

U.S. DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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MEETING

+ + + + +

THURSDAY
APRIL 25, 2019

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The Board convened in the Lamar Ballroom at the Augusta Marriott at the Convention Center located at 2 Tenth Street, Augusta, Georgia, at 8:30 a.m. Eastern Daylight Time, Steven Markowitz, Chair, presiding.

PRESENT:

SCIENTIFIC COMMUNITY

- JOHN DEMENT
- GEORGE FRIEDMAN-JIMENEZ
- MAREK MIKULSKI
- KENNETH SILVER

MEDICAL COMMUNITY

- MANIJEH BERENJI
- STEVEN MARKOWITZ, Chair
- CARRIE REDLICH

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CLAIMANT COMMUNITY

KIRK DOMINA
RON MAHS
DURONDA POPE
CALIN TEBAY

DESIGNATED FEDERAL OFFICIAL

DOUG FITZGERALD

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

8:42 a.m.

MR. FITZGERALD: Good morning, everyone. My name is Doug Fitzgerald, and I'd like to welcome you to the second day of this meeting of the Advisory Board on Toxic Substances and Worker Health. I'm the Board's designated federal officer, or DFO.

Before we convene, just wanted to go over some general housekeeping and remind people that should there be an emergency, the exits are to the back of the room. Please exit and find your way outside if there is an emergency.

Also, there are restrooms located out the back and to the left down the hall, and there are water fountains there by the restrooms as well.

Our agenda today will take us to around the noon hour. We'll do our best to try to adhere to that schedule. There will be no public comment period today.

And with that, Mr. Chairman, I will turn it over to you.

1 CHAIR MARKOWITZ: Thank you. Unless
2 someone requested, I think we might skip the
3 introductions today, because everybody in the room
4 here at least was present yesterday. So unless
5 there's an objection? Okay.

6 So I thought we'd continue the
7 discussion about the claims review from yesterday.

8 If there were any additional claims that people
9 wanted to discuss? Dr. Silver?

10 MEMBER SILVER: An interesting
11 Parkinson's claim was for a Y-12 machinist who hired
12 on in the 1950s and spent 45 years mostly as a
13 machinist. He had a couple of managerial positions
14 towards the end of his career in 1995.

15 His primary care doctor diagnosed him
16 with Parkinson's at age 82. The family had already
17 interacted with the EEOICPA program for squamous
18 cell carcinoma. Under Part B he did not get
19 compensation because the probability of causation
20 was never more than about 15 percent. But if I
21 remember correctly, people keep coming back as they
22 get additional skin cancers, and the IREP model

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1 sometimes comes out in their favor, but it did not
2 in his case.

3 His primary care doctor made the
4 diagnosis of Parkinson's and said, I feel it's due
5 to job exposures, citing welding fumes, carbon
6 steel, and stainless steel. The primary care
7 doctor didn't say that the worker was a welder,
8 so it's ambiguous as to whether he had bystander
9 exposure or direct exposure to welding fumes.

10 I don't know if this helped or hurt,
11 but the primary care doctor also said that the
12 worker's spouse could really use some help with
13 in home care in that diagnostic letter.

14 So there were two industrial hygiene
15 reviews, one out of Jacksonville. A deficiency
16 there is that they ignored the two types of steel
17 that are in the site exposure matrix.

18 The DC industrial hygiene group did a
19 better review and pointed out that there was a
20 direct disease link work process for Y-12 stainless
21 steel, carbon steel, and Parkinson's. A
22 deficiency of the DC review was that they didn't

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1 seem too curious about the percent manganese in
2 the metals that he was working with, and that
3 baffles me.

4 When an agent has been associated with
5 a specific outcome, why wouldn't they put it any
6 brain power into estimating the percent manganese
7 in the ore or the metal over that period of time?

8 When it came to levels of exposure, they
9 characterized them as low, and when the CMC looked
10 over the file in the IH report, the CMC concluded
11 that none of the exposures could have resulted in
12 this gentleman's Parkinson's disease.

13 The CMC report I referred to yesterday
14 has appeared to have a lot of cut and pasted
15 boilerplate; in particular, a sentence about
16 Parkinson's under 50 being associated with genetic
17 factors. Well, this man was 82 when he was
18 diagnosed, so that's kind of irrelevant, but it
19 was in there.

20 I learned a lot about Parkinson's and
21 secondary Parkinsonism yesterday, but a chapter
22 by Robert Feldman, the late, great neurologist from

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1 Boston University who trained a lot of
2 occupational, environmental, and neurotoxic
3 specialists, asserted that PET, positron emission
4 tomography, was helpful for the differential
5 diagnosis of idiopathic Parkinson's disease versus
6 toxic Parkinson's disease.

7 I know Dr. Berenji said there was
8 mixed evidence on that, but I thought that was a
9 missing piece of information from his file.

10 So the claim was denied -- oh, one other
11 relevant fact is that the primary care doctor
12 mentioned that L-DOPA was slowing the progression
13 of disease, and although there's a lot of nuance
14 to this, kind of heuristic, is that if L-DOPA works,
15 it may not be a toxic agent that's causing it.

16 So despite my problems with the
17 exposure assessment in the CMC report, I came down
18 on agreeing with the determination, as the onset
19 was 82 years old, L-DOPA was working, and in my
20 gut, I felt it was probably idiopathic Parkinson's
21 disease.

22 CHAIR MARKOWITZ: Questions or

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1 comments?

2 MEMBER SILVER: And I'm not heartless.

3 I also want you to know that he also developed
4 D-cell lymphoma and they got Part B compensation
5 and survivor's compensation.

6 CHAIR MARKOWITZ: Dr.
7 Friedman-Jimenez?

8 MEMBER FRIEDMAN-JIMENEZ: A couple of
9 comments: first, rather than speculate about the
10 percent of manganese in the various steels, which
11 does vary quite a bit, is there any way to get actual
12 information data from the SEM or -- some of this
13 may actually be classified. Is there a way to find
14 out what the percent manganese in the various steels
15 that were used in the different plants, or is that
16 just futile?

17 MEMBER SILVER: Well, if I had been
18 asked to work on this case, I would have gone to
19 a couple of reference sources. I'm at a school
20 without a lot of library resources, so we
21 inadvertently have a great historical collection
22 of the Kirk-Othmer Encyclopedia of Chemical

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1 Technology, 2nd Edition, from the era of the Cold
2 War.

3 It often has chapters written by
4 engineers and chemists who worked in the DOE
5 complex. So that is one reference source that I
6 would have checked on typical manganese
7 concentrations.

8 I think it might be available in the
9 open literature, but -- in curiosity, we've seen,
10 on the part of the CMCs and the IHS tells that you
11 never take that kind of deep dive into the
12 literature.

13 MEMBER FRIEDMAN-JIMENEZ: Okay. It
14 sounds kind of difficult to determine with any
15 confidence for a particular job, not to mention
16 a whole career, but I think manganese is a pretty
17 common alloy in most of the stainless steels ever
18 used. Is that right, John?

19 MEMBER DEMENT: Yes.

20 MEMBER FRIEDMAN-JIMENEZ: Yes. So
21 the second question: I don't know that the test,
22 for example, the globus pallidus versus the

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1 substantiation diagram finding are really accurate
2 enough to distinguish with confidence idiopathic
3 Parkinson's from manganism.

4 Typically, manganism shows findings in
5 the globus pallidus, but they are not very
6 sensitive, and they're not very specific either.

7 So I don't know that we would expect that that
8 would be used to distinguish.

9 I think a default presumption that
10 Parkinson's and manganism are not clinically
11 distinguishable with confidence would be
12 reasonable. Marek, do you think that's accurate?

13 MEMBER MIKULSKI: I think that's a fair
14 comparison. I was looking at this last night
15 actually, and this is exactly what you have been
16 saying. There's really -- those are not sensitive
17 enough to use diagnostic testing in order to be
18 able to use it as definite diagnosis.

19 CHAIR MARKOWITZ: This is Steve
20 Markowitz. I think the Procedure Manual actually
21 recognizes that -- I'll try to find the section
22 -- but I think they aggregate the various relevant

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1 ICD diagnoses and consider them to be subject to
2 the issue, so -- Mr. Nelson, do you have a comment
3 you want to make?

4 MR. NELSON: Just a point of
5 clarification. In the Procedure Manual in Appendix
6 1, Chapter 15-4.16 of the Procedure Manual says
7 tells CEs to develop claims for Parkinsonism,
8 Parkinson's disease, and any reasonable alias in
9 the same manner.

10 CHAIR MARKOWITZ: Okay. Thank you.
11 That was the section I was referring to, yes. So
12 that's a healthy approach. Dr. Redlich?

13 MEMBER REDLICH: I think that case also
14 illustrates one other aspect of Parkinson's, which
15 is the incidence does increase with age, and he
16 was 82 years old, and age is considered a risk
17 factor. It's also more common in men than women,
18 especially in the older age group.

19 MEMBER MIKULSKI: Do we know at what
20 age he was diagnosed?

21 MEMBER SILVER: Eighty-two.

22 MEMBER REDLICH: That's right.

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1 MEMBER SILVER: Is it at all relevant
2 that when he retired, he had no neuro symptoms at
3 all? At age 64? If it had been the manganese,
4 would you have expected some neurotoxicity before
5 the later onset of full-blown Parkinson's? Or is
6 that not a predictable case representation?

7 MEMBER MIKULSKI: I don't know.

8 MEMBER FRIEDMAN-JIMENEZ: I think
9 that's a valid question. I don't think anyone here
10 knows the answer, but what is the latency period
11 for manganese-induced Parkinsonian-type symptoms?
12 It's something that may be studied or may not have
13 been studied.

14 But these kinds of facts or factors,
15 I think, are useful in distinguishing, but even
16 with that, with the age, with the response to
17 L-DOPA, with the imaging findings, it's still quite
18 difficult to distinguish -- and I don't know that
19 it's a reasonable goal, and I think the Procedure
20 Manual really has it as well as we can formulate
21 it -- to consider them indistinguishable,
22 clinically.

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1 CHAIR MARKOWITZ: Steve Markowitz. I
2 think, Marek, the issue of latency maybe is
3 something that, when we move forward on providing
4 some advice to the Department, we should -- if there
5 are data on that issue.

6 Any other questions or comments on this
7 claim? Is there another claim that people want
8 to review? Dr. Dement.

9 MEMBER DEMENT: This is a fairly brief
10 review. This is an interesting case. This is an
11 individual who worked at Sandia as a metallurgist,
12 a materials scientist from '78 through 2008.

13 He developed symptoms of Parkinson's
14 at age about 60 and submitted a claim. The claim
15 was originally denied, or the recommended decision
16 was to deny it based on lack of finding exposure
17 information on the SEM.

18 His authorized representative, who was
19 his spouse, asked for an appeal at the time the
20 recommended decision was made and stated it was
21 difficult to get information on his exposure from
22 the cause of classification. The case was

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1 recommended for further development.

2 So the interesting thing about this is,
3 this individual published a number of articles that
4 specifically talked about his work with these metal
5 alloys, and as they produced a whole list of
6 publications that came along with it, peer-review
7 publications that demonstrated it.

8 The claims examiner went back and made
9 the direct disease link between manganese alloys
10 and Parkinson's, and it was awarded. So that's
11 a good story.

12 CHAIR MARKOWITZ: So it is useful to
13 publish. Is that the lesson?

14 MEMBER DEMENT: Yes, sometimes people
15 read them for different reasons. I looked at the
16 publications. They were really complex
17 publications, quite detailed.

18 MEMBER MIKULSKI: What was the site
19 that he worked on?

20 MEMBER DEMENT: Sandia.

21 CHAIR MARKOWITZ: Questions or
22 comments on this case? Are there additional cases?

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1 Dr. Silver?

2 MEMBER SILVER: Are we ready for some
3 more COPD?

4 CHAIR MARKOWITZ: Yes, we can move back
5 to COPD, that's fine.

6 MEMBER SILVER: The claimant was a
7 laborer --

8 CHAIR MARKOWITZ: Is this an accept or
9 a denial? Just to --

10 MEMBER SILVER: This was a denial.

11 CHAIR MARKOWITZ: Okay.

12 MEMBER SILVER: Employed at the Nevada
13 test site for eight years, from 1980 through 1987.

14 There were several sources of exposure
15 information. The SEM was the main one relied upon
16 by the IH and the CMC.

17 But the employer also had hazard
18 profiles for some of the work areas that were
19 included in the file, and I was distressed that
20 the DOL people did not rely very much on the
21 information provided by the employer.

22 But the main exposures considered were

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1 silica, asbestos, certain metals, lead, diesel
2 exhaust as well, wood dust, welding fumes, and
3 cement.

4 She was not diagnosed with COPD until
5 age 73, after having left the Nevada test site for
6 a couple of decades. Early in the assembling of
7 facts for her, it was referenced to six years of
8 heavy exposure to asbestos when she started at the
9 Nevada test site, but that dropped out of the
10 documentation as the claim progressed, and I'm not
11 sure why.

12 Missing from her files were the actual
13 pulmonary function test data. Her primary care
14 doctor diagnosed her with COPD, referred to the
15 six years of heavy asbestos exposure and the other
16 vaporous gases, dust, and fumes that I've
17 mentioned. He didn't use that phrase, but we all
18 know diesel, cement, silica dioxide fall into that
19 category.

20 She reported smoking only one to two
21 cigarettes per day, and no one ever questioned that
22 in the documentation that I saw. But when it

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1 reached the CMC, the CMC saw fit to include a
2 paragraph about how 80 to 90 percent of COPD cases
3 are due to smoking, and it seemed like cut and pasted
4 boilerplate with no reference to her actual smoking
5 habits over the years.

6 She also developed Lewy body dementia
7 while the claim was being processed and relied on
8 her authorized representative, a family member,
9 to advocate for her.

10 So the claim was denied, and then on
11 the question of whether I agree with that, I just
12 looked at the Board's presumption that it's not
13 yet been accepted by DOL and saw that she had five
14 years of exposure to asbestos, diesel, cement,
15 other vapors, gases, dust, and fumes. With that
16 as my guiding light, I felt it was an unfair denial.

17 She had not been through the former
18 worker program; I think that would have helped her,
19 since I know they do some fine grains,
20 characterization of people's work histories for
21 the Nevada test site program.

22 I think DOL ignored the fact that she

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1 spent time at Area 51. I'm not the conspiracy
2 theorist I used to be, but we do know that they
3 had a lot of exotic materials being incinerated
4 out there.

5 They also overlooked information about
6 her work with molten asphalt rubber to fill cracks
7 in the road. That information was provided by her
8 employer, and other information provided by her
9 employer said she spent time around a tank farm,
10 which would have resulted in gas and vapor exposure.

11 So that's my take on it. Any insights
12 on Claim Number 5427?

13 CHAIR MARKOWITZ: So I reviewed that
14 claim also, and my take on this is that one doesn't
15 need to resort to the approach of vapors, gas, dust,
16 and fumes, but actually for a laborer in the SEM,
17 the Nevada test site, if you look at how labor and
18 COPD overlap, what the exposures are, which
19 includes cement, diesel exhaust, and the like, she
20 would appear to have had those exposures.

21 In fact, my puzzle on this case -- the
22 CMC just followed what the IH said, so I ultimately

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1 said there wasn't significant exposure, and the
2 CMC followed.

3 But let me just read from the IH report
4 briefly. Conclusion, quote, in the absence of
5 compelling data to the contrary, it is highly likely
6 that the Claimant, in her capacity as a laborer
7 at the Nevada test site, was significantly exposed
8 to cement, diesel exhaust, lead, mercury,
9 crystalline silicon dioxide, welding fumes, and
10 wood dust.

11 Any exposure to these agents that she
12 might have received would have been incidental in
13 nature, parentheses, occurring in passing only,
14 end parentheses, and not significant.

15 So there's a direct contradiction within that
16 statement, and I don't know that that was ever
17 corrected or not, but it was puzzling. The other
18 aspect is the references that the IH provides are
19 the usual references; meaning, the site exposure
20 matrix, facility database, and then a number of
21 textbooks, which clearly don't have the detailed
22 kind of information that would allow a person to

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1 make these conclusions.

2 So clearly, they were relying on their
3 expertise understanding of the site and industrial
4 hygiene. So that's where I found this case to be
5 puzzling.

6 CHAIR MARKOWITZ: Comments?
7 Questions?

8 MEMBER POPE: I also see that -- I
9 reviewed that case as well, and I concur with Ken,
10 and as well with you, Dr. Markowitz. But it
11 seemed like there was a trend or commonality with
12 the IH starting out saying there is a connection,
13 and then having that contradicting language
14 following. It says there is a connection, and it
15 says no, I think it's environmental related.

16 CHAIR MARKOWITZ: Yes, Mr. Domina.

17 MEMBER DOMINA: I guess a couple of
18 questions. Some of these claims -- I apologize,
19 I haven't had a lot of time to review, but some
20 of them are still open, and we have questions about
21 -- there's got to be a mechanism for us to talk
22 to DOL about them, to get more information or see

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1 where some it is going, in my opinion.

