U.S. DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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THURSDAY
MAY 18, 2023

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The Advisory Board met in the Snake River Room at the Holiday Inn and Suites Idaho Falls, 3005 South Fork Boulevard, Idaho Falls, ID, at 8:30 a.m. MDT, Steven Markowitz, Chair, presiding.

SCIENTIFIC COMMUNITY
AARON BOWMAN
MARK CATLIN*
GEORGE FRIEDMAN-JIMENEZ*
MIKE VAN DYKE

MEDICAL COMMUNITY
MARIANNE CLOEREN
STEVEN MARKOWITZ, Chair
MAREK MIKULSKI*
KEVIN VLAHOVICH*

CLAIMANT COMMUNITY
JIM H. KEY
GAIL SPLETT
DIANNE WHITTEN

DESIGNATED FEDERAL OFFICIAL
RYAN JANSEN

ALSO PRESENT
KEVIN BIRD, SIDEM
CARRIE RHOADS, DOL
JOHN VANCE, DOL*

*Present via video teleconference

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

(8:30 a.m.)

MR. JANSEN: All right. Let's get started. Good morning, everyone. My name is Ryan Jansen. I'm the Designated Federal Office for the Department of Labor Advisory Board on Toxic Substances.

I'd like to welcome you to Day 2 of this meeting of the Advisory Board here in Idaho Falls, Idaho. Today is Thursday, May 18th, 2023. We are scheduled to meet from 8:30 a.m. to 11:30 a.m. Mountain Time. There will no public comment period today.

The Board's website, which can be found at dol. gov / owecp / energy / regs / compliance/advisoryboard.htm has a page dedicated to this meeting. The page contains all materials submitted to us in advance of the meeting, and will include any materials that are provided by our presenters today.

There you can also find today's agenda, as well as instructions for participating

remotely. If any of the virtual participants have technical difficulties during the meeting please email us at nrgadvisoryboard@dol.gov.

If you are joining by WebEx this session is reviewing only, and microphones will be muted for non-Advisory Board members. So, the public may listen in but not participate in the Board's discussion during the meeting.

A transcript and minutes will be prepared from today's meeting. As the Designated Federal Officer I see that the minutes are prepared, and ensure that they are certified by the Chair.

The minutes of today's meeting will be available on the Board's website no later than 90 calendar days from today. But if they're available sooner they'll posted sooner.

Although formal minutes will be prepared according to the regulations we also prepare verbatim transcripts, and they should be available on the Board's website within 30 days.

During the discussions today please

speak clearly enough for the transcriber to understand. When you begin speaking, especially at the start of the meeting, make sure you state your name so that it's clear who is saying what.

Also, I would like to ask that our transcriber please let us know if you have trouble hearing anyone or any of the information that is being provided.

I'd also like to mention that there is currently one vacant position on the Board, and as such we have invited interested parties to submit nominations for individuals to serve on the Board.

The selected nominee will serve as a member from the Claimant Community under the Board's statute and charter.

Nominations for individuals to serve on the Board must be submitted by May 27th, 2023. For further information including details about how to submit a nomination please visit the Board's website.

As always I would like to remind

Advisory Board members that there are some materials that have been provided to you in your capacity as special Government employees and members of the Board, which are not suitable for public disclosure, and cannot be shared or discussed publicly, including during this meeting.

Please be aware of this throughout the discussions today. The materials can be discussed in a general way which does not include any personally identifiable information or PII, such as names, addresses, or a doctor's name if we are discussing a case.

And with that I convene this meeting of the Advisory Board on Toxic Substances and Worker Health. I will now turn it over to Dr. Markowitz for introductions.

CHAIR MARKOWITZ: Welcome to the Board members who are here, who are online. Welcome to the public, and the public who are participating remotely as well.

So, let's do introductions, and then

we'll move on. I'm Steven Markowitz. I'm an occupational medicine physician, epidemiologist from the City University of New York.

And for the last 25 years run the largest former worker program for the Department of Energy, with the United Steel Workers, and also the Atomic Trade Labor Council at 14 different sites, seven different states, for former, mostly former DOE workers. Ms. Whitten.

MEMBER WHITTEN: Good morning. Dianne Whitten. I'm the health advocate for the Hanford Atomic Metal Trades Council. I've been a radcon tech at Hanford for, well, since 1988.

MEMBER BOWMAN: Good morning. My name is Aaron Bowman. I'm a toxicologist. And I'm also a professor and head of the School of Health Sciences at Purdue University.

MEMBER VAN DYKE: Good morning. Mike Van Dyke, industrial hygienist and associate professor at the Colorado School of Public Health.

MEMBER SPLETT: I'm Gail Splett. I'm

retired from the Hanford site as a DOE employee. Right before I retired I was the EEOICPA program manager for Hanford.

MEMBER KEY: Good morning. I'm Jim Key, labor climate community representative on the Board. I'm President of the United Steel Workers International Union Atomic Energy Workers Council in Washington, DC.

I'm also a cold war veteran, having served 48 years at the Paducah Gaseous Diffusion Facility. Look forward to the Board's discussions and interactions today.

MEMBER CLOEREN: Marianne Cloeren. I'm an associate professor at the University of Maryland School of Medicine Occupational Medicine and Internal Medicine, and a medical director for the BTMed Former Worker Program.

CHAIR MARKOWITZ: Dr. Mikulski.

MEMBER MIKULSKI: Good morning. Marek Mikulski, University of Iowa, occupational epidemiologist. I direct the Iowa Former Worker Program for former DOE workers from the state.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: Hi. I'm George Friedman-Jimenez. I'm an occupational medicine physician and epidemiologist. And I direct the Bellevue/NYU Occupational Environmental Medicine Clinic for the last 32 years.

CHAIR MARKOWITZ: Dr. Vlahovich.

MEMBER FRIEDMAN-JIMENEZ: You're on mute.

CHAIR MARKOWITZ: Dr. Vlahovich, we couldn't hear you if you said anything. So, yes.

MEMBER VLAHOVICH: I'm Kevin Vlahovich. I'm an assistant professor at the University of New Mexico, and an occupational medicine physician.

CHAIR MARKOWITZ: Okay. Thanks. And, Mr. Catlin, the remaining Board member, wrote in that he's going to be a few minutes late. So, he'll be here later. Mr. Vance.

MR. VANCE: Good morning, everybody. My name is John Vance. I'm the policy branch

chief for the Energy Compensation Program.

CHAIR MARKOWITZ: Okay. So, if we can do the people in the room here in Idaho Falls.

MR. FISHER: Good morning. Good morning. This is Miles Fisher, the assistant director of Building Trades National Medical Screening Program, known as BTMed. And we offer free medical exams to construction workers that worked on DOE facilities.

CHAIR MARKOWITZ: No advertising, Miles. No advertising.

MR. DOMINA: I'm Kurt Domina. I'm a retired Hanford worker.

MS. HUNT: I'm Annette Hunt. I'm a benefits specialist for United Energy Workers.

MR. TOWLER: Steve Towler. I'm just a local citizen.

MR. LARSON: Dave Larson, local DOE employee.

MR. CUNNINGHAM: John Cunningham. I work at AMWTP out at the site.

CHAIR MARKOWITZ: And Carrie Rhoads,

without whom we wouldn't be here today.

MS. RHOADS: Hi. I'm Carrie Rhoads. I'm the alternate DFO for the Board at the Department of Labor.

CHAIR MARKOWITZ: Okay. So, we have, we're scheduled to continue until 11:30 today. Let me ask the Board members who are here whether anyone needs to leave earlier than that because of an airplane, or whatever. So, Mr. Key, what time roughly do you think you need to leave to -- Okay. Okay.

So, the agenda for today, we're going to switch around a little bit. I thought we would discuss public comments from yesterday, and the written comment that came in. Because sometimes we don't get a chance to discuss that if we leave it to the end. So, we would start off with that.

And then we'd continue with the case review. The Board has looked at a number of claims of cases that were submitted and completed over the last several years, in order to understand the claims review process and to raise

questions to improve our understanding of that process.

And I thought then that we would look at, go back to some of the issues from yesterday that were raised. Actually, there's one issue I would like to discuss after we do the public comments, before we go into the case review.

In any event, in any event the public comments. So, there was one written public comment that's come in that's on our website. Ms. Rhoads did any additional written comments come in?

(Off-microphone comments.)

CHAIR MARKOWITZ: Okay. So, we haven't seen those. But we will look at those. The one comment that came in had to do with, it was from Donna Hand, who I think is an authorized representative.

Had to do with the medical findings of chronic beryllium disease. And it was an excerpt from the Agency for Toxic Disease, Toxic Substances Disease Registry, ATSDR's profile on

beryllium.

And it was simply a listing of the medical findings. And no comment was made on those medical findings. I think the implication was that the findings are broader than what's in the Act, or what's used by the program.

But I advise the Board members to take a look at that and see if, see what meaning you attach to it.

So, we had a number of public comments yesterday. Any thoughts on those comments? Dr. Bowman.

MEMBER BOWMAN: Yes. This is Aaron Bowman. One of the, a theme that I thought that arose from the public comments, including even the large amount of comments about the accident.

But there was a theme that came out of a need for IH or CE to reach out to claimants to get additional information. And I think that was one of the underlying themes of what was being asked for relating to the accident. But that was a much broader incident.

But in addition, some of the other public commenters I think brought that up. And we talked about that as a Board as well yesterday. And so, I thought that sort of emphasized that discussion as well.

CHAIR MARKOWITZ: This is Steve Markowitz. There was a comment from a former industrial hygienist at the site. One of the first, I think it was the second public commenter, who talked about when he first started in 1981 I think it was.

And was surprised by some of the conditions he found, the relative lack of control of exposure to salient toxic substances.

And it made me wonder, you know, how much of that is actually captured in the DOE records, or the contractor records, which DOE would have, and is documented for the purposes of claims review.

And not just those particular episodes. It's really anecdotes. But in general I was surprised that into the '80s, early '80s that

there was what appeared to be a pretty severe lack of controls for some obvious toxins.

In any event, I don't want to read too much into it. But I was struck by that. Any other comments or thoughts? Okay.

So, before we go to the case review I wanted to raise something that we had discussed briefly yesterday. And really for the purposes of brainstorming and exploration, not necessarily for the purposes of developing a recommendation.

Which is, when changes in the SEM are made, when knowledge, new data become available from DOE about, historical data about what was used in various sites, various buildings, and that new information could support finding of causation for claims, the challenges of using that new information retrospectively, or for people who had been through the claims process and had been denied years before.

And someone mentioned that in the special, on the radiation side of the program, which is not our business. We're on the toxic

substances disease site.

But on the SEC, the special exposure cohort side, the original Act had really I think three special exposure cohorts. They were the gaseous diffusion plants.

But since that, but identified a way to add special exposure cohorts where, for those of you who are unfamiliar, it's a way of adding groups of workers at various sites who meet certain criteria.

