
17 they knew that I had a certain amount of
18 radiation, that they would send this to the
19 reconstruction, is it N-O-I-S-H, and then in a
20 few weeks or months, I don't recall, they come
21 back and measured in rems, the dosage that I
22 got to my right eye, and that it looked like

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1 that would be a plus, the way it was stated. I
2 paraphrased this for, you know, my approval.

3 But anyway, a few weeks later, I got
4 another letter that showed they were revision
5 in my reconstruction. They lowered it. Then I
6 got a denial and then, of course, I sent them a
7 letter that I wanted another review, and I had
8 a video conference and all that.

9 Then they sent me my final letter,
10 and I was denied. Now, one thing I think
11 people ought to be informed more, even the --
12 back in the 60s and 70s, about really what
13 hazards was I working in. You know?

14 I mean, I knew three or four I put
15 down, but I had no idea, you know. I'm just an
16 old country farm boy. I had no idea what was
17 going on.

18 Well, then they need to do that, let
19 people know, and give them a list, right here
20 is everything in Building 5 or -- I worked in
21 many buildings over there that were hot and
22 mercury all over everything and demolition and

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1 putting in new systems, electrical.

2 But what I'm saying is that people
3 needs to be aware when they fill these forms
4 out, what they been into, you know. They don't
5 know. They're ignorant, like I was. They look
6 on the computer and do some research, you could
7 find out. You know, well, that and another
8 thing is that I don't feel good about and of
9 course, I've told them, which is my
10 indifferent, but about this uncertainty with
11 NIOSH, based just consumptions and stuff,
12 because you don't have no real data that you
13 can do with it, and I was just disgusted when
14 they revised this, and all, about that, but I
15 am sure they need to work on a different system
16 to calculate someway better, about where there
17 was no monitoring, you know, and I'd appreciate
18 if you all can do something to help in that
19 aspect, you know, and help in getting clients
20 to understand hey, I was exposed to all these,
21 you know. All these, you know.

22 So, that's all I have. I appreciate

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1 it. Thank you very much.

2 CHAIR MARKOWITZ: Thank you. Thank
3 you very much. The last speaker is Hugh
4 Newsom.

5 MR. NEWSOM: Thank you very much. I
6 want to address a couple of things that, I
7 filed for claim back, couple of years ago,
8 based on cancer, and I also had pre-cancerous
9 growths on my head, which the dermatology that
10 I sought consulting with, which he said if I
11 don't have those removed, they'll eventually
12 turn into melanoma, which I go every six months
13 and have removed.

14 In the dosage that I listed and the
15 people here in Oak Ridge, I want to pay a
16 compliment to them, in helping the -- get the
17 claim documented and everything.

18 When the dosage came back, it listed
19 me working at Portsmouth from 1975 to 1999. I
20 didn't know where Portsmouth was during that
21 period of time. Then it listed Paducah,
22 Kentucky, periods of time from 1996 to 2013. My

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1 last trip to Paducah, Kentucky was in 1999 in
2 January, where I closed out my Coast Guard
3 career at the Marine Safety Office there.

4 I have noted these discrepancies in
5 writing, in the hearing that was conducted here
6 in Oak Ridge, teleconferencing with the
7 Department of Labor hearing officer, and
8 submitted a copy of my resume. He didn't
9 accept that. He says, why should we accept
10 that? I said, well, everyone else does.

11 So, I had to go back to TVA, which I
12 was employed from 1963 to 1989, and get them to
13 write me a letter documenting my employment.

14 As of today, I have not received any
15 acknowledgment of the correctness of that
16 dosage records in writing, verbally or
17 otherwise.

18 Now, that leads me to one thing.
19 How many -- how much in error is the dosage
20 record that my denial was based upon, the
21 actual real dosage records?

22 I've been to every plant with the

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1 exception of Hanford. Some of them, you exited
2 through monitors. Some, you didn't. I've been
3 in every building at Y-12, 98 percent of them
4 at X-10, and those dosage records don't show
5 up, but I'm still saddled with Portsmouth and
6 Paducah.