2 Then the other part where we always see
3 below regulatory limits; who is that? Who is the
4 regulatory limits that they're referring to? What
5 agency is that, and are they all citing the same
6 agency?

7 And then an observation from me: You
8 look at all of these sites that have SECs for the
9 Part B for radiation; if you don't have any
10 radiation data, you don't have any data for anything
11 else either, because that always came first.

12 We need to come up with a mechanism --
13 just me saying out loud -- if there's an SEC, they
14 need to look at stuff different for the chemical
15 exposure or any other exposures, because you know
16 there is no monitoring, because a bunch of us lived
17 it.

18 And to put the onus on the worker to
19 come up with stuff when the claim is not properly
20 adjudicated, just like the one John just talked
21 about -- well, the guy's a metallurgist. Then
22 you're taking somebody who is obviously at a lot

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1 lower level, trying to tell them they weren't
2 exposed. I mean, that's criminal.

3 CHAIR MARKOWITZ: Any other comments
4 or questions?

5 MEMBER MAHS: Yes, I just had a look,
6 and I think that four out of the six that I reviewed
7 had that same contradictory statement. It says
8 substantially exposed, but to low or very low or
9 in-passing exposure.

10 CHAIR MARKOWITZ: By the way, just to
11 follow up on Mr. Domina's question: Mr. Vance,
12 are you on the -- if you're on the phone, the
13 question is whether any of the claims we were
14 provided for review are still open cases. I would
15 have thought they would be closed.

16 MR. VANCE: Hi, good morning, Dr.
17 Markowitz and the Board. Yes, John Vance. That
18 was not a criteria we were looking for, so we were
19 just looking for cases that met the requirements
20 for the pool, which was Parkinson's denied,
21 Parkinson's accept.

22 So there could very well be cases in

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1 that sample size that have other ongoing issues
2 or are currently in some sort of appeal.

3 CHAIR MARKOWITZ: Okay. Okay, thank you.
4 Dr. Silver?

5 MEMBER SILVER: What a great idea,
6 Kirk. If a site has an SEC, it's an admission by
7 government that radiation, kind of the main act
8 at the site, is not being adequately monitored.
9 So it's not a great stretch to infer that chemicals
10 were not being well monitored in that time frame.

11 I don't know how we get that recognized
12 administratively and legally, but it's just
13 exploding with common sense.

14 CHAIR MARKOWITZ: Steve Markowitz.
15 In any of the claims that people looked at, in the
16 pre-1995 period, was there any evidence that the
17 industrial hygienist actually used monitoring data
18 from the site in order to influence their decision?

19 I didn't see any reference to any
20 monitoring data in the decision-making, and that's
21 not a criticism, that's just an observation
22 reinforcing what you're saying; that there is

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1 minimal highly relevant monitoring information for
2 decision-making on a claim.

3 MEMBER BERENJI: Hi, this is Mani
4 Berenji. So to answer Dr. Markowitz' question,
5 I actually did review a claim, COPD, that was
6 approved. Case ID is 017, Date of Birth,
7 (Redacted).

8 This was an individual who worked at
9 multiple locations within the Rocky Flats Plant,
10 so this individual worked as a radiation monitor,
11 machinist, tool maker, construction millwright,
12 as well as a supervisor. He was involved in
13 construction and welding inspections, and he worked
14 for multiple subcontractors over multiple periods
15 of time.

16 So his work history, at least with DOE
17 was fragmented. From what I was able to gather
18 from the record it appears that he worked from 1962
19 to 1967, then there was a two-year lag, and then
20 he worked from 1969 to 1973, and then from 1999
21 to 2003.

22 This is an issue I had with some of the

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1 claims that I reviewed, especially with the folks
2 who have had fragmented work histories. So I'm
3 not really sure what he was doing between 1974 and
4 1998. I wasn't able to gather if he was still
5 engaged in some sort of other type of activity that
6 could have introduced him to additional exposures.
7 That wasn't very clear to me.

8 But at least from that I was able to
9 review, I thought that first and foremost, there
10 were actually the occupational medicine reports,
11 so this individual had multiple injuries at the
12 Rocky Flats Plant, and there was actually good
13 occupational medicine records with respect to the
14 injuries that he had.

15 With respect to actual exposure data,
16 again, I just did a brief review of this case, so
17 I'd probably have to go back to get some more detail,
18 but at least from what I was able to see, there
19 were some sampling reports done by industrial
20 hygiene at the Rocky Flats Plant.

21 This is addition to SEM, as well as the
22 fact that this individual was in the Former Worker

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1 Medical Screening Program.

2 I think it was just in this particular
3 worker's interests that he was close to National
4 Jewish, which is a very renowned health care system,
5 and they actually have some of the best
6 pulmonologists in the country. So he actually did
7 have good surveillance screening program.

8 They actually did screen for beryllium,
9 and he actually had some additional screening
10 surveillance, monitoring for metals.

11 So I think this individual, by the fact
12 he was at Rocky Flats, had good access to medical
13 care, good access to screening protocols at
14 National Jewish, and at least the industrial
15 hygiene report that was issued on June 19th, 2018
16 did incorporate both the SEM as well as some of
17 the sampling reports.

18 But again, I always run into this issue
19 as well, with respect to the exposures that were
20 listed in the industrial hygiene report, because
21 I do find that there is still a discrepancy.

22 The exposures that were listed were

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1 asbestos, cement, diesel engine exhaust,
2 endotoxins, silicone dioxide, welding fumes,
3 ammonia.

4 But I think we've all mentioned this
5 at some point during this meeting, but the low to
6 moderate, low to very low exposures in terms of
7 the way they categorize the exposures, I feel like
8 this is an underlying thing that we've come across
9 day in and day out.

10 Despite the fact that this individual
11 on the DOE Former Worker's Medical Screening
12 Program actually had some sampling data -- I'd like
13 to get John Dement's input on that at some point
14 -- I feel like there's not a comprehensive way to
15 incorporate all those data points. I feel that
16 the industrial hygienists and DOL still resort to
17 SEM at least 90 to 95 percent of the time.

18 CHAIR MARKOWITZ: I'm sorry, I didn't
19 catch that last point. They still resort to 90,
20 95 percent what?

21 MEMBER BERENJI: The SEM. I feel
22 that's their main go-to. Again, I feel that if

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1 you get some industrial hygiene input from some
2 of our colleagues here, but despite the fact that
3 there was actual sampling data, I feel that the
4 DOL still resorts to the SEM. I feel that that's
5 an unfair protocol.

6 CHAIR MARKOWITZ: This is, oh yeah I'm
7 sorry, Calin Tebay.

8 MEMBER TEBAY: Calin Tebay.
9 Oftentimes we only see at the HWEC when folks come
10 in with claims. The IH data that's in the file
11 is submitted by the claimant.

12 MEMBER BERENJI: That wasn't made
13 clear to me, because I wasn't there. But I'm not
14 sure if DOL actually --

15 MEMBER TEBAY: That's what my question
16 was going to be.

17 MEMBER BERENJI: Yes, that I don't
18 know.

19 MEMBER TEBAY: I've personally never
20 seen -- and to be honest with you, a year ago, almost
21 to the day, we met with the DOL, the district office
22 in Seattle with DOE and the HWEC. And this the

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1 topic we discussed for two hours, this boilerplate
2 language of not significant or significant but not
3 above OELs and PELs, and where they're getting their
4 information for this boilerplate language.

5 So this has been going on for quite some
6 time, and the only time we've seen IH data that
7 could potentially back up those kind of statements
8 is when the claimant themselves had mined some kind
9 of IH data from their own site and then submitted
10 it themselves.

11 MEMBER BERENJI: Yes, I'm not sure
12 about this particular case. It wasn't made exactly
13 clear to me whether this was submitted by the
14 claimant or DOL.

15 CHAIR MARKOWITZ: You know -- Steve
16 Markowitz -- the other aspect of this is from the
17 medical end. If you receive an IH report that lists
18 some exposures and then ranks them frequent or
19 occasional, low, very low, or frequent, I would
20 expect there to be significant variation among the
21 CMCs on how to interpret that information.

22 I could easily see that one CMC would

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1 say that a frequent low exposure to X is not
2 significant because its low; whereas, another one
3 would say it's frequent even though it's low, and
4 therefore it is relevant to the person's disease.

5 Consistency is very important, and I
6 don't know that that's been looked at or how you
7 develop a system that would be consistent so the
8 claimants are treated equitably.

9 MEMBER MAHS: Kirk asked about any open
10 cases. One of mine definitely is, 5227, a lady
11 from Savannah River. They had asked for a review
12 due to them not giving her the final recommendation,
13 just the final decision, and they didn't use the
14 testimony of two of her co-workers.

15 CHAIR MARKOWITZ: A question for Mr.
16 Vance, just following up on Mr. Domina's
17 suggestion. So if there are cases that are in some
18 sense open, and Board members want to submit
19 comments on those cases that might be useful in
20 the review of those case, how should we handle that?
21 Should we submit them to the Department?

22 Before you answer that question, I'm a little

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1 uncomfortable with, in any sense, setting up an
2 expectation that all the claims we look at and that
3 all Board members would be obligated to do this,
4 because that's not our role.

5 However, if we find issues that the
6 Department would want that feedback on, then there
7 should be an avenue to do that.

8 MR. VANCE: Yes, this is John Vance.

9 Yes, I think that would have to be a conversation
10 between the Board and the DFO and the program, as
11 far as how that mechanism would want to work.

12 I'm just not sure how we want to do that.

13 I mean, some of these cases were in some process
14 of adjudication for a variety of things, so what
15 their status is now or what it will be in the future
16 is hard to tell. So I think that's a conversation
17 between all three parties.

18 MR. FITZGERALD: This is Doug
19 Fitzgerald, DFO. I wouldn't want to make a
20 decision on the fly here without looking at this
21 a little more closely, but I think the charge of
22 the Board should be one that looks at more general

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1 sort of application of the statute and the laws
2 and how the program is conducting its business,
3 rather than getting into individual cases.

4 I would hate to set up that expectation
5 that the Board is going to weigh in and actually
6 weigh in on individual cases. That's not to say
7 that if things that are found in the normal course
8 of business appear to be egregious, that the program
9 should be made aware of, I don't want to cut off
10 that opportunity either.

11 But to set up a sort of formalized
12 process where the Board weighs in on individual
13 cases I think might be problematic.

14 MEMBER SILVER: Dr.
15 Friedman-Jimenez?

16 MEMBER FRIEDMAN-JIMENEZ: So, I
17 understand your point, and I agree. I think,
18 though, it's very useful for us to communicate in
19 some formal way our opinions on various good and
20 bad things that we've discovered in these reviews.

21 So maybe we should aggregate our
22 findings in our reviews in a systematic way that

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1 we can then transmit to the DOL that will hopefully
2 be useful in changing some of the problematic things
3 and reinforcing positively the good aspects of the
4 reviews.

5 CHAIR MARKOWITZ: Steve Markowitz.
6 You know, we do, this segues into the larger issue
7 of, how do we move forward on claims review, and
8 what do we do about it? We've been given 20 claims;
9 we've had some time review them. I'm sure we
10 haven't reviewed all of them. I'm sure we haven't
11 been able to spend sufficient time on many of them
12 to be able to weigh in properly.

13 Nonetheless, it's been a very useful
14 exercise for us to understand the claims process
15 and how the various pieces of information are used.

16 We do have an outstanding request to
17 the Department for an additional 80 claims to
18 review, including -- and this is from the December
19 10th request, just to remind you -- including 20
20 chronic beryllium disease claims, 20 sarcoidosis
21 claims, 20 interstitial lung disease claims, and
22 20 asthma claims. So that's an outstanding request

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1 already.

2 The second issue above and beyond that
3 is, how do we want to move forward with getting
4 to what I think Dr. Friedman-Jimenez was talking
5 about, which was being able to do our Task number
6 4 of our charter, which is to evaluate the
7 industrial hygienists and the physicians for
8 objectivity, consistency, and quality of their
9 input into the process. So if we could discuss
10 that, how to move forward.

11 The floor is open for ideas. Dr.
12 Dement?

13 MEMBER DEMENT: I think, as we walk on
14 through these claims, and as we continue to go
15 through the claims, I think there's some themes
16 that recur in some of the claims across the board,
17 and that's -- I really think that's the areas we
18 ought to concentrate on.

19 Some of them have to do with the issues
20 of consistency between IH assessments and CMC
21 assessments. So I think, rather than concentrate
22 on any particular IH or CMC or any particular claim,

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1 I think it might be beneficial, as we sort of wind
2 down, and we go through a set of claims, COPD,
3 Parkinson's, asthma, or whatever, that each one
4 of us sort of synopsizes our observations.

5 After you've taken a look at all of
6 these claims, what are the major points that you
7 have seen with regard to the positive aspects of
8 how the process works and perhaps those that need
9 to be have some attention paid to.

10 And after we've had a chance to do that
11 sort of by category, I think maybe if we reconvene
12 and sort of compare notes, if you will, and we see
13 some commonality in observations across the claims
14 that might have some areas that could be addressed.

15 I don't know how else to bring this to
16 a reasonable conclusion. I think the discussion
17 that we've had in the last day or so has been
18 helpful, and I think we have seen some emerging
19 things, but I think we may see more as we dive more
20 deeply into the process.

21 CHAIR MARKOWITZ: Dr. Silver?

22 MEMBER SILVER: What is the status of

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1 the Board's request for an outside contractor to
2 assist with claim reviews? I agree with Dr.
3 Dement's approach, but the phrase, after we've
4 reviewed all these claims, gives me pause, because
5 most of us have day jobs.

6 I love doing this stuff, but it would
7 be really helpful to have an outside contractor.

8 The first version of this board thought our
9 colleagues at the Association of Occupational and
10 Environmental Clinics could help us get this done
11 if resources were available.

12 CHAIR MARKOWITZ: Steve Markowitz.
13 The short answer is, we have no outstanding request
14 to the Department for resources to do any work.
15 In other words, there was a request of the first
16 board. That board's term has expired; this board
17 has not made that request.

18 MEMBER SILVER: I think we should move
19 to make that request again, and maybe we could add
20 some more specificity to it as we sort of move
21 forward.

22 CHAIR MARKOWITZ: So that's not a

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1 formal motion, but we can discuss that and formulate
2 a formal motion. Dr. Friedman-Jimenez?

3 MEMBER FRIEDMAN-JIMENEZ: I agree with
4 both Dr. Dement's proposal of synopsisizing our
5 findings and requesting additional resources.

6 And to make things maybe a little bit
7 more difficult, I think it's also important to look
8 at cancers: lung cancer, mesothelioma, some of
9 the leukemias, bladder cancer, cancers that are
10 likely to be caused by chemical carcinogens.

11 These are a different framework for the causal
12 inference, and I think it's important for us to
13 look at the cancer cases as well. I don't know
14 how many there are, but I wouldn't want to
15 completely ignore the cancers.

16 CHAIR MARKOWITZ: Well, it is true --
17 Steve Markowitz -- it is true that we only looked
18 at claims -- this board -- for two conditions:
19 COPD and Parkinson's disease, and it may well be
20 that the approach that the industrial hygienists
21 and physicians take is somewhat different by
22 different condition because of availability of

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1 information, their own working assumptions, or
2 whatever.

3 So I would agree that, not just cancer,
4 but we need to figure out, not necessarily today,
5 but we need to figure out the portfolio of different
6 types of claims that we think should be looked at
7 so we end up with a credible set of conclusions,
8 recommendations, that's based on a broad look at
9 the program. Dr. Redlich?

10 MEMBER REDLICH: I think in that regard
11 having a better sense of which are the most common
12 claims, under which categories, and also what the
13 trends have been, because I gather that there may
14 be more of X disease and less of Y in terms of where
15 to focus efforts.

16 CHAIR MARKOWITZ: Well --- Steve
17 Markowitz -- in our December 10th data request we
18 asked for that information for lung diseases, for
19 the most common Part E conditions in general, for
20 neurologic conditions, for cancers, and for kidney
21 disorders. So that information has been
22 requested.

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1 MEMBER REDLICH: Yes, it would be very
2 helpful to get that data to best focus efforts.

3 MEMBER BERENJI: This is Mani Berenji.

4 I do agree with that. I think we should be able
5 to compile all the statistics and then at least
6 try to have some spreadsheet where we can actually
7 kind of tease out these particular cases, approved
8 and denied.

9 And then there are obviously some other
10 extenuating circumstances with some of these
11 claims, but I feel like we should have a systematic
12 approach, and we should hopefully be able to at
13 least get some quality data.

14 So at least from my experience on this
15 board so far, I feel like we've never actually
16 gotten an actual handout or spreadsheet just
17 looking at how many claims they process per year,
18 what percentage are denied, what percentage are
19 approved. I feel like, at least for me, it's been
20 a struggle.

21 CHAIR MARKOWITZ: Steve Markowitz. We
22 did get some data on Parkinson's disorders, but

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1 no data on the rest of the conditions, at least
2 this board.

