UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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MEETING

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WEDNESDAY
OCTOBER 19, 2016

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

MEMBERS

SCIENTIFIC COMMUNITY:

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

MEDICAL COMMUNITY:

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

CLAIMANT COMMUNITY:

DURONDA M. POPE
KIRK D. DOMINA
GARRY M. WHITLEY
JAMES H. TURNER
FAYE VLIEGER

DESIGNATED FEDERAL OFFICIAL:

ANTONIO RIOS

ALSO PRESENT:

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

*Participating by phone

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

(8:40 a.m.)

DEFINING EEOICPA'S STANDARD FOR WORK-RELATEDNESS

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

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

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

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

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

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

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

We can then discuss the status, if

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

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

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

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

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

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

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

MEMBER REDLICH: -- sooner.

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

MEMBER REDLICH: Okay.

CHAIR MARKOWITZ: Because it was --

MEMBER REDLICH: I understand.

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

MEMBER REDLICH: Okay.

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

MEMBER REDLICH: Okay, sorry.

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

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

CHAIR MARKOWITZ: The public comments are transcribed, right?

PARTICIPANT: Yes.

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

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

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

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

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

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

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

CHAIR MARKOWITZ: Yes, Dr. Redlich?

MEMBER REDLICH: No.

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

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

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

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

that it would so clearly dwarf an occupational factor.

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

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

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

CHAIR MARKOWITZ: Yes.

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

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

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

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

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

percent or more likely to have caused the injury.

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

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

CHAIR MARKOWITZ: Dr. Sokas?

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

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

with the very common diseases.

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

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

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

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

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

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

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

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

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

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

So, if you have 10-fold or 10.2-

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

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

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

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

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

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

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

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

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

CHAIR MARKOWITZ: Dr. Cassano?

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

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

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

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

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

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

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

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

and therefore, nothing else counts.

CHAIR MARKOWITZ: Ms. Vlieger?

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

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

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

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

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

CHAIR MARKOWITZ: Dr. Boden?

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

MS. LEITON: This actually means a new draft.

MEMBER BODEN: Good.

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

MEMBER BODEN: Okay, good.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I think they may be considered at some point.

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

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

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

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

MEMBER REDLICH: I think Leslie was first.

CHAIR MARKOWITZ: Dr. Boden?

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

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

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

CHAIR MARKOWITZ: And for people who

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

(Laughter.)

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

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

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

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

agree with what Steve says.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We don't have to wait six months to

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

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

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

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

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

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

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

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

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

CHAIR MARKOWITZ: Okay.

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

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

MEMBER CASSANO: I can go through recommendation one.

CHAIR MARKOWITZ: All right, okay.

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

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

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

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

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

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

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

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

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

John?

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

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

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

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

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

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

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

MS. LEITON: John.

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

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

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

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

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

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

MR. VANCE: Yes.

MEMBER BODEN: Yes?

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

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

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

MEMBER CASSANO: John?

MEMBER BODEN: Right.

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

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

MEMBER CASSANO: Okay.

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

MEMBER CASSANO: So.

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

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

that.

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

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

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

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

occupational asthma or aggravate or contribute to it.

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

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

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

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

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

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

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

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

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

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

MR. VANCE: Actually, that

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

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

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

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

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

CHAIR MARKOWITZ: Dr. Welch?

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

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

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

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

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

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

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

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

CHAIR MARKOWITZ: Dr. Sokas?

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

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

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

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

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

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

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

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

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

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

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

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

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

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

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

CHAIR MARKOWITZ: Dr. Welch?

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

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

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

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

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

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

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

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

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

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

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

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

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

But I think the majority of CMCs

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

CHAIR MARKOWITZ: By the way, why does the industrial hygiene need the medical records? MEMBER CASSANO: I don't know if the industrial hygienist needs the medical records per se, but maybe there is something in the medical records that clues an industrial hygienist to, oh, this guy actually has this particular disease, and gee, maybe I need to look for this exposure, to see if this disease was actually caused by an exposure that's possible in this environment.

CHAIR MARKOWITZ: Ms. Vlieger?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER SOKAS: Yes, I really don't

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER REDLICH: Can I --

CHAIR MARKOWITZ: Yes, I'm sorry.

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

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

MEMBER WELCH: NIOSH has that.

MEMBER REDLICH: Okay, so the --

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

MEMBER REDLICH: Okay.

MEMBER WELCH: I mean, they list

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

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

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

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

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

MEMBER REDLICH: Okay.

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

MEMBER REDLICH: Sure, okay.

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

these are ones --

MEMBER REDLICH: Sure.

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

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

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

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

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

MEMBER REDLICH: Okay, thank you.

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

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

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

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

CHAIR MARKOWITZ: Dr. Cassano?

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

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

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

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

MEMBER WELCH: But I think part of

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

MEMBER CASSANO: Okay.

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

MEMBER CASSANO: Right.

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

MEMBER CASSANO: Twenty-zero-eight?

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

so that it's delayed getting going.

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

MEMBER WELCH: Okay.

MEMBER CASSANO: Rather than --

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

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

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

completion.

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

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

MEMBER WELCH: Yes, I think that's it. CHAIR MARKOWITZ: No, are included, or I'm sorry. After the IOM report, are included in the SEM.

MEMBER WELCH: Are included in the SEM.

CHAIR MARKOWITZ: Dr. Sokas?

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

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

that.

CHAIR MARKOWITZ: Dr. Boden?

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

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

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

Okay, so --

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

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

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

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

One is that the individual contract

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

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

MEMBER REDLICH: Well, I guess --

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

MEMBER REDLICH: I guess --

CHAIR MARKOWITZ: -- and then we can --

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

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

MEMBER WELCH: It does both. It does both.

MEMBER REDLICH: Okay.

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

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

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

They go into it and say, well, I

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

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

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

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

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

MEMBER WELCH: Not my committee.

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

CHAIR MARKOWITZ: Okay.

MEMBER REDLICH: Is someone going to fix it?

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

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

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

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

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

CHAIR MARKOWITZ: So, everything is --

MEMBER REDLICH: John and --

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

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

MEMBER DEMENT: No.

CHAIR MARKOWITZ: Okay, Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Well,

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

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

So, there needs to be a process.

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

PARTICIPANT: Yes.

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

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

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

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

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

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

CHAIR MARKOWITZ: Dr. Sokas, yes.

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

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

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

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

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

Okay, so, any further comments on this?

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

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

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

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

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

MEMBER WELCH: I have two more.

CHAIR MARKOWITZ: Yes, and you have

--

MEMBER SOKAS: Three.

CHAIR MARKOWITZ: Okay.

MEMBER WELCH: I think the other two, I do think we -- I really do think we already definitely all agree on the other two recommendations. So, we could hold back our comments that may be, "Wow. Great idea. I like it. Can we extend it this way," blah, blah, blah. CHAIR MARKOWITZ: So, let's do those two, actually.

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

MEMBER SOKAS: Yes. Second the motion.

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

PARTICIPANT: No.

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

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

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

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

PARTICIPANT: To this facility.

MEMBER WELCH: Right.

PARTICIPANT: Or that DOE facility.

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

every DOE community.

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

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

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

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

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

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

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

CHAIR MARKOWITZ: Dr. Boden?

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

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

So, your prior recommendation was

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

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

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

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

recommendation.

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

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

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

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

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

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

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

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

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

So, every -- it's unanimously --

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

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

CHAIR MARKOWITZ: Right, right.

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

CHAIR MARKOWITZ: Yes, I apologize actually for --

MEMBER CASSANO: Thank you.

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

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

recommendations?

PARTICIPANT: No.

CHAIR MARKOWITZ: Okay, you have three?

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

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

MEMBER SOKAS: Move to approve.

MEMBER BODEN: Second.

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

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

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

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

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

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

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

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

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

recommendation. Okay.

MEMBER SOKAS: And take out quotes.

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

CHAIR MARKOWITZ: Okay, but that's fine.

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

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

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

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

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

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

So, we recommend DOL consider

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

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

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

CHAIR MARKOWITZ: Discussion? Garry?

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

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

CHAIR MARKOWITZ: Other discussion?

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

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

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

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

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

CHAIR MARKOWITZ: Which is not in

the recommendation. The recommendation is redacting confidential information.