They worked for a certain amount of time, certain years at particular sites or at particular places within those sites, who would have been, or should have been monitored for exposure to radioactive materials.

That's roughly the criteria for an SEC. They're more specifically written. But in any case, when there have been some 110, 120 new SECs, I think there are probably some people here who know the exact number, developed over the last 30 years since, 20 years since the Act was passed in 2000.

And when they pass a new SEC the DOL actually informs people who would submit from those special exposure cohorts or from those sites who may now be available, may now be eligible for compensation.

The DOL affirmatively, proactively informs those previously denied claimants of the special exposure cohort and their possible eligibility at present, given the change.

That seems to be a very appropriate and claimant friendly process that when you change the policy, develop new information, that you go back retroactively and inform claimants that they may be eligible. And they may want to resubmit a claim.

It also strikes me as something pretty easy to do, at least from the outside. Because you know a lot about that claimant already. You know where they worked. You know the years that they worked.

And so, it's probably relatively easy to identify who's likely to be now newly eligible

based on that special exposure cohort. Because you know what that worker did, where they did it. It's in the file of their original claim, which site, what years, et cetera.

So, whether they are likely to be now eligible under the special exposure cohort criteria is mostly known from available data, data available to DOL.

And so, when they reach back they do so based on knowledge about that claimant, and a fairly high likelihood that the claimant is now going to be eligible. That's a very favorable situation.

Now, let's move on to our side of this, which is toxic substances and occupational diseases. And now the SEM is continually improved, right, with new understanding, new data became available from DOE, from the contractors on the various sites.

We learned a little bit about that yesterday. And it's an ongoing process. It may not be perfect. We'll talk more about that I

think going forward.

But when that new information is integrated into the SEM we've learned that a parallel process of going back and informing claimants previously denied, that they may now be eligible based on the new knowledge in the SEM about the sites, that that is, that that's not done. The Department of Labor doesn't proactively go back and inform previously denied claimants that they may now be eligible.

And I think we've heard, we haven't really discussed that. But I think it was written in one of the communications to us. And also, we heard very briefly yesterday that part of the problem is that they don't, either they don't have the data or they don't have, the data aren't available in order to make that decision.

And, I mean, we could ask for some clarification about that. But I would think part of the problem is, I mean, picture it. A toxic substance disease claim, a person based on their job title, based on their exposure submits a

claim. Various toxins are identified in the process, some by the claims examiner through the SEM, and others through information provided by the claimant.

And then you would need to have that information available, and good information about the health condition, the medical condition, in order to identify who might be eligible looking back, who might be newly eligible based on those data.

And it makes sense to me that it would be a challenge for the program to be able to identify those data from the previous claim in a way that, in a comparable way to the radiation side where, you know, there's a fairly high likelihood that you're newly eligible for compensation based on this new information.

So, I really just wanted to open that up for discussion. Because it struck me as, first of all, there's this like obvious difference between the two parts of the program.

On the radiation side they can go back

and inform claimants that they may be newly eligible. And there, it's very challenging. And there's no, or it seems to be little intent or actually implementation of going back based on new information on the toxic substances side.

And it struck that that kind of asymmetry, whether it's possible to bridge that somehow. That the toxic substance side could do a better job comparable to what's done on the radiation side. So, Ms. Whitten.

MEMBER WHITTEN: I agree with you. And I think a good example of that will be when and if Patty Murray's bill gets passed in the Senate to line up the Department of Labor's beryllium sensitivity testing to mirror Washington state's and DOE's. There should be a mechanism for the Department of Labor to go back to all those denied claims and make those right.

CHAIR MARKOWITZ: Mr. Key.

MEMBER KEY: Yes. I agree with your comments. One of the main problems that I see from the claimant community and the Worker Health

Protection Program coordinators, and us even as Board members, when changes are made to the SEM.

We have discussed yesterday several omissions that we have made to the Department of Whereof, correction of those have not occurred. We also had this discussion at our fall meeting.

When any changes to a SEM is made, it is my opinion and belief that those proposed changes should first come to this Board. And after that, prior to implementation a bulletin needs to be issued by the Department advising of the specific changes.

Because without having that knowledge we stumble upon these changes as we're going through and trying to file or help assist someone, a claimant, in filing a claim. And we discover that this information's not included or has been removed. Or something else has been added.

You have to understand, from a claimant in a Worker Health Protection Program coordinators the SEM is the bible that they use

in preparation of the claimant's claim prior to them taking it to any resource, regional resource office to be filed.

So, if they don't have the accurate information, of course the claim goes through the process, is denied. So yes. There needs to be major program improvements to that issue.

CHAIR MARKOWITZ: Other comments? Dr. Van Dyke.

MEMBER VAN DYKE: So, getting back to your, do we need to go back and review claims based on new information? I mean, I definitely see that as, you know, radiation and toxic substances are similar, but a lot different.

And I think at a minimum, you know, if something like this beryllium bill passes, or if there are new exposure disease relationships, those should be looked at. Because you could just look at the diagnosis and go back at claims that were denied based on a particular diagnosis.

But I think trying to figure out a way to do that when the SEM is changed, you know,

there's so many variations of what could happen with the SEM changing. I think that makes it more difficult. But I agree. Something needs to be done to look at denied claims when things change.

CHAIR MARKOWITZ: Ms. Cloeren.

MEMBER CLOEREN: I agree very much with Mike. I think it would be impractical to try to do this based on changes in the SEM. That said, I think we need more visibility about how the SEM is changing.

And I wonder about the change plan. There's probably, I believe in the responses that there is like the change plan. It would be good to review that so that we could maybe identify like big chunks of deletions that need to be looked into further.

But I think when the policy changes that would change eligibility, that I think that is much more practical and really should be done, you know, looking at denied claims that would be affected by policy changes.

CHAIR MARKOWITZ: Yes. It's Steve

Markowitz. I think most changes in the SEM would not lead to previously denied claims being accepted. Because they're probably not either so informative or so universally applicable that they're going to affect the vast majority of claims.

I do worry if, you know, for instance, if the Department were to, when they make a change in the SEM at a given site send a letter to all previously denied claimants. We've changed the SEM. You may want to, you know, look into whether you want to resubmit a claim.

But that would lead to an enormous number of disappointed claimants. Because for the most part the information is not going to really change the outcome. In some cases it does, it would. But probably not in the majority.

And you're sort of setting up a lot of people for disappointment. That strikes me as a definite down side to this.

But while we're discussing the SEM, and we're going to continue the SEM Working

Group. And I take it the SEM Working Group would probably welcome some new members of that Working Group to discuss SEM issues. So, if there's anybody on the Board who would like to join that group I'm sure you would be welcome. So, think about it.

MEMBER FRIEDMAN-JIMENEZ: One comment I'd like to make. George Friedman-Jimenez. I put my hand up. But I don't know if --

CHAIR MARKOWITZ: Yes. I'm sorry, George. I'm not paying attention to the Board. So, this is true for all of you. Just break in as you did. So, thanks.

MEMBER FRIEDMAN-JIMENEZ: Okay. My comment. I don't entirely agree with what you just said about that you don't think that changes to the SEM would affect compensability for the majority of claimants.

There is one change to the SEM that we have made based on recommendation in the past, which is adding IARC Group 2A probable carcinogens, to the list in the SEM, when

previously it had only been Group 1 known carcinogens.

And I think this is a substantial change that could potentially affect compensability of people with cancer. The 2A list is at least, it's longer than the Group 1 list.

So, there are some people whose cancers might now be considered potentially caused by toxic exposures that previously weren't. So, I just want to make that comment.

Incidentally, in my case review I did find that for prostate cancer, malathion, which is a Group 2A probable carcinogen, has been added to the SEM. So, that's one encouraging data point.

But I think it would be good to review the SEM, and see if all of the 2A carcinogens have been added yet, and discuss this.

Does anyone from the Department of Labor happen to know how complete this addition process for the probable carcinogens is to date? Has it been completed? Or is it in progress?

What's the status?

MR. VANCE: Dr. Friedman-Jimenez, this is John Vance. We made the changes that the Board had recommended for all the added health effect information the Board had agreed on, I want to say quite a while ago.

We did provide a written response to the Board about those changes. But I know the prostate cancer one was added. We added some health effect data on a series of lymphomas. We added a breast cancer one, I believe.

There was a series that the Board had recommended. And we did make those changes. And I think we confirmed that in a written response to the Board.

MEMBER FRIEDMAN-JIMENEZ: Excellent. Thank you.

CHAIR MARKOWITZ: Other Board comments. So, yes, go ahead Ms. Splett.

MEMBER SPLETT: I was involved at Hanford when the Part B SECs were changed. And the Department of Labor did indeed come to the

Tri-Cities and hold public meetings.

And they independently reached out to every claimant in telling them about those meetings and what process they should follow. Not that they individually had to open or reopen their claim. But the Department of Labor was doing that directly.

And so, something similar could be done. Because to expect someone, a member of the public, depending on their age and other kind of status, to follow the SEM changes and understanding whether a certain toxin was, status was changed, is really not very plausible.

I think there would be such a small percentage, unless the Department of Labor independently reached out to those claimants.

CHAIR MARKOWITZ: But, Steve Markowitz. But, you know, it so clearly demonstrates the Department understands and believes in the value of reaching back to people who may be newly eligible, and assisting them. Dr. Van Dyke.

MEMBER VAN DYKE: So, this is a new topic. But based on public comments. Are you ready for a new topic, Mr. Chairman?

CHAIR MARKOWITZ: Let's just close this out if we could first --

MEMBER VAN DYKE: Come back.

CHAIR MARKOWITZ: -- for a couple of minutes. Yes. So, I want to just ask Mr. Vance, what is the complexity? What are the challenges involved with doing, with reaching back to people on the toxic substances side of the ledger when the SEM is changed?

MR. VANCE: I mean, you're, Dr. Markowitz, you're aware of how fun dealing with data analytics is with this program, just in how we adjudicate our cases and the information we maintain about that case management process.

So, the challenge is always going to be I think the things that you've touched on, is it's going to be very difficult for the Department of Labor to do some sort of automatic kind of data screening to determine which cases

are potentially impacted by a change in the Site Exposure Matrices.

What you're generally going to be talking about if we're even going to be in a position to do that, you're talking about a manual review.

Somehow identifying cases potentially impacted, having individual claims examiners taken off the normal process of case adjudication to go back and look at whatever this inventory of cases are that are impacted.

You'd then have to determine whether or not there's a likelihood that something that has changed in the Site Exposure Matrices is going to potentially positively impact that case.

And don't forget that this is an exposure component. This is not necessarily going to be something that's going to change the entire dynamic of the case unless we would potentially be looking at a triggering of a presumptive standard. So, you have a lot of these variables and parameters that you're going to have to think

about in doing it.

And if you're going to take an entire category of denied cases since the inception of the program under Part B for a particular type of cancer, you're going to have to figure out the criteria that you're going to want to apply to look at those cases, to determine what's the likelihood that this data change is going to affect the outcome of the case.