3 But I think the use of the word
4 systematic is key, because so far what we have are
5 claims for two conditions. We have, on a
6 relatively short time for review, our impressions,
7 our initial impressions about what these claims
8 show, and we're not going to draw any conclusions
9 from those initial impressions because it wouldn't
10 be appropriate. What we need is a more systematic
11 approach to examine the appropriate set of claims.

12 What we've done so far has been very
13 useful because it does allow us to send out some
14 preliminary categories of concern; issues that we
15 would raise with industrial hygiene evaluation with
16 the medical evaluation and the like, so it helps
17 us design that kind of systematic evaluation.

18 But that's what's needed in order to
19 understand the issues, because we have a taste of
20 it, but we don't have a full understanding, and
21 we couldn't credibly represent to the Department
22 that we had any particular recommendations or, I

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1 should say, not any particular recommendations,
2 but a set of recommendations.

3 That wasn't meant to be a summary
4 statement. Dr. Friedman-Jimenez?

5 MEMBER FRIEDMAN-JIMENEZ: Two other
6 potential issues that I want to ask whether we
7 should raise them. One is injuries like
8 chemical-induced injuries, chemical burns,
9 dermatoses; the second is impairment, disability
10 and impairment. In other words, time lost from
11 work. Do we want to get involved in those two
12 issues?

13 Because also those are involved in
14 occupational medicine decision-making and would
15 be related to chemical toxic substance exposure.

16 So I'm raising it as a question; I'm not advocating
17 for doing that.

18 CHAIR MARKOWITZ: Steve Markowitz.
19 Well, the first question is, is it within our
20 domain? Is it within our charter to address those
21 issues?

22 And I would say to the extent that Task

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1 4 is looking at the objectivity, consistency, and
2 quality of the industrial hygiene and the medical
3 input into the program, that impairment and
4 chemical-induced injuries, which are just another
5 outcome, would fall within what we're -- the advice
6 that DOL has asked us to produce. I'm not asking
7 for a bigger set of issues, by the way, but I don't
8 see how they wouldn't be conceived as being within
9 the domain. Dr. Dement?

10 MEMBER DEMENT: Sort of by definition
11 of what our charter is on that part to look at issues
12 of across claim in terms of objectivity,
13 consistency; there's no other way to get at that
14 without looking at claims in rather great detail.

15 And that, by definition, is a time- and
16 effort-intensive process.

17 So I think we're all interested in
18 spending time on these claims, but each one of us
19 has limitations; we have other jobs to do. And
20 so I think we do need some other hands to take a
21 look at this and help us with the process.

22 I don't know quite what that looks like

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1 yet; where do we find that expertise, but I think
2 it's appropriate that we request some assistance
3 to get to the point that they've asked us to get
4 to.

5 CHAIR MARKOWITZ: And that statement
6 was in reference to claims review in general,
7 perhaps including impairment, including chemical
8 injuries and the like; is that right?

9 MEMBER DEMENT: Yes, broadly speaking.

10 CHAIR MARKOWITZ: Well, it seems the
11 sense is, and correct me if I'm wrong -- Dr. Redlich,
12 you wanted to say something?

13 MEMBER REDLICH: I mean, I think
14 there's a Workers Comp system for acute events like
15 a person is actively working. I don't think that
16 it's part of our task. I think if there were a
17 chronic, long-term sequellae of that acute exposure
18 event that then resulted in a chronic condition,
19 that that would be.

20 CHAIR MARKOWITZ: Steve Markowitz.
21 It's hard to believe that we could rely on the
22 excellent review by state workers' comp system of

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1 chemical-induced injuries. It's possible, but
2 it's not a default conclusion. And to me, it's
3 just another outcome that could be within the
4 ballpark of what's looked at.

5 MR. FITZGERALD: This is Doug
6 Fitzgerald, DFO. I've been listening to your
7 back-and-forth on this, and there's some unknowns
8 right now in terms of whether or not there will
9 more resources, or if we have the capability of
10 doing that.

11 I think you could probably make all
12 sorts of connections and linkages between what
13 you're asking, as others have said, to look at.
14 But is the link really a strong one? If you have
15 limited resources, and you all have limited time
16 and other jobs and that sort of thing, what is the
17 work that this board should be focusing on and
18 prioritizing? Is that going to spread us too thin
19 in the absence of other resources?

20 CHAIR MARKOWITZ: So I think the sense
21 of what I've heard so far is that the Board would
22 request additional resources in order to conduct

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1 an appropriate systematic evaluation of an
2 appropriate number and variety of claims in order
3 to weigh in our task of contributing to an
4 assessment of the objectivity, consistency, and
5 quality of the industrial hygiene and medical input
6 into the program. Is that an appropriate summary?

7 MEMBER DEMENT: It's an excellent
8 summary of where we are.

9 CHAIR MARKOWITZ: I think we should
10 formulate that or some version of that as a
11 recommendation. I'm looking to Kevin because I'm
12 hoping we can get it on the board, hoping he's
13 remembered exactly what I said.

14 (Laughter.)

15 MR. FITZGERALD: This is Doug
16 Fitzgerald again, DFO. I just want to raise the
17 issue that what the Board may not be familiar with
18 is our procurement process. Even if we, as an
19 agency, agreed with the request and thought it was
20 a valid one, the procurement process within the
21 federal government is lengthy, and it requires a
22 lot of -- it will take time.

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1 So like I said, in the absence of any
2 additional resources coming in, this Board still
3 has to pursue its mission. So I'm just cautioning
4 you in trying to manage expectations that even if
5 there was an agreement immediately that we should
6 provide the Board more resources that you're
7 asking, it would be some time before those resources
8 were available.

9 CHAIR MARKOWITZ: Thank you for that
10 advice. To me, what that translates into is that
11 we move in parallel on this issue, meaning that
12 we make our recommendation about a request for
13 resources to do that systematic evaluation, even
14 as we continue to review claims, aggregate our
15 concerns as I think Dr. Friedman-Jimenez mentioned,
16 Dr. Dement said, from the claims we have now,
17 perhaps from a limited number of additional claims
18 for different -- not necessarily 80, but a limited
19 number of additional claims for different outcomes
20 so that we're able to design that systematic
21 evaluation with greater specificity within a
22 reasonable period of time.

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1 But a recommendation that asks for those
2 resources, at least puts it on the table that
3 frankly, to weigh in on the issues that we need
4 to weigh in on Task 4, we can do so, but it's limited
5 unless we have additional resources. But to move
6 in parallel, because we know it will take time to
7 get those resources. Ms. Pope?

8 MEMBER POPE: Yes. I think it's very
9 important for us to -- it's great for us to
10 acknowledge and identify the different concerns
11 that we have about these claims that we're
12 reviewing, but is there a way that we can, and
13 especially for the benefit of the new members on
14 the Board, to find out the recommendations that
15 we did submit that have been approved and accepted
16 by DOL?

17 CHAIR MARKOWITZ: What the status is?

18 MEMBER POPE: Yes.

19 MEMBER BERENJI: This is Mani Berenji.
20 So yes, I think that would be great to have some
21 sort of dashboard in terms of questions that we've
22 brought up, the DOL's responses, what percentage

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1 have been implemented, what percentage are still
2 outstanding. I think that way we have some sense
3 of what's happening, and we can hold ourselves
4 accountable, but we can also hold DOL accountable
5 for what's being done and what's still outstanding.

6 So honestly, I'm happy to put that
7 together; that's not hard. We'll just have to get
8 a spreadsheet and create a dashboard.

9 CHAIR MARKOWITZ: That would be great,
10 and I think we'll make that as an action item.
11 In fact, Ms. Leiton yesterday volunteered to bring
12 us up to date on the status of the interview of
13 the claimant by the industrial hygienist, which
14 they agreed to, as long as the claims examiner was
15 involved.

16 She didn't quite know the status, but
17 volunteered to -- so that applied to the other
18 recommendations, we will ask them for, and I'm sure
19 they will accept Dr. Berenji's assistance in
20 organizing that. So we will do that, thank you.

21 MEMBER DOMINA: This is Kirk Domina.
22 You know, yesterday when Ms. Leiton was talking,

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1 they just came out with Procedure Manual 3.0, and
2 she said it's soon going to be 3.1. I'm just
3 curious if something they're doing there affects
4 anything that we could be doing, so that we're not
5 doing something that we've got to redo.

6 MEMBER BERENJI: That's where the
7 dashboard would come in. So like I said, at least
8 we can have some sort of working document we can
9 add on to it over time, but at least we have some
10 way to kind of keep ourselves accountable.

11 Because at least from my perspective,
12 I find this kind difficult to be able to track,
13 so it would be good to have some systematic way
14 of tracking what we're doing, what they've been
15 able to accomplish, what's still outstanding, and
16 then really trying to advocate for more concrete
17 data.

18 I know we keep asking for specific
19 numbers, but I would love to be able to see some
20 bar graphs starting from the date of implementation
21 of Part E from, I believe it would be, what, 2004,
22 2005 to the present.

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1 I'm not sure why it's difficult to get
2 that concrete data just in terms of how many claims
3 come in on a yearly basis, what percentage are
4 approved, what percentage are denied. I mean, at
5 least we'll have a better sense of what's happening,
6 because at this point, I still don't know.

7 I'm not sure if you folks have
8 additional data that I don't have access to; I still
9 don't know.

10 CHAIR MARKOWITZ: To follow up on your
11 comment, Mr. Domina, we've raised this issue before
12 about Board input into the policy-making process,
13 and I think I recall that the Department's position
14 is that it is not the Board's role to review policy
15 changes that are under consideration, except for
16 the initial Board's weigh-in on the that official
17 rule. But it's not our role to weigh in on changes
18 as they are under consideration.

19 And that's understandable. I must say,
20 it gets awkward sometimes, because the new
21 Procedure Manual 3.0 removed the section about
22 asbestos exposure from 1986 to 1985, which is a

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1 topic that the Board, in general, has spent a lot
2 of time on, asbestos consumption.

3 That section was removed unbeknownst
4 to us, and then we discussed it initially yesterday:
5 what does that mean? And there will be some
6 back-and-forth between the Board and the Department
7 about that. Maybe the next version will have it
8 restored, and maybe not.

9 So it's awkward, because that's a topic
10 that we spent a fair amount of time on, and a section
11 is gone that's obviously relevant. Now, after the
12 fact, we're going to provide our opinion about that,
13 but it's an awkward process, let me just say that.

14 So I think Kevin's put the agenda back
15 on, thinking that we should probably move on. But
16 I would like to go back to that recommendation.

17 So the recommendation is that the Board
18 requests resources in order to conduct a systematic
19 evaluation of an appropriate number and variety
20 of claims in order to assess the objectivity,
21 quality, and consistency of the industrial hygiene
22 and medical evaluations that are part of the claims

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1 process, parentheses, Task No. 4.

2 Okay. So how should that be modified,
3 now that we see something in writing? To conduct
4 a timely systematic evaluation? Okay. So take
5 out the, and put in a timely.

6 MEMBER BERENJI: I think we need to
7 specify what exactly we mean by resources. Are
8 we talking about manpower? Are we talking about
9 technological? I think we need to specify that.

10 CHAIR MARKOWITZ: Okay, so let's
11 suggest some words.

12 MEMBER BERENJI: I would probably put
13 in parentheses, personnel. I mean, do we have a
14 specific number of folks -- I mean, we could
15 probably put a range.

16 CHAIR MARKOWITZ: Well, we clearly have
17 to flesh out some details, but I don't think we're
18 capable of doing that right now. I think we should
19 flesh it out over the next four to six weeks so
20 that they have something real to go on.

21 But I don't think we need to do that today.

22 MEMBER BERENJI: Okay.

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1 CHAIR MARKOWITZ: But the categories,
2 I agree with.

3 MEMBER BERENJI: So personnel and IT
4 support; I would probably at least put that in
5 there. And then in terms of timely, I think we
6 need to specify that too. Within what, a six-month
7 time frame, a one-year time frame?

8 CHAIR MARKOWITZ: Well, there are two
9 time frames: one is receiving resources, and the
10 other time frame is actually conducting
11 evaluations.

12 Of course receiving resources, we want
13 to make that as short a time period as possible,
14 and finishing the evaluations, we want to be
15 realistic.

16 MEMBER BERENJI: I feel like we really
17 need to be specific with these folks, because I
18 feel like a lot of these recommendations are very
19 vague, and these folks need to be told, like, we
20 want this, this and this, and we need to be very
21 specific. At least that's been my experience so
22 far. I'm not sure if you folks agree, but --

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1 CHAIR MARKOWITZ: I agree with the need
2 for specificity; I don't think the recommendations
3 have been all that vague, but that's another issue.

4 Dr. Silver?

5 MEMBER SILVER: I'm concerned that the
6 phrase, personnel and IT support could be
7 misinterpreted to mean that DOL would reassign
8 their personnel on an in-kind basis to assist us.

9 I think what we really want is what the NIOSH
10 radiation board has, which is an external
11 contractor.

12 CHAIR MARKOWITZ: Now it says, in order
13 to conduct -- that could be interpreted that we
14 set out the general framework of that evaluation,
15 but then don't necessarily oversee that evaluation.

16 So the question is, do we need to be, in this
17 request, more specific than simply to say, to
18 conduct? For instance, we could say, to design.

19 MEMBER SILVER: Design and direct?

20 CHAIR MARKOWITZ: Dr.
21 Friedman-Jimenez?

22 MEMBER FRIEDMAN-JIMENEZ: Rather than

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1 say design, I would -- I like the word conduct.
2 I mean, there are several epidemiologists,
3 industrial hygienists on this Board that can help
4 with the design. That's not where the
5 labor-intensive part of it is.

6 But actually doing the record
7 organizing, selecting the records; we could design
8 what kind of sampling we want, what diagnoses we
9 want, but the actual work involved is beyond our
10 capacity.

11 CHAIR MARKOWITZ: I see. So resources
12 to support the Board to -- is that what you're
13 getting at? So after, the resources would be to
14 support the Board in order to conduct?

15 MEMBER BERENJI: I think this is
16 getting too wordy already. I mean, I feel like
17 this needs to be pretty concise and succinct.

18 CHAIR MARKOWITZ: So this is what we're
19 looking at. Either, does it need any additional
20 wording or, for that matter, should any wording
21 be deleted to reflect what we're after?

22 MEMBER MIKULSKI: Take out the second

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1 in order?

2 MEMBER BERENJI: Yes, I think that's
3 a little too much wordiness.

4 CHAIR MARKOWITZ: I'm sorry; take out
5 in order?

6 MEMBER BERENJI: In order --

7 MEMBER MIKULSKI: The second one. And
8 then the variety of claims to assess the
9 objectivity, quality, consistency --

10 CHAIR MARKOWITZ: Yes, that's fine.
11 I don't know whether, Doug, as the designated
12 federal official, whether you see any areas of that
13 request that are so vague that it wouldn't transmit
14 the intended request?

15 Obviously, there are going to be details
16 about numbers of claims, types of claims, and all
17 that. That, we will provide. But at this level,
18 is there anything additional in specificity --

19 MR. FITZGERALD: If you're trying to
20 kind of create a placeholder for a more refined
21 request later, I don't know that you need to be
22 more specific than this. But you were going to

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1 have more discussions, I think, about the wording
2 of this, so --

3 MEMBER REDLICH: Did we want to specify
4 an external contractor?

5 CHAIR MARKOWITZ: Questions?
6 Comments?

7 MEMBER SILVER: If this is just a
8 placeholder, I don't think we're going to bring
9 on the wrath of government procurement specialists
10 if we mention the would-be contractor by name.

11 I mean, we're going to refine this, so
12 if this is a statement of our sentiments, then I
13 would propose we put in the Association of
14 Occupational and Environmental Clinics as the first
15 board discussed.

16 CHAIR MARKOWITZ: Mr. Mahs?

17 MEMBER MAHS: It may be just me, but
18 you have the support to support, but would it be
19 better to replace the support with, assist the
20 Board, instead of two supports there?

21 CHAIR MARKOWITZ: All right. That's
22 good. Speaking about -- I don't think we should

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1 name a particular -- at this point, I don't think
2 we should name a particular -- it could be limiting,
3 actually, because what if that particular
4 organization doesn't want to do it?

5 But my concern is that it's possible
6 that a blend of internal and external resources
7 might be able to make this happen.

8 For instance, the claims need to be
9 organized, indexed, and it's possible that there's
10 internal support that could do that in preparation
11 for, ultimately some -- we need some physician time
12 and industrial hygiene time to evaluate these
13 claims, and we wouldn't want that from inside the
14 Department, because of conflict of interest,
15 essentially. So it could be some blend of internal
16 and external.

17 MEMBER REDLICH: That was what I was
18 asking, not knowing what resources are available
19 internally, it seems that that request should just
20 be as open as possible, the point being, request
21 resources.

22 MR. FITZGERALD: I don't want to speak

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1 officially for the energy program, but I think,
2 in general, the availability of federal personnel
3 is going to be very limited.