7 Now I admit, I was at Paducah in
8 1991, as a consultant on an audit, but
9 otherwise, I have never been to that plant, and
10 I have -- it looks like 12 visits listed here
11 that's in the documentation.

12 Now, if this collection process is
13 this bad, somebody needs to look into it.

14 Now, I talked to some people on the
15 phone about it, and their reply was, hey, we
16 don't make mistakes. So, what -- what was my
17 alternative?

18 CHAIR MARKOWITZ: We'll have to
19 remember that one.

20 MR. NEWSOM: Now, before the hearing,
21 I thought, well, maybe I need legal counsel.
22 So, I called up one of these law firms here

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1 that's quite active in this field. They
2 advertise as they are, and I went over my
3 record with them, cancer, and they said, has it
4 metastasized, and I said, no. What about your
5 pre-cancerous growths on your head? Have they
6 developed into melanoma? I said, no.

7 Well, they said, you ain't going to
8 get no compensation then, because it's got to
9 metastasize, that cancer's got to metastasize
10 first, or you're going to have to develop
11 melanoma, or they're not going to pay you
12 anything, and so, that's where I'm at, and they
13 kind of equate to this process, to the book
14 that John Grisham wrote, called The Rainmaker.

15 Some of you probably are aware of
16 that book, where the insurance company's policy
17 was to deny all claims at least three times. I
18 hope this is not the process, this organization
19 is doing.

20 But this is -- is kindly -- what do
21 I do on these dosage records? I know it's an
22 error, but nobody will listen to me. So, I'm

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1 kind of left at a place where if no one will
2 listen to me, what do I do?

3 I do want to pass one compliment,
4 the Energy Employee's Compensation Resource
5 Center here in Oak Ridge is very helpful.
6 They're very active. One particular person,
7 Josh Philips there is very helpful, and I
8 appreciate your time. Thank you.

9 CHAIR MARKOWITZ: Thank you. That
10 completes our public comment session, and I'd
11 like to just thank people again for attending,
12 for sharing your stories. I know it's not easy
13 to talk about some of these things, but we
14 appreciate it.

15 Is there any other member of the
16 Board who wants to make a comment to the
17 public, briefly? Ms. Vlieger, yes.

18 MS. VLIEGER: I just have one
19 comment for everyone that presented information
20 here today at the Board.

21 You have a representative from the
22 Ombudsman's office from D.C. here. He's in the

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1 back, Malcolm Nelson. You need to address each
2 and every one of your concerns about the
3 inadequacies or difficulties with the program,
4 to his office, and he may be able to offer you
5 some constructive information.

6 (Applause.)

7 CHAIR MARKOWITZ: Okay, sure. Have
8 a seat and you -- have a seat, so we can hear
9 you at the microphone.

10 MR. DAN MORGAN: This is what your
11 head looks like when you have skin cancer.
12 I've had a bunch of them. My wife will tell
13 you what kind I have.

14 But one of the things is, I've
15 worked at the Y-12 for 31 years. Been in every
16 building over there. Been exposed to
17 everything over there.

18 One of the things that I think is
19 interesting, and I'm sure others have the same
20 problem, is that I told them that my biggest
21 time for exposure was from 1958 to 1963.

22 After that, maybe the supervisors --

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1 at that point, I gave up, but in 1963 I went to
2 work at -- I graduated from UT in Knoxville and
3 went right to work in computer science, and one
4 of the things I discovered is, it's hard to
5 believe really but -- I'm kind of nervous here.

6 MS. NONA MORGAN: Are you talking
7 about your records?

8 MR. MORGAN: Well, the --

9 MS. MORGAN: Are you talking about
10 your missing records?

11 MR. MORGAN: Yes.

12 MS. MORGAN: Well, tell them about
13 it.

14 MR. MORGAN: Okay.

15 CHAIR MARKOWITZ: You can both
16 speak, if you'd like.

17 MS. MORGAN: I can't give you the
18 dates, but he has a block of missing records.
19 Well, you know, you make good money working at
20 -- he worked at Oak Ridge, and those records
21 are missing. How could that happen?