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

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

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

MEMBER SOKAS: That's right.

CHAIR MARKOWITZ: -- not broadly applicable.

MEMBER SOKAS: That's right.

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

MEMBER SOKAS: I'm sorry? Thank you.

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

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

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

MEMBER REDLICH: Yes.

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

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

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

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

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

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

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

CHAIR MARKOWITZ: Open for discussion. Dr. Boden?

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

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

MEMBER SOKAS: Okay, thank you.

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

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

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

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

CHAIR MARKOWITZ: Sure.

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

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

So, that might be the difficulty,

just for your information.

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

CHAIR MARKOWITZ: Dr. Cassano?

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

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

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

MEMBER SOKAS: Yes.

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

MEMBER SOKAS: Right.

MEMBER CASSANO: -- they need to call up.

MEMBER SOKAS: They need to call up, right.

MEMBER CASSANO: And talk to somebody.

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

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

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

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

OWCP Steering Committee hat on.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

order to facilitate that occurring. Ms. Vlieger?

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

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

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

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

CHAIR MARKOWITZ: Yes.

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

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

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

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

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

MS. LEITON: That's correct.

CHAIR MARKOWITZ: Additional discussion? Dr. Welch?

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

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

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

CHAIR MARKOWITZ: Dr. Silver?

MEMBER SILVER: Maybe one of the

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

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

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

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

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

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

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

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

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

Dr. Cassano.

MEMBER BODEN: Are we voting?

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

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

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

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

A positive BeLPT is not required to

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

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

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

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

CHAIR MARKOWITZ: Discussion? Dr. Welch?

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

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

MEMBER WELCH: Yes.

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

MS. LEITON: Yes, that should work.

MEMBER REDLICH: Thank you.

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

For instance, biopsy-proven

sarcoidosis or some qualification.

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

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

MEMBER REDLICH: Yes.

CHAIR MARKOWITZ: Okay.

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

CHAIR MARKOWITZ: Okay, Dr. Welch?

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

MEMBER REDLICH: Yes.

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

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

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

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

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

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

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

MEMBER REDLICH: No, I think that

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

CHAIR MARKOWITZ: Right, okay.

MEMBER REDLICH: Something like that.

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

MEMBER REDLICH: That's right.

CHAIR MARKOWITZ: -- what are --

MEMBER REDLICH: For how you actually just implemented it.

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

Okay, so, let me read the recommendation.

We recommend a presumption of

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

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

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

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

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

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

MEMBER CASSANO: Okay.

CHAIR MARKOWITZ: I'll introduce

that one after you.

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

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

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

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

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

CHAIR MARKOWITZ: So, discussion? Dr. Welch?

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

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

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

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

MEMBER CASSANO: What I was trying to --

MS. LEITON: I agree.

MEMBER CASSANO: Rachel?

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

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

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

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

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

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

CHAIR MARKOWITZ: So --

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

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

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

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

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

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

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

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

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

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

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

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

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

set first.

CHAIR MARKOWITZ: Dr. Sokas?

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

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

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

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

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

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

CHAIR MARKOWITZ: Mr. Turner?

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

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

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

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

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

MEMBER CASSANO: Yes.

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

MEMBER CASSANO: Yes.

CHAIR MARKOWITZ: -- for reconsideration?

MEMBER CASSANO: For tweaking.

CHAIR MARKOWITZ: Okay, Dr. Boden?

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

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

about it for further discussion.

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

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

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

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

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

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

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

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

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

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

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

But that's kind of important

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR MARKOWITZ: But then -- so,

let me just understand.

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

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

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

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

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

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

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

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

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

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

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

CHAIR MARKOWITZ: Dr. Boden?

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

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

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

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

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

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

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

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

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

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

MEMBER WELCH: We did get that.

MEMBER CASSANO: We did?

MEMBER WELCH: We did get it.

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

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

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

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

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

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

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

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

review of the letter sent by ANWAG to us.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR MARKOWITZ: Friday. Last Friday.

MEMBER WELCH: From the Board, and

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

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

CHAIR MARKOWITZ: Dr. Welch?

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

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

I mean, we could, in theory, weigh

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

CHAIR MARKOWITZ: Yes, Mr. Domina?

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

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

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

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

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

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

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

CHAIR MARKOWITZ: Dr. Sokas?

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

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

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

I see this as kind of another

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

CHAIR MARKOWITZ: Dr. Cassano?

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

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

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

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

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

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

MEMBER WHITLEY: Second.

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

So, the recommendation is that we

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

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

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

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

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

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

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

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

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

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

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

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

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

CURRENT AND FUTURE USE OF PRESUMPTIONS IN THE EEOICP

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

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

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

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

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

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

how we might approach this. Dr. Sokas?

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

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

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

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

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

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

MEMBER WELCH: Yes.

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

important.

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

CHAIR MARKOWITZ: Dr. Dement?

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

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

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

particular observations or any particular, even soft recommendations.

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

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

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

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

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

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

CHAIR MARKOWITZ: Ms. Vlieger?

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

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

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

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

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

MS. VLIEGER: No, no.

CHAIR MARKOWITZ: -- there is a recent response.

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

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

CHAIR MARKOWITZ: Okay, Dr. Boden?

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

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

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

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

So, who would like to serve on that

working group, to cut to the chase here?

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

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

CHAIR MARKOWITZ: Okay.

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

CHAIR MARKOWITZ: Okay.

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

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

ADVISORY BOARD PROCESS: DISCUSSION

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

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

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

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

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

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

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

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

CHAIR MARKOWITZ: Okay.

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

CHAIR MARKOWITZ: Dr. Sokas?

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

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

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

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

CHAIR MARKOWITZ: Dr. Boden?

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

who came in through the leadership in the program.

CHAIR MARKOWITZ: Dr. Cassano?

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

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

CHAIR MARKOWITZ: Other comments? Mr. Turner?

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

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

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

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

MEMBER DOMINA: Vegas, baby.

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

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

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

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

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

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

Does anybody have anything to add to that?

MS. VLIEGER: Before we get too far

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

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

MEMBER DOMINA: Well --

MEMBER REDLICH: -- reasonable.

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

CHAIR MARKOWITZ: Right, right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR MARKOWITZ: Right, right.

MEMBER REDLICH: But --

CHAIR MARKOWITZ: I think we probably --

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

CHAIR MARKOWITZ: Yes.

MEMBER REDLICH: They could use a

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

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

MEMBER REDLICH: And that's beyond today.

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

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

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

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

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

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

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

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

MS. LEITON: Thank you for letting me --

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

MS. LEITON: Thank you.

CHAIR MARKOWITZ: -- speak slowly.

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

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

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

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

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

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

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

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

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

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

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

So, thank you all for that very

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

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

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

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

PUBLIC COMMENT SESSION

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

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

an additional nine speaker who would like to present.

So, to accommodate everybody, we would ask that the scheduled speakers try to restrict their comments to closer to five minutes. If I interrupt you, I apologize in advance, but it's merely for the purpose of trying to make sure we have enough time for everybody.

So, we will start with Paige Gibson.

MS. CISCO: Hello. Thank you, Board. This is actually -- I'm Jeannie Cisco, right now. She's from Portsmouth and she is also with and she worked at Portsmouth for 30 years. She was unable to be here, due to some family illness.

She wanted to make sure that you knew that she and a group of her work turned in over 200 chemicals with MSDS sheets, and letters from the -- the company, explaining what buildings those chemicals were in. They were added to the SEM and then mysteriously,

they were taken out with no explanation.

So, she wanted you all to know that, and would really like to know why, especially with all the background information they had.

She also heard DOL make the statement that people diagnosed with beryllium sensitivity are flying all over the country to receive medical treatment. I caution the subcommittee to evaluate that statement.

An individual diagnosed with beryllium sensitivity has to travel to receive treating -- treatment or testing for chronic beryllium disease. DOL wants a medical protocol from the subcommittee. Form EE7 is explicit. The choice of doctors, very important to the DOE workers, most do not trust Oak Ridge, due to the conflict of interest.

The treatment and testing should be determined by the treating physician, not DOL, and this has to do with flying out west, and most of their sensitivities, once they fly out west, their blood sensitivities turn into the

flow blow disease, when the further testing is done.