4 CHAIR MARKOWITZ: Is what?

5 MR. FITZGERALD: Very limited.

6 CHAIR MARKOWITZ: Very limited. Okay.

7 So we could leave it, then, as external contractor,
8 and if some limited internal resources are
9 provided, as long as there's no conflict of interest
10 or whatever, that would be fine with us.

11 MEMBER REDLICH: It could be such as
12 --

13 CHAIR MARKOWITZ: Such as an external
14 contractor? This is part of the reason why many
15 chapters in medical industrial hygiene texts have
16 single authors; otherwise, they'd never get done.

17 MEMBER BERENJI: This is Mani Berenji.
18 So I'm thinking the way we should probably break
19 this down is maybe have some bullet points, so that
20 way it's a little easier to read.

21 So, the Board requests resources (such
22 as external contractor to provide personnel and

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1 IT support) to assist the Board with the following:
2 and then just literally bullet points, so at least
3 it's easier to read.

4 Then we can just list by bullet point
5 what we want. In order to -- get the colon in there,
6 and then we just bullet-point, just go for it.
7 We just add whatever we want. At least it will
8 be easier to read.

9 CHAIR MARKOWITZ: I wouldn't
10 underestimate the ability of the Department of
11 Labor to read these requests.

12 MEMBER BERENJI: I don't think so, at
13 least from my --

14 CHAIR MARKOWITZ: I would read bullet
15 points if they were multiple parallel tasks, right?

16 So conduct this, to assess that, to provide that:
17 three equivalent parallel paths. But this is just
18 a single function, which is to allow us to conduct
19 a systematic evaluation of X, Y, and Z.

20 Why don't we do this? Why don't we go
21 with bullet points and see what they sense. But
22 while we do that --

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1 MEMBER REDLICH: It's a related
2 concept, so -- I'm normally in favor of short
3 bullets and short sentences, but I think in this
4 case they're linked.

5 CHAIR MARKOWITZ: Right. Because the
6 conduct and evaluate -- to assess is the function
7 of the evaluation, right? So it's, they're linked.

8 So other comments, questions? This is
9 now a motion, or someone needs to make a motion
10 to accept this recommendation.

11 MEMBER BERENJI: I make a motion to
12 accept this recommendation.

13 MEMBER REDLICH: Second.

14 CHAIR MARKOWITZ: So the floor is open.

15 The motion is to accept the recommendation that
16 the Board requests resources (such as an external
17 contractor to provide personnel and IT support)
18 to assist the Board in order to conduct a systematic
19 evaluation of an appropriate number and variety
20 of claims to assess the objectivity, quality, and
21 consistency of the industrial hygiene and medical
22 evaluations that are part of the claims process.

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1 I would make a friendly amendment that
2 the phrase, to provide personnel and IT support
3 and additional resources as required, just to leave
4 open that we may have forgotten something.

5 MEMBER REDLICH: Yes.

6 CHAIR MARKOWITZ: Okay. It's open for
7 comments. I'm just looking for the Board charter
8 to make sure that this language is entirely
9 consistent. So I would actually make another
10 friendly amendment. Where it says in the third
11 line, to assess, I would say, to assess and to
12 ensure. I add that because that's what the charter
13 says.

14 Okay. Are there additional comments
15 on this, because the floor is open. Otherwise,
16 we need to take a vote.

17 MEMBER BERENJI: So this is just a
18 placeholder, correct? I mean, we're going to
19 refine this over time.

20 CHAIR MARKOWITZ: Well, this is a
21 request to transmit to DOL, and yes, we need, over
22 a relatively short period of time, to start to fill

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1 out exactly what that would look like.

2 So let's take a vote. How do we take
3 a vote? I can't remember.

4 MR. FITZGERALD: We'll run down the
5 list and get everyone's --

6 CHAIR MARKOWITZ: Okay. Okay.

7 MR. FITZGERALD: And then just go with
8 the names as they're represented here. Dr. Dement?

9 MEMBER DEMENT: Yes.

10 MR. FITZGERALD: Dr. Dement is a yes.
11 Dr. Friedman-Jimenez?

12 MEMBER FRIEDMAN-JIMENEZ: Yes.

13 MR. FITZGERALD: Dr. Mikulski?

14 MEMBER MIKULSKI: Yes.

15 MR. FITZGERALD: Dr. Silver?

16 MEMBER SILVER: Yes.

17 MR. FITZGERALD: Dr. Berenji?

18 MEMBER BERENJI: Yes.

19 MR. FITZGERALD: Dr. Markowitz?

20 CHAIR MARKOWITZ: Yes.

21 MR. FITZGERALD: Dr. Redlich?

22 MEMBER REDLICH: Yes.

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1 MR. FITZGERALD: Mr. Domina?

2 MEMBER DOMINA: Yes.

3 MR. FITZGERALD: Mr. Mahs?

4 MEMBER MAHS: Yes.

5 MR. FITZGERALD: Ms. Pope?

6 MEMBER POPE: Yes.

7 MR. FITZGERALD: Mr. Tebay?

8 MEMBER TEBAY: Yes.

9 MR. FITZGERALD: It's unanimous.

10 CHAIR MARKOWITZ: Then let's discuss
11 two things: one is, the claims we already have,
12 with additional time to review those claims, what
13 are we going to do with our observations?

14 I think there's been a suggestion that
15 we aggregate those, sort of categorize and
16 aggregate those observations, looking at
17 commonalities across claims. Not that that work
18 will necessarily lead to specific recommendations
19 to the Department, but at least it organizes our
20 thoughts and prepares us to perform a more
21 systematic evaluation.

22 So should we do that over the next period

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1 of time, and then have a telephone Board meeting
2 in two to three months in order to discuss the
3 aggregated observations about the claims we have
4 so far?

5 We just need a sense of the group; we
6 don't need to actually vote on that, I think.

7 MEMBER BERENJI: Yes.

8 CHAIR MARKOWITZ: Okay. So what I
9 think I'll do is, I'll propose, after the Board
10 meeting, a way in which we do that so that, in terms
11 of who's reviewing what and which claims are already
12 reviewed, et cetera, so that we come up with a common
13 output. I don't think we need to do that right
14 now.

15 MEMBER BERENJI: I'm sorry, I just
16 think it would be good to at least have a couple
17 of general things we can already at least kind of
18 put into respective buckets, at least with respect
19 to the industrial hygiene, CMC.

20 At least we can kind of put some general
21 categories, because I feel like those were where
22 we found the issues, so at least we can kind of

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1 set up some sort of form at least some sort of way
2 to organize our though process with respect to the
3 most common issues that we came across.

4 CHAIR MARKOWITZ: So what we could do
5 with reference to that is, within the next week
6 or two, send in our preliminary issues that we've
7 found so far so that we can begin to develop some
8 categories which we then can use to further look
9 at these claims. So that's a good idea; we'll do
10 that.

11 There is the issue of our request for
12 80 additional claims. I detect a lot of
13 enthusiasm. But that is an outstanding request,
14 and we need to -- if we're going to modify it, modify
15 it. But right now, that's our outstanding request
16 to the Board.

17 Those are in, as I said before, chronic
18 beryllium disease claims, sarcoidosis,
19 interstitial lung disease, and asthma. So do we
20 want to take a look at that again? Do we --
21 internally, do we have the capacity to review 80
22 claims?

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1 PARTICIPANT: Depends on the time frame

2 --

3 MEMBER REDLICH: I think it would be
4 helpful because we've already reviewed those
5 claims, and I think to see if there's been any
6 changes.

7 CHAIR MARKOWITZ: Dr.
8 Friedman-Jimenez?

9 MEMBER FRIEDMAN-JIMENEZ: Why don't we
10 write up what we have now, the ones we've already
11 reviewed, and then when we see what we have, then
12 we can decide what additional diagnoses or
13 additional information we would want to request.

14 But I think we already know a lot of
15 what we want to say, based on reviews we've already
16 done. So why don't we just write them up now and
17 then revisit this in our conference pool and design
18 what we want to request?

19 Do we want a random sample of all claims?

20 Do we want specific diagnoses? Do we want some
21 information on the frequency of each diagnosis?
22 What exactly do we want to ask for?

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1 Because we're generating a lot of work for
2 the DOL, and also, we want the most useful
3 information that we can get. We've already
4 reviewed a lot of these claims; we know a lot about
5 what we're going to say in our synopses.

6 CHAIR MARKOWITZ: That's entirely
7 sensible. Here's my problem with that: if we
8 suspend our request and wait to reformulate that
9 for two to three months, there's just a time delay.

10 Obviously, it takes time to identify and prepare
11 those claims.

12 MEMBER REDLICH: So you were on a
13 different subcommittee. We have reviewed prior
14 beryllium and sarcoid claims, and I think that was
15 now two years ago. And I think what we'd like to
16 see is, we have a sense of what has been done, and
17 see of that process has changed at all over this
18 period of time.

19 So I agree potentially for other
20 categories, but there was a subcommittee that did
21 review the respiratory claims.

22 CHAIR MARKOWITZ: So then the question

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1 is, do we really want 20 claims of each of those
2 four different categories? If we shrank the number
3 of claims, then things might happen more
4 expeditiously.

5 MEMBER BERENJI: We could to a random
6 sampling of 20 of the CBD, sarcoid, ILD, and asthma,
7 so five from each cohort.

8 MEMBER REDLICH: We had also seen the
9 data on the numbers of new claims in those
10 categories, and they were not that huge, is my
11 recollection. You had looked at that, John,
12 annually, so I think, at least for the -- I think
13 we need more than five.

14 CHAIR MARKOWITZ: Okay. Well, there
15 are some numbers between five and 20.

16 MEMBER FRIEDMAN-JIMENEZ: We are
17 already over-sampling diagnoses of interest like
18 beryllium, sarcoid, so I would propose that we
19 request a random sample of, say, 100 claims that
20 will give us rough, small numbers on the relative
21 frequencies of different diagnoses; that we request
22 the categories you listed; and also, I would like

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1 to add cancers: lung cancer, mesothelioma, and
2 leukemias; maybe bladder cancer.

3 MEMBER REDLICH: We do have a piece of
4 it. We know from the prior look at the data that
5 John -- that was focused on respiratory, so we do
6 have that sense of -- as far as the respiratory
7 claims. But I think that all the other conditions,
8 I think we do want to see what the most common ones
9 are in terms of where to focus our efforts.

10 So I think, in terms of the cancers and
11 the like, I'd first like to see where the big buckets
12 are; where the --

13 MEMBER FRIEDMAN-JIMENEZ: A random
14 sample will answer that question, the most common.

15 It won't answer the question of how many leukemias
16 and the rare ones.

17 MEMBER REDLICH: I mean, John had
18 nicely organized five respiratory diseases -- we
19 can probably even pull that up -- asthma, COPD,
20 the number of claims, the percentage accepted.
21 And that did identify areas to target. I think
22 if we had that for other conditions, then it would

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1 help focus.

2 MEMBER FRIEDMAN-JIMENEZ: So you think
3 random sample by strata of respiratory,
4 neurological --

5 MEMBER REDLICH: No. I personally
6 would stick with our current request of the 20
7 claims. For those of us who are familiar with
8 looking at the respiratory ones, we could go through
9 those rather quickly.

10 It would favor for other conditions that
11 the request we've already put in, which is to get
12 the sort of basic data on what those claims are:
13 cancer, neurologic. And then when we see that,
14 decide which claims outside of the respiratory
15 arena --

16 MEMBER FRIEDMAN-JIMENEZ: Could we
17 request a data run that would just give us the
18 diagnoses of everybody, of all claims, so that we
19 could see the relative frequencies of them, rather
20 than giving us all the information on each case?

21 MEMBER REDLICH: That's what was
22 requested, basically, already.

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1 MEMBER FRIEDMAN-JIMENEZ: Okay, but
2 that would be a separate request than the actual
3 medical records.

4 MEMBER REDLICH: Can I -- I can quickly
5 pull up John's --

6 CHAIR MARKOWITZ: But the question is,
7 for outstanding requests, four pulmonary
8 conditions, 20 claims each; do we really need 20
9 denied claims each?

10 MEMBER REDLICH: We probably don't need
11 the 20 accepted for each.

12 CHAIR MARKOWITZ: No, our request was
13 only denied claims, actually, for the five
14 pulmonary conditions. So do we need 10 denied
15 sarcoidosis?

16 I'm questioning the Board's ability to
17 thoroughly evaluate a large number of claims, and
18 I hesitate to ask the Department for products that
19 represent considerable work if it's --

20 MEMBER REDLICH: So what if we just did
21 15?

22 MEMBER FRIEDMAN-JIMENEZ: I would

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1 propose that we request, say, 10 denied, oversample
2 the denied, and five accepted. I think we should
3 look at some of the accepted. I think there's some
4 useful information there. But we don't need as
5 many, I don't think, and we could concentrate our
6 efforts on the denied claims but still look at
7 accepted, smaller numbers. We probably don't need
8 20.

9 CHAIR MARKOWITZ: For these
10 conditions, given the fact that we've looked at
11 some of these things before, is it really useful
12 to look at accepted claims?

13 MEMBER BERENJI: I think it's good to
14 look at accepted claims because you can look at
15 what was done right, and I feel that it's good to
16 provide -- at least inform the DOL that there are
17 things that are working in the process. I think
18 it's good to have that.

19 And then you can also look at the denied
20 claims, and then you're able to kind of bring up
21 the themes and the issues that were seen on a
22 repeated basis. So I think it's good to have both.

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1 CHAIR MARKOWITZ: Dr. Dement?

2 MEMBER DEMENT: I'd like to weigh in
3 on that. If we're looking at consistency, there's
4 no way to do that unless you look at accepted and
5 denied claims. There's no way to assess that.
6 I mean, we can concentrate on more denied than
7 accepted, but I think you have to look at both.

8 CHAIR MARKOWITZ: So is it the sense
9 that 15 claims of each of those conditions, 10
10 denied and five accepted, is a better formula?

11 MEMBER BERENJI: I think it should be
12 five and five; at least a total of 10. I just feel
13 that we don't have the manpower in the field to
14 reveal those cases unless we create a separate
15 working group to focus on those only. And I really
16 like what Dr. Friedman-Jimenez was mentioning,
17 doing a random sample. That way we're able to
18 capture more cases and be able to identify more
19 diagnoses.

20 I mean, at least we could create two
21 working groups in parallel, and Dr. Redlich could
22 kind of focus on the respiratory. I'm happy to

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1 kind of focus on the general sampling, because I
2 do feel that will capture a lot more information
3 if we're able to cast a wider net as opposed to
4 just homing in on respiratory, even though I do
5 feel that it's important.

6 I feel there's already been work done.

7 I think we really need to focus on capturing other
8 diagnoses: cancers, other types of diseases that
9 we don't even have a clue about.

10 MEMBER FRIEDMAN-JIMENEZ: Well, the
11 reason I proposed the random sample was mainly to
12 get the information on relative frequencies of
13 different diagnoses, especially the common ones.

14 But that's already been requested in a different
15 form that's much less labor intensive.

16 So maybe we could go through that
17 information and then make a second request on the
18 ones we feel we want to oversample and look at in
19 detail and actually go through claims.

20 But to go through 100 random-sample
21 cases is a lot of work, and we'd probably be better
22 spending our time on five and five or 10 and five,

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1 of the specific diagnoses of interest.

2 So I would withdraw the random sample
3 idea, give what Carrie's saying that we've already
4 requested, the information that would answer that
5 main question.

6 Is that true, John, that we can get that
7 information from what we've already requested, for
8 all diagnoses, including injuries? Including
9 everything? Has that already been requested?

10 MEMBER DEMENT: I thought we had
11 requested it.

12 CHAIR MARKOWITZ: Are you talking about
13 the Power Point that --

14 MEMBER REDLICH: I have it here. I
15 just couldn't --

16 CHAIR MARKOWITZ: I sent that Power
17 Point to Carrie. Maybe in the briefing book. I
18 think it might have Dement Power Point or something
19 like that, slides.

20 MEMBER REDLICH: I'm sending it.

21 CHAIR MARKOWITZ: In any event, let me
22 continue the conversation. Dr. Dement, you were

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1 --

2 MEMBER DEMENT: I sort of lost my train
3 of thought.

4 MEMBER FRIEDMAN-JIMENEZ: What has
5 been requested in terms of the overall view of the
6 database and the diagnoses? The frequency of
7 diagnoses?

8 MEMBER DEMENT: I think we concentrated
9 on the respiratory conditions in that one. We were
10 given a -- I think it was in an Excel file, a data
11 dump, and all I did with that was to pull it into
12 some programs I can use to summarize the data.
13 But I don't think we got everything, and that was
14 old, anyway, and we're a couple of years out.

15 So we've got two issues: I think the
16 program can provide that summary, similar to what
17 we have; or alternatively, I guess we could do
18 another overall data dump and do it ourselves maybe.

19 That's part two.

20 Now, I'm willing to take it on if that's
21 something the Board wants to do, but it's in and
22 of itself, a little bit labor-intensive.