Because that's going to take time for the Department to reopen those cases, to go through the process of redoing the exposure analysis, and then sending that off to a physician, or obtaining information from the claimant's physician as to whether or not that data in some way changes their interpretation of causality, given that we probably previously denied the case.

So, you have a lot of these very complicating factors that you have to think about. And you have to be aware of the production side, and the administrative challenge of doing

this work and determining what the benefit versus the cost might be for that.

And the Site Exposure Matrices is a gigantic database. So, if you're talking about the type of changes that are occurring, you know, you could be talking about very small minor issues that are being updated, additional toxins being added.

You know, there could be wholesale information being added about labor categories or what have you. So, you also have that dynamic as well. What is the impact of those changes? Are they significant, insignificant? You know, where is your cut off?

So, you have a lot of issues that are involved with this kind of thing. And I think the Department's position would be, you know, where we can feasibly do something, and we think it's going to produce a good benefit for the claimant population, we're going to do that.

So, I think that would be something the Board would have to consider in any

recommendation about this topic.

CHAIR MARKOWITZ: Thank you. Actually, Dr. Van Dyke's idea of identifying a subset of claims that are more likely to be impacted, for instance, as an example let's say at a given site, Pantex, we've learned that trichloroethylene was used, certain buildings, certain operations, certain job titles over a certain period of time.

And we didn't know that before. And there were say, since trichloroethylene is associated with kidney cancer, and there were claims that came in for kidney cancer previously, now learning that trichloroethylene was at the site in a significant way, one might reach back to previously denied kidney cancer cases and raise the issue about resubmission based on potential exposure to trichloroethylene.

So it may be subsets that would be feasible, given the way the data are established. But we probably should move on. So, my question really for the Board is, is this a topic that we

want to continue to discuss?

So we don't need to vote on this. But for the Board members who are online, the people in the room here are shaking their heads yes, by and large. What do you all think online, Dr. Vlahovich, Mikulski, and Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: I think following through on this to make sure that recommendations that have been accepted in the past are actually implemented is worthwhile.

It sounds like the Department of Labor is already well on the way to doing that. But I think we do need to discuss how the addition, for example, of the 2A carcinogens should be disseminated or acted upon retrospectively.

You know, moving forward into the future it's clear. But past cases it's not clear how people would find out, and whether cases should be reopened.

And doing it in an efficient way I think is important. But I think it's important to do it.

CHAIR MARKOWITZ: Okay. I think we should move this topic into the SEM Working Group, which again invites new members to assist with this.

But I think one of the first steps should be to engage with the Department more, and get a deeper understanding of the challenges here. Because clearly they would be formidable.

And we don't want to make any recommendations that really are so off target that they're unlikely to be accepted just because they're totally unrealistic. So, let's move on. Dr. Van Dyke.

MEMBER VAN DYKE: So, I just had one more thing based on public comments yesterday. Mr. Tebay made comments about use of an interview system.

And I think we've talked about that as Board over and over, that we think an interview is a really good way of collecting the data about exposures in jobs.

I mean, the public comments seem to

indicate that the exposure interview process was not being used. So, is there any place to really ask that question of the Department, around, you know, are these IH interviews or CMC interviews being done?

CHAIR MARKOWITZ: Yes. We can ask, but the procedure is that if an interview is requested either by the industrial hygienist or by the claimant, that it's the claims examiner who acts as the traffic cop.

And I think the procedure reads that the industrial hygienist actually submits questions to the claims examiner, who conducts the interview. I don't think the CMC is even part of the picture.

But when we last asked about this mechanism it was very rarely used. I think there were, when we last asked probably like one to two years ago they cited maybe there were a total of two to three interviews done.

Mr. Vance, has that changed at all? Is the interview being used any more than it was

previously?

MR. VANCE: It's being used primarily where we have relatively contentious arguments over the extent of exposure. I've talked to our industrial hygienist team. I've been encouraging its use. And I'm going to say a couple of things about that process.

We have used it to resolve questions about exposure in some contentious situations. And I will say that has resulted in positive outcomes for certain cases.

In other situations the interview has actually sort of worked against the claimant. Because when they are asking specific questions about the extent of their exposure, their proximity to particular materials, the IHs are also collecting information that's not necessarily going to be beneficial to the claim.

So, keep in mind that that dynamic may also exist, that our industrial hygienists, when given the opportunity to ask really specific questions about, how did you actually use this

material, how close were you to this material, the answers may not actually be amplifying a significant exposure. So, we've encountered that as well.

So, I think that the IH interview process can be useful where we are, you know, encountering something that's really contentious. But it has just not been something that has been used frequently by the Department of Labor, because the process is working relatively efficiently based on the information that we do get.

And that's why it's so important and so critical for folks to be providing as much information up front in their occupational history questionnaire, or any information that they're supplying to the Former Worker Program.

Because all of that information would be really setting the framework for industrial hygienists to have a pretty good understanding about the extent of exposure that they would characterize in the first place.

So, I think that whatever the Board would recommend, just be aware of those contingencies there. Because the interview process may not always work to the advantage of the claimant.

CHAIR MARKOWITZ: Thank you. I personally believe that the claims should be decided based on the best available information, however that information rolls. So, you know, so be it.

Let me make a request though, that we, the Department provide, not now, but provide us with the number of these interviews, either initiated by the Department, by the program, or by the claimant that have been conducted each year over the last three years, so we have an understanding.

But I have just one last comment. One of the changes in the Procedure Manual is this, on the level of exposure by the industrial hygienist.

It used to be there was either

incidental, meaning, you know, unimportant exposure. Or it was significant, and then significant was divided into low, medium, and high.

And now there's a new category, which is between incidental and significant. And my concern is that without good information it's hard to make that determination of where the exposure belongs.

And I suspect this new category, given insufficient information is going to be used a lot. And this is new to the program.

So this, I think, intensifies the need for as good information as they can get in terms of characterizing the exposure. Dr. Cloeren.

MEMBER CLOEREN: Hi. Marianne Cloeren. If the logistics are actually that the industrial hygienist submits questions for the claims examiner to ask the claimant, then I think we're missing a good opportunity for the industrial hygienist to be able to ask follow-up questions.

So, I would hope that there's an

opportunity for maybe the claims examiner and the industrial hygienist to participate in a conference call with the claimant.

CHAIR MARKOWITZ: So that's, yes, a factual question. Mr. Vance, how does it actually work? Is the IH on the phone with the interviewer, or with the claimant?

MR. VANCE: The industrial hygienist is part of the conversation that they have with the claimant. Because there's a lot of interaction and dynamic questioning that can flow from that interview.

So, the claims examiner and the industrial hygienist coordinate with regard to what it is that they are going to be seeking information about, whatever the particular topic of contention might be, or whatever it is that they want to know about.

They then have the call. The industrial hygienist will go through whatever questions or issues and follow-up that they have with the claimant. The CE will be participating

to be aware of what the nature of the conversation is.

The CE is then responsible for recording the conversation, or the facts of the discussion in some sort of memorandum that will then be forwarded back to the industrial hygienist for them to consider, as far as, you know, conducting any kind of reassessment of the level of exposure.

So, it is going to generally inform what the industrial hygienist will be doing as far as characterizing the exposure.

And in most of the interviews that I think that I'm aware of, the interview has always been some sort of argument over the extent of exposure that has been previously assigned by an industrial hygienist.

And they're trying to seek clarification because of some concern or issue that the claimant has raised in the adjudication process. And they want to talk to the claimant about that.

CHAIR MARKOWITZ: Thank you. Mr. Key.

MEMBER KEY: Yes. Jim Key. Is the claimant provided with the list of questions prior to the telephone interview, to allow them to recall their memory, to allow them to better inform the CE and the industrial hygienist of the activities that they performed?

MR. VANCE: Mr. Key, I'm not 100 percent certain that they would notify the claimant up front. I do know that they schedule the call, and they do alert the claimant or their representative about the nature of what it is they're going to be talking about.

So, they will have a semblance of an idea as to what it is that they're going to be calling and talking about. Whether or not they provide the specific list of questions that they're going to be pursuing, I'm not certain of that.

I think my general understanding would be, no they don't. But I'd have to check and follow up with our folks in the field, and just

take a look at the procedure again. I just don't remember off the top of my head if they provide those questions before the call.

MEMBER KEY: Yes. Jim Key again. I would expect if I'm going to be conducting a telephone interview on my exposures or past work histories, I would expect to have the opportunity to have that list of questions a week before any telephone conference.

CHAIR MARKOWITZ: Steve Markowitz. I would agree. I mean, we're asking people to recall events, circumstances from years and decades ago.

And if the claims examiner has a list of written questions that they're going to ask it seems kind of straightforward that those questions would be provided to the claimant before the interview. Dr. Van Dyke.

MEMBER VAN DYKE: So, this is about the more than incidental but less than significant. Are we ready to talk about that?

CHAIR MARKOWITZ: Yes. I think we are

ready to talk about that.

MEMBER VAN DYKE: Okay. So, you know, we had a long discussion about this yesterday. And I feel like we've talked more about significant than I've ever talked about in statistics class. And I feel like adding this category just paints it even more grey.

And if you look at the case reviews that we've done, most of the time what you see in the exposure is you see significant low to very low. That seems to be something that you see over, and over, and over.

I feel like this category really replaces the very low significant exposure. And the discussion yesterday really focused on, we needed to be very sure whether it was significant or incidental, that that was very much of a trigger for other things.

And now in this policy, you know, the Department, I'm not sure why, has added a layer of grey between those two.

So, my question would be for the

Department, really, you know, why this change? And how did this come about? And what purpose is it serving?

CHAIR MARKOWITZ: I don't, Mr. Vance, do you want to answer those questions?

MR. VANCE: I can try to provide sort of a summary description of what occurred here. So, I think what we're dealing with is we're touching on the reality of the history of the atomic weapons production process.

And the issues that are involved with these claims that we received that involve sort of more recent claims involving toxic substance exposures.

And we've always hovered around this sort of like understanding that in the 1990s is where we sort of settled, is that the Department of Energy had a much more rigorous set of occupational safety and health standards which they applied, you know, in protecting worker health.

Now, that being said, that does not

mean that there were not instances where employees, you know, starting in the 1990s and all the way through to the present could have been put in a situation where they were being exposed harmfully to toxic materials.

But, you know, in our discussions with our industrial hygienists and in discussions with the Board in the past, we've tried to wrestle with this reality.

And the Board had expressed some real concerns about this language that the industrial hygienists were trying to use to communicate that, you know, starting in the 1990s it's hard for them to say that there would have been a consistent type of exposure by a lot of employees that would have put people into some sort of occupational threat or hazard without somebody knowing about it, without there being some sort of record or monitoring.