Two points that came up today. On the hearing and in general in the SEM, I can't stress enough, the job classifications and the tasks for each site is different.

The SEM doesn't address this. Out of the 22 job categories that are listed for the hearing, for example, the letter I gave you of that gentleman, his basic job was a radiation control technician, a surveyor. He worked with 19 of those 22 jobs, in a hot area, with the chemicals and the noise, dressed exactly the same way they were, and because DOL does not know what we do for our jobs, they don't list it.

The same is true -- a custodian, they are on the list. However, a decontamination worker who not only does custodial work, but also radiation work and chemical work is not on that list.

So, the list just really needs

looked at. You can't narrow it to 19. At Portsmouth, their RCTs, HPs don't go in on jobs, but at Hanford, they do.

So, you know, you have to look at these jobs independently and you have to have someone with knowledge in order to get this classifications right.

Just to let you know, the occupational worker -- or health questionnaire, they're already being done on the phones. So, it doesn't matter where the former worker lives. They can still do it on the phone. Okay, thank you.

CHAIR MARKOWITZ: Thank you very much. Next is Terrie Barrie.

MS. BARRIE: Hello, again, and this is Terrie Barrie with the Alliance of Nuclear Worker Advocacy Groups, and I thank you all again for all the hard work. You've been working very hard to get those recommendations out in such a short amount of time.

There is discussion about -- oh, and

I also want to thank you for discussing the ANWAG letters, and considering them. We do really appreciate that.

There is a lot of discussion about, you know, reviewing certain diseases that could be presumed from being exposed at the workplace, and I would like to offer a suggestion to look at the Radiation Exposure Compensation Act.

This is for -- strictly for uranium workers, and some down-winders, and under that legislation and program, lung cancer, certain non-malignant lung diseases, renal cancer, chronic renal disease and the 22 specified cancers are presumed to be the result of working or being -- or working with uranium or being exposed to atomic testing, and it would seem since this is similar, a lot more similar than the VA benefits and the -- that we could -- or you could probably take a look at this and see if it can be brought over to EEOICPA.

The last thing I'd like to just to

remind everybody of is, when I hear the discussion of this chemical or this exposure, I want everybody to remember that the workers worked daily in a toxic soup. It was not just working with TCE or with radiation. They worked -- you know, they would take the part and then dip it in carbon tetrachloride, and then move on.

So, it's multiple exposures that they were -- they experienced every day, and I thank you again.

CHAIR MARKOWITZ: Okay, thank you. So, I just want to point out to people here that we're not -- the Board isn't responding to any of the commenters. There is no normal, kind of discussion back and forth, because that is not the format that we use. It would also cut into time for the public to make their comments.

So, don't be put off by that lack of interaction. We do want to hear what you have to say and we value your remarks.

Next is Vina Colley on the phone, and while she is getting set up, if Tim Lerew and step forward and sit down and be prepared to be next, just in case there is a delay on the telephone.

MR. LEREW: Thank you, Dr. Markowitz and Board.

CHAIR MARKOWITZ: But Mr. Lerew, hold on a second, because if we can get Ms. Colley on the phone, we'll go with her. I just don't want to --

PARTICIPANT: And let her know to take it off mute. Sometimes she leaves it on mute.

CHAIR MARKOWITZ: Ms. Colley, are you --

MS. COLLEY: My name is Ms. Colley and I'm a worker in Piketown, Ohio, and I co-chair the National Nuclear Workers for Justice. Thank you for allowing me to speak.

We are inviting you again, and encouraging you to have a meeting in

Portsmouth, Ohio, where breaking the story about plutonium at the plant on the same day as the Bazooka workers in 1999, that made the news spread fast and everyone scramble to help these workers.

DOE failed to protect workers with adequate monitoring, protection from radiation, UF6, heavy metal, toxic chemicals, beryllium, strontium, cesium, a whole list of chemicals that Jeannie Cisco says that she -- the union put together, and they're paying no attention to that list.

Workers were never told until we released the records in 1999, that we were working with plutonium. The story was downplayed. We've had plutonium here since 1953, and I have the documents to back it up, those are company documents.

The plutonium started fading out on the equipment in 1962. You have failed to recognize the relevant causation which are affirmed by the claims experts and the treating

physicians. Withholding of the sick workers entitlement and medical benefits under the stipulation of the Act, can not be viewed in any other manner then death of entitlement and medical benefits. It's a crime, and it has been well documented by the U.S. Department of Labor, and the U.S. Human Health and Services secretary.

If we are focused -- if we are focused as a force to file a federal lawsuit, we will request compensation and punitive damages that shall be worth millions of dollars.

There is so many conflicts of interests in these cases and this program regarding the energy employees compensation act. We object to the demands that the sick workers have to go through.

An example, NIOSH is a conflict of interest because they have been used in court cases against the sick workers, for the DOE and the corporations, in demonstrating that they

are not acting in the best interest of the workers.

There is so many contractors involved that the left hand doesn't know what the right hand is doing, which prevents money from going out to get the claims paid. It is time to cut out the studies and take care of the sick workers, who are listening to the doctors that treat us and are experts.

On Monday, I heard you talk about workers wearing protective clothing. You cannot protect these workers in these plants. Many jobs should have called for a robot. The best, at least you can do is start fighting the illnesses.

If we are forced to -- okay, I listened to the Oak Ridge workers testify yesterday, and it took me back to the 80s, when we started this process, and when the government was letting workers give testimony by 1992, in D.C., we were called whistle blowers then.

We seem not to be going forward, but backwards. In 1999, Congressional hearings were held and workers told all they knew. We recommend that the workers be compensated and stop the studies and get the workers medical cards that is owed to them. We are being studied to death.

I am going to try to explain to you why workers can't be evaluated by -- we are talking about multiple chemical exposures daily. At a meeting yesterday, I heard that these workers found out a worksheet that is used as part of the way they look at our case. Many workers never knew what they were exposed to.

Currently, workers are at a high risk of exposure also, and they are not protected under this bill. As electrician, I clean down uranium contaminated electrical equipment in confined spaces for six months at a time, with no respiratory protection, until I got so sick, they finally come and took a test

and I exceeded a 15 minute test in seven minutes, the first time that I ever had wore a respirator and they done away with that job and no one was allowed to do it.

Actually, I cleaned this radiation from the piping -- the piping system in these process buildings, they had oil leaking out of them. I found out that the oil had radioactive material.

The workers who went into these process buildings where the oil was were being exposed to radiation on a daily basis. Workers would take air hoses and they would blow uranium contaminated dust into -- without us having protection on. We would walk into the area, when a worker was taking an air hose to blow off the dust, that they thought was dust, that was uranium contaminated dust.

Workers at the nickel plant in 1979, one of my friends who helped bury that plant, at age 42, died of a brain tumor.

You have a cylinder that drops 1978,

that lost over 21,000 pounds of uranium tetra chloride to the air and the water. We are not checked for these exposures.

According to a Congressional hearing, from 1953 to 1992, you have six releases every day, exposures on a daily basis and the piping plant. The 720 building was a machine shop. We worked with welders, machinists, lab people, varnishing paint, electrical shop, all these shops was in this one building, and it was open to the atmosphere and no one, not even supervisors, wore protective equipment.

Just walking into the plant, we was getting contaminated. Not to mention, taking it home to our families.

Since the position has elapsed, I have not been able to get any of my conditions compensated or they've all been denied from the Cleveland office.

My claims for pulmonary neuropathy, multiple myeloma, hypothyroidism, lung nodules,

pulmonary edema, toxic pneumonia, immune system disorder, was sent to the Cleveland office and remanded for further investigation.

Amanda Bauer, who works for the Trial Board in Washington, D.C., in my records, that says that medical records of -- the medical evidence of record is significant enough to establish the diagnosis of neuropathy, multiple myeloma, hypothyroidism, arthritis, and lung nodules and pulmonary edema and immune disorder.

All of these went to the Cleveland office. When they got to the Cleveland office, they were turned down, and I want to mention that you just awarded these women for their follicle tubes and their uterine cancer. So, I have three tumors. I went to my gynecologist and he called me, it was two months later, that he did another test on me, and within two months, I had three large tumors.

He called me at home at 7:30 at night and said, "We need to do emergency

surgery on you because of the chemicals that you worked in and your job classification and the enlargement of your stomach."