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1 CHAIR MARKOWITZ: Steve Markowitz.
2 I'm looking at that request from December 10th,
3 and it included the 20 most common conditions in
4 descending order for which claims had been filed
5 since 2013. Then we provided a sample table of
6 what we wanted it to look like, which reflected
7 John's work previously.

8 We then requested 10 most common
9 neurologic conditions, 10 most common cancers, and
10 the 10 most common renal or kidney disorders. So
11 that's the information that would be very useful,
12 yes.

13 MEMBER FRIEDMAN-JIMENEZ: That sounds
14 excellent, and what is the status of that? Are
15 we going to receive that any time soon, that we
16 can use it in our decision-making of what we want
17 to look at in detail?

18 CHAIR MARKOWITZ: Mr. Vance, are you
19 still on the phone?

20 MR. VANCE: Yes, I am.

21 CHAIR MARKOWITZ: Do you have any --
22 I don't know if this is within your area, but do

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1 you have any sense on the progress on that part
2 of the request?

3 MR. VANCE: Not at this time. I know
4 that we've got a lot of different requests floating
5 around.

6 CHAIR MARKOWITZ: Okay. So we need to
7 make our decisions today without knowing when that
8 information will come.

9 MEMBER REDLICH: I think -- this is what
10 John had done before and, John, you're welcome to
11 speak. I think part of our new request for data
12 was based on this data, such as when we happened
13 reviewed the sensitization claims, we thought those
14 were very reasonably adjudicated, and we did not
15 request more of them.

16 So we were -- and also taking into
17 account their trends, and there were trends over
18 the past 10 years in terms of more asthma, more
19 COPD. So we had this in mind.

20 John might want to quickly run through,
21 or I can, either one, but please speak up. I think
22 -- let's see, the first slide -- is that the first

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1 of the data slides? I think if you go to the first
2 of that section.

3 So this, I believe, was the total number
4 of claims over -- it was a 10-year period of time
5 -- under each category. I think it will be more
6 helpful to go through the next slide.

7 Also, this is not given individuals,
8 because a given individual could have more than
9 one claim. So an individual could have a claim
10 of beryllium and COPD. But the next slide -- this
11 one just gives you some idea of the trends.

12 It shows the third column down is the
13 total number of claims under, let's say, CBD
14 beryllium sensitization. CS is chronic silicosis,
15 approved and denied under each of those.

16 And I believe this was the -- because
17 a given condition could recirculate, so --

18 CHAIR MARKOWITZ: These are just
19 counter-claims where people sent --

20 MEMBER REDLICH: That's right. We had
21 highlighted certain trends so that there were more
22 of the CBDs, and also as a percentage approved,

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1 that the CBD claims, that percentage had gone down,
2 that may have been because -- or reasonable claims
3 had been approved, but we were just looking at the
4 trends.

5 I think the next slide --

6 (Simultaneous speaking.)

7 MEMBER REDLICH: Yes, because it was
8 the year, I believe, is referring to the year that
9 the claim was processed. That could be processed
10 for a pre. I think over time, more of them are
11 in post 1996 simply because of the timing.

12 The next slide, this was additional --
13 it's the same organization. These were the
14 additional conditions we had gotten, the data John
15 had analyzed for: asthma, COPD, ILD, and sarcoid.

16 So I think you can see that from 2005
17 the number of asthma and COPD claims had gone up.

18 The ILD was really a total of only 21 total claims.

19 Most of those were denied, so that was the reason
20 we had an interest in looking at more of those,
21 and sarcoid was a relatively small number of claims,
22 but they were denied. So we had targeted our recent

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1 request with this in mind.

2 CHAIR MARKOWITZ: One thing that this
3 shows -- Steve Markowitz -- is that we request five
4 or 10 approved sarcoidosis claims, we're not going
5 to get any. Similarly with ILD, we're going to
6 get a large percentage of those that had been
7 approved. So we might consider modifying that.
8 But I didn't mean to interrupt you.

9 MEMBER REDLICH: I thought that that
10 was the upper limit, that there might be not as
11 many claims in the category that we requested.

12 I think the next slide -- please, John,
13 speak up, because you did this. These were the
14 denial reasons, and I believe this was not -- these
15 were the reasons that John -- there was a reason
16 given in the database.

17 And the reasons varied somewhat for the
18 different conditions, so for CBD and BS, beryllium
19 sensitization, the most common reason was medical
20 information insufficient. For chronic silicosis,
21 it was some additional reasons too, in terms of
22 whether the employee was covered.

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1 For some of these, we saw examples of
2 them: where there was a claim for beryllium
3 sensitization and there wasn't a result of the test,
4 and the claim that someone submitted that, and there
5 was a final adjudication, all of which was
6 appropriate.

7 I think there's one more slide. These
8 were for, then, the additional COPD, asthma, and
9 these were a different negative-positive result
10 for COPD, and I think we saw -- we've seen some
11 examples of that. So it is a different reason than
12 insufficient medical information, and same with
13 asthma and interstitial lung disease. So we had
14 an interesting focus on these conditions.

15 CHAIR MARKOWITZ: Is there anything
16 else --

17 MEMBER REDLICH: I think some of these
18 negative-positive results, based on the records
19 that we had reviewed, relate to the interpretation
20 of the exposure information, and the issues that
21 we discussed yesterday at length.

22 And I think -- is there one more?

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1 That's it, I think. So our feeling was that it
2 would be useful to have this data updated for the
3 past two years to see if there's been a change in
4 these trends, since we have been working on this
5 and meeting, and then to use that information to
6 best target where we focus our efforts.

7 But, George, I totally agree, this is
8 focused on the respiratory component.

9 CHAIR MARKOWITZ: Right.

10 MEMBER BERENJI: But I just want to
11 comment; Dr. Dement and Dr. Redlich, you guys
12 did a great job at least kind of developing the
13 methodology. It would be great to able to kind
14 of apply this basic methodology to other organ
15 systems, perhaps Parkinsonism, manganism. We
16 could definitely apply the same methodology,
17 because it looks like we've already got it down
18 to a science, pretty much.

19 MEMBER DEMENT: I wouldn't necessarily
20 call it a science at this point. The data came
21 in an Excel file, and it took a bit of going back
22 and forth of the program staff to interpret some

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1 of the fields.

2 I guess we got it down to a possibility.

3 If it's the Board's desire that we expand that
4 and look at it across the board for other
5 conditions, then I guess I could take that on if
6 needed.

7 MEMBER REDLICH: John did this; I
8 simply took his tables and formatted them to put
9 them into the Power Point.

10 CHAIR MARKOWITZ: Well, we're going to
11 take a break, and I'll try to look at -- in our
12 request, we did request data for a variety of
13 conditions in a certain form which reflected what
14 we've been looking at. So let me just take a look
15 at that detail, and then we can discuss that
16 further.

17 But I propose that we take a break and
18 reconvene in 10 minutes, at 20 of 11, if that's
19 all right.

20 (Whereupon, the above-entitled matter
21 went off the record at 10:29 a.m. and resumed at
22 10:46 a.m.)

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1 CHAIR MARKOWITZ: We have a very
2 engaged public here. We're going to get started.

3 Okay. So we have a pending data request on a
4 number of important conditions, including
5 pulmonary disease, neurologic, cancer, and kidney
6 disease, and the most common conditions overall,
7 organized in a way that should be similar for all
8 the outcomes.

9 We're not sure when that data request
10 will be fulfilled, but it's pending, and it will
11 be useful.

12 I would just suggest that we, on the
13 claims request, we modify our current request.
14 Pending is four outcomes, 20 each, so that's a total
15 of 80 claims. And so the question is, how many
16 of those claims do we actually want, believe that
17 we can review if it's less than 20? And then,
18 what's the breakdown, accepted versus denied?

19 I would suggest that requesting claims
20 for any other conditions such as cancer and the
21 like, that we wait until we get the data so that
22 we can make an intelligent choice about --

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1 meanwhile, we get additional claims, we'll have
2 our hands full taking a look at those claims. Dr.
3 Redlich?

4 MEMBER REDLICH: I think the point
5 about wanting to look at some accepted claims is
6 appropriate.

7 MEMBER FRIEDMAN-JIMENEZ: Move closer.

8 MEMBER REDLICH: I'm sorry. So I think
9 that the point made that we should need to look
10 at both accepted and denied claims, so we could
11 do something like five accepted and 15 denied for
12 the different conditions.

13 I'm open to others. I found that the
14 pulmonary ones, once you are familiar with them,
15 can be reviewed rather quickly.

16 CHAIR MARKOWITZ: It is true. Dr.
17 Redlich reminded me at the break that for these
18 outcomes, as opposed to COPD, and as opposed to
19 Parkinson's disease, the path for decision-making
20 is much clearer because it's set out in part by
21 the regulation in the statute, for instance,
22 chronic beryllium disease, sarcoidosis and, to some

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1 extent, asthma. So reviewing those claims is more
2 straightforward, takes less time, than the claims
3 that we've looked at to date.

4 But then you're proposing the same
5 number, 20 divided by five accepted and 15 denied.

6 MEMBER REDLICH: Yes.

7 CHAIR MARKOWITZ: For the four
8 conditions. And my question is, do we need that
9 many?

10 MEMBER REDLICH: Based on our past
11 experience, there were a number of claims that were
12 very appropriately adjudicated. So we want to
13 identify any issues, I think, that the team denied
14 would be appropriate.

15 CHAIR MARKOWITZ: We need some
16 consensus on this, because we're --

17 MEMBER REDLICH: John and Kirk also
18 reviewed them. I'm open to other suggestions.

19 CHAIR MARKOWITZ: We need some
20 consensus on this, because this is work that we're
21 going to do ourselves. So this is synonymous with
22 a commitment by the Board to get this claim review

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1 done. Board is smaller this iteration than it was
2 previously, so if we're going to stick with a
3 request for 20, we should just be assured that we're
4 going to be able to do that work.

5 MEMBER DEMENT: Would you remind us
6 again of what we've asked for, because I'm a little
7 lost. I know we have 80, but how do they distribute
8 themselves?

9 CHAIR MARKOWITZ: Sure. So the
10 original request was for a total of 120. Twenty
11 of those were for Parkinson's disease, and we have
12 those. The remaining 100 of those were for lung
13 diseases, and it was each of five different
14 conditions. So five times 20 is 100.

15 We have the ones for COPD, so there are
16 four pending pulmonary disease requests, and those
17 four conditions are chronic beryllium disease,
18 sarcoidosis, interstitial lung disease, and
19 asthma.

20 The request was that only denied claims
21 should be included, and the most recent claims
22 available should be selected. We should exclude

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1 claims that were previously reviewed by the Board.

2 Let me just say, the Department of Labor
3 has already done work. The pool claims, in
4 compliance with this request. We should not
5 reverse or modify our request. That, in any way,
6 subverts any work they've done to-date on these
7 claims. We're not sure where they are with this
8 request, but just, the request is not to undo work
9 that they've done so far.

10 MEMBER MAHS: Ron Mahs. Was there a
11 chance you could continue with those 20 and just
12 ask for an additional five accepted? Because those
13 were all denied that you asked for correct? That
14 you asked for?

15 CHAIR MARKOWITZ: You mean increase the
16 number to 25?

17 MEMBER MAHS: Well, whatever we're
18 allotted to do each, if we can get to them all,
19 that's fantastic. If we can't get to them all,
20 at least we've got the opportunity there.

21 CHAIR MARKOWITZ: Well, I mean, the
22 problem is that it appears to be considerable work

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1 on the part of the Department to secure and provide
2 these claims, so I don't think we should make a
3 request unless we believe we can do our work on
4 those claims.

5 MEMBER REDLICH: So I had proposed that
6 we reduce the number from 20 to 15 of the denied
7 claims, but also include five accepted.

8 CHAIR MARKOWITZ: Okay.

9 MEMBER REDLICH: It is still 20, but
10 if people want to reduce that further, I -- other
11 people's thoughts.

12 CHAIR MARKOWITZ: Right.

13 MEMBER REDLICH: My guess is also that
14 in that number what happened last time was, there
15 was overlap. So it would be like COPD, the same
16 claim could end up in both buckets, because the
17 person could have a claim for COPD and
18 pneumoconiosis, so the total number of people was
19 less than the number of requests.

20 CHAIR MARKOWITZ: Okay. So the
21 proposal is that we stay with 20 claims request
22 for each of the four conditions, but modify the

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1 request to include 15 denied and five accepted.
2 However, if DOL has already done the work to provide
3 the 20 denied claims, that would be fine.

4 So does anybody want any departure from
5 that? I don't think we need to formulate an
6 official recommendation about that.

7 MR. FITZGERALD: No. In fact, that's
8 one of the reasons we created the form that we
9 discussed yesterday, to try to avert this sort of
10 issue where there is maybe some uncertainty or
11 changes going on in terms of the thinking.

12 We want the Board to be able to really think
13 about what the requests are, formulate the data
14 requests, be very specific about what the use of
15 that data is going to be so that we're not grappling
16 with trying to address those issues. I think the
17 form will actually help us, and that process will
18 get better.

19 CHAIR MARKOWITZ: Okay. So let's move
20 on. Let's get back to the agenda. Mr. Tebay?

21 MEMBER TEBAY: Calin Tebay. Before we
22 leave today, I know we're running out of time, but

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1 I'd like some help in this matter where the Board
2 will make a formal recommendation regarding the
3 IH response.

4 Basically, what they're saying is the
5 lack of data is lack of risk, or the fact that an
6 OEL or a PEL determines a diagnosis.

7 I think we should come up with some kind
8 if recommendation here to modify that response or
9 that language so it doesn't almost set the claim
10 -- I mean, the IH is driving the diagnosis at this
11 point. It seems to be; maybe I'm not communicating
12 that correctly, but I'd like to -- maybe we can
13 make a formal recommendation to change how that's
14 being worded.

15 CHAIR MARKOWITZ: So just a point of
16 clarification. You're talking about the
17 boilerplate language about post-'95 exposures.
18 That the lack of data means that it doesn't exceed
19 --

20 MEMBER TEBAY: Not meeting regulatory
21 limits is seeming to drive the direction of the
22 claim.

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1 CHAIR MARKOWITZ: Okay. Discussion?
2 And I would say that this relates to Task 4 of the
3 Board: in duty to assess the quality of the
4 industrial hygiene evaluation.

5 So if we're going to elaborate a
6 recommendation, then we need to actually put that
7 text on the board and see if we can come to
8 agreement. This relates to the rescision of
9 Circular 15-06. So how do we want to phrase this?

10 MEMBER DEMENT: This is John. I think
11 it ought to be phrased first in stating what we've
12 observed based on the case review.

13 So the observation is that the IH
14 assessments continue to use the phrase and the
15 determination that exposures in the past, the
16 mid-1990s, would not exceed regulatory limits, but
17 without supporting information, both with regard
18 to levels and what regulations are actually being
19 referred to. So that's an observation.

20 I think the second part of it is, the
21 Board recommends that this language be omitted from
22 the IH report, and the basis for determination

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1 exposures in mid-1990s and be stated by the IH that
2 is -- period. That's a first draft.

3 And basis for exposure determination
4 be provided by the IH in the report. Be provided
5 by the IH in the report.

6 CHAIR MARKOWITZ: Well, their
7 statement that no monitoring data exist as evidence
8 of exceeding regulatory limits, to play devil's
9 advocate, would be their basis for their exposure
10 determination. We don't have any data to suggest
11 it's above the limits. That's the basis for our
12 exposure determination.

13 MEMBER DEMENT: The alternative would
14 be to the --- rescinding the circular, and the
15 observation is it continues to use the language
16 contained in the circular, basically.

17 I don't know how to phrase this
18 perfectly, but just say get it out of there.

19 CHAIR MARKOWITZ: How about that the
20 absence of monitoring data post-1995 should not
21 be automatically interpreted as representing an
22 absence of risk?

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1 MEMBER DEMENT: I would say, in absence
2 of exposure or risk.

3 CHAIR MARKOWITZ: Right.

4 MEMBER DEMENT: Because there's two
5 things that are going to be addressed by that
6 statement: one is the absence of exposure, and
7 the second is, the assumption is, if you were within
8 the regulatory limits, there is no risk. And we
9 know that not to be the case for many materials.

10 CHAIR MARKOWITZ: Well, that
11 observation will be in the rationale for this.
12 It will be addressed, unless you want to put it
13 here, right in the front.

14 MEMBER DEMENT: And I think we should
15 modify this second part of the recommendation:
16 the basis for a negative exposure determination
17 be provided by the IH.

18 CHAIR MARKOWITZ: So to fill out this
19 first line, The Board has observed that industrial
20 hygiene assessments -- or rather, recent industrial
21 hygiene assessments appear to frequently use
22 stereotypic language, indicating that the absence

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1 of monitoring data above the established regulatory
2 levels.

3 So I think indicating has to be changed
4 to citing. They use stereotypic language that cite
5 the absence. After cite, you can just take out
6 that.