And so, they used this language that the Board didn't like that spoke to, within regulatory limits. And that definitely had some

flaws. And so, the Board had asked the Department of Labor to take a look at how we could address this.

And so, what we did was we spent a good chunk of time trying to figure out how do we characterize this exposure in such a way that makes sense from an industrial hygiene perspective.

And so, what you saw was the production of this admittedly hard to define kind of concept. But what the industrial hygienists with the Department of Labor sort of agreed on is that you're going to have these situations where you're going to have employees that really are working with materials quite frequently.

But there are going to be probably pretty rigorous occupational safety and health standards in place that are not going to allow that person to be put into a situation where they're inhaling large amounts of dangerous material, or they're going to be exposed externally to this material, or ingesting this

material.

And so they were trying to come up with some classification of that type of environment. And so what you'll see in our existing procedure is this sort of language that says, well, they weren't not working with this stuff in an incidental way.

In other words, they were working with this material. But it wasn't some sort of non-routine kind of contact. It's routine contact. But it's not something that they can say this person was routinely inhaling and being dermally exposed to this material, or ingesting this material.

And so, they can't really argue that that's a significant exposure. So, you have this kind of weird middle ground where it's, you were routinely working with this stuff, but not in a way that was going to result in a significant exposure.

Because there were mitigation thresholds that were existing at the site that

prevented that from occurring. There were personal protective equipment standards that were much more rigorous, and that sort of thing.

And that's what our industrial hygienists are doing now. They're looking at the data and they're saying, do we see any issues here? Do we see any evidence of violations of the protocols?

Because generally there would have been much more rigorous safety, reporting of violations involved. There would be monitoring data.

So, they're basically looking at the data and saying, is there any evidence there that there was an exposure that could have been a threat to the employee from an occupational standard.

And so, that's what that language is trying to get to, is that you have workers after the 1990s that were working in environments where there could have been hazardous materials.

But how do you communicate that we

don't think that there was a significant threat to that individual, because there were significant occupational safety and health thresholds that were in place to prevent that type of dangerous exposure?

At the same time acknowledging there could have been instances where violations did occur. And we have seen that. And that's what the industrial hygienist would be looking for, examples or monitoring data in the record that would suggest that there was some sort of threat that occurred because of an exposure.

And that's what they would report out as like, if that is occurring in case evidence, then that's probably a finding that the industrial hygienist would say, that's a significant exposure because that person went beyond what was in place at the time, and recognize it as an occupational and safety threat.

So, it's a very complicated topic. We have amended our Procedure Manual. And I think

the focus should be of the Board looking at that language and trying to ascertain how to deal with this reality that the Department is trying to wrestle with, with regard to profiling and characterizing these exposures in a way that's not the same as you would look at somebody from the 1940s, '50s, and '60s, all the way through history.

So, you've got to look at that sort of like that flow, the history of the production complex. So, hopefully that gives you a little bit of a better understanding. It's definitely something that is complicated. And I know that our industrial hygiene team has really wrestled with this.

And the production of our Procedure Manual edition that includes this new language is the outcome of our discussion about it. But I'm certain we would welcome any kind of input or thoughts about the topic from the Board.

CHAIR MARKOWITZ: Thank you. Dr. Van Dyke.

MEMBER VAN DYKE: I was just going to say that it sounds like your industrial hygienist staff hates the word significant just as much as we do, and is really struggling with how to define that. So --

MR. VANCE: I'll just say no comment on that.

MEMBER VAN DYKE: So, yes. I don't know what else to add about that.

CHAIR MARKOWITZ: Yes, Steve Markowitz. This feels a little bit like whack a mole, I have to say. Because previously the program used 1995 as a dividing line that there was a new Executive Order, DOE 440.1 I think it was, 1995.

And the assumption was post '95 the conditions of work were cleaner. People had fewer exposures. And, you know, you had to prove to the program you had exposure.

Then the Board pointed out that seemed a little arbitrary to us. Maybe it didn't correspond to reality. And so, they took that

away. And they started using does not exceed regulatory standards.

But that was problematic for a number of reasons we don't need to go into, program agreed. And they took away use of that term. And now we have yet another category which is, the exposure wasn't significant. It was there, but it wasn't significant.

Significant is a very important word in this program because it triggers some presumptions, triggers the way in which the claim is evaluated.

So, I understand the problem the program had, which is you either had incidental exposure, which is essentially nothing, or you had significant exposure. It was either/or.

So now they have this intermediate term, which we don't really have a good name for. It's called more than incidental but less than significant, where you can park a lot of exposures, which means that, I think that categorization of exposure is going to

communicate to the CMC this is not an important exposure. You don't have to worry about this.

I mean, as a CMC, as a physician that's the way I would interpret that, and probably correctly so.

So, I come back to, to me the challenge is you've got the reality of what the person did in the workplace, whatever that entailed in terms of exposures.

And then we're struggling with, we have the industrial hygienist's representation of that, their understanding of what happened, right, based on their knowledge, expertise, judgment. Based on the occupational health questionnaire and the like.

And the struggle is how to get that, what the IH understands as close to what the worker actually did as possible. And I'm not sure that this new categorization is an advance on that. Dr. Bowman.

MEMBER BOWMAN: Yes, Dr. Markowitz. I was actually going to make a comment directly

related to what you were saying about how the CMC or other physician might interpret this term of between significant and incidental.

And as I understand this term is used mostly then for an exposure that might otherwise have been significant if there weren't controls in place.

And so I think having some specification that that's what that means, then if a CMC sees a medical condition that is highly consistent with exposure to that substance, that would imply that the controls did not work, I think.

And so, but saying this other term just between, I think that might leave it unclear, was there even the absence of any controls, of chance for an exposure that could lead to a disease.

But if it's in fact cases where there could be an exposure, but the belief is they were controlled, and, you know, we know from everything we have heard that there are

potentially many instances in which those controls may not have worked, even though there may not be evidence against that.

But I think something about the terminology should imply. Because we're talking about, all of yesterday with what we did with the form is to better inform the CMC to make a good judgment call on causation.

And knowing that an individual was working in an environment that had chemicals, and if those chemicals happen to be directly relating to the medical condition, at the heart of it knowing that just the failure of those controls could have contributed, they might conclude that.

CHAIR MARKOWITZ: Other comments, or the Board members who are on the phone? Ms. Whitten.

MEMBER WHITTEN: This is Dianne Whitten. I disagree with the 1990 date that it seems the Department is training the IHs to understand that there were better controls possibly implemented by DOE.

But even on our tour Tuesday we found that up into 2011 there were no beryllium controls in one of the facilities that we visited.

And being from the tank farms, it wasn't until 2015, 2014 that our council had to do a stop work because we had so many, many vapor exposures. And the company wasn't doing anything to protect our workers.

So, to keep throwing this 1990 date out there that there were better controls, it just to me, it seems like it's teaching the IHs to disregard what was actually happening. Just a comment.

CHAIR MARKOWITZ: Ms. Splett. And after Ms. Splett I think Dr. Friedman-Jimenez wanted to make a comment. But, Ms. Splett.

MEMBER SPLETT: I have a question. Who makes the determination, or the call whether it's significant or not? On that form I was expecting to see a bottom line that said significant low, significant high. Does the IH make that call? Or

does the CMC make that call?

CHAIR MARKOWITZ: The IH.

MEMBER SPLETT: And is that communicated in writing to the CMC?

CHAIR MARKOWITZ: In most of the IH reports I've seen there's a description of the exposure. And then there's some use of the word significant or not, attached to low, medium, high, or not.

MEMBER SPLETT: Thank you.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: Yes. I think that the significant incidental classification is in practice a part of the larger causation analysis. Because in essence significant is being defined as sufficient to be a possible causal contributing or aggravating factor.

And it's not just a function of how much or the type of exposure, but rather whether that exposure is potentially sufficient to cause the disease.

And this is being assigned now by the industrial hygienist. And there are other members of the team that should have input into the causation decision. And I will give one example, which is admittedly an extreme example, but I think can be extrapolated to others.

For example, the term incidental. Exposure to a few drops of dimethylmercury solution to a gloved hand of a chemistry professor could easily meet the definition of incidental, or at least between incidental and significant, based on the IH evaluation.

However, this level of exposure has been reported to be fatal in at least one case that was published, which gave strong autopsy evidence of causation.

Causation was proven. And it was a few drops not even to the skin, but to a gloved hand. So, this could apply to incidental exposures of say, asbestos in mesothelioma cases. So we have to see it in a larger context I think.

I think that the discussion on how to

use the terms significant and incidental should be tabled for now. And we should include that in a larger deep dive discussion by the Board, or a Working Group that focuses on the causation analysis in the compensation process.

I think that we can't isolate this, in isolation discuss this without discussing the larger process of determining causation. And this is done by the team, including the industrial hygienist and the CMC, and the treating physician, and auditors that look at the cases later.

So, I think that I would ask the Board to consider forming a Working Group to focus on the causation analysis. Because I don't think you can in isolation define these terms significant and incidental without looking at the bigger picture.

CHAIR MARKOWITZ: Steve Markowitz. Can we just wrap that into the current Working Group on significance? It's significance by another name. Will it be --

(Simultaneous speaking.)

CHAIR MARKOWITZ: Let me rephrase that. Does anybody not think we should wrap that into the Significance Working Group? Okay. So, we accept the advice here to suspend this discussion, unless anybody has other comments, and then put this back in the Working Group for further discussion.

MR. VANCE: Dr. Markowitz, can I add a really quick comment --

CHAIR MARKOWITZ: Sure.

MR. VANCE: -- and just to make a point here is that even with this characterization of exposure that the Department of Labor is utilizing, you know, we are receiving medical opinions from physicians that do argue that even at that level of not incidental but not significant could have been a factor in the development of disease.

And I do know that the Department of Labor, you know, works with physicians, claimants' physicians and RNCMCs. And we've seen

instances where that is not necessarily going to result in a denial.

So, remember the distinction here between the exposure analysis and the interpretation of that evidence by a physician. So, simply because the Department of Labor characterizes an exposure using this criteria that we now have in the procedure does not mean that a physician can't interpret that in a way that would allow for a compensable finding.

It's just going to depend on how well the doctor would be able to formulate an argument supporting that the exposure, in whatever way it's characterized, was a contributing factor.

So, going back to the example that was just talked about, an incident where you have a very incidental level of exposure to mercury, that the doctor's like, hey, this mechanism of exposure, whatever it was, was probably a significant factor in causing this significant illness.

If the doctor can fashion an

explanation of that, that reasonably convinces the adjudicator that there's a compelling relationship, that case is going to be approved.

And I know personally of many cases where we're seeing doctors arguing that, you know, some, any level of asbestos exposure, whether it's incidental or not, could potentially be a significant factor in developing all sorts of disease. And those are the types of arguments that are being made.

So, just make sure that, I just want to make sure to, that everybody on the Board understands, the question really is, how can we communicate this information to a physician so that they are well informed, to allow them to come to a good interpretation of that evidence.