So, he did a total hysterectomy at age 35, and I have all these consequential illnesses from these exposures that I can't get taken care of, because insurance will not pay for job-related illness, and then I wanted to touch a little bit on the --

CHAIR MARKOWITZ: Ms. Colley? Ms. Colley? If you could wrap it up. You've got about a minute. That would be great.

MS. COLLEY: Okay, and the prostate cancer is being turned down.

So, I found in February 10th of 2004, that skin cancer and prostate cancer was granted to a person, the docket number is 118302004.

So, they had skin cancer and was granted their prostate cancer.

Again, I want to stress, this is where the story broke about the contamination

in the plant, and we have been looked over. I'm asking you guys to have a meeting here, and give our workers the chance to come out and explain to you and show you what they have been working in and how they've been exposed to it, and until they look at us and -- on a one to one basis, to see what we've been exposed to, they're never going to be able to document this.

So, we're asking you to come here and let us tell our story again. I mean, you know, this is pathetic that we have to keep doing this, but there is so many conflicts of interest and I'm asking you to stop the study, and that we know that from John Hoffman, Dr. Alan Stewart, and my friend Dr. Rosa Patella. We know all these studies that have gone way, way back to the radiation that harmed the fetus of a baby when they took an X-ray.

We have the highest rate of cancer in this area. We're asking you to hold a meeting here.

CHAIR MARKOWITZ: Okay, so, thank you, and if you have --

MS. COLLEY: And if you need any more --

CHAIR MARKOWITZ: Ms. Colley, we need to close now, but if you have additional comments, please submit them in the record -- DOL through their email, so that they can be part of the written record. That would be very useful. But thank you very much. Next will be Tim Lerew.

MR. LEREW: Thank you, Dr. Markowitz and Board.

This morning I spoke with Richard Anderson, a retired Y-12 engineer, who is married Janine Anderson. Some of you know Janine from her work with getting the original energy employees compensation act passed. She was present at the White House on October 30th, back in 2000, when that was signed into law.

Eight years ago, we had our first National Day of Remembrance, and we can thank

Janine and many others, but especially Janine for her work with that. I had sent earlier in the day, an email to Carrie, that might be forwardable to the Board members if that's possible, Carrie, with a short one and a half minute video of a news piece on that first National Day of Remembrance and how it came to be.

This year, starting at the end of this week and into next, we'll have our eighth National Day of Remembrance around the complex, 10 different sites, including the Doubletree Hotel here in Oak Ride, on Monday at 10:00 a.m., and anyone in the audience of course, is welcome to participate in that.

But one of our missions at Cold War Patriots is to keep the memory of the 700,000 men and women who have worked in the nuclear weapons complex alive. You know, the complex is a shadow of its former self. We're going to be down to 1550 operational warheads next couple of years, from the peak of 70,000 that many of

the men and women here and around the country helped create.

But the human legacy is going to go on for decades yet. The work of this Board is going to be instrumental in meeting the ongoing health needs of that human legacy, and we're just very, very appreciative for the hard work you've done and will continue to do on behalf of the worker community. Thank you.

CHAIR MARKOWITZ: Thank you. Next is Tee Lea Ong.

MR. ONG: Hi. This is Tee Lea Ong, Professional Case Management.

First of all, thanks to the Board, as well as Dr. Markowitz, for allowing me to speak, as well as the incredible amount of work that you put into this.

I sat through the April event and yesterday and today. So, I really appreciate the in depth discussion and analysis you've done on the topic.

Please continue on. This is going

to be very important for a lot of former workers out there.

The topic I'd like to comment on, it will be brief, is that it -- the headline is still medical second opinion, but it is timely that Rachel Leiton this morning brought up, the role of the nurse consultants.

I would urge the Board, especially the two subcommittees, primarily the medical evidence subcommittee, secondarily, the one on CMC, to take a look and perhaps help the sick former workers and other stakeholders understand the scope and medical practices of these nurse consultants, because as -- especially as it relates to the MSO. What is in scope, what is out of scope, perhaps the experience and expertise within the certain illness categories of these people, the training that they brought with them to the job, the job description, as well as perhaps initial onboarding training, when they joined the Department of Labor, as well as ongoing

training.

It's a very similar topic, I know the Board spent a lot of time on, in terms of claims examiners, what is the background, what is the training, what's ongoing training?

I think similar attention -- guidance from these two subcommittees, especially by the Board, would be very important, because we want to make sure that there's ongoing attention paid to make sure that what's in scope and out of scope is clearly specified for everybody.

There are two topics related to that, and it's related to what was brought up on day one by Dr. Markowitz.

One is that if there are changes proposed to the roles, the scope of these positions, nurse consultant positions, then it ought to be communicated in a timely fashion to this Board, as well as to all stakeholders.

As I understand from day one's communication, there are oftentimes bulletins

and transmittal sheets and so on, that does not make it in time to people, for them to comment on ahead of time, before the changes are made, especially for this Board, which is well positioned to advise people on that.

Secondly, there has been a history of topics that were not spelled out, but -- or rather it was spelled out in one way, in procedural manuals, and current practices, but it slipped over time, due to scope changes or scope creep and so on, and over time, it became -- while we're not changing any rules, we're just codifying what's current practice anyway.

So, that will be a very important topic for the Board to take on. So, I just urge the Board and the Department of Labor to pay special attention to the role of nurse consultants, their background and expectations and scope, especially as it relates to medical second opinion. Thank you for your time again. Safe travels.

CHAIR MARKOWITZ: Okay, thank you.

Next is Janet Michel, and then as she's coming -- I just want to, for the next people who are going to speak, I just want to reassure you, sometimes people get a little nervous speaking in public or whatever. Don't worry about that. We just want to hear stories, we want to hear about issues. We are on your side on this -- on the issue of improving the compensation program. So, we're all kind of in the same place.

MS. MICHEL: Hi, and good afternoon, and thank you for the opportunity to speak. I am Janet Michel. I'm a first-generation Oak Ridger, and born to parents who both worked at K-25, and I worked at K-25, and I apologize for being late, not being here on Monday, but I've been very sick with bronchitis, probably hear me coughing in the back, and I've been working on these issues since late 1995, as my health has allowed me.

I started with the group called The Exposed and then Coalition for a Healthy

Environment. As president, it was a non-profit. We incorporated, and it was a support group, and then with ANWAG.

With a Coalition, we held many public meetings in East Tennessee. We made many trips to D.C., to educate both the Executive and Legislative Branches of government, and we wrote hundreds, if not thousands of letters to newspapers, agencies and elected officials.

In my professional capacity, I worked as a pollution prevention project manager, and I spent two years at DOE headquarters. I visited many of the DOE sites, and I organized and ran DOE-wide technical conferences, put on training programs and ran many projects.

So, with all that said, just to kind of tell you who I am, I waited -- I became disabled in 1996. So, just to let you know, things were not perfect in 1995, as I think you understand.

In 1996, I worked in the barrier plant at K-25, which is where they processed the nickel. So, in that letter that you received, Dr. Markowitz, I am the person that was the Development Associate 3, which tells you nothing about what my job was, and I was exposed to nickel in the barrier plant.

So, because of the way the law was structured, it didn't make sense for me to file a claim until about -- until 2006, and during all this time, I had researched nickel. Incredibly, I submitted 3,000 pages of medical records and medical journal articles, some of which Dr. Silver helped me find. It was -- since I don't have access to the libraries at universities, and all of this was cross-referenced in three-ring binders. I basically did the job for my claims examiner, with maps of the site, and all the things that I had been exposed to.

But I was denied twice, and I requested my complete file and I saw the SEM

that was used to look at my claim, and it was pathetic.

So, it -- part of it, I think was probably my job title that threw them off, and then maybe part if it was a nickel study that was done in the early 80s, where DOE had contracted with Oak Ridge Associated Universities. I don't know if you are aware of that study. It's a pretty pathetic scientific study, where the conclusion is stated in the hypothesis, and if you haven't seen that study, you might want to take a look at it.

So, anyway, I finally was approved for nickel, but not any of the other contaminants that I had asked for, and I was also approved for 14 consequential conditions, but the diagnosis codes that I was given, about half of them made absolutely no sense.