7 So I wonder there on the last line where
8 we talked about the basis for negative exposure
9 determination be provided, whether we should add,
10 if available?

11 MEMBER DEMENT: I guess, back to our
12 discussion yesterday, just trying to get to the
13 rationale behind that determination. Sometimes
14 it's based on monitoring data; sometimes it may
15 be based on professional judgment. If so, that's
16 what it is; it's professional judgment based on
17 IH. I'd just like to see that in there.

18 CHAIR MARKOWITZ: Right. And that can
19 be perfectly acceptable.

20 MEMBER DEMENT: Sometimes it's just
21 common sense.

22 CHAIR MARKOWITZ: Right. Dr.

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1 Friedman-Jimenez?

2 MEMBER FRIEDMAN-JIMENEZ: In the
3 spirit of providing, not just an explanation of
4 the problem but a proposed solution, I think that
5 the data largely don't exist at all. What we're
6 seeing is a paucity of monitoring data in general,
7 not just monitoring data above some limit.

8 And the reality is that many of these
9 jobs do have some information on exposure that's
10 reflected the SEM and in the industrial hygienist's
11 knowledge of those kinds of jobs. These are people
12 that have specific knowledge of many of these jobs.

13 And so the exposure assessment will need
14 to reflect the industrial hygienist's expertise
15 and judgment. I think that word is useful:
16 judgment, as to what level of exposure actually
17 existed in the absence of individual or area
18 monitoring data for that particular site and
19 person.

20 It's going to have to be job-specific,
21 not individual-specific, and that's the reality.

22 So I think we should suggest that they use

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1 industrial hygiene literature as well as their
2 specific knowledge of these work sites to generate
3 these exposure assessments.

4 Because exposure assessments have to
5 be generated, and we don't have this Holy Grail
6 of individual or area monitoring data. So we have
7 to suggest something, I think.

8 CHAIR MARKOWITZ: Well, I disagree,
9 actually. They could talk to the claimants. They
10 could find out what actually happened post-'95 in
11 the workplace.

12 They could find out what they did and
13 whether that disruption likely produced results,
14 because they're not going to find them in the text,
15 and their professional judgment is great, but DOE
16 is a very big complex, and they've been everywhere
17 and assessed all those jobs.

18 So there are multiple sources, but
19 frankly I think upgrading their interaction and
20 understanding of what actually happened in the
21 workplace to that claimant post-'95 would be a good
22 place to start. So I don't want to be specific

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1 here.

2 MEMBER FRIEDMAN-JIMENEZ: So this
3 prohibition against subjective information, I
4 think we have to address that. What people imagine
5 is objective measurement really isn't objective
6 at all; it reflects a lot of variables. So
7 I agree with you completely, that starting with
8 the occupational health questionnaire, the
9 individual's perception of exposure, that's
10 important information that has to be factored in
11 by the industrial hygienist.

12 CHAIR MARKOWITZ: Well, and DOL
13 recognizes that, because part of their assessment
14 is the occupational health questionnaire and
15 whatever affidavits are submitted and the like.

16 So they recognize the legitimacy of that
17 information. We're talking about amplifying it;
18 we're talking about emphasizing it for post-'95
19 where it's not clear what was going on.

20 MEMBER TEBAY: What -- Calin Tebay.
21 But we have hundreds of IHs on these sites, and
22 each working group has a -- what do they call them

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1 -- they're a project IH for each individual working
2 group.

3 If they're using professional judgment,
4 the contracted IHs, why aren't they reaching out
5 to these project IHs or these work groups, along
6 with the workers and saying, What were the exposures
7 that exist?

8 I can tell you from working at a couple
9 of sites in different places, that I think a lot
10 of professional judgment is used. I don't think
11 there's a bunch of IH data that exists for each
12 one of those work groups, but the professional
13 judgment is there to say, These are the possible
14 potentials. We don't know what levels, because
15 we don't monitor for them, but there's definitely
16 these potentials for these exposures.

17 But once again, the IHs are not being
18 forced to reach out to the worker or the other
19 resources at all. They're just making a
20 boilerplate response and walking away. Why aren't
21 they being forced to reach out to the people with
22 the information?

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1 CHAIR MARKOWITZ: Dr.
2 Friedman-Jimenez?

3 MEMBER FRIEDMAN-JIMENEZ: George
4 Friedman-Jimenez. One potential problem with that
5 is that it puts the individual IHS in the workplace
6 in an awkward position. They are responsible for
7 the health and safety of the people on their site,
8 and for them to say, Well, the exposures were really
9 pretty substantial and could have led to health
10 defects, would maybe be difficult for them.

11 So it puts them in a difficult position
12 and almost a conflict of interest. I'm not sure
13 that that's going to lead to objectively better
14 estimates of the exposures. So we'd have to think
15 about that. I don't know the specifics, but --

16 MEMBER TEBAY: Sure, I understand.

17 MEMBER POPE: It seems like the cases
18 I've looked at, the IHS that were making these
19 blanket statements, saying that the exposure was
20 low, and I totally agree with Dr. Dement's comment
21 about, if you don't know, then say no, the exposure
22 did not exist.

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1 But for you to blanket and say that the
2 exposure was low just to forward that claim through,
3 I think we've seen a lot of that, where the IHS
4 are making that statement. So the CMC is
5 concurring with that assessment from the IH.

6 CHAIR MARKOWITZ: Mr. Vance, are you
7 still on?

8 MR. VANCE: Yes, I am.

9 CHAIR MARKOWITZ: So an interesting
10 question has been raised about the industrial
11 hygienists that you have that are working on these
12 cases, claims whether any consideration of reaching
13 out.

14 I know that there's a request for
15 whatever records DOE has, but has it ever been
16 discussed, any sort of communication with the
17 currently-employed industrial hygienists at the
18 sites?

19 MR. VANCE: Not that I'm aware of. We
20 would always be getting information from the
21 Department of Energy with regard to any individual
22 monitoring data that we have on an employee, but

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1 as the Board noted, oftentimes that information
2 might not be very comprehensive or cover the entire
3 working history of an employee.

4 The context of our discussions up to
5 this point have been mostly focused on what
6 information would be best obtained through the
7 occupational health questionnaire and
8 modifications to that process, but I don't recall
9 discussing specifically or engaging in any kind
10 of formal interaction between our industrial
11 hygienists and site industrial hygienists.

12 CHAIR MARKOWITZ: Okay, thank you. So
13 we're looking at -- we have language of -- we're
14 looking at language of a recommendation. Before
15 we receive an official motion to accept this
16 recommendation, is there any change in the language
17 that we're looking at that anybody proposes?

18 MEMBER MAHS: I would like to make a
19 statement if I can, Ron Mahs.

20 CHAIR MARKOWITZ: Sure.

21 MEMBER MAHS: In the last 15 years
22 before I retired, I was general foreman at Y-12

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1 and the other two plants. We toured many buildings
2 every day, because I had people working all over
3 the place. And in all of those years, about the
4 only thing I saw IH ever monitor was for asbestos
5 or for radiation.

6 If you're on the job looking for toxin
7 or something, the safety person assigned to that
8 job did it. IH had no contact or no idea what the
9 exposures would be.

10 CHAIR MARKOWITZ: Thank you.

11 MEMBER REDLICH: Carol Redlich. I'll
12 just add that I think the cases that we've reviewed
13 to date, the prior ones, the major reason we
14 disagreed, in cases where we did disagree with the
15 final adjudication was where the CMC interpreted
16 the IH report differently, given our expertise in
17 occupational lung disease, occupational medicine,
18 industrial hygiene exposure, based on the
19 information we had from the occupational health
20 questionnaire, the type of work the person did,
21 and the time period, that we felt that the SEM was
22 not accurately representing the exposure, and that

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1 the CMC, then, didn't have our expertise to also,
2 let's say, look at the questionnaire and put a lot
3 of weight on the SEM that we felt was not accurately
4 reflecting the exposure.

5 One example, just being a miner of 15
6 years where the SEM said that the only relevant
7 exposure as far as COPD was aluminum or -- and
8 knowing the nature of what mining work is like,
9 we felt that that was not correct. So we knew how
10 to interpret the SEM. So I think that's why it's
11 so important that that wording be modified.

12 CHAIR MARKOWITZ: When you say that
13 wording, you're talking about what we're looking
14 at now?

15 MEMBER REDLICH: Yes, exactly.
16 Because I think that, given the nature of the
17 physicians who are the CMCs, given that they're
18 more limited expertise in pulmonary occupational
19 medicine conditions are weighing the SEM very
20 heavily.

21 CHAIR MARKOWITZ: So I have some
22 suggestions for the language: the Board has

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1 observed, comma, based on review of a limited number
2 of recent claims, comma, that -- leave that second
3 recent in, just to be duplicative, but you can take
4 out that the before the recent -- appear frequently
5 to use. So we don't have a split infinitive.

6 And then above the established
7 regulatory levels in the mid-1990s, so we're clear
8 what time frame we're talking about. Any other
9 suggestions on the wording? Yes, Dr. Silver.

10 MEMBER SILVER: Should we put in a
11 phrase that draws attention to Circular 15-06,
12 rescinded by Circular 17-04? That is what we're
13 talking about, despite the official rescinding of
14 Circular 15-06, the Board has observed --

15 CHAIR MARKOWITZ: You know, we could
16 put in something to the effect of it. I wouldn't
17 write this, that this appears to contradict the
18 rescission of -- but we actually raised this
19 yesterday with Ms. Leiton, and she had a response
20 to that, how this language did not contradict the
21 rescission.

22 So I'm a little concerned that we --

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1 it doesn't further our recommendation. Dr.
2 Redlich?

3 MEMBER REDLICH: My reading, and I
4 think others can correct me, was that it's not that
5 they cite the absence of monitoring data; they don't
6 state the basis of their conclusion that there is
7 no low exposure or low risk.

8 Did you just check what the wording was?

9 I think we should just check what the wording is.

10 MEMBER DEMENT: The actual phrase that
11 consistently appears is that no available evidence,
12 i.e., personal or area industrial hygiene
13 monitoring data, paren close, to support after the
14 mid-1990s, as exposure would have exceeded existing
15 regulatory standards.

16 So you said, there's no available
17 evidence. So they're sort of saying there's no
18 sampling data. Then I look at what I got from a
19 DAR, the request for information, and for the most
20 part there's nothing there except for some
21 radiological monitoring data; very little IH data
22 that I've seen in what I've reviewed so far.

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1 So the question is, so nobody sampled,
2 so therefore you assume that because some programs
3 were beginning to be implemented to have industrial
4 hygiene at these sites, that exposure didn't
5 exceed; that's not an appropriate conclusion to
6 draw.

7 MEMBER REDLICH: Yes, okay. So I'm
8 just wondering what the most clearest way to state
9 what our concern is. It might be first that they
10 should, number one, clarify the source of the data
11 that their decision is based on; and number two,
12 that lack of data should not be interpreted as low
13 or no risk. We may have worded it that way.

14 MEMBER DEMENT: I think the source and
15 basis -- support the negative exposure.

16 MEMBER REDLICH: Yes. But I think we
17 just put in active of what we want.

18 MEMBER DEMENT: So down at the bottom
19 of the recommendation, I guess.

20 MEMBER REDLICH: Okay. So I'm sorry.

21 MEMBER DEMENT: I support the data
22 sources in basis for negative IH reporting.

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1 MEMBER REDLICH: So why don't we just
2 make it more general for whether it's negative or
3 positive, we would like clarification on the source
4 of the exposure data? And then that statement that
5 lack of data should not be interpreted as --

6 MEMBER TEBAY: So real quick, because
7 I've read the version that you read, what I've seen
8 is the lack of data. But then there's the version
9 that says that there's significant exposure, and
10 there's a lack of data showing that you've been
11 exposed over an OEL or a PEL; therefore, having
12 or contracting some kind of disease or condition
13 would be not -- so I want to make sure we're still
14 covering that portion, right? Because that's what
15 happens.

16 When they say that there's a lack of
17 information, we know you've been exposed. But it's
18 going to be below an OEL or a PEL, and then when
19 that moves on to the CMC, the CMC then interprets
20 that as, there's no way this person was exposed
21 at enough of a level to create some kind of condition
22 or disease.

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1 So as long as this is covering that,
2 I'm good, and I'll rely on you folks to determine
3 that.

4 MEMBER DOMINA: This is Kirk Domina.
5 One of the other issues I have when Mr. Vance was
6 on the phone about the information he gets from
7 DOE; well, DOE didn't have a moratorium on
8 destroying records until way after '95. So you're
9 always going to get that answer.

10 So even if there was data, they didn't
11 have to keep it. And so to me in my thinking, we
12 need to move that '95 date out because of their
13 moratorium of not having records. It's biased
14 against the claimant.

15 MEMBER REDLICH: I think we're all
16 saying the same thing; it's just a matter of how
17 we word this recommendation.

18 CHAIR MARKOWITZ: Well, and what we
19 could do actually, in the last sentence: the
20 absence of monitoring data post-1995, or evidence
21 of data showing exposure levels of below regulatory
22 limits. Does that capture --

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1 MEMBER DOMINA: That's better.

2 MEMBER DEMENT: I would say, absence
3 of -- You could say significant exposure. I mean,
4 the issue is -- sometimes they'll say significant
5 exposure, but they did say it's a low regulatory
6 limit so therefore, de minimis. They don't say
7 de minimis, but that's they really interpret it
8 as.

9 CHAIR MARKOWITZ: So, Kevin, the third
10 word from the last, exposure? If you could just
11 put in in, significant, before that. Yes, that's
12 it.

13 MEMBER REDLICH: And so omitting
14 language; there's variations on the language, so
15 I think what's most important is that we want
16 clarification of the basis of the exposure data,
17 because that's usually not stated, and the absence
18 of monitoring.

19 We also are concerned about the
20 language. I just don't think that that is the
21 number one piece, because there's lots of variance
22 of language.

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1 CHAIR MARKOWITZ: Yes, but the question
2 is whether what we're looking at now captures what
3 we mean.

4 MEMBER REDLICH: So industrial hygiene
5 folks, what do you think would be appropriate
6 information to include as justification for the
7 conclusions that the IH has come up with?

8 MEMBER DEMENT: There can be lots of
9 things. There can actually be some experience with
10 the industrial hygienist's experience with that
11 particular job, that work site, that task, and
12 that's all legitimate.

13 There can be published literature that
14 supports in that time frame that exposures were
15 significantly reduced. So we all come to this with
16 our own experiences, knowledge, and
17 determinations, if you will. I just think they
18 need to put it there.

19 If it's in IH's -- based on my own
20 personal experience and the published literature,
21 exposure were likely not to have exceeded
22 regulatory limits, then that's our basis.

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1 It does three things: it gives you the
2 basis for the decision; it also sets some parameters
3 about your certainty about that decision.

4 MEMBER REDLICH: I understand. Are
5 they providing the basis of their conclusions?
6 What IH data do they use to determine?

7 MEMBER DEMENT: Yes, I mean --

8 MEMBER MAHS: No, is that partly
9 happening?

10 MEMBER DEMENT: We saw yesterday, I
11 think the standard reference list, most of which
12 don't provide a basis for determination of
13 exposures for that job. I mean, it's a standard
14 IH set of references, some of which are actually
15 on some medical texts.

16 CHAIR MARKOWITZ: Very good, very good
17 medical texts, I would add.

18 MEMBER DEMENT: Yes, they're old.
19 Some of them are quite old. They really don't
20 provide a basis for that decision. Now, if you
21 were to go on diesel exhaust, for example, you can
22 go to the literature, and you can find exposure

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1 determinations based on objective measurements
2 that would actually support, in the mid-1990s and
3 early 2000s, that exposures to diesel exhaust in
4 a general way, were reduced.

5 MEMBER REDLICH: So all I'm -- is it
6 appropriate for us to request as a recommendation
7 that they provide a better basis for their
8 assessment?

9 CHAIR MARKOWITZ: But no. The
10 language currently in there on the second sentence
11 says that we recommend that language be omitted
12 from the industrial hygiene report and that the
13 basis for a negative exposure determination be
14 provided by the industrial hygienist.

15 MEMBER DEMENT: Yes, I don't know how
16 to get more specific than that. For example, if
17 the document request came back and there were some
18 industrial hygiene monitoring data, not even for
19 that person, but at least for a similar job or a
20 similar location, that could be used. That's
21 legitimate information, so I don't know think we
22 want to box ourselves in to specify exactly what's

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1 needed, because it can vary a lot.

2 MEMBER REDLICH: Okay. I agree. So
3 I just think we want the wording to be broad enough
4 so it's both a negative or a low. So I just think
5 that we should start with the request that we want
6 the basis for the determination of the exposure
7 assessment.

8 And we want to get rid of certain
9 language. But I think that the more active thing
10 is, we need the basis for their determining low
11 or no risk.

12 MEMBER DEMENT: Right. You know, if
13 you went on the second sentence after IH report,
14 put a period and then start a new sentence --

15 MEMBER REDLICH: Yes, that's fine.

16 MEMBER DEMENT: -- so now, one line up,
17 IH report, period. Right, okay. Then start a new
18 sentence: The basis -- is that?