So, just be mindful of that dynamic that exists. And that's it. Thanks.

CHAIR MARKOWITZ: Okay. Thank you. Mr. Key.

MEMBER KEY: Yes. Jim Key. I just want to add on to Ms. Whitten's comments. DOE and

their contractors have always, speaking from personal experience since 1974, have been slow to implement any regulatory change of outside agencies.

Therefore, the IH, contracted IH personnel and the CMCs need to understand that just because a chemical was outlawed for whatever reason and pulled off the market, the Department of Energy and its contractors had voluminous inventory of some of these chemicals.

And when that announcement was made, don't be so naive to think that the DOE directed the contractors to conduct an inventory within their facility, and to go and pick up all of these chemicals at various locations for disposal. That did not happen.

These products were continued to be used up and through, safe to say 2008, until one, a replacement solvent could be purchased, and two, the existing inventory was then depleted.

So, I have a feeling that these IH consultants and CMCs are evaluating the

information based upon anything, as Ms. Whitten said, this 1995 date and above, which in actuality that did not occur. Those chemicals continued to be used.

CHAIR MARKOWITZ: Thank you.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez.

CHAIR MARKOWITZ: Sure. Go ahead.

MEMBER FRIEDMAN-JIMENEZ: I would like to respond to Mr. Vance's point. I think that's an excellent point that you make, that the physicians do have independence and are able to take whatever the classification of exposure was by the IH and consider if that could be causal.

That was a large part of the intent of creating the exposure assessment reporting form in a way that would allow it to serve as a tool for the CMC or the other physicians to quickly find the documentation of exposure in this huge non-searchable medical record PDF file.

But I think if an exposure is called incidental, or even incidental, between

incidental and significant, this would push the physician who's making the causation judgment toward saying that it's non-causal.

Because it's actually fairly rare that an incidental exposure would be more likely than not a cause or contributing factor, or aggravating factor for the disease.

But it's not, it does happen. So, that was my argument for saying let's not use the words significant or incidental. But I understand that there is a potential role for them to keep them. But I think it's a complicated issue that we should explore in detail. Because it's loaded with a lot of baggage for those words.

CHAIR MARKOWITZ: Steve Markowitz. I would agree. I don't think the doctor, the CMC, is looking at the occupational health questionnaire. I don't think they're looking at the form that the claimant fills out about their occupational history. I don't think they're getting their exposure information directly from those sources.

I think for the most part the CMC is probably just using the industrial hygiene report. Because they think, well, that's the expert on exposure. And they've looked at all the primary sources. So, I can just rely on whatever the IH says.

And if the IH says it's not significant, meaning it's below significant low, then it's not a meaningful exposure, except in the rare, you know, instance. So, these categorizations are very important.

I think that just reinforces what you're saying, Dr. Friedman-Jimenez. And I think that we should, we can move, we should move on. We should put this back into the Significance Working Group, which probably also welcomes new members, I might add, if anybody wants to join that group. Mr. Key is smiling, by the way. So, I think he might be a candidate.

In any event I think that's the end of this discussion, unless anybody else has anything else. It's a quarter of 10:00. Question to the

group. Do you want to take a ten minute break? Or do you want to start in on case reviews and take a break in 15 minutes? Okay. Okay. We have a five minute break. Okay. So, we'll come back at ten of 10:00.

(Whereupon, the above-entitled matter went off the record at 9:42 a.m. and resumed at 9:51 a.m.)

CHAIR MARKOWITZ: So we reviewed a number of cases yesterday, but we still have a number more to go. Does anyone want to start off by reviewing a case or have a good particular case to review? Or shall I just call on you?

MEMBER FRIEDMAN-JIMENEZ: I could start off with 7855.

CHAIR MARKOWITZ: Okay, great. Let me just find 7855.

MEMBER FRIEDMAN-JIMENEZ: It's a cancer case.

CHAIR MARKOWITZ: What kind of --

MEMBER FRIEDMAN-JIMENEZ: It's the one --

CHAIR MARKOWITZ: Oh, it's a cancer, with Ms. Whitten?

MEMBER FRIEDMAN-JIMENEZ: Yes.

CHAIR MARKOWITZ: With Ms. Whitten. Okay, go ahead.

MEMBER FRIEDMAN-JIMENEZ: Ms. Whitten, is it okay if I start off?

MEMBER WHITTEN: Yes, please.

MEMBER FRIEDMAN-JIMENEZ: Would you like to start off? I didn't hear you.

CHAIR MARKOWITZ: Yes, she said yes, George.

MEMBER FRIEDMAN-JIMENEZ: Okay, great. Okay, this is a case of a 73-year-old man with prostate cancer and squamous cell cancer of the skin on his ear, who also had asthma. And he worked as a clerk and administrative assistant for Union Carbide at the Y-12 facility from 1970 through 1976.

He was listed -- he listed himself as assistant statistician as his first job in 1970 and then assembly auditor as his second job from

'72 to '76. But they called him a clerk and administrative assistant.

Anyway, he did not report any job that is likely to entail possible exposure to Malathion, which is the only toxic substance that has been associated with prostate cancer. The causes of prostate cancer have been quite thoroughly investigated in many, many studies, and very few toxic substances have been associated with it in reports. And really the only one that has emerged as, you know, a probable human carcinogen causing prostate cancer is Malathion, which is a pesticide.

He also did not report any job likely to entail possible occupational exposure to ultra-violet light or to arsenic or coal tar, which are the two toxic substances that have been causally associated with squamous cell carcinoma of the skin. He did not check the box on herbicides and pesticides.

He did have documented exposure to ionizing radiation, which was separately

evaluated by the Part B Board and the NIOSH dose reconstruction and calculations for both cancers combined yielded an estimate of 99 percent upper bound of the credible interval for the assigned share, which was interpreted as a 1.38 percent total probability that either one or both of his cancers was caused by that radiation exposure.

So this is far less than the 50 percent threshold, which is required for the more likely than not causation criterion. It's not even close. And so I think that the radiation is far from being accepted as a more likely than not cause. So focusing on the toxic substances for prostate cancer, I think it's pretty clear that this is not work-related.

There were no known or probable carcinogens identified in the SEM as causes of prostate cancer except Malathion which, as I mentioned before, is an IARC Group 2A, i.e. a probable human carcinogen. And this was recently added. And although it actually wasn't mentioned in his report, but he did not have documentation

of potential Malathion exposure. I believe the report was done before the 2A carcinogens were added to the SEM. But there's no change there.

But I think it's encouraging to see that the 2A carcinogen is in the SEM and, looking forward into the future, will be available to the claims examiners, CMCs, IHs, and others looking for chemical causes of prostate cancer.

Likewise, there is no documentation that I found in the 402-page record of jobs with potential occupational exposure to sunlight or other sources of ultraviolet light or arsenic or coal tar. So I agree with the cancer claim decision in summary.

I do have an editorial comment on my review of this case, which I think now is probably a good time to mention it. I noted that a large fraction of the time that I spent searching the medical record file was scrolling manually through this 402-page file looking for relevant information such as the statement of accepted facts, the occupational health

questionnaire, IH report, CMC report.

This time could have been reduced substantially if the file were a searchable PDF file. More importantly, I am not entirely confident that I found all of the information that's relevant to the exposure assessment or to the causation analysis and decision. I mean, this was a little bit haphazard in my scrolling multiple times through parts of this 402-page file.

So I would think that it would be more efficient if either there were a table of contents that would be constructed by the Department of Labor to assist staff and others who need to review the medical record quickly and thoroughly, or the PDF file could be converted to a searchable PDF file. And I've raised this before. It wasn't clear what the problem was with converting the files to searchable PDFs.

The table of contents approach may be more labor-intensive than converting to the PDF searchable format. And it still would not ensure

complete inclusion of all the relevant and important information for each of the reviewers, the IH, the CMC, medical director, external auditors. So that's a comment that I would make on the process of reviewing this case. So that's my take on this case.

CHAIR MARKOWITZ: Okay, thank you. Ms. Whitten?

MEMBER WHITTEN: This is Dianne Whitten. I believe that they wrongly assigned his job as a clerk. For his facility, if you look up clerk, there are no chemicals associated with that position. I was going through his file, and I noticed he had radiation exposure. And I was, like, not too many clerks get radiation exposure.

So I did a little deep dive into it, and he was actually a QA person that would go into the area where they were doing top secret stuff. And he would have to, like, inventory every little piece that went on this thing that they were making. So when they sent the stuff to the IH, I don't believe they had the right

information to send to the IH.

He also filed for asthma. They did ask the IH about his asthma claim. But I don't believe they asked about his skin cancer either. So I just think they could have done a better job of doing a little more deep dive into his actual job classification.

CHAIR MARKOWITZ: Okay. Thank you. Let's move on to Case 7904, Parkinson's disease. Dr. Vlahovich and Mr. Catlin. That's 7904.

And after that we'll do 8666, Dr. Bowman and me.

MEMBER VLAHOVICH: So Catlin, did you want me to start, or would you like to go first?

MEMBER CATLIN: Sure, why don't you start, please?

MEMBER VLAHOVICH: All right. So this individual was a security guard at Oak Ridge and had worked there for 28 years, five months. The claim was for Parkinson's disease as well as chronic encephalopathy and toxic neuropathy, with the exposure of interest being lead. And this

case was accepted for those three conditions as well as coronary artery disease.

Let's see, it was sent to an IH for review. I would agree with their assessment of it. Mr. Catlin, did you have anything else to add?

MEMBER CATLIN: No, thank you. That's -- it seemed pretty straightforward after you got through the 1000th page of the report.

MEMBER VLAHOVICH: Yeah.

MEMBER CATLIN: A couple of things I found interesting compared to the few other cases I've looked at is I liked the language the IH used. He used two separate sentences in summarizing exposure. He first said exposure to lead he thought was significant. And then he used a separate sentence to say that the exposure level was low.

And I thought separating those out made it -- when I read that it's, like, oh, if I'm reading this he's given his first opinion on significance very clearly, and then he's

describing the level of exposure. And I thought it was really helpful to separate those two out. I've not seen that language before.

The other thing I liked was I think it was in the Parkinson's case. The claims examiner sent the IH report back to the patient's physician, and then the patient's physician was able to write a stronger medical report that was then accepted. And I think that -- I had not seen that before either. So those were two interesting facts in addition to what doctors described.

CHAIR MARKOWITZ: Steve Markowitz, I have a question. This is a Parkinson's disease case which was ascribed to lead exposure?

MEMBER VLAHOVICH: Yes.

CHAIR MARKOWITZ: And was there a CMC involved?

MEMBER VLAHOVICH: I believe there was, yes.

CHAIR MARKOWITZ: Okay, thanks.

Does anybody remember whether lead is associated with Parkinson's disease in the SEM?

Remember, Dr. Mikulski, we looked into this when we were looking at Parkinson's disease two, three, four years ago?