So, before I even received my money, I wrote a letter. I got no response. For six years, I have written letters. I have called. I have faxed and no one had ever responded

about these crazy diagnosis codes.

So, finally I went to the resource center and I was told, you have to re-file your claim. So, anyway, I'm not going to go into all that.

I wanted to say that in addition to what Terrie was saying about the toxic soup, some of the things that have happened at K-25, that you may or may not have heard about, are the cross-connection of pipes that took place out there.

This was another thing that we uncovered as our -- with our sick worker group, where potable water and process water got cross-connected in the pipes at the site, and Richard Anderson, who Mr. Lerew talked about, Janine is one of the people that I worked with a lot on this issue, and Richard still has the draft report, that has all the engineering drawings that shows all these cross-connected pipes.

This was all turned in to DOE and it

came back 25 pages that basically said, if there is a problem, we'll fix it.

So, this is the kind of thing that comes out of DOE.

Another thing that happened during this time was the cyanide problem, where they did relining of the old sewer pipes and super-heated this epoxy resin, which gave off cyanide compound. So, every person on the site was exposed to that. So, those are just a couple of things. I will try to hurry, okay.

CHAIR MARKOWITZ: Yes, because we have a lot of people, so I need to ask you to wrap up.

MS. MICHELLE: Okay, that's what I'm doing.

Okay, so, I just want to say that I see sort of two choke points in the work that you all are doing, and one of them is the claims examiners, and of course, I'm seeing this from my viewpoint.

I've had many claims examiners over

these years, only one of them has been helpful, and most of them act like they have a chip on their shoulder. Most of them seem like they don't care.

So, I know you guys are working on that. I don't know if more training is needed or whether different ones need to be hired, but that seems to be a choke point in the whole process.

The other choke point is, no matter how many issues you all are dealing with and the in-depth that you are going through and looking at all these issues, the choke point is whether DOL will accept them and implement them, and I just am hoping and praying, because we have wanted so long for this Board to come into being, and I just hope that it will happen. So, thank you for your time.

CHAIR MARKOWITZ: Thank you, and just to remind you, for those of you who don't get to say everything that you want to say, we welcome written comments.

Donna Hand is next, and I forgot to say that people need to really take just three or four minutes for their remarks.

MS. HAND: I'll be very quick and try to get this done and taken care of.

OWCP was committed to helping claimants. It says so in the statute, and it is mandated by 42 USC 7384(b) that they shall, the CE shall develop pertinent facts relevant to the claim. That's binding, weight of law, force.

It also in the rules and regulations, which is binding, the OWCP exposure matrices are site profiles of toxic substances. Toxic substances is defined as any material, because of its radiological nature, chemical nature and/or biological nature.

As we spoke to DOE, when they were talking about the proposed beryllium rules, beryllium compounds is soluable and insoluble. So, there is a different biokinetic. So, there is a different health effect.

You know, you inhale, you ingest, you absorb, and it comes through the wounds, as well. So, you've got external, internal exposure. So, it's -- and this is what a case examiner normally wouldn't even address.

But this is what the IHs should be addressing. Was it inhaled? Was it soluble? Was it insoluble? You know, does it have a possibility? Is it plausible, a potential?

From the very beginning in 2005, when Part E was implemented, into October of 2004, the policy procedure manual kept on insisting for the CEs -- it doesn't have to be 100 percent. It doesn't have to be definitive. All it has to be is plausible, potential exposure. That's it.

Does that toxic substance have the plausible or potential to do that? In fact, the OWCP in the regulations, interpreted significant factor to mean any factor.

Also, when they did the DMC handbook, which is now the current CMC

handbook, the medical director and the solicitor got together and said OWCP will use the Federal Rules of Evidence and make it reasonable suspicion. So, it's got to be more than a reasonable suspicion, but less than the preponderance of evidence.

So, you've got less than 50 percent, but you have more than a reasonable suspicion. The EconoMatrix was the one that said, well, if we're going to do a site exposure matrix, let's make it a two to one. If the risk is more than a two to one statistical, then we're going to say that that actually causes it. That's a known established causal link.

When the SEM finally became public, that's exactly what it says, these are known toxic substances with a known causal link. We do not address aggravating or contributing to.

They will list, and in fact, even now, you can go to and you do pulmonary disease, without a site, just go to pulmonary disease, and it will list 25 agents and 19

processes.

You go to X-10, it lists a lot less. In fact, and so, in fact, it lists 19 agents and only nine work processes. So, those other 25 agents, are they there or not there?

Also, in the site exposure matrix, in the very front page that they have, quote, when a labor category is displayed with no buildings identified, it does not mean that the worker was not on the site. Instead, it can mean that the labor categories work location on the site is unknown, or in the case of labor categories, such as janitors, guards and groundskeeper, they worked in many locations all over a site.

So, if you cannot find that labor category, then you have to presume again, that they were everywhere. So, the whole site exposure, they have potential to.

The regulation says proof of exposure is did that employee come in contact with? Was it in that building? So, we don't

need a high standard. We don't need medical certainty. We don't need statistics. That was the whole thing when doctor -- when they first implemented this, with DOE, everything, is that it is all plausible presumptions. That's all that's required.

CHAIR MARKOWITZ: If you could wrap it up.

MS. HAND: Programmatic evidence was always accepted, and in the DMC handbook, OWCP gave the references. The references then were to be ATSDR, hazard substance database and some other internet, the NIOSH, OSHA and they could be all used as references.

But when we turn those references in, especially you know, coming from the internet part of the NIOSH or OSHA, they will not accept the programmatic evidence, but regulations and rules says you can.

We even used the same reference sources that the CMCs use to confirm our claim on toxic substance. They refused to accept

them.

So, basically, I will be turning in other things to address other issues, but we need also for the Committee on the Chronic Beryllium Disease, to define chronic respiratory disorder, because that's one of the issues and also, the characteristics of the X-ray abnormalities, they list in a procedure manual, but that should not be limited to, because in the reference sources that I have found, you can have a normal chest X-ray and still have chronic beryllium disease.

So, these are a couple of issues that needs to be addressed and I will follow up.

CHAIR MARKOWITZ: Thank you very much. Etter Pegues.

MS. PEGUES: Good afternoon. I thank you all for listening to me today. My name is Etter Pegues and I am the widow of Eldred Pegues. He worked at Y-12 for 32 years. Sadly, he passed away on January of 2015, with

lympho-myeloma, bone cancer.

While he was there working, Eldred came down with -- he had a problem with a tumor in his head, and it was protruding out his eye, and we had to go to -- go to Vanderbilt, because there was no one here in Knoxville that -- Knoxville or Oak Ridge that could help him.

So, we had to go down there, and they was able to shrink that tumor, but a few months later, the cancer came back in his shoulder. He had to have rotator cuff surgery. The tumor -- I mean, the cancer ate up two of his ribs.

Few months later, then he had to have a partial hip replacement and a few months later, he end up having to have -- he broke his femur bone, just crossing his leg, and the doctor told him, he said that -- his bone was so fragile, just brittle, that it's just like a Mack truck had came in and hit him and just broke every bone in his body, and in 2014, he was just sitting, and he just broke

his bone here.

But some of the things that, you know, he went through -- he went through a lot with that, and some of the areas that Eldred worked in, he was a machinist, but he was there for 32 years. He was a machinist. He worked in the landfill. He worked in laborer. He was a chemical operator. Some of the areas he worked in, he worked in Alpha-5, 9201, 9212, Beta 4, Beta 3, 9201, 9204, and he was exposed to benzene, beryllium, plutonium, which he was grinding tubes that was contaminated with -- in the hot area there, and ferrum and uranium, in the depleted area there and they also had some type of little chemical fire or something during the time he was there.

So, he was exposed to a lot of things. So, he wasn't just confined to just one area there, at all. So, I just wanted -- I'm just glad, you know, to talk to you all about him. I'm glad you all are not just focusing just on the diseases and things that going on,

because there -- I'm glad you all are looking at some of the exposure that these workers, you know, affected by there in the plant. So, I thank you for listening.

CHAIR MARKOWITZ: Thank you very much. Dorothy Colquitt.

You know, I'm wondering, can we move the microphone to her, to make it a little easier? Up to you.