19 MEMBER REDLICH: Yes. I think
20 sometimes they are mentioned as being low, and I
21 think that's --

22 MEMBER DEMENT: We're asking for the

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1 basis of their determination. So if they determine
2 that it's low, fine. What's the basis?

3 MEMBER REDLICH: Yes, but you have
4 negatives. So I think whether it's low, whether
5 it's negative, we want the basis for the exposure
6 determination provided.

7 MEMBER DEMENT: Right.

8 MEMBER REDLICH: We want it broader.

9 MEMBER DEMENT: So what language do you
10 want, where?

11 MEMBER REDLICH: The basis for the
12 negative or low exposure determination. We want
13 the basis for all exposure determinations. I defer
14 to John and --

15 CHAIR MARKOWITZ: My concern -- I
16 understand that, but it dilutes the impact, because
17 we're really zeroing in on use of specific language.

18 MEMBER REDLICH: Okay.

19 CHAIR MARKOWITZ: I'm afraid our main
20 point may get a little lost or diluted.

21 MEMBER REDLICH: Okay.

22 MEMBER DEMENT: I think it will be,

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1 because in some cases IH is making a determination
2 that, prior to this time frame, in the mid-1990s.

3 In some cases they are making a determination that
4 exposures were significant and sometimes not higher
5 than low anyway. So I that's -- they're using a
6 time frame reference to make that determination.

7 I think that's fine.

8 MEMBER TEBAY: Can I ask a quick
9 question of Mr. Vance? Is he still on the phone?

10 MR. VANCE: Yes, I'm still here.

11 MEMBER TEBAY: This recommendation,
12 how does that get distributed? Because really,
13 there's part of this that apply to different people
14 in the process, right? I mean, you've got the IH
15 that's going to read it; the CMC is going to utilize
16 it, and the CE. The last sentence of it is really
17 important for the CE. How does this get
18 distributed?

19 MR. VANCE: What specifically are we
20 talking about?

21 MEMBER TEBAY: For instance, the last
22 part of this recommendation says, the absence of

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1 monitoring data post-1995 -- you follow me there?

2 That piece?

3 MR. VANCE: Right. You have to keep
4 in mind that what the Department of Labor is
5 utilizing is the opinion of subject matter experts.

6 So what the Board is always going to struggle with,
7 what the Department of Labor is struggling with
8 is the absence of information.

9 We do not have direct, personal
10 information about many workers, so we leave it to
11 the judgment of the industrial hygienist's team,
12 toxicology team, the medical folks, and other
13 experts to give us information.

14 So a lot of the information that you're
15 discussing is directly attributable to an
16 industrial hygienist looking at it and saying, This
17 is my best understanding of the information that
18 I have in case, in my knowledge, my education, and
19 background in being able to respond to this.

20 So what we did was, we took away the
21 ability of claims examiners who make those
22 generalizations, and now it's the industrial

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1 hygienist that's incorporating that information
2 and their best understanding of the information
3 that they're being asked to respond to from an
4 extent and nature or duration of exposure.

5 So that's sort of where that information
6 comes from. So that's what I think the Director
7 was talking about the other day, is that what we
8 did was, we said, Okay, but this is not a claims
9 examiner generalization any longer. This is an
10 industrial hygienist looking at it and applying
11 their best understanding of exposure information.

12 I think Dr. Dement was talking a little
13 bit about that. They operate in sort of these
14 generalizations and their own understanding of
15 their expertise as industrial hygienists. And
16 there can always be a lot of discussion about that
17 interpretation of whether that's accurate or not.

18 But that's the general source of that information.
19 Does that make sense?

20 MEMBER REDLICH: Yes.

21 MEMBER SILVER: A comment.

22 CHAIR MARKOWITZ: Go ahead, I'm sorry.

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1 MEMBER SILVER: Yes. Mr. Vance, you
2 said there can always be a lot of discussion, but
3 it can't be an informed discussion unless we crack
4 open the black box of their judgment.

5 An analogy to radiation for a long time,
6 the health physics profession said, We're the
7 experts; we've got it figured out. The NIOSH
8 Advisory Board has cracked open that black box in
9 various perspectives have been brought to bear on
10 the large number of assumptions that are made in
11 the absence of hard data very often, and we're
12 looking to do the same thing here.

13 This dovetails nicely with our
14 long-standing recommendation that the industrial
15 hygienist be able to talk to the claimant.

16 When that additional data from the
17 claimant is part of the determination, it can be
18 laid out with various sources of information;
19 documents and literature; there are models; there's
20 a rational process that starts with a volume of
21 material; the energy that's applied to it; the
22 volume of the work space in which it's diluted;

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1 the presence or absence of ventilation systems;
2 the position of the worker in relation to the
3 sources of contaminant.

4 You can get that from talking to the
5 worker and spell out as much of that as is available
6 in the hygienist's brain.

7 CHAIR MARKOWITZ: So we do need to move
8 on, so I just want to make sure we don't -- and
9 I'm not suggesting Dr. Silver did this, but we
10 shouldn't repeat comments that have previously been
11 made. But I'm not suggesting you did that. Dr.
12 Friedman-Jimenez?

13 MEMBER FRIEDMAN-JIMENEZ: A quick
14 point of information; question: Does this site
15 exposure matrix have a time dimension? Does it
16 differentiate between pre-1995 and post-1995?

17 CHAIR MARKOWITZ: The answer is --

18 MEMBER FRIEDMAN-JIMENEZ: That's an
19 area in which individual workers can have perceived
20 a change or no change. Assuming that they have
21 a good memory, and they're not memory loss people
22 with Parkinson's disease, but they may not know

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1 exactly the identity of the dust that they're
2 exposed to, but they would know if it's decreased
3 a lot recently.

4 So I think, again, we should really push
5 for the industrial hygienist having access to ask
6 the claimants what their perceptions were and take
7 that for what it is. I mean, it's a subjective
8 piece of information, but it is a data point where
9 we're really -- there's a real absence of hard data.

10 CHAIR MARKOWITZ: Right. So take a
11 look at this language. We need a proposal, a motion
12 on this.

13 MEMBER REDLICH: I just would suggest
14 one or two minor modifications of the wording.
15 That recent IH assessments -- it's based on review
16 of a limited number, so I think we could take out
17 the appear.

18 CHAIR MARKOWITZ: That's fine.

19 MEMBER REDLICH: And there was one
20 other -- just to make it more -- and then the
21 absence, the last sentence? Automatically -- I
22 think the word automatically could be removed.

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1 CHAIR MARKOWITZ: That's fine also.
2 Friendly amendments accepted. We could also spell
3 out IH; that would help. Dr. Friedman-Jimenez?

4 MEMBER FRIEDMAN-JIMENEZ: The last
5 sentence: The absence of monitoring data
6 post-1995 or evidence of data showing exposure
7 levels below -- that is ambiguous as to whether
8 you mean the absence of evidence of data showing
9 exposure levels or -- I think we should clarify
10 that language.

11 CHAIR MARKOWITZ: I think we should
12 have a comma after post-1995. And if you want to
13 put either at the beginning of the sentence, would
14 that help, George? Put either the absence or
15 evidence, to make it clear that there are two
16 distinct conditions.

17 MEMBER FRIEDMAN-JIMENEZ: Yes. I
18 think that clarifies it well.

19 CHAIR MARKOWITZ: Aren't some of you
20 glad you don't work for a university?

21 MEMBER REDLICH: One other friendly
22 suggestion: the first sentence, they use language

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1 that cites the absence of monitoring data above
2 the regulatory levels as -- they're using that data
3 as indication of no risk, or --

4 CHAIR MARKOWITZ: They don't say that,
5 actually. They just make the statement; they don't
6 actually draw that conclusion. You know what I
7 mean?

8 MEMBER REDLICH: Corrected?

9 CHAIR MARKOWITZ: Yes. Okay. Is
10 there a motion?

11 MEMBER TEBAY: Yes.

12 CHAIR MARKOWITZ: Okay. That's a
13 motion to accept this recommendation. Is there
14 as second?

15 MEMBER MAHS: Second.

16 MEMBER FRIEDMAN-JIMENEZ: Do you want
17 to take out that and where the cursor is now? So
18 it would be provided by the industrial hygienist
19 in the report?

20 CHAIR MARKOWITZ: So right now it says,
21 The Board has observed, based on a review of a
22 limited number of recent claims, that recent

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1 industrial hygienist assessments frequently use
2 stereotypic language to cite the absence of
3 monitoring data above the established regulatory
4 levels in the mid-1990s.

5 The Board recommends that this language
6 be omitted from the industrial hygienist's report.

7 The basis for a negative exposure determination
8 should be provided by the industrial hygienist in
9 the report.

10 Either the absence of monitoring data,
11 post-1995 or evidence of data showing exposure
12 levels below regulatory limits should not be
13 interpreted as representing an absence of
14 significant exposure or risk.

15 MEMBER REDLICH: Evidence of data
16 versus just data. Do we need the evidence of?

17 CHAIR MARKOWITZ: We can take that
18 evidence off; that's fine, in the interest of
19 shortening the recommendation. Okay. Open for
20 discussion, final discussion.

21 MEMBER FRIEDMAN-JIMENEZ: Do we want
22 to only ask for negative exposure determination

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1 basis be provided, or also low or all exposure
2 determination? The question that --

3 MEMBER REDLICH: I -- we --

4 CHAIR MARKOWITZ: No, no. That
5 dilutes the impact of -- this is targeted to
6 specific language, and I'm afraid if we expand the
7 domain of this, the impact will be diluted.

8 MEMBER REDLICH: I already took back
9 that suggestion.

10 CHAIR MARKOWITZ: He's reneging it.

11 MEMBER REDLICH: I agree with Steve.

12 CHAIR MARKOWITZ: Okay. Final
13 comments; otherwise, we're going to take a vote.
14 Okay.

15 MR. FITZGERALD: All right, I'll call
16 the role here. Dr. Dement?

17 MEMBER DEMENT: Yes.

18 MR. FITZGERALD: Dr. Friedman-Jimenez?

19 MEMBER FRIEDMAN-JIMENEZ: Yes.

20 MR. FITZGERALD: Dr. Mikulski?

21 MEMBER MIKULSKI: Yes.

22 MR. FITZGERALD: Dr. Silver?

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1 MEMBER SILVER: Yes.

2 MR. FITZGERALD: Dr. Berenji?

3 MEMBER BERENJI: Yes.

4 MR. FITZGERALD: Dr. Markowitz?

5 CHAIR MARKOWITZ: Yes.

6 MR. FITZGERALD: Dr. Redlich?

7 MEMBER REDLICH: Yes.

8 MR. FITZGERALD: Mr. Domina?

9 MEMBER DOMINA: Yes.

10 MR. FITZGERALD: Mr. Mahs?

11 MEMBER MAHS: Yes.

12 MR. FITZGERALD: Ms. Pope?

13 MEMBER POPE: Yes.

14 MR. FITZGERALD: Mr. Tebay?

15 MEMBER TEBAY: Yes.

16 MR. FITZGERALD: All right. Vote
17 passes unanimously.

18 CHAIR MARKOWITZ: Okay. We're going
19 to resume with the agenda. We will not finish by
20 11:45 today. Could you bring up the language on
21 the non-cancer outcomes?

22 So this is a brief item. Dr. Silver,

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1 just to remind you, fashioned some language trying
2 to add some, I think, specificity or helpful
3 language to DOL's request to us. They requested
4 that we help them with looking at non-cancer
5 outcomes of radiological materials.

6 So this is just a reformulation of that
7 language, which actually I think we reviewed at
8 the February 28th meeting and pretty much approved.

9 I just want to put it out there.

10 We have no plan to actually work on this as
11 of yet, but I want to make sure it remains on the
12 radar.

13 And let me say that I don't think we
14 necessarily need to engage in an extended
15 discussion about the specific words of this. As
16 long as it get the gist of what we think they might
17 be after, we can submit it, because this is going
18 to go to DOL. They're going to tell us whether
19 this is what they had in mind. So, Dr. Silver.

20 MEMBER SILVER: That's the key point:
21 we want DOL to give us feedback on whether this
22 is what they were after.

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1 CHAIR MARKOWITZ: You want to read
2 this, Ken?

3 MEMBER SILVER: Some of this language
4 was adopted in whole cloth from what DOL originally
5 gave us, and then other language here was our
6 reformulation.

7 In reviewing some of the radioactive
8 substances found in DOE sites, the SEM only linked
9 uranium with non-cancerous condition of acute
10 tubular necrosis.

11 DEOIC asked the Board to conduct
12 research, a peer review, human studies, to
13 ascertain whether there are additional non-cancer
14 diagnoses that literature link to exposure to
15 radioactive substances such as uranium, plutonium,
16 polonium, thorium, and americium.

17 While all are technically heavy metals,
18 plutonium, polonium, and americium have no stable
19 isotopes. Health effects may be based upon
20 non-cancer effects of radiation, high LET alpha
21 radiation in particular, chemical toxicity, or a
22 combination thereof.

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1 A related set of issues pertains to
2 non-cancer effects, especially circulatory
3 diseases observed in the life span study of atomic
4 bomb survivors with an association with low LET
5 radiation exposure.

6 Evidence of such non-cancer effects in
7 nuclear worker cohorts or other occupational groups
8 would be of interest. The Board could offer advice
9 on the results of its analysis, including
10 recommendations, additional links produced by the
11 division as part of an update to the SEM or its
12 policy guidance.

13 CHAIR MARKOWITZ: So were there any
14 comments on this? It's a different matter as to
15 the extent to which Board members are currently
16 willing to volunteer to work on this issue, but
17 in any event, this is the reformulation.

18 Anybody have any discussion on this?
19 Okay, that's fine. Actually, I think I submitted
20 it, but only within the past week to DOL, so
21 obviously there wouldn't be a response.

22 Then we can postpone the issue of who

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1 wants to work on this particular subject, so we
2 needn't have that discussion. Thank you. Ken,
3 yes.

4 MEMBER SILVER: Thinking one or two
5 steps ahead, if DOL wants us to take this on, I
6 would do a little outreach to the NIOSH Advisory
7 Board, because they may have thought about this,
8 and dose matters, whether you're talking about
9 cancer or non-cancer effects, and they have some
10 top-shelf expertise.

11 CHAIR MARKOWITZ: Okay. So let's wait
12 until they get back to us, and then we can consider
13 whether we have -- we're also one person short on
14 the Board, whether we have time and resources to
15 address this issue.

16 The next item on the agenda is review
17 of public comments. I thought that we should --
18 we received a number of comments that were posted
19 on our website, the written submissions, and there
20 were a number of comments yesterday.

21 I thought we should just take a few
22 minutes to mention some of those and also address,

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1 I think, the status of some of the issues raised
2 in those public comments.

3 I've done some of that. If others want
4 to chime in, that's fine. There was one comment
5 we received about raising the issue of the quality
6 of an industrial hygiene assessment on a peripheral
7 neuropathy case, that certain relevant exposures
8 were not adequately considered.

9 The submitter also provided the example
10 with personal information, identifiable
11 information, deleted.

12 Frankly, I think this issue falls within
13 our discussions about the claims and about
14 assessing the adequacy of the industrial hygienist
15 assessment. So it's an argument, actually -- in
16 this case it was peripheral neuropathy, which is
17 probably a fairly common claim, but I think we're
18 going to address this in our recommended claims
19 evaluation.

20 There was one comment citing the
21 ombudsman 2017 report, that it contained items
22 relevant to our mission, and thankfully, Mr. Nelson

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1 and Ms. Felin have attended this meeting and
2 yesterday gave us an update on the 2017 report,
3 which we should review as a board.

4 There is a comment on -- a couple of
5 comments actually, on this issue that we just made
6 a recommendation about. So we've addressed that.

7 There's a comment on impairment. This
8 came in a couple of months ago, actually, having
9 to do with the question of what the policy of the
10 program is. Let me just read this short section
11 here, because it encapsulates what the issue is.

12 This a is January 28th, 2019 letter from
13 ANWAG: It has come to our attentions that DOL's
14 Division of Energy Employees, Occupational Illness
15 and Compensation changed their policy regarding
16 assigning impairment ratings for pulmonary
17 disease.

18 This policy is not published on the
19 DEOIC's website. It is our understanding that this
20 policy was issued only to DOEIC's contract medical
21 consultants and not to private practice impairment
22 specialists. And then it gives an example of use

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1 of impairment ratings.

2 So I think what we need to do is simply
3 ask for clarification from DOL about what this
4 involves so that we can understand the issue. Not
5 right now, Mr. Vance, but we just should request
6 some clarification.

7 And this pertains to our Task number
8 4. I'm already assimilating that data form that
9 you used. This relates to Task number 4, which
10 is our obligation to look at the consistency,
11 objectivity, and quality of the medical input into
12 the claims process.