MEMBER MIKULSKI: No, we have not added that in the recommendation. There was very limited evidence on metals exposures in Parkinson's.

MEMBER CATLIN: I believe, I'm sorry, Dr. Markowitz, I believe they used -- the reports used Parkinson's disease, but I think they used kind of a larger or a broader description of, like, Parkinson-like illness.

CHAIR MARKOWITZ: Yes.

MEMBER CATLIN: But didn't that also include a toxic encephalopathy and toxic neuropathy kind of all together? Am I accurate in that?

MEMBER VLAHOVICH: That's how I recall it, yeah.

CHAIR MARKOWITZ: Okay. So probably it was lead encephalopathy that --

MEMBER VLAHOVICH: Yeah, toxic

encephalopathy.

CHAIR MARKOWITZ: Okay. Thank you.

MR. VANCE: Dr. Markowitz, this is John Vance. I just looked at it. It's not listed in the Parkinsonism health effect category.

CHAIR MARKOWITZ: Yeah. So it was probably the neuropathy and the encephalopathy that swung the day. Okay, thank you.

I think we're going to do 8666, Parkinson's disease, Dr. Bowman and me. Do you want to -- this is a, yeah.

MEMBER BOWMAN: This is Parkinson's --

CHAIR MARKOWITZ: Yeah.

MEMBER BOWMAN: Parkinson's --

CHAIR MARKOWITZ: Why don't you start, Dr. Bowman?

MEMBER BOWMAN: This is a Parkinson's deny case.

CHAIR MARKOWITZ: Yeah.

MEMBER BOWMAN: I have just a brief summary of the case from my notes. This is a former worker classified as a chemist, worked for

a period of about eight years during the '70s. They also had a denial case for hearing loss, which I know we talked about yesterday in general, and that was for insufficient amount of time. Following the work period of about eight years, there was a much longer period of intermittent visits as well to the same site.

So this definition of chemist led to three chemicals being focused on in the context of the IH. These include monel, steel, and trichloroethylene, TCE. I did wonder if there might have been additional relevant chemicals for anyone working as a chemist in terms of their relationship to Parkinson's disease.

The IH report indicated exposure classified as occasional and very low levels not exceeding the regulatory standards. Then the causation took this into account but made a determination of does not rise to the level of at least as likely as not.

And this was based in part on the statement that approximately one third of

individuals of this age have Parkinsonian features or, as actually stated, quote, "symptoms of Parkinson's disease." The latency of 23 years was noted as well in the context of the negative causation decision.

There is, of course, a fairly high incidence of Parkinsonism. In this particular case, it's a Parkinson disease diagnosis, which is not a third of individuals at that age in question.

I wonder if this might be one of the cases where you can have two reasonable opinions on either side, and some might have concluded the other way around, given that this is Parkinson's disease and not just a claim for Parkinsonian-like features.

Dr. Markowitz, do you have any other comments?

CHAIR MARKOWITZ: So I think the real exposure in play here is trichloroethylene. And the industrial hygienist is a chemist for nine years. Industrial hygienists characterize the

trichloroethylene exposure as frequent, very low to low.

And I likewise had trouble with the medical report, the CMC report here, which gives a short but broad overview of toxins and Parkinson's disease but doesn't really focus in on trichloroethylene, which is the exposure of relevance. You know, I think the fact that the physician claims that a third of patients have symptoms of Parkinson's disease when they're 65 or over, it is news to me and of no real relevance.

The CMC said that the exposures were within regulatory standards and therefore are not significant. Because they are said to cause harm in no more than one in a million exposed people, which I think is not universally true of regulatory standards.

And then the medical report says that the latency is 23 years which is too long. And I don't recall that we have a good handle on latency in Parkinson's disease. I don't know.

Dr. Mikulski, do you remember when we looked at this, whether the latency on Parkinson's disease was well characterized or not? So I think the -- do you remember, Dr. Mikulski? Did we address the issue of latency?

MEMBER MIKULSKI: No. This issue was not addressed in the recommendation, as there was very limited data on the latency for occupational causes of Parkinson's disease. But we did address the issue of prodromal stage of Parkinson's, which can precede the Parkinson by over 20 years, which certainly implies a longer latency than what the studies would have shown.

And with regards to the case that you've just talked about, I took the liberty of looking up the CMC report. And it is a word-to-word, exact copy with the exception, of course, of personal identifying information.

Of the report that I looked at and reviewed in the Parkinson's case yesterday, this claim, this CMC uses exactly the same statements to support her argument of this not being as

likely as caused by the occupational exposures. So it is truly a word-to-word copy of what we found in other use.

CHAIR MARKOWITZ: Well, maybe she was dealing with universal truths. But let me just make one quick response to this. I think my problem here, aside from the generalities in this report that are not wholly relevant, is that I don't see that the doctor is actually taking all the issues seriously about the trichloroethylene exposure. There may be no causation, but deal with the issue, deal with the relevant issue at least, address it, discuss it.

And so I think, frankly, this report is not one that falls within reasonable differences. I think it doesn't meet the well rationalized standard, because it doesn't -- it's long enough, but it doesn't really target the key issue.

Dr. Bowman?

MEMBER BOWMAN: Sorry, just on the issue of latency in terms of occupational

exposure, there is, I would consider it strong, epidemiological-based evidence of agricultural workers with exposures to various insecticides and pesticides of heightened risk for Parkinson's disease diagnosis.

And that occurs over very long periods of time, multiple decades even between the start of exposure and when disease begins to commence. So I think there is clear evidence, at least within the occupation of agricultural workers, of a long latency for Parkinson's disease associated with exposures.

And then, you know, I also thought potentially monel was a potential link as well in addition to the TCE, because there's a number of metals in that alloy that have been linked at epidemiologically to Parkinson's disease.

Where I was coming from, Dr. Markowitz, in terms of your last comment about is this -- could people, reasonable people go either way on this case, I do agree that this was not a good, spelled-out rationale.

But I am aware, just back when I was a basic scientist in a neurology department, that there are a number of neurologists that would point to this more as age-related and tend to ignore, I would disagree with that, but tend to ignore the environmental impact. And so that's where I was coming from.

CHAIR MARKOWITZ: Sure.

MEMBER BOWMAN: I know there are physicians who would tend to ignore that.

CHAIR MARKOWITZ: Okay. Yeah. And let me just say that for the issue of latency, latency is the time period, the gap between first onset of exposure to the material of interest, and later clinical diagnosis of disease. It's usually very long for the toxins that produce chronic diseases.

It's best characterized for cancers. And for most other chronic diseases we don't really have such a good handle on latency. And I mention that in particular because there was a case we looked at with COPD in which the, I think

it was the CMC said the latency was too long for COPD. And frankly, we don't have really good information about latency, toxic exposure, and COPD. So in any case, anything else on this case or --- okay.

MEMBER BOWMAN: No.

CHAIR MARKOWITZ: Okay. I don't know, did people have -- I think Dr. Friedman-Jimenez and Mr. Key, you had 2282. I don't know whether you had a chance to review that one or a chance to look at the file or not. But if so, that's one of the ones we're -- 2282 and 8472 are ones we haven't reviewed.

MEMBER FRIEDMAN-JIMENEZ: 2282 I looked at. Mr. Key, would you mind starting off on this or I could -- I don't have a well-organized presentation, but I have reviewed most of this case. And I have some thoughts that I want add. But I could start with that or if you want to present, that would be fine too.

MEMBER KEY: No, sir, Doctor, I will defer to you.

MEMBER FRIEDMAN-JIMENEZ: Okay. This is a gentleman that worked for five months as an electrician in the [facility name redacted] Plant in 1999. He was diagnosed with COPD and emphysema in 2019, 20 years later. And the exposure that was considered as a potential compensable cause of his COPD was asbestos.

So I would agree with the decision to deny this claim based on his very low asbestos exposure. However, there is a very substantial literature that has found that about 15 percent of COPD, and higher in non-smokers or ex-smokers, is caused by occupational exposures to vapors, gases, dusts, and fumes which are not precisely characterized as individual toxicants with known molecules that have been studied but are mixtures and unmeasured or unidentified dusts.

And we've had discussions about this in the past of why, they call it VGDF, vapor, gas, dust, fumes, exposures are not admissible as possible causes in this compensation program.

However, in my view, I believe that

this policy is problematic, and it's too facile a dismissal of quite a substantial literature by now that does support this as a causal relationship, in spite of the heterogeneity, the variety, variability of the exposures in different work places. Even dusts, the dusts are of different chemical composition in the different workplaces.

But clearly, not all COPD is caused by smoking or only by smoking. In this particular guy, after about 15 minutes, I found the smoking history. I still haven't found a good, thorough smoking history in the chart. But he's an ex-smoker who quit in 1986. I did not find a pack/year quantification of how much he smoked or how long he smoked. But he quit 13 years prior to starting his DOE work.

And the COPD was diagnosed in 2019 which is 34 years, is that right, 35 years after he quit smoking. So it seems to me that it's reasonably likely that he had other contributing causes and certainly aggravating causes for his

COPD.

You know, his five months work as an electrician, it could be argued that no matter what he was exposed to it was a low exposure and maybe not sufficient to cause COPD. But I do think that at some point we should reopen the discussion on the VGDF exposure and the literature on COPD. Because this is a -- it's an easy dismissal, but I think that there is something there, there's a real signal.

But I can't make a strong argument in this case, because he had five months of work in, you know, 20 years before his COPD diagnosis with very small asbestos exposure and unmentioned VGDF exposure. So I can't really argue with that. I'm just raising a problem with the policy.

CHAIR MARKOWITZ: Mr. Key?

MEMBER KEY: Yeah, Jim Key. What I found difficult to figure out in this case, the Claimant had put down different dates of work when he started and then when his employment ended. We did a Social Security search and found

these quoted five years.

Then I had a little bit of problem about the latency period. All of us are different in our biological makeups. And so I would question the decision on the latency period relating to this case.

Also as an electrician, which has been my occupation for 48 years also, I would have to question if all of his work was in the underground at [facility name redacted] where there were apparent ventilation problems, even to today for installing the new vent system there, and the exchange of air.

If his exposure to asbestos, be it probable asbestos, was of a low magnitude, though he did not have sufficient air flow in the underground, that would, to me, raise his exposure level to a higher level.

So there's a lot of questions with this case that we don't have the information to which drives the questions that I have about it.

CHAIR MARKOWITZ: This is Steve

Markowitz. I actually looked at this case. And I just want to raise an issue, I think it's a general issue about latency. Because the CMC said that the occurred in the year 1999. And the COPD was diagnosed in 2016. And that's 17 years between exposure and diagnosis. And that's too long for occupational COPD.

And actually that's a tough question. I don't think that there's necessarily a consensus in occupational medicine about latency and COPD. We do know that many people have COPD for years before it's diagnosed. Because it's gradual in onset, it's slow in onset, and people tolerate shortness of breath.