MS. COLQUITT: Good afternoon. My name is Dorothy Colquitt. I worked at Y-12 since 1980 to 1999.

I am a victim, I guess you would call -- say, of nine borderline and abnormal results from beryllium. I worked there in packing. That's where I came into contact with the beryllium parts.

I was working one day and I found out that my arm done got as white as a piece of cotton. I'm sorry, and I asked my supervisor, I said, what is this stuff on me? Oh, it's nothing. Don't worry about it. I said, yes,

it's something.

So, he said, well, I'm going to call Health Physics and let them come and do air testing, and I said, I think you need to do that.

So, he did, and he said he got back a negative result. But my hand -- arm, from my finger tip to my shoulder, I had rolled up my sleeve and pinned it, was white as this paper, and I started wearing the face mask, little paper thing you cut grass in, and I believe that's why I'm still alive, because we did a lot of those parts, shipping them out. When the bags come in, you had to take the bag out of a locked container that -- you had to pull this bag and then pull the part out.

But I'm just wondering what's going to happen to this. Dr. Ficker talked to case workers, downtown Oak Ridge, and this guy was very rude to him. I hate to say this. I hope nobody is here, that work. But he was rude to him.

So, in the meantime, Dr. Ficker called me that afternoon. He said, Ms. Colquitt, this guy in Oak Ridge has got the wrong information on you. I said, well, how did he get that? I don't have any idea how he got information on me, he said, but he did, and Department of Labor is trying to -- you know, deny this, and they did deny it.

Every time that these -- well, I get -- I don't know who send forms in now, to them, but it's been denied two or three times, and I'm just wondering why, you know, they are denying me, because I've had nine studies done, and five of them was borderline abnormal. The other four was borderline normal. So, I don't know what's going on with my body. I don't have no idea.

If you all would, if you get a chance, kind of check it before I leave here, if you would, and another thing, I like to thank Mr. Whitley. He's been very nice. Very nice. Call him anytime. He's same thing, but I

thank you, and you all have a blessed day.

CHAIR MARKOWITZ: Thank you. Thank you very much, and yes, we'll be in touch. We'll be in touch. Susan Adkisson.

MS. ADKISSON: My name is Susan Adkisson. I just wanted to discuss a case that I worked on.

This gentleman was a fireman for a short time at K-25, not long enough to be special exposure cohort.

He then transferred to Y-12. He came down with B-cell mantle cell lymphoma, non-Hodgkin's lymphoma. At the time his claim was in process, we searched the SEM database and there was a link to diesel and gasoline exhaust.

The SEM sheets were printed. He took his exposure history and the SEM printouts to his physician at Vanderbilt. Discussed what he had done in his work with the physician, who wrote a well-rationalized letter with regards to benzene which is a component of the exhaust

fumes.

The fire engines were started daily in the fire hall with no ventilation. Some of the firefighters did request that ventilation be put into the fire hall. To my knowledge, that has not been done yet.

During the claim process, there was an update to the site exposure matrix. The gasoline and diesel exhaust fumes were removed because they were mixtures of compounds.

So, at the time, a few months later, his claim was denied for that reason. He passed away. The family had an oral hearing with the final adjudication branch, discussed the site exposure matrix issues with them, and they were told well, it could have been in reverse.

The exhaust fumes from gasoline and diesel could have not been in the SEM, and it could have been added, and then your claim would have been approved.

They also objected to the fact that

no IH or CMC review was done on this case. It never was done. So, to date, the claim is still denied.

There was another fireman who worked in the same area at Y-12. He had been a fireman at X-10 prior to going to Y-12. He has the same type of cancer and is fighting a denial on his claim at this time. Thank you.

CHAIR MARKOWITZ: Thank you. Sherry Oran.

MS. ORAN: Thank you for hearing me today. I hope you'll bear with me, because I really wasn't prepared to speak today. I have a few papers with me, though, and I would like the opportunity, if you'll bear with me.

I worked at K-25 and ORNL for 10 years. I had several job classifications, but I believe that my problems occurred when my office was located at K-1200 near the TSCA incinerator, and at that time, I was in telecommunications, and I went throughout the plant, all over the place, being in

telecommunications, as well as some of the other plant sites.

I'm glad to hear the discussion of the respiratory illnesses today because COPD, I do believe my problem was caused by inhalation from TSCA.

COPD and the whole umbrella of COPD, including asthma and bronchitis is sometimes hard to tear apart, even in a hospital stay or with your physician, sometimes the terminology is quite interchangeable, and so, I appreciate you addressing this today.

I was a young mother of two children. I was a single mom. My career had just started. I was finally an exempt employee at K-25, and I suddenly started having COPD-type symptoms that were just unreal.

I would wind up in the hospital for up to 30 days. People think asthma is just little squirt of an inhaler and go your way and breathe better. We're talking about lying in the hospital for up to 30 days at a time, with

IVs, with Solu-Medrol, Decadron, PICC lines because your veins are going, and ultimately, ports implanted.

I would get out of the hospital, I would try to go back to work, and Medical would send me home, or I would wind back up in the hospital through the ER. Approximately nine or 10 hospital visits in three years during that time. So, it was very severe.

In fact, I got on Social Security much quicker than even some people I know who developed cancer, and I would like to say that I went to my closest coworker's funeral, with brain cancer.

Like I said, I wasn't prepared here. I do have some paperwork though. I'd like to just cite one or two things for you.

I was denied and then my request for reconsideration to reopen the case was denied, and there were two words used earlier today, that I made note of, commonsense and rationale. Okay, and I want to cite two of the -- two of

the statements, when I was denied for reconsideration, and this is actually the first one.

You state that the final decision and recommended decision were in error in finding that you were diagnosed with bronchitis in 1965. Yes, I had some childhood asthma. At the same time, I had gone to UT. It had been 12 years since I had any problem at all, and I'll address that here in just a second too.

That diagnosis of bronchitis -- and the diagnosis of bronchitis was made in 1989, one year after you started your employment.

A review of the record shows that you were first diagnosed with acute bronchitis on November 17th, 1965. Three years old, I had bronchitis.

You have not submitted any new argument or evidence to dispute the diagnosis of acute bronchitis. I wasn't trying to dispute it.

There is no new argument or evidence

to warrant reconsideration.

My FAB hearing officer found the fact in my records. It was in my medical at K-25, that says that, you know, the patient has come in with bronchitis now, bronchitis-type symptoms and has not had any problems for 12 years.

Number four, you state that the recommended denial was in error in finding that you did not submit sufficient medical evidence for a pre-1993 diagnosis of CBD. You state that facts were ignored that show asthma had been resolved for 12 years, that work records diagnosed a respiratory illness before 1993, and the decision ignored the physician's letter stating you had abnormalities characteristic of CBD.

The diagnosis of asthma was made in childhood in 1965. Work records show ongoing treatment for your asthma and bronchitis, but do not show that exposure to a toxic substance used in the production of atomic weapons was a

significant factor in aggravating, contributing to or causing your bronchitis.

The medical record from Dr. Keith Kelly dated August 16th, 2012 indicates that he reviewed chest X-rays from November 24th, 1999 and April 4th, 2000, and a pulmonary function test.

Dr. Kelly indicated that these findings could be characteristics of abnormalities of CBD. He did not make a definite diagnosis of CBD or bronchitis.

I do show a trace amount from Dr. Markowitz's study of CBD in my blood. But it's not up to the limits.

I did have a hearing, and the hearing was actually stopped and muted. I don't understand why, but there was conversation going on, on the other side, and I said, okay, all you need is a letter from Dr. Kelly, stating this fact. I said, so, that's all that I need to prove -- prove my illness, and they said yes. That's in the transcript.

So, I feel like I was lied to, even in the hearing, and it has been an -- you know, I have not even looked at my case, you know, for two years. I just now wrote to Jacksonville and requested the paperwork be sent back to me, because I felt like it was time to review it again, and so, I am very happy to hear you talking about the --

CHAIR MARKOWITZ: Ms. Oran, I need to ask you to wrap it up.

MS. ORAN: Certainly. Certainly. But to wrap it up, I submitted all factual evidence, affidavits from coworkers, letters from the doctors. I did meet all criteria that I was asked to meet, that occurred at the hearing.