13 A couple of comments that came up
14 yesterday: I did ask the Department of Labor, Ms.
15 Leiton if, as a standing request, if we could have
16 their participation in all of the board meetings,
17 which I had not asked prior to the February 28th
18 meeting, and they have agreed.

19 They will either attend in person or
20 attend by phone our meetings to be available for
21 clarification. I want to thank you, Mr. Vance,
22 for being available today.

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1 A question arose yesterday about
2 whether this board needed to re-approve or confirm
3 the prior board's recommendations. So this is a
4 question I've always -- I saw no need in that.
5 I assume those recommendations still to have full
6 weight or standing. Isn't that right, Doug?

7 MR. FITZGERALD: Yes, I mean, the Board's
8 made determinations of which --- and the agency
9 --- yes. I would say that is correct.

10 CHAIR MARKOWITZ: Okay. There's also
11 a question raised, which we've talked about briefly
12 before, that the industrial hygiene assessment
13 seems to focus on a limit of seven toxins, despite
14 the fact that the SEM frequently has a much larger
15 number of toxins in association with any given job
16 title.

17 I think that's something we should
18 discuss in the future.

19 MEMBER DOMINA: Steve.

20 CHAIR MARKOWITZ: Yes.

21 MEMBER DOMINA: On the comment just
22 before there that Doug was talking about, I saw

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1 a letter from Ms. Hearthway where we had asked in
2 a prior board about an advisory committee or someone
3 to help us, and she said that this board, if I
4 remember correctly, did not ask for it, and so it
5 was null and void, something to that effect.

6 I think that letter was like, maybe last
7 fall, early --

8 CHAIR MARKOWITZ: Well, yes. I think
9 that refers to the previous board's request for
10 resources, which we've taken care of today.

11 MEMBER DOMINA: All right. I just want
12 to be clear.

13 MR. FITZGERALD: I think there was
14 discussion within the past boards about resources,
15 but I don't think there was any formal request that
16 came forward from the Board.

17 CHAIR MARKOWITZ: There was a comment
18 yesterday about a preponderance of evidence. The
19 Board needs to look at that issue, a: whether it's
20 relevant to our assigned tasks, and then b: if
21 so, what it means. But we're not going to do that
22 now. We actually need to read that comment, I

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1 think, which will be in the transcript.

2 I think actually that same comment has
3 been made before, so if it's relevant to our
4 assigned tasks, then we need to look at that and
5 discuss that.

6 Any else on the public comments that
7 I didn't -- I didn't review all of them, but many
8 of them.

9 Okay. I can give a brief update on the
10 Presumption for Solvent-Induced Hearing Loss. We
11 haven't forgotten about it, but we also have not
12 prepared a response to DOL's response, pretty much
13 a rejection of our recommendation regarding
14 solvent-induced hearing loss.

15 I think they did, in the most recent
16 version of the Procedure Manual, 3.0, I believe
17 they've added a couple more solvents to the list.

18 I believe that may have come out of our
19 recommendation; I don't quite remember. If so,
20 that's great. But we will continue to look at that
21 issue and see whether there's evidence that we can
22 assemble that would be persuasive to Department

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1 of Labor.

2 Any comments on that? Okay. Maybe the
3 new Board member will be an expert in
4 solvent-induced hearing loss, with any luck.

5 I want to, in a few minutes, go over
6 what we expect to do in the next couple of months,
7 the things that we've assigned ourselves, but I
8 think we should spend a couple of minutes. And
9 I'm thinking we don't have that much more, so that
10 we can just continue to work and then adjourn,
11 instead of taking a lunch break.

12 But I'd like to put on our agenda some
13 reflection, a little bit of time to reflect on the
14 workings of the Board and whether there are some
15 alternative structure, alternative means, or
16 additional communication that would improve the
17 functioning of the Board. So this is a moment when,
18 if you have suggestions on how we work and how we
19 can be more effective, then let's discuss them.

20 So while you're thinking, I would note
21 that this Board has not developed committees per
22 se. The previous board did, and those committees

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1 had meetings, telephone meetings that were open
2 to public.

3 We have a single working group with this
4 board, which is on the Parkinson-related disorder,
5 which we intend to continue. There's no particular
6 reason why those discussions wouldn't be open to
7 the public as a committee, except for the fact that
8 it may just prolong the process. But we should
9 discuss that, I guess. Dr. Dement?

10 MEMBER DEMENT: I guess we had a working
11 group on the OHQ as well. I think the process of
12 having that working group report back to the Board
13 anything that's at least for the discussion
14 development, I think that works reasonably well,
15 other than having standing committees, per se.

16 CHAIR MARKOWITZ: In the past, working
17 groups -- we have not scheduled them. The Federal
18 Register had the six weeks' advanced notice. It
19 gave us a lot of flexibility. On the downside,
20 it meant that the public didn't have as much access
21 to the discussions. What do we want to do about
22 that?

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1 MEMBER DEMENT: This is John again.
2 I guess, unless there are some objections from the
3 public, we could change where we are. I think it
4 gives us more flexibility to have a meeting to
5 exchange information and work on issues; no
6 decisions are made, obviously. They're just
7 working groups to assemble data and facts to present
8 to the Board for discussion.

9 And those discussions, whatever the
10 working groups bring forward, need to be open to
11 the public. I think it works reasonably well
12 unless there are some objections to it.

13 CHAIR MARKOWITZ: The committees had
14 broader domains. Working groups are really very
15 targeted, task-specific, and it frankly is helpful
16 to be able to have the flexibility of having those
17 discussions on a more frequent basis without
18 scheduling them two months ahead of time.

19 I'm thinking about Parkinson's disease,
20 for instance. That group could easily make
21 excellent progress over the next period of time,
22 and then have a discussion.

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1 So unless there's a big objection, I
2 would agree that for these two working groups, we
3 continue them as they are, but be thinking, first
4 of all, the logic -- the discussion that is had
5 in those working groups be brought both to the full
6 Board, which has the benefit of the full Board being
7 involved, but also has the benefit of the public
8 having access to the thinking that comes out of
9 those working groups.

10 I think that would address the issue
11 of public access adequately. But that's my
12 opinion. Dr. Silver?

13 MEMBER SILVER: When a meeting is
14 announced in the Federal Register, our DFO and
15 assorted staff make sure that all relevant
16 documents get posted on the web. I'm happy with
17 the working group arrangement, but to strike a
18 balance with public transparency, let's just try
19 to be scrupulous about posting any and all documents
20 that don't contain PII.

21 Our review sheet, for example, for the
22 claims and any other things that the working groups

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1 develop before the next full Board meeting.

2 CHAIR MARKOWITZ: That's reasonable.

3 I mean, in the Parkinson's disease, some of those
4 documents were published articles, and actually
5 we discussed that. We published the names of the
6 articles, but we couldn't publish the articles
7 because there are restrictions on those.

8 But if we were, for instance, to come
9 up with a draft of an OHQ, yes, we could put that
10 online. As it stands now, it's not up to us to
11 come up with a new draft; it's actually up to the
12 Department to look at the advice that we've given
13 them.

14 Okay. So we'll go, then, as we've been
15 proceeding, and if we hear a lot of objections,
16 or if we, in our self-monitoring, think that we're
17 engaging in discussions that the public ought to
18 have access to, then we'll change our way of
19 working, if that's all right.

20 Any other aspects of the way the Board
21 works that you think need attention, could be
22 improved, aside from me getting the agenda out with

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1 a little bit more notice? Dr. Friedman-Jimenez?

2 MEMBER FRIEDMAN-JIMENEZ: I want to
3 make a request that I've made before, which is that
4 the medical records that are provided in PDF files
5 be provided as searchable PDFs, rather than
6 bitmapped PDFs. It would save us a lot of time
7 in reviewing; it would probably save the CEs and
8 CMCs a lot of time too.

9 It's an extra step, running it through
10 an optical character recognition program, but I
11 think it would really add to the efficiency of the
12 record review.

13 MEMBER DEMENT: This is John. Some of
14 these documents are barely readable, and some of
15 them are not readable at all.

16 MEMBER FRIEDMAN-JIMENEZ: Sure.

17 MEMBER DEMENT: And so there's going
18 to be a lot of garbage that comes out of the optical
19 character reading. The other thing that I've
20 experienced in optical character reading is that
21 sometimes you can't rely on the words that come
22 out of that thing.

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1 So indexing of where things are in this
2 big file, what page number the OHQs or what page
3 number the CMC report is on -- IH report -- you
4 know, key pieces of information of where you can
5 find them, that would probably be of much greater
6 benefit to me. I can go in and read them and know
7 I'm reading the exact words, rather than maybe
8 something I have to verify.

9 MEMBER FRIEDMAN-JIMENEZ: So you're
10 saying having someone actually go through the file
11 and index where the different key sections are?

12 MEMBER DEMENT: Well, I --

13 MEMBER FRIEDMAN-JIMENEZ: That would
14 work too, yes.

15 MEMBER DEMENT: Yes, maybe that's sort
16 of this -- you know, we've asked for some help to
17 do this. It would greatly cut down on our time
18 if that were done. You know, we could review the
19 cases much more quickly if that were done. That
20 wouldn't be a great burden, I don't think. It would
21 take some time on the individual's part.

22 But now, I would say that half the time

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1 I spend on these cases was on my thumb, going through
2 them, back and forth, back and forth, trying to
3 find something. That's a waste of time.

4 CHAIR MARKOWITZ: Okay. Let me ask,
5 actually, the Department: Communications from the
6 public come addressed to me. I'm assuming that
7 those are disseminated to the Board without my
8 asking, assuming that the Department decides that
9 it's relevant to the Board's mission. That's true?

10 MR. FITZGERALD: Yes, that is true.

11 CHAIR MARKOWITZ: Okay.

12 MR. FITZGERALD: I mean, what is
13 relevant to the Board's work is posted unless it
14 involves individuals and things that are more
15 case-specific things. We make a determination and
16 make sure the information with the Board is not
17 public because it's not necessarily prudent to
18 share some of the things.

19 But if it involves the Board's work or
20 -- I will also say, we also get correspondence and
21 communication from to the Board that is not in their
22 area. It may go on to the program; those things

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1 get referred to the program for a response.

2 MEMBER REDLICH: We can't hear you.

3 MR. FITZGERALD: I'm sorry; I don't
4 know why this microphone is giving me so much
5 trouble.

6 So basically, yes, we do post everything
7 that's relevant to the Board's work on the website;
8 however, sometimes we get information that's very
9 case-specific, and it's not prudent to share that
10 information with the public.

11 We may alert the Board to the issue.
12 Whether or not it's in their scope, it could be
13 contextual: here's some information that you
14 should be aware of, but it doesn't necessarily
15 reflect on what the Board's work is.

16 Other times information and questions
17 and correspondence comes in to the Board and to
18 the Chair that's really not in the Board's purview,
19 and we refer that on to the program usually, where
20 it's best responded to.

21 CHAIR MARKOWITZ: Okay. Dr.
22 Redlich, you wanted to --

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1 MEMBER REDLICH: Just a request. In
2 terms of our requests of information, do we know
3 when we will be getting the additional materials
4 that we requested such as the data and the other
5 cases? I think it would -- I understand if it takes
6 time or if certain of our requests may not be
7 reasonable in the form they were in, but it would
8 just be very helpful, and I think enable us to plan
9 our time better if we knew this will take us
10 approximately this much time, or could we get part
11 of the request, so we just know what the plan is?

12 MR. FITZGERALD: Yes, that was actually
13 one of the reasons we created the form, the request
14 process we created, so that there can be some
15 limited back and forth between the Board and the
16 program, refining the request to make sure that
17 we're doing the most efficient --

18 MEMBER REDLICH: Okay.

19 MR. FITZGERALD: -- as possible. Or
20 if the data you were asking for may not be available
21 in the form you're requesting it in, but maybe
22 there's proxy data that we could provide or

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1 something of that nature, and then determine what
2 the time frame would be for making that deliverable.

3 MEMBER REDLICH: Okay.

4 CHAIR MARKOWITZ: Okay. So we expect
5 we'll probably have a telephone meeting in a few
6 months; probably three months, and then another
7 in-person meeting in about six months. I'll talk
8 about that in a moment.

9 I just want to talk about what we're
10 going to do in the next three months, so there's
11 some understanding. I have a list; I think maybe
12 it's a full list, not quite sure.

13 But we're going to continue to look at
14 the claims we have, and we're going to develop,
15 each and every one of us, a list of concerns about
16 the claims, and at the telephone meeting, we're
17 going to try to identify a set of common concerns
18 that appear across claims.

19 If, in the interim, we aggregate, we
20 can discuss them as to what the most sensible
21 organization of them is going to be.

22 So at the next telephone meeting, then,

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1 we will probably not spend a lot of time reviewing
2 claims, you'll be happy to know, but we will be
3 shooting for a list of, however long it is, of issues
4 that are of concern.

5 And that's going to help us when we have
6 the opportunity to conduct a larger, systematic
7 evaluation of the claims.

8 Two working groups: I think the
9 occupational health questionnaire, I think it's
10 a question of just waiting for DOL to respond to
11 the recommendation that we made at the February
12 28th meeting. And there were two other
13 recommendations we made, one on asthma, one on
14 asbestos, and we're waiting on response to those
15 as well.

16 On the Parkinson's disease working
17 group, great work so far. Clearly, we can make
18 additional progress on both -- there are four
19 aspects to DOL's request, but they really focus
20 on the diagnosis, advice on the diagnosis, and
21 advice on causation. So I think we can continue
22 to make progress.

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1 Now, that working group right now is
2 Dr. Mikulski, Ms. Pope, and Mr. Mahs, right?
3 Okay. So I'll join that -- what's that? And I'll
4 join that working group.

5 But if anyone else wants to participate,
6 you're welcome. If you want to think about it,
7 you can join next week too; it will remain open.

8 We're going to get, I think, an update
9 on the status of the approved recommendations from
10 the Department. I think this was a dashboard
11 issue. Our hope is to get an update and then a
12 periodic update automatically, not by request when
13 we think about it.

14 And finally from this meeting,
15 hopefully Carrie has developed a list of some action
16 items which I will review and circulate to see if
17 we've gotten it right, see if we've left anything
18 off and the like.

19 Are there any other issues that we have
20 promised to look at over the next period of time
21 that have come out of this meeting? Yes.

22 MEMBER POPE: The replacement of Dr.

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1 Cassano.

2 CHAIR MARKOWITZ: Yes. Well, we've
3 been told that pretty soon, the announcement will
4 come out in the Federal Register, and then we tell
5 all our friends and get them to apply, those who
6 are still talking to us.

7 And I think, Doug, you said yesterday
8 that we expected appointment by someone during the
9 summer. Hopefully, it will be by the time we have
10 the telephone meeting so they can participate, but
11 if not, hopefully several months before the next
12 in-person meeting so they can get oriented.

13 Any additional comments, questions?
14 Any you want to say?

15 MR. FITZGERALD: No. I just want to
16 thank the Board for all their work. We've covered
17 a lot of territory over the last day and a half,
18 and I appreciate all your efforts.

19 I thank the public for participating
20 and coming here to listen to deliberations, and
21 I think the SIDEM; the contract staff here is really
22 doing a great job with the logistics and

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1 coordinating all the travel, meeting set-up and
2 everything else, and Carrie Rhoads, my alternate
3 DFO.

4 CHAIR MARKOWITZ: And I want to echo
5 those thanks. Kevin becomes, next week, the most
6 popular person, because that's the person we submit
7 our reimbursement form to, and if you don't submit
8 it, he'll remind you. So don't worry about that;
9 he's very good about that.

10 The next in-person meeting: the way
11 we select the location has generally been where
12 -- who's next on the list in terms of the number
13 of claims or claimants? We try to hit that
14 geographic area.

15 I haven't looked at the list lately,
16 so I don't know. NTS? All right. Okay. But
17 we're going to base that decision on objective data,
18 not lack of data.

19 And the telephone meeting at three
20 months arrives towards the end of July. We may
21 have a bit of a challenge, because of people's
22 different schedules, scheduling that, so we'll

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1 trying to schedule that sooner rather than later.

2 But be responsive to the request to schedule that,
3 because we may have to go back and forth a bit.
4 We'll try to be as inclusive as we can. Mr. Tebay?

5 MEMBER TEBAY: Could we add to the
6 agenda to revisit the borderline test results for
7 beryllium sensitization or the diagnostic
8 criteria? Before, when we did that, it was based
9 on two borderline tests. They're utilizing three
10 borderline tests. I think we could just add it
11 to the agenda as a reminder to discuss, rather than
12 -- but I would appreciate it if we could do that.

13 CHAIR MARKOWITZ: Yes, that's fine,
14 particularly if DOL has anything new to add, because
15 we've made that recommendation, and they haven't
16 accepted it, based on the statute. But we should
17 keep it on the agenda when we can.

18 MEMBER TEBAY: Thank you.

19 CHAIR MARKOWITZ: So I guess the
20 meeting's adjourned. Thank you.

21 (Whereupon, the above-entitled matter
22 went off the record at 12:13 p.m.)

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