22 Now, we're both 89 years old, so

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1 we're really worn out, but I was a teacher, and
2 matter of fact, I taught filing for a while,
3 and I just don't see how they could have lost
4 his records, and I think it's not only his,
5 both other's.

6 His time was at Y-12, and after he
7 was supervisor, I got calls 24 hours a day,
8 because he was being called in all the time,
9 and my boys have -- I have two sons, and one of
10 them was so disappointed, he never got to see
11 where his dad worked. You know, that's big
12 secret.

13 So, now, we have the big secret of
14 where are his records, and maybe there's
15 nothing could be done about it. He's had more
16 cancers than I can count.

17 One doctor retired couple years ago,
18 so he has a new one, and I mean, they know it's
19 a real, real problem, and he had surgery in
20 June and the first of September.

21 Those were just three times, those
22 three times. One time, as many as five

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1 biopsies.

2 Now, the first doctor was going to
3 do one. I don't know why, the difference in
4 their training, but they'll only do one at a
5 time. So, went to the doctor a lot of times.

6 So, anyway, I butted in because like
7 I said, our parts are worn out. We're 89.

8 CHAIR MARKOWITZ: Right. Well,
9 thank you so much.

10 MS. MORGAN: So, what can you do for
11 him? He has a whole mess of stuff here, and
12 the young lady who called and talked to me
13 about making this trip, and then I'm seeing all
14 these people whose names are called. Well,
15 maybe we just got listed.

16 He was denied. Somebody in Kentucky
17 named Daryl, as his advisor, and he has said --
18 of course, our parents are gone, but his
19 parents, his spouse, his children, even his
20 grandchildren, could pursue, I guess they're
21 waiting on him to die. You know, sometimes,
22 only the good die young. So, here we go.

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1 But he said his thing came back
2 final. So, I called Darryl and I said, what
3 about this final? Well, final is really not
4 final.

5 So, that's kind of hard to figure
6 out, and listening to all these other people,
7 and your attention has been -- I've got to tell
8 you all the way around, I grade everybody,
9 because I taught for 25 years. But the
10 attention has been pretty doggone good. People
11 writing notes. Well, they could be playing
12 tic-tac-toe.

13 CHAIR MARKOWITZ: Not really. Not
14 really. So, no tic-tac-toe here.

15 MS. MORGAN: Okay, writing notes.
16 But anyway, here were are, and I thought since
17 we got the call and I talked to this young
18 lady, she sounded young, about the final not
19 being final, and I figured, did that many any
20 sense to you, and she said, no.

21 So, that's why we came up here. We
22 live on Signal Mountain, and it's not a bad

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1 trip, but you make an effort. You don't come
2 and just, you know, have lunch.

3 CHAIR MARKOWITZ: Right, okay.
4 Well, thank you very much. Thank you for --

5 MS. MORGAN: So, what can you do?

6 CHAIR MARKOWITZ: Well, you know,
7 actually as Ms. Vlieger said, the Ombudsman for
8 the program is in the back. He's about to
9 stand up, and you can talk to him, because he
10 really helps people. So, thank you.

11 MS. MORGAN: So, thank you for
12 listening to me.

13 CHAIR MARKOWITZ: Thank you.
14 Carrie, if you get their name for the record.

15 Okay, so, one final announcement for
16 the Board. Actually, Kirk Domina reminded me.

17 We looked at the calendar. To have
18 a subcommittee meeting, before the middle of
19 December, would probably be important, right,
20 because things tend to get slow by middle of
21 December.

22 If you go back six weeks, that means

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1 that basically, the subcommittee chairs, by
2 next Wednesday, have to arrive on a date to
3 communicate with DOL, to schedule the
4 subcommittee.

5 So, for the three chairs, and I'll
6 have to remind Carrie, if you could, by next
7 Wednesday, communicate a date for the first
8 half of December, before December 16th, if you
9 would like to have a subcommittee meeting.

10 Okay, thank you, and this meeting is
11 now adjourned.

12 (Whereupon, the above-entitled
13 matter went off the record at 2:24 p.m.)
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