I would just like to say briefly, that when the EEOICPA was signed into law, it was signed into law to help people like myself and all the other workers, but we've seen the administrative cost increase. We've seen the number of approvals decrease and we're seeing

people in our community die before they get approved. Thank you for the opportunity to speak.

CHAIR MARKOWITZ: Thank you. Next is Shirley Watkins.

MS. WATKINS: Good afternoon. I appreciate the opportunity to speak this afternoon. I am Shirley Watkins, and I worked at the Y-12 plant in 1969 to 1973.

I worked at the Y-12 plant from 1969 to 1973 and I was diagnosed with Parkinson's disease in 2012.

When I was working at Y-12, my office was off of -- in the area where machinists and welders worked. It was about 150 feet from where they worked.

The toxin that I have in my body was mercury, and the Beta building, one of the Beta buildings that I worked in was known to have a lot of mercury in there, in that building.

When I was here, it came to my memory yesterday, that I was -- I had tremors,

internal tremors. I thought it was dizzy spells, that I was going to treat -- was treated for, and that's the thing that was really prevalent.

The thing that got me, they disproved this 40 years later. You know, I claimed injury compensation, but this is -- this disease is really crazy. It -- no two people are affected the same way. It's just affecting me differently. I just thank God that I was able to work as long as I did to be able to get retirement, because you know, I couldn't make it otherwise.

But anyway, I'd like to see my -- I was a secretary, stenographer, and I'd like to see it be part of the SEM, because it's not the disease or my position was not a part of the SEM. So, that's all.

CHAIR MARKOWITZ: Thank you. Thank you very much. Next is J.B. Hill.

MR: HILL: Good evening. My name is J.B. Hill. I am a sick worker and identified as

a beryllium worker.

Now, not necessarily sure, and was still classified as that. There's some, what we call, information that's not been passed on on a regular basis. But I do want to say that I'm glad to be here this evening, to see each and every one of you. Hope that you have a pleasant stay in our atomic city of Oak Ridge.

I started to work at the Y-12 working plant in 1970, April of 1970. I came here from the military to work in the T&T, that's training and technology facility, at the Y-12 working plant. There, I taught non-destructive testing. It has to do with X-ray, has to do with ultrasonics, eddy current, liquid penetrant examination. I am an inspector, a third level degree inspector. That means I went through the training of level one and level two, and got certified as a professional, as a level three.

So, when you talk to me about non-destructive testing, that's my bailiwick. But

nevertheless, I'm glad to see each and every one of you, like I said before, and I wanted to say, put a little plug in, and say something about the doctors on the panel. I don't know how many are here on panel.

But it's good that you're here, because in Oak Ridge, the doctors, for some reason, are not in our favor. The doctors are not in our favor in Oak Ridge.

Give you one -- one example. I didn't want to get into this, but let me say this. We had a doctor who would diagnose his patients with illnesses that was related to exposure at the plants. Well, that doctor is no longer here. They ran him off because of his opinion.

But nevertheless, there are doctors here, and when you say get a doctor's opinion, I kind of smile, you know, get a doctor's opinion. Yes. Okay, but nevertheless, in my case, as I said, I'm a beryllium worker. I'm hoping that being a beryllium worker will keep

me in line with the -- what we call the health effect program that they got going on, where you actually go every so often, to get examinations, and I was talking to the doctor here, about that.

I was last diagnosed as being borderline. What does that mean? Borderline? Either I got it or I don't have it. That's what we're here for. Do you have it or do you not have it, and if you've got it, what can we be doing -- done about it?

I'm sitting here, been here all day, yesterday and the day before, just sitting in the back, looking and observing. But I do applaud your efforts for coming here to Oak Ridge and seeing what Oak Ridge is about, because Oak Ridge is a secret city, so to speak. There's a lot of secrets still kept.

There is a sign that I do -- posted for the visitors. I didn't bring it with me, but it's one that says, what you see here, you leave it here. You don't take it with you.

You leave it here. Asa cautionary measure.

But nevertheless, after spending 33 years at the plant, I retired in 2003. I applied for compensation and been denied, and I'm going to apply again, but I was hoping that it was some direction that would -- hopefully, before I leave here, there will be some direction, which way I should go with my next steps, because there is a lot of people who applied for the sickness for the compensation, and not been given the opportunity to apply again, or they -- like the lady said, there was some individuals and I had some conflict with Jackson Square also. There's an individual up there, he really doesn't need to be there because he's not in our favor. He's really not in our favor. I don't know what's wrong with him, but the fact is, something needs to be done about that.

But nevertheless, let me get off that. This Advisory Board, hope you can do something positive, and as an action item, I

know you had some recommendations, but as an action item, I would ask that you would actually make sure that the individuals, the workers, the -- whether they're sick workers or beryllium workers, let them be aware that they're being followed, and what I mean followed, that means that we haven't forgot about you.

I'm a sick worker. I'm a beryllium worker. But right now, I'm not sure what I have -- what I am. I don't know how they got me classified now. All right?

CHAIR MARKOWITZ: Okay.

MR. HILL: Thank you so much.

CHAIR MARKOWITZ: Thank you. We're going to just a little bit beyond 2:00 p.m. Next is Carl -- we have two more speakers, Carl Richardson.

MR. RICHARDSON: Good afternoon. I'm Carl Richardson. I've worked at X-10, Y-12, K-25, all these plants. I just received my 50-year reward this week, belonging to

International Brotherhood of Electrical Workers here in Oak Ridge, and I filed a claim and it's been four or five years ago, and what happened, I had a melanoma in my right eye, and very thankful that, going to Memphis, that they got -- I go every six months, that they got that cleared up.

But anyway, I'll be fast. I know you in a hurry. You want to get out of here.

But anyway, I was denied, like I believe 2/13, right at early 2/14. But anyway, they agreed with -- that I did receive a certain dose of radiation in my right eye, from places of work, back in 1969 at Y-12, and no monitoring very hazard conditions, then in the 70s, then you come back and see them dressing you out, later years, shoes and all and it scares you.

But anyway, the reason I'm wanting to say this, maybe it will help people that's going to file a claim. You know, one of the questions they put to you first thing is, what

chemicals were you exposed to, hazardous chemicals?

Well, back late 60s and 70s, they didn't tell me what chemicals I was exposed to, you know, and then after -- I got denied here, I get on the computer and do research, there's a lot of them, you know.

Now, what I'm saying, that ought to be brought out to new clients, if you say, I worked in Y-12 in Building 5 in 1968, they know exactly what chemicals was in there. It's on the computer, you know.

But now, anyway, there was -- we all know, very little monitoring. All I had was a film badge, and but anyway, they made me feel good. They said they were going to -- being as they knew that I had a certain amount of radiation, that they would send this to the reconstruction, is it N-O-I-S-H, and then in a few weeks or months, I don't recall, they come back and measured in rems, the dosage that I got to my right eye, and that it looked like

that would be a plus, the way it was stated. I paraphrased this for, you know, my approval.

But anyway, a few weeks later, I got another letter that showed they were revision in my reconstruction. They lowered it. Then I got a denial and then, of course, I sent them a letter that I wanted another review, and I had a video conference and all that.

Then they sent me my final letter, and I was denied. Now, one thing I think people ought to be informed more, even the -- back in the 60s and 70s, about really what hazards was I working in. You know?

I mean, I knew three or four I put down, but I had no idea, you know. I'm just an old country farm boy. I had no idea what was going on.

Well, then they need to do that, let people know, and give them a list, right here is everything in Building 5 or -- I worked in many buildings over there that were hot and mercury all over everything and demolition and

putting in new systems, electrical.

But what I'm saying is that people needs to be aware when they fill these forms out, what they been into, you know. They don't know. They're ignorant, like I was. They look on the computer and do some research, you could find out. You know, well, that and another thing is that I don't feel good about and of course, I've told them, which is my indifferent, but about this uncertainty with NIOSH, based just consumptions and stuff, because you don't have no real data that you can do with it, and I was just disgusted when they revised this, and all, about that, but I am sure they need to work on a different system to calculate someway better, about where there was no monitoring, you know, and I'd appreciate if you all can do something to help in that aspect, you know, and help in getting clients to understand hey, I was exposed to all these, you know. All these, you know.

So, that's all I have. I appreciate

it. Thank you very much.