They think I'm just out of shape, you know, I can't do what I used to. But that's called getting old. And so there's often a delay in the diagnosis of COPD. So if you use the time that the doctor says yes, you have COPD, that may be late, not late but well along in the process. So that's one thing.

Second thing, we know from smokers and

COPD that it is the natural history of what happens to the airways is that it takes years for the cigarette smoke, from the initial inhalation and irritation, for cellular changes to develop and advance to the point where a person actually had some obstruction, physiologic change in the lung.

And so we know that the process of developing COPD takes years, at least from cigarette smoking. And with occupational agents it would be most likely the same thing. So latency is a tough issue with COPD. And we faced it in our own Former Worker Program, because we have many people with COPD.

And we puzzled about the attribution. You know, they stopped work in 1990, and their COPD was diagnosed 10 years, 20 years later. Should we say they were contributed, aggravated, or caused?

And our thinking is that it's just like the cigarette smoking. If a person was a heavy smoker, and they quit 15 years ago, and

then they were diagnosed with COPD, chances are cigarette smoke contributed to that in some respect, even though I'm not sure that latency for cigarette smokers is well defined. But I think the same logic would apply to occupational.

And what I wonder is, it's not just relevant to this case, but I think the occupational medicine docs or the CMCs are going to --- their opinions are going to be all over the place on this issue. In this case it was 17 years is too long a latency. And I think in another case a physician could come to a different opinion. And it's probably within the realm of reasonable differences.

But the question is whether the program should actually have some guidance in the Procedure Manual for the CMC in saying, you know, if X amount of time has elapsed since last exposure to the DOE site, we would consider this to, you know, be aggravating or contributing to it. So it's nothing we need to resolve, but it may be an issue that we could advise the

Department on.

Dr. Bowman?

MEMBER BOWMAN: Dr. Markowitz, thank you. This issue of latency came up in the previous one that we talked about. There are some ones that are maybe on the docket for us to discuss as well.

This has come up so many times. And with the differences of opinion, I wonder if we might consider, maybe some deliberation is needed first, but consider some sort of a recommendation, when the principle basis of a denial is a latency issue, that a second opinion may be worthwhile, given that there could be a large variability in opinion when latency is the only issue.

CHAIR MARKOWITZ: That's interesting. Other comments on this issue?

MEMBER FRIEDMAN-JIMENEZ: Yeah. I think there's generally an inverse relationship between the magnitude of the exposure and the latency. In other words people that are really

highly exposed tend to have earlier onset of disease with a shorter latency. And people with lower exposures, it can often take longer.

And so I can't see how 17 or 20 years is too long a latency. That just, I don't think there's evidence to support that statement. So I agree with you, Steven. And I think that's not an adequate reason.

But five months is quite short relative -- and given that it was probably a low to moderate level of exposure, Mr. Key, it's really helpful to hear your personal take on the exposures of electricians. Because it's something that doesn't come across in the data that are available. And that's very valuable.

So yes, I mean, he can have a moderate exposure. Five months is fairly short, and you do need a pretty substantial asbestos exposure, I think, to cause COPD, as opposed to mesothelioma which could occur at much lower exposures. But I'm still not sure that we have a viable case to reverse this decision. But I think there are some

problems here that we're discussing.

CHAIR MARKOWITZ: Okay. So I think we will keep the latency issue on our to do list to look at again without putting it into a working group.

Are there other cases that we haven't looked at? Yes, Ms. Splett, what number is it?

MEMBER SPLETT: 8474, Parkinson's. And the issue is latency.

CHAIR MARKOWITZ: I'm sorry, 8472?

MEMBER SPLETT: Yes.

CHAIR MARKOWITZ: Okay. And, Dr. Friedman-Jimenez, if you have something to say on that, I don't know who wants to begin.

MEMBER FRIEDMAN-JIMENEZ: I have not reviewed that case in detail, and I apologize. I've had so much on my plate in the last week and a half, I haven't had time to prepare that case.

CHAIR MARKOWITZ: Not a problem. We're not going to dock your pay for that.

And for those who don't know, actually we don't get paid. So that's another reason we're

not going to dock your pay.

Ms. Splett?

MEMBER SPLETT: The file was 863 pages. It's an individual who's 79 currently, the claim was denied, almost 19 years at Los Alamos and Lawrence Berkeley as a mechanical technician, liaison specialist, and maintenance machinist.

He filed for stroke and Parkinson's disease. The Parkinson's was reviewed for bronze, carbon, steel, and stainless steel. The IH did say significant exposure to all three of those metals, but the claim was denied.

His doctor came back for consideration under TCE exposure. The CMC's final decision was that it was latency. It wasn't diagnosed for 22 years after last toxic exposure and 37 years after significant exposure. And that was the basis for the denial.

But I did notice in the letter to the Claimant that was never mentioned. It just said, the CMC said it's not related, so it's denied. But they never talked about the latency period,

but that was the crux of the diagnosis, or the decision, excuse me.

CHAIR MARKOWITZ: And when you say it was the crux, because the IH made it --

(Simultaneous speaking.)

MEMBER SPLETT: The CMC did. The IH referred and said there was significant exposure that was well documented, all the materials that he had worked with, but the CMC finally, after reviewing all the documentation, just said it was too long, the exposure wasn't linked.

But again, they did not tell the Claimant that. I noticed that in either the recommendation letter or the FAB evaluation. It just said the CMC denied it.

CHAIR MARKOWITZ: That's interesting, because I would have been skeptical of there being decisions made only on the basis of latency, but here's an example of that.

Dr. Bowman?

MEMBER SPLETT: Again, not a physician, but that's just -- as a lay person

reading it, that's what I got.

CHAIR MARKOWITZ: Okay. Dr. Bowman?

MEMBER BOWMAN: Yes, thank you, Dr. Markowitz, Aaron Bowman. I only gave a cursory overview of this, just given the Parkinson's disease and association. And there's an interesting note, given our conversation from the previous case in Parkinson's disease, relating to TCE exposure.

There was an IH determination in this case that there is no causal link between occupational exposures of TCE and Parkinson's disease. And that was in the final. And so TCE was not considered as a relevant toxic in the context of this case, rather a few of the metals that were listed were what was considered. And it was for that that the latency decision was made by the CMC with very little reference, from what I could tell in my skimming, to the TCE exposure.

CHAIR MARKOWITZ: I think the TCE, Steve Markowitz, the TCE Parkinson's disease or syndrome link was only added relatively recently

to the SEM. I think that may explain where Dr. Bowman --

MEMBER BOWMAN: Yeah, sorry, in that context there was -- the official term is, but there was a rebuttal to the decision in this case that I saw in which relatively new literature pointing to the link between TCE and Parkinson's disease was cited which was then re-reviewed by the IH in this case and deemed to be insufficient, because it wasn't population-wide in its evaluation. And so I thought that was an interesting opinion to express.

CHAIR MARKOWITZ: Yes, interesting.

Dr. Cloeren?

MEMBER CLOEREN: Marianne Cloeren. It doesn't sound like it's the right person to be weighing in on that, but anyway, what I was -- I have a question that's actually, I guess, more of a question than fact, how are the CMCs, via the contract company, informed when there is kind of a change, like the change related to Parkinsonism and relation to specific toxicants?

CHAIR MARKOWITZ: Mr. Vance?

MR. VANCE: I mean, any information that we would be providing to the CMC is going to be incorporated into a referral. Now how well the CMC is aware of specific procedural changes or that sort of thing, we don't provide that kind of notification to the CMC.

So in other words, if we would go and issue a, you know, issue a referral to a CMC, and that CMC comes back and something changes in the future when we would resubmit that, we would update it based on the new data that we had collected, including any new health effect or exposure data that would be going to the doctor for consideration.

CHAIR MARKOWITZ: Other comments? Are there other cases that we looked at that we haven't had a chance to discuss?

Dr. Bowman?

MEMBER BOWMAN: Sorry, just one other feature of this particular case, the 18472, the CMC report rests on old data, quite old. I'm

going back to the 1950s, 70s. And it's focused on the levels of metals, the ones implicated in the IH report, in the brains of patients, and not the evidence of exposure, risk links to Parkinson's disease and references that there's a lack of evidence in this area.

But at the time this done, there was a plethora of evidence. It just pre-dated the 1980s or so which is, like, almost the not very current literature that was cited.

CHAIR MARKOWITZ: Is that the same CMC that had the same opinion and the same rationalization in two separate reports?

MEMBER BOWMAN: No, I don't think so.

CHAIR MARKOWITZ: Okay. What claim was that?

MEMBER BOWMAN: This one here, I'm talking about the one that we were just talking about.

CHAIR MARKOWITZ: Oh, I see.

MEMBER BOWMAN: The 18472.

CHAIR MARKOWITZ: Oh, I see. Okay.

MEMBER BOWMAN: Yeah.

CHAIR MARKOWITZ: Okay. So I know I see Mr. Key is getting ready to leave. I think that actually we've covered most of the items on our agenda, or all the items on our agenda, or any new items that we came up with.

In terms of the working groups, we have two working groups, Significance and SEM. They welcome new members. I suspect they want new members of the working groups.

Dr. Bowman?

MEMBER BOWMAN: So I was wondering if I might move groups to the SEM group. Because I think potentially, since the SEM group is discussing the addition of toxicants to the SEM, that I could be of help to that working group.

And while I very much enjoy the conversations about significance, I think there is some redundancy in our expertise. And so I'm not certain it is as critical.

CHAIR MARKOWITZ: Okay, sounds good.

Mr. Key?

MEMBER KEY: Yeah, I would like to join that SEM working group, because we get to receive the appropriate answers that we have been asking for since last fall, and evidence while we're out at this meeting regarding changes in missing information. So yeah, I would volunteer to be a part of that.

CHAIR MARKOWITZ: Okay. So, Dr. Bowman?

MEMBER BOWMAN: Sorry, just on that similar -- my understanding is it's Gail, Dianne, now Jim, and myself. Is that the entire group?

CHAIR MARKOWITZ: Correct.

MEMBER BOWMAN: I think it would be helpful to have a member from the medical community on that group.

CHAIR MARKOWITZ: Sure. That's an excellent suggestion. And a medical member will volunteer to join that group once the medical members caucus and elect one of our own.

So the working groups should meet before the next meeting. I warn you that summer

is coming, and so finding a time when the working groups can get together on phone may be challenging. So I encourage you to schedule it sooner rather than later, like in the next week or so. It would make sense to set a date for meeting.

Whatever action items or items that come out of this meeting won't be ready for a while, because it takes a while for us to get a draft of the minutes and a transcript of the program. But that will be coming along. I don't know that we've -- I'll have to check those to see if we have any new information requests from the Department or not.

In terms of the recommendations we've elaborated to, I'll write up the rationalization for the CMC, the quality assessment, and then the other evaluation having to do with the industrial hygiene exposure assessment.