CHAIR MARKOWITZ: Thank you. Thank you very much. The last speaker is Hugh Newsom.

MR. NEWSOM: Thank you very much. I want to address a couple of things that, I filed for claim back, couple of years ago, based on cancer, and I also had pre-cancerous growths on my head, which the dermatology that I sought consulting with, which he said if I don't have those removed, they'll eventually turn into melanoma, which I go every six months and have removed.

In the dosage that I listed and the people here in Oak Ridge, I want to pay a compliment to them, in helping the -- get the claim documented and everything.

When the dosage came back, it listed me working at Portsmouth from 1975 to 1999. I didn't know where Portsmouth was during that period of time. Then it listed Paducah, Kentucky, periods of time from 1996 to 2013. My

last trip to Paducah, Kentucky was in 1999 in January, where I closed out my Coast Guard career at the Marine Safety Office there.

I have noted these discrepancies in writing, in the hearing that was conducted here in Oak Ridge, teleconferencing with the Department of Labor hearing officer, and submitted a copy of my resume. He didn't accept that. He says, why should we accept that? I said, well, everyone else does.

So, I had to go back to TVA, which I was employed from 1963 to 1989, and get them to write me a letter documenting my employment.

As of today, I have not received any acknowledgment of the correctness of that dosage records in writing, verbally or otherwise.

Now, that leads me to one thing. How many -- how much in error is the dosage record that my denial was based upon, the actual real dosage records?

I've been to every plant with the

exception of Hanford. Some of them, you exited through monitors. Some, you didn't. I've been in every building at Y-12, 98 percent of them at X-10, and those dosage records don't show up, but I'm still saddled with Portsmouth and Paducah.

Now I admit, I was at Paducah in 1991, as a consultant on an audit, but otherwise, I have never been to that plant, and I have -- it looks like 12 visits listed here that's in the documentation.

Now, if this collection process is this bad, somebody needs to look into it.

Now, I talked to some people on the phone about it, and their reply was, hey, we don't make mistakes. So, what -- what was my alternative?

CHAIR MARKOWITZ: We'll have to remember that one.

MR. NEWSOM: Now, before the hearing, I thought, well, maybe I need legal counsel. So, I called up one of these law firms here

that's quite active in this field. They advertise as they are, and I went over my record with them, cancer, and they said, has it metastasized, and I said, no. What about your pre-cancerous growths on your head? Have they developed into melanoma? I said, no.

Well, they said, you ain't going to get no compensation then, because it's got to metastasize, that cancer's got to metastasize first, or you're going to have to develop melanoma, or they're not going to pay you anything, and so, that's where I'm at, and they kind of equate to this process, to the book that John Grisham wrote, called The Rainmaker.

Some of you probably are aware of that book, where the insurance company's policy was to deny all claims at least three times. I hope this is not the process, this organization is doing.

But this is -- is kindly -- what do I do on these dosage records? I know it's an error, but nobody will listen to me. So, I'm

kind of left at a place where if no one will listen to me, what do I do?

I do want to pass one compliment, the Energy Employee's Compensation Resource Center here in Oak Ridge is very helpful. They're very active. One particular person, Josh Philips there is very helpful, and I appreciate your time. Thank you.

CHAIR MARKOWITZ: Thank you. That completes our public comment session, and I'd like to just thank people again for attending, for sharing your stories. I know it's not easy to talk about some of these things, but we appreciate it.

Is there any other member of the Board who wants to make a comment to the public, briefly? Ms. Vlieger, yes.

MS. VLIEGER: I just have one comment for everyone that presented information here today at the Board.

You have a representative from the Ombudsman's office from D.C. here. He's in the

back, Malcolm Nelson. You need to address each and every one of your concerns about the inadequacies or difficulties with the program, to his office, and he may be able to offer you some constructive information.

(Applause.)

CHAIR MARKOWITZ: Okay, sure. Have a seat and you -- have a seat, so we can hear you at the microphone.

MR. DAN MORGAN: This is what your head looks like when you have skin cancer. I've had a bunch of them. My wife will tell you what kind I have.

But one of the things is, I've worked at the Y-12 for 31 years. Been in every building over there. Been exposed to everything over there.

One of the things that I think is interesting, and I'm sure others have the same problem, is that I told them that my biggest time for exposure was from 1958 to 1963.

After that, maybe the supervisors --

at that point, I gave up, but in 1963 I went to work at -- I graduated from UT in Knoxville and went right to work in computer science, and one of the things I discovered is, it's hard to believe really but -- I'm kind of nervous here.

MS. NONA MORGAN: Are you talking about your records?

MR. MORGAN: Well, the --

MS. MORGAN: Are you talking about your missing records?

MR. MORGAN: Yes.

MS. MORGAN: Well, tell them about it.

MR. MORGAN: Okay.

CHAIR MARKOWITZ: You can both speak, if you'd like.

MS. MORGAN: I can't give you the dates, but he has a block of missing records. Well, you know, you make good money working at -- he worked at Oak Ridge, and those records are missing. How could that happen?

Now, we're both 89 years old, so

we're really worn out, but I was a teacher, and matter of fact, I taught filing for a while, and I just don't see how they could have lost his records, and I think it's not only his, both other's.

His time was at Y-12, and after he was supervisor, I got calls 24 hours a day, because he was being called in all the time, and my boys have -- I have two sons, and one of them was so disappointed, he never got to see where his dad worked. You know, that's big secret.

So, now, we have the big secret of where are his records, and maybe there's nothing could be done about it. He's had more cancers than I can count.

One doctor retired couple years ago, so he has a new one, and I mean, they know it's a real, real problem, and he had surgery in June and the first of September.

Those were just three times, those three times. One time, as many as five

biopsies.

Now, the first doctor was going to do one. I don't know why, the difference in their training, but they'll only do one at a time. So, went to the doctor a lot of times.

So, anyway, I butted in because like I said, our parts are worn out. We're 89.

CHAIR MARKOWITZ: Right. Well, thank you so much.

MS. MORGAN: So, what can you do for him? He has a whole mess of stuff here, and the young lady who called and talked to me about making this trip, and then I'm seeing all these people whose names are called. Well, maybe we just got listed.

He was denied. Somebody in Kentucky named Daryl, as his advisor, and he has said -- of course, our parents are gone, but his parents, his spouse, his children, even his grandchildren, could pursue, I guess they're waiting on him to die. You know, sometimes, only the good die young. So, here we go.

But he said his thing came back final. So, I called Darryl and I said, what about this final? Well, final is really not final.

So, that's kind of hard to figure out, and listening to all these other people, and your attention has been -- I've got to tell you all the way around, I grade everybody, because I taught for 25 years. But the attention has been pretty doggone good. People writing notes. Well, they could be playing tic-tac-toe.

CHAIR MARKOWITZ: Not really. Not really. So, no tic-tac-toe here.

MS. MORGAN: Okay, writing notes. But anyway, here were are, and I thought since we got the call and I talked to this young lady, she sounded young, about the final not being final, and I figured, did that many any sense to you, and she said, no.

So, that's why we came up here. We live on Signal Mountain, and it's not a bad

trip, but you make an effort. You don't come and just, you know, have lunch.

CHAIR MARKOWITZ: Right, okay. Well, thank you very much. Thank you for --

MS. MORGAN: So, what can you do?

CHAIR MARKOWITZ: Well, you know, actually as Ms. Vlieger said, the Ombudsman for the program is in the back. He's about to stand up, and you can talk to him, because he really helps people. So, thank you.

MS. MORGAN: So, thank you for listening to me.

CHAIR MARKOWITZ: Thank you. Carrie, if you get their name for the record.

Okay, so, one final announcement for the Board. Actually, Kirk Domina reminded me.

We looked at the calendar. To have a subcommittee meeting, before the middle of December, would probably be important, right, because things tend to get slow by middle of December.

If you go back six weeks, that means

that basically, the subcommittee chairs, by next Wednesday, have to arrive on a date to communicate with DOL, to schedule the subcommittee.

So, for the three chairs, and I'll have to remind Carrie, if you could, by next Wednesday, communicate a date for the first half of December, before December 16th, if you would like to have a subcommittee meeting.

Okay, thank you, and this meeting is now adjourned.

(Whereupon, the above-entitled matter went off the record at 2:24 p.m.)

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