I think a member of that committee should take the current writing, which is considerable, and probably edit it for a

rationale for that. And if you all will let me know who's going to take the lead on that, that would be good.

I think we should submit those within the next couple of weeks. The recommendations are done. The question only is really the rationale. And I encourage a relatively short rationale, because most things can be expressed succinctly and maybe are best received if they're relatively succinct.

If you want to send around the rationale to other people on the Board you can, for input. And if you have any questions about whether you've appropriately captured the rationale, then you probably should send it to the other Board members for review.

I think, actually. let me -- it think you should send the rationale to all the Board members. Some may choose not to look at it, but just everybody can take look at the rationale for each of the recommendations to decide whether it's on target or not. Yeah, okay. And then

ultimately I submit the recommendation to the Department with the rationale.

Any other, oh, when we're going to meet is going to be in the fall. Where we're going to meet remains to be determined. Normally we pick sites. We run down the list of sites since 2017 when we began, where many of the claims came from to give the public the opportunity to participate in person.

And we've gone to most of the larger sites for sure. So we'll have to figure out what the most profitable site is to go to in terms of access to the public and also the ability for the Board to do our work.

So are there any other remaining items that need some closure?

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez. I think we should deal with the issue of non-searchable PDF files for the medical records. We've discussed it before. I don't remember if there was a formal recommendation made and denied, or if this was

just a discussion that we had.

But I think we have a good reason to ask for this. It basically would shift a substantial part of the workload from the IH, CMC, medical director to the claims evaluator and clerical staff of the Department of Labor. And this would be both cost effective but, more importantly, would help us to ensure thoroughness in searching these medical records for relevant information which could be anything from exposure history to smoking history, to the various reports from the IH, CMC, et cetera.

So whether we should make a formal recommendation or just ask again, I would leave it up to you. But I think that this is an issue that could be addressed and should be addressed.

CHAIR MARKOWITZ: Well, you know, my question about that is, first of all, I think you don't mean just medical records. You mean the records of the file, right? Because there are many records that are part of the file that aren't medical records.

MEMBER FRIEDMAN-JIMENEZ: Yes, these large PDFs that we get that, frankly, are very time consuming and unwieldy to search efficiently for the pieces of information that we need in order to evaluate the case. And I'm sure that everyone struggles to some degree with that.

But I still don't remember what the -- if there was a clear rationale why they are not searchable PDF files. I know some of it is handwritten and couldn't be easily converted. But most of it is typed text and could be converted to searchable PDFs.

MR. VANCE: Dr. Markowitz, I can sort of elaborate a little bit, so ---

CHAIR MARKOWITZ: Go ahead.

MR. VANCE: What the Board is getting is actually image copies of records out of our OWCP imaging system. So what you're getting is basically the metadata that we have which is, like, the raw information that's contained.

When I have the administrative folks that are assembling these case files, they are

basically going in and saying just print out everything or download everything in the case file

And so what you get is this one single PDF within the imaging system that we maintain. We do have an indexing capability, but that does not get reflected in the material that the Board is provided.

Yes, it is possible to do an optical recognition conversion on some of these, but we've tried that in the past. And it is a laborious and very resource-intensive effort to convert these files

Because as you know, these files are very large and actually contain a lot of hand-written notes that would not convert over to an optically recognized text.

So just be aware that we do maintain these records in an index format, that we break them out by different kinds of categories and subjects

But just the mechanism of providing

that information to the Board, what you're getting is just the documentation in whatever order it is downloaded into a single PDF. So I just thought I'd elaborate on that.

CHAIR MARKOWITZ: Yeah. Dr. Bowman.

MEMBER BOWMAN: Yeah. This is Dr. Bowman. John, just a quick clarity on that. When it's converted to a single PDF, is it multiple PDFs that are just merged? And I'm just wondering, is there a file name system?

Even if in the merging you maintain the file names of the clusters, if that file name is remotely useful, like a CMC is labeled CMC, some numbers, just that alone could be very helpful.

MR. VANCE: I know, I totally understand. And if there was an easy way for me to facilitate that, in providing this information to the Board, we would have done that. It's simply not something that would be easily done in a timeframe that we need in order to collect all of the case files that did go to the Board.

I mean, we've looked at different options, but the only way that we really can do it and facilitate it in a timely manner is this sort of raw download of all the material. And basically, the system allows us to just say give us everything, put it into a PDF, and then we transmit it.

It doesn't allow us to categorize the material in any kind of download that we do. It would be an extremely laborious process to try to convert what is in OIS with its categories and indexing into something like what I know the Board is looking for. So it's just not something that is easily done.

We've looked at a couple of different things but they're just -- but nothing is workable. So, yeah, what you see here is just the raw, thousands of pages of some of these cases

And I knew that that was going to make some minds melt. But because this was a random sample, we did try to limit some of the cases to something that we thought was workable by the

Board.

But these cases, as you can see, have a tremendous amount of paperwork. I think that we had some restriction saying let's not make it one of these cases with, you know, tens of thousands of pages of material. But we do have that. And so I understand the concern.

CHAIR MARKOWITZ: So this is Steve Markowitz, one solution for us, the Board, if we ask to review additional cases is to request that those cases be received with a table of contents with the documents that we really care about identified. And that would require some work by the Department. But that work would be finite and would help us a lot.

Any further comments on this?

So there is an issue from previous meetings that we need to discuss a little bit. You may recall that the Board has requested a supporting contractor for two types of work. One was to review a significant number of claims so we could understand more generally issues

involving claims in cases.

And the second was to provide some scientific support so we could assist the Department in updating exposure-disease links or the like. And Mr. Jansen has an update on that status.

MR. JANSEN: Thank you, Dr. Markowitz. It's probably not the news that the Board wants to hear, but the bottom line is that, because funding for a technical support contractor was not approved this fiscal year, OWCP is not in a position to move forward with efforts to secure a contractor for the Board at this time.

Until funding is made available, we will continue to support the Board in furtherance of its important mission but without a contractor.

CHAIR MARKOWITZ: And so just let me ask you, what's the time of year, or when can that be revisited for next fiscal year?

MR. JANSEN: Yeah, there are normal budget cycles that we go through each year. And

that's something that we can talk about.

CHAIR MARKOWITZ: So I'm sorry, this is May. I'm just asking when in the budget cycle we should raise this again, that's all.

MR. JANSEN: I think it normally starts again over the summer.

CHAIR MARKOWITZ: So is this something that the Board could wait until our fall meeting to discuss, or do we need to discuss it before the fall meeting?

MR. JANSEN: It might be something to discuss before the fall meeting, I would think.

CHAIR MARKOWITZ: Okay. Comments? Dr. Van Dyke?

MEMBER VAN DYKE: So do we need to make a specific request for a budget now in terms of a recommendation?

CHAIR MARKOWITZ: I'm sorry, could you repeat the question?

MEMBER VAN DYKE: So should we, in our recommendations, should there be a request that not only do we get a contractor but we get a

budget for that contractor as well?

CHAIR MARKOWITZ: Yeah, that would be a question for the Department, whether a request for contractor support is sufficient or whether that request has to explicitly say that the funding for that contractor should be provided.

MEMBER VAN DYKE: I mean I think it's up to the Board about what type of recommendation you want to make. I think we understand that obtaining a support contractor is important for the Board.

CHAIR MARKOWITZ: Dr. Bowman?

MEMBER BOWMAN: If I understand, there was no line item in the budget for such a contractor. Does DOL make requests for the budget, and was a line item for that requested? And then that request was denied or -- just a little bit more about that.

MR. JANSEN: Yeah. All I can really say right now is that the funding was not approved.

CHAIR MARKOWITZ: Ms. Splett?

MEMBER SPLETT: Would it be preferable for the budget request to be very specific about what sort of -- not just we want a contractor, but we want a contractor with this ability, because we want these four or five tasks accomplished?

I would think the more specific itemizing that need would be more influential in getting a budget versus we just want a contractor.

CHAIR MARKOWITZ: Let me just say that if we come back and make that request, we will provide some specificity for sure. That would be part of our rationale.

All right, anybody else? Ms. Whitten?

MEMBER WHITTEN: I believe the Board made a request, and it was approved. And they did send out a request for contractors. And I remember seeing that. So do we have to make that request again?

CHAIR MARKOWITZ: I think if we continue to be interested in securing that

assistance that it would behoove us to make that request again, sure, that we remain interested in those functions and getting support to do that work.

Other comments? Dr. Bowman?

MEMBER BOWMAN: I believe at some point this Board's term expires. Is that next year?

CHAIR MARKOWITZ: July, 2024, I think.

MEMBER BOWMAN: Is there, at some point --

(Audio interference.)

CHAIR MARKOWITZ: I'm sorry, say that again?

COURT REPORTER: December, the Board is established through December 2024.

CHAIR MARKOWITZ: Okay.

MEMBER BOWMAN: And that would be -- that's not up to the Department, right? This is up to Congress. That is a congressional thing.

Is there a reason for our Board to make some report to Congress to say this is what

we've accomplished, and we believe we might have additional services, that the Board might remain useful. Is there a reason for that? Or shall we submit something like that to the Department of Labor that they would then pass along?

I just, is there some way we could communicate whether or not we think the Board might remain useful past December of 2024?

CHAIR MARKOWITZ: So is the December 2024, is that the date of this two-year, the end date of this two-year term? That's the ten-year end date of the -- yeah.

Well, you know, we communicate with, by charter we provide advice to the Secretary of Labor. So if we think that it's worthwhile to continue the Board beyond December '24, we could communicate that to the Department.

Ms. Whitten?

MEMBER WHITTEN: Dianne Whitten. I believe in Patty Murray's bill that included the beryllium sensitivity testing, she requested to extend the Board until 2029.

CHAIR MARKOWITZ: Again, that would be the overall charter, I think, for the Board. I remind the Board members that we serve at two-year terms. And you're not destined to be here until 2029.

Dr. Van Dyke?

MEMBER VAN DYKE: Just for clarification, the only way the Board gets extended is through legislation. Is that correct?

CHAIR MARKOWITZ: Yes, I think that's correct, that Congress has to extend the charter of the Board.

MEMBER VAN DYKE: So that would mean that people that like the Board should contact their people about that, right?

CHAIR MARKOWITZ: I don't know that I have the wherewithal to answer that question.

Other comments or questions?

So, you know, we should -- it sounds like if we want to request a contractor that we might consider a relatively brief telephone Board meeting during the summer to discuss that and

make that recommendation if we want.

Otherwise, if we wait until the fall, that might be too far into the budget process. It would be a short meeting. And I think probably an open meeting, right? Right, an open meeting, which is fine, it just means more advance notice.

But in any case, we may move forward with that, to resolve that issue.

Comments, questions?

Okay, I think that concludes our business for this meeting. Do you officially adjourn?

MR. JANSEN: The meeting is adjourned.

CHAIR MARKOWITZ: Thank you.

(Whereupon, the above-entitled matter went off the record at 10:56 a.